Practitioners' experiences of collaboration, working with and for rural Māori

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To understand the unique experiences of collaborating across health and social services in a rural setting with and for Māori with substance use and related problems, two focus groups were undertaken. This preliminary study used qualitative methods, following theory and practice informed by Māori values. Three culturally relevant themes were identified: collaboration as a tikanga (practice informed by Māori values) based practice, whanaunga (relative) or kupapa (traitor)?, and whanaungatanga (relationships) as collaborative practice. These themes highlighted the importance of Māori values in collaborative relationships, and the positive benefits for clients and practitioners collaborating to meet the holistic needs of whānau (family). Several unique experiences of Māori practitioners working and at times living in small rural communities were identified; these included the tensions associated with practitioners who may have existing relationships with clients through roles as family members, tribal members or within the wider community. Enablers to collaboration were argued to exist within the dynamic of whanaungatanga. Understandings and skills in applying tikanga, whakapapa (genealogy), confidentiality, and connecting clients with broader community activities were identified as important aspects in the practice of whanaungatanga.

Addressing the cultural beliefs and practices of Māori with substance use problems has been referred to as the 'crux' of effective treatment (Huriwai, Robertson, Armstrong, Kingi & Huata, 2001) and the 'path to wellness' (Huriwai, Sellman, Sullivan, & Potiki, 2000). Contemporary Māori models of health and wellbeing, such as Te Whare Tapa Whā (Durie, 1994), Te Wheke (Pere, 1984), and Ngā Pou Mana (Henare, 1998), highlight the symbiotic relationship between the individual, the collective (whānau, hapū and iwi), the environment, and te ao Wairua (the spiritual world) (Huriwai, 2002). An attempt to encapsulate these principles can be seen in the recent major health initiative 'Whānau Ora' (family wellbeing). The initial task force report noted that "assurances will be required from a number of government departments and a spirit of collaboration must be embedded between funders, providers, practitioners and whānau" (Whānau ora Taskforce, 2009, p. 5).

In its most basic form, collaboration is "the act of working with another or others on a joint project" (Collins English Dictionary, 2009, p. 338). Craig and Courtney (2004) suggest that collaboration exists as part of a Partnering Continuum that spans coexistence through to partnership (Figure 1). Partnering was proposed to differ according to the purpose, focus, governance, range of participants, timeframes or funding arrangements. This Continuum has been used widely within the voluntary and community social service sector (Public Health Advisory Committee, 2006; Walker, 2006).

Despite the popularity of the model, Craig and Courtney identified that for many Māori, the term relationship was preferred to partnership, which was seen as akin to the

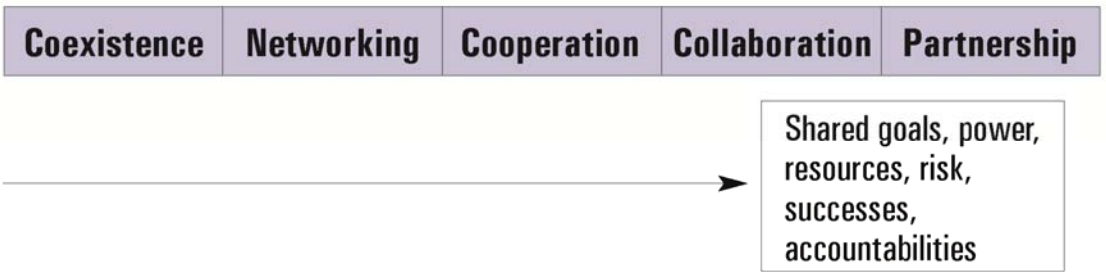

Figure 1. Partnering Continuum (adapted from Craig & Courtney, 2004, p. 38).

partnership principle within the Treaty of Waitangi (the original treaty signed between Māori and representatives of the British crown). Therefore the term partnership was seen as more relevant to relationships between Māori and the crown, as opposed to relationships between agencies and communities.

The Māori concepts and terms most closely aligned with the basic definitions of collaboration are mahi tahi (working together) and kotahitanga (unity). As collaboration is a social concept, a wide range of Māori values inform and guide behaviour around relationships, these include what is and is not appropriate in certain contexts and relationships, engaging in new relationships, status within relationships, behaviour that enhances relationships, and practices that address problems in relationships. Ritchie (1992) argued that it was difficult to portray Māori values in simple or analytic terms. This reflects the interrelated and symbiotic nature of Māori indigenous beliefs. Collectively the beliefs and concepts inherent in Māori values and the practices informed by these values are termed tikanga (practice informed by Māori values) (Mead, 2003). These values both transcend the material world (Ritchie, 1992) and provide the central tenant for maintaining the socially mediated model of health. Māori values relevant to relationships include whakapapa (geneology), whanaunagatanga (relationships, kin and non-kin), manaakitanga (hospitality), wairuatanga (spirituality), rangatiratanga (status) and kotahitanga (unity). Each of these values and concepts also include and relate to other values and concepts. As an example, Mead (2003) identified that the terms tika (right/ correct) and pono (honest/true) were important concepts that underpinned values, and were important evaluative principles for behaviour. Whanaungatanga (relationships) has been cited as the "the basic cement that holds things Māori together" (Ritchie, 1992, p. 67), in fact understanding the dynamics of whananaungatanga and whakapapa (genealogy) have been cited as integral for working with Māori in substance abuse treatment although Huriwai et al. (2001) cautioned that "not all Māori have been raised or live in a 'customary' context and the relevance of 'traditional' values is not the same for all" (p. 1035). This highlights the diverse realities that Māori live in, and the importance of understanding that Māori practitioners and those Māori accessing services may have different understanding, experience and comfortableness with the use of tikanga (practice informed by Māori values).

While the value of collaborative relationships in a therapeutic environment are widely acknowledged, there is a lack of research identifying the specific barriers and enablers to effective collaborative

relationships between substance abuse treatment and ancillary health and social services, particularly for Māori, and Māori in rural communities. A study by Holdaway (2003) on collaboration across primary health and mental health providers captured the unique experiences of Māori community support/health workers in rural and urban areas. Māori community support/health workers reported several barriers to collaboration, including a lack of recognition or respect for "our knowledge and skills from mainstream and others"(Holdaway, 2003, p. 13); a lack of information sharing within and across the sectors, contributing to whānau "falling through the cracks" (Holdaway, 2003, p. 13), and a lack of commitment from all parties in integrating care. This study identified the importance of "partnerships to solve the problems of resources, communication, and coordination in health and social care" (Holdaway, 2003, p.18).

According to the literature, and current national service provision models (Whānau ora) there are strong arguments for addressing the interrelated social needs and cultural needs of those with substance use and related problems. This research project aims to extend upon Holdaway's (2003) work by documenting and discussing the experiences of practitioners from a range of social services that work with Māori with substance use and related problems in a predominantly Māori rural community in New Zealand.

Methods

This study uses qualitative methods that are guided by Kaupapa Māori Research (KMR) principles. KMR was developed by Māori, as a transformative process in order to assert self-determination in responding to the negative health, education and social outcomes of Māori (G. Smith, 1997; Walker, Eketone, & Gibbs, 2006). KMR is beyond a simple description or definition as it has been described as a philosophical framework and theory, a set of methodological principles and processes, and as an intervention strategy (G. Smith, 1997; L. Smith, 1999). KMR does not preclude other methodologies, in fact G. Smith (2000) argues for the utilitarian value of western research practice, arguing for being "open to using any theory and practice with emancipator relevance to our Indigenous struggle" (p. 214). Therefore KMR can be used to shape and inform different research methods. As a theory, KMR engages in a rigorous critique of western theories and practices impacting on Māori, and has the explicit goal of improving outcomes for Māori (L. Smith, 1999). As a guide to research practice, tikanga (practice informed by Māori values) can be seen in each step of the research practice. This includes, the research being undertaken for Māori by Māori; Māori direction, guidance and participation across the focus, design, application, analysis and dissemination of research; and the use of Māori rituals of engagement and hospitality within the research.

Participants

The host Iwi (tribal) service provided a list of key stakeholders (personnel and agencies) operating within the local rural community to be invited as research participants. The stakeholders came from within its services, and collaborative partners from statutory, district health board and non-Governmental health, mental health and social service providers that operated within the local community. Stakeholders were sent an introduction to the study and an invitation to participate. Participants were required to work as paid or volunteer staff members of health and/or social services that work directly with adults 18 years and older who have substance use problems and/or their family members. By recruiting groups with a history of working together there was the opportunity to observe naturalistic exchanges (Freeman, 2006) which underpin collaborative relationships.

Participants completed a group demographics form at the start of each focus

group which included a range of questions related to their demographic status, roles, workplace and length of service in the community. The majority of the 21 participants were either in the 36-50 year old age band (*n* = 10, 48%) or 50-65 year age band (*n* = 9, 43%), female (*n* = 16, 76%), and identified as Māori (*n* = 13, 62%). The largest proportion of participants identified their profession as 'whānau/family support (*n* = 12, 57%), with an even spread of small groups within nursing, counselling, and education (*n* = 9, 43%). Most worked in non-governmental organisations (*n* = 13, 62%), with the remainder working in public health (*n* = 3, 14%), an Iwi based social service (*n* = 3, 14%), and an alcohol and drug service (*n* = 2, 10%). Participants could identify more than one work role, with most engaged in direct client contact (*n* = 17, 81%), and small numbers providing supervision of other staff (*n* = 6, 29%) and management roles (*n* = 4, 19%). Participants identified a significant history of working in the geographical area, with 33% (*n* = 7) reported working in the area for five to ten years, and 29% (*n* = 6) for more than ten years.

Data Collection

Two focus groups were held at the local Iwi providers offices, for approximately one and a half hours each, co-facilitated by authors AM and RH. There were 15 participants in the first focus group and six in the second. Digital audio recordings were made of both focus groups. Each session, following the principles of tikanga was facilitated by a staff member from the host Iwi (tribe) service provider chosen by the host organisation due to their knowledge and skills in Māori protocol. This process was termed a whakatau (settling), and included practices at the opening and closing of each session, such as acknowledging the important spiritual and cultural features and people of the area (whai korero); greeting the participants and researchers (mihimihi); prayer (karakia), song (waiata), and a shared meal.

We utilised a semi-structured interview format to guide discussions. Questions were developed in response to the literature reviewed and the experience of the primary researcher who has a 20 year history of working in community development and clinical settings in the capacity of a youth worker and then alcohol and drug clinician. This included five years working within the geographical area the study was conducted in.

Questioning followed a logical progression starting from (1) a general discussion in response to 'what is collaboration?'. This was scribed on the whiteboard; (2) Participants were then asked to categorise the data on the whiteboard according to whether they viewed them as values or practices. Additional prompt questions were used in these discussions to identify participants' views on any issues which may have been specific to living or working in a rural community, and working with whānau/family with substance use and related problems; and (3) In each focus group, a small group exercise was conducted, with participants forming groups of between two and three people, and discussing and writing a group response to the following three questions:

- What are the barriers to collaboration?;
- What are the barriers to collaboration in relation to working with whānau with substance use problems?; and
- What are the barriers to collaboration for staff and agencies in rural communities?

Groups reported back to the larger group, and written responses were handed to the researcher. All whole group discussion was audio recorded and transcribed verbatim.

Data Analysis

Our analysis of data followed that suggested by Marshall and Rossman (2011). All focus group data (audio transcripts and participant notes) were read and reread

(organising the data and emersion in the data). This was followed by generating categories and themes, coding the data, offering interpretation through analytical memos, and searching for alternative understandings. A constant comparative method was used (Glaser & Strauss, 1967) with authors AM and RH comparing comments for similarities and differences over a series of three meetings. This process was strengthened by undertaking a member checking process which included forwarding typed audio transcripts and preliminary key themes to participants for comment. The acts of peer debriefing, member checking and reviewing national and international literature on collaboration supported the process of triangulation; that is, using multiple methods to "generate and strengthen evidence in support of key claims" (Simons, 2009, p. 129). Finally, a written report and physical presentation was provided to the host organisation and participants.

Findings

There were three key themes identified from the focus groups that represented the participants' views of and experiences with collaboration. These were: Collaboration as a tikanga (practice informed by Māori values) based practice, Whanaunga (relative) or kupapa (traitor)?, and Whanaungatanga (relationships) as collaborative practice.

Collaboration as a Tikanga (Practice Informed by Māori values) based Practice

It was evident that participants viewed collaboration through the lens of relationships established and maintained through Māori values, as opposed to collaboration being a simple set of practices, such as having a meeting. The beginning of each focus group involved a brain storming session on what collaboration was. Principles of aroha (love), tika (doing what is right) and pono (honesty) were proposed as cornerstones of collaboration. Whakawhanaungatanga (creating relationships) was also used to express collaboration. These values were proposed to have been handed down through whakapapa and from nga atua (gods). "Nga kete e toru iho mai no Rangiatea" (The three baskets of knowledge passed down from the heavens) (Participant Focus Group 1, PFG1). These values were also proposed to be interrelated to spirituality and Māori worldviews. "Something that we haven't got up there is spirituality, and when you talk about a Māori....a lot of those things had to do with a Māori world view" (PFG1). Participants related collaboration to a social model of care, and an holistic approach. One participant reflected this in her comment "It's that saying of, it takes a village to raise a child" (PFG1).

This social model of care was argued to provide positive benefits for both the workers and the whānau (families) they work with. "I'm not sure how to say it succinctly, but the work that you can do together has a bigger effect than the work that you can do separately or apart from each other" (PFG1). Collaboration was argued to require concerted effort "We're stronger as a group, so there's strength in numbers essentially" (PFG2) and planning:

> Planning for the whānau should be together, not as individual agencies or me. Because collaboration can only work for the whānau ... if you've got 60 organisations banging on your door, I'd be pretty pissed. I would rather meet with the organisations that are working with the whānau, plan together, go with one plan to the whānau and work it that way. (PFG2)

The act of planning was also proposed to contribute to improved outcomes "and maybe when it comes together it's stronger too, because the focus is common" (PFG1).

The strength that participants gained from collaboration, that is working together, was argued to come from the sharing of

expertise and the sharing of responsibility. "It's less stressful I think, sharing that responsibility, because you don't have to try and be an expert at everything" (PFG1). Whereas another practitioner identified that sharing was a key value for Māori. "Yeah, shared burden or shared load, because that's the basis in some ways of kotahitanga [unity] and manaakitanga [hospitality], is around sharing loads" (PFG2). A participant highlighted the practical challenges of working with whānau (families) with complex problems, and the benefit of this sharing for improved outcomes for whānau:

> I have 24 hours in the day and even then I struggle to make it through, and so if I'm the only person dealing with that one whānau and yet .... might have 16 or 17 or 20 whānau, how am I supposed to do everything for them without some help essentially? It's kind of... I know what I know, but I also know what I don't know and by collaborating.... in the real sense of the word, for me it's about I can't do everything because I don't know everything. (PFG2)

It was evident from the above discussion that collaboration was a strongly endorsed, and culturally relevant approach to working with whānau experiencing complex difficulties. However, when the participants in focus group two were asked what the costs of collaboration to them as practitioners were, several participants stated that there were no costs, just benefits. However one participant stated "There must be a cost because it's not happening...there'll be a trade-off" (PFG2). This highlights the dichotomy between wanting to collaborate, and actually collaborating. This provided the rational for exploring the barriers to collaboration.

Whanaunga (Relative) or Kupapa (Traitor)?

This theme reflected several unique challenges of rural Māori communities, in which service users and staff members interact, live in close proximity and are often whānau (family). Therefore these staff can wear many hats in the community, that is, they have roles within whānau (family), services, marae (meeting area of local sub-tribe, made up of communal buildings), and sports clubs. The question a service user is potentially faced with is; are you (the staff member) here as a family member focused on the best interests of the whānau? Or will you be a traitor (kupapa) and breach my trust and confidentiality?

One of the positive implications of being related to a client was that this relationship could provide a foundation for engagement: "It gets you in the door" (PFG1). These relationships can also place workers in positions of discomfort when working with a whānau whom they may interact with and have responsibilities to within the broader social and cultural context. The term tau kumekume (tension) was presented by a participant in the second focus group, acknowledging the tensions inherent when having the responsibility to manage commitments in personal and professional worlds.

A participant in focus group one stated that one of the discomforts faced by practitioners when entering collaboration was related to the cultural concept of kupapa (traitor):

> Every time I keep thinking collaboration, I keep thinking kupapa [traitor]. Kupapa [traitor] was in the times of war, that's what they used to do is they used to use their own people to work out how they could beat them. That's what I always looked at as what collaboration was about. (PFG1)

This sense of being a traitor represents a real challenge for practitioners, as they may be in a position where sharing information is disallowed, (even if sharing this may address

a problem), or conversely where sharing information may contribute to further distress for the whānau.

Another participant identified that negative past experiences can contribute to the ongoing fears and apprehension inherent with practitioners not wanting to be a traitor, and in turn this can act as a barrier to collaboration.

> It's doing things that are close to you that you've shared with people that you thought you trusted that have absolutely been destroyed .... So you may have gone in to the collaboration with an open and honest... but suddenly that kupapa thing comes in too, because you don't want it to be as collaborative as... and it might be a personal or it might be a provider organisation or whatever, because you keep things close to you. (PFG2)

This experience was also proposed to be a real problem for service users: "If people have let you down in the past because of not carrying out their end of the deal or breaching confidentiality, you're not going to have that trust, so you're not going to be able to move forward" (PFG2). Addressing the existing issues between agencies and the past experiences of service users was seen as a first step in developing a platform of trust with whānau (families) and other services:

> Yeah, because it is our 'take[1]' [issue/problem] and if we take our 'take' [issue/problem] to the whānau, the whānau's already messed up. They don't need us to be messing their heads again. So collaboration for me is doing things together and what's best for our community and our whānau. (PFG2)

Confidentiality was argued to be another challenge to addressing issues of mistrust in collaborative relationships with whānau (family) and other services: "Because often we will talk around it, but we won't actually say that this is what we won't be confidential about and so everybody's just skirting on the outside and nobody's actually saying anything" (PFG2).

Whanaungatanga (Relationships) as Collaborative Practice

A range of issues in working collaboratively with people with substance use and related problems within a rural context were identified. It was stated that many of the people with complex substance use and related problems in the area came from outside of the area: "Connectiveness in the community. Not knowing anyone, no whānau" (PFG1). This could leave this group feeling isolated from important factors of wellbeing, including whānau (family), hapū (sub-tribe) and whenua (land). Another participant summarised many of the common rural barriers identified by participants:

> ... it's a number of things that are sort of interlinked where we've got lack of services, this is talking rurally, distance, staffing levels or qualified staff, coming through lack of knowledge across to no ability to change by the whānau, shared information; all these things, sort of looking in and just putting up huge barriers. (PFG2)

The comment 'no ability to change by the whānau' within the above quote reinforced comments from participants in both focus groups that people with substance use problems were either not able to change or "not ready to change" (PFG1). Participants related part of this inability to change to the ingrained nature of substance use problems in families, proposing that there is a "normalisation of substance abuse" (PFG2) in families. This normalisation was proposed to impact on the fabric of the values of families that have substance use problems and sometimes acted as a barrier to collaboration:

> And it becomes a value [substance use]. It becomes what a whānau instilled value into, which can distort other values, and we see that a lot. Their children's health is no longer a priority. Or their children's education. It's just no longer a priority to send your kids to school because the whole value system changes. (PFG2)

One participant identified that engaging with whānau in relation to substance use and related problems was a sensitive issue, and that there were important steps to take place before discussing confidentiality and before attempting to collaborate with other agencies involved with a particular family:

> One that we had was whakamā [shame]. .... it's quite intense and painful.....you've got mamae [hurt] in there and they won't feel comfortable to divulge that information anyway.....before you begin to even start talking about confidentiality. You know, it's about working first, what's happening for the... not just that individual, but also in the whānau as well. (PFG1)

As has been identified, there are several barriers to collaboration, including the multiple and complex relationships held between staff and service users in this Māori rural community, confidentiality, the ingrained nature of substance use and related problems in families, practical barriers related to rurality, such as transient families, travel and staff recruitment, and the sensitive nature of engaging with families about substance use and related problems. Solutions to several of these barriers were also located within or associated to the barriers, that is whakapapa (kin relationships) and the natural resources and cultural history of the area.

One of the key barriers to collaboration involved the proposed ingrained nature of substance use in families. The following comment identifies how practitioners and families can engage with the broader family system in order to access activities that can encourage and support wellbeing, and re-connect families:

> ... in the substance abuse area, is actually using the kaupapa (issue) in terms of other members of that whānau who may be either connected to a religion or connected to a sports club where there's not that usage, but the usage has actually moved them apart and so it's the actual substance that's actually moved the whānau apart, and trying to look, trying to move, I guess, move that to the side and saying, "Hey, we're still whānau. (PFG2)

One participant identified that even those Māori families with substance use and related problems that come from outside of the area, have a cultural and family history that can be used to connect them to the area and people within it:

> And that comes back to what ..... said… certain people get certain things, and that's where him and I fit in terms of our, how we can make the connections. And you know, if they're from Kahungunu [a tribe located on the central eastern shores of the North Island], we talk about Mahinarangi [name of a female ancestor from the Kahungungu tribe] and Turongo [name of a male ancestor of the Tainui tribe]**,** when we make that connection through the whakapapa [genealogy] lines, then they feel comfortable enough to start sharing… (PFG1)

This highlights the importance of practitioners having an understanding of the whakapapa of the area, and of other tribal areas in order to effectively build these connections through whakapapa (genealogical) lines. Another practitioner extends upon this theme by highlighting the specific cultural history of the

area, and the importance of exploring how this history can be used to inform practitioners practice:

> They know their history from around here with regards to what their tupuna [ancestors] went through with regards to kingitanga [the history of Māori kingship], the wars, confiscation, the awa [river]... I think one of the questions is, how do we as social service practitioners operate in a model of a kingitanga framework? (PFG1)

The above themes reinforces the complex interrelated nature of history, context and people; and how these factors can influence both staff and those with substance use and related problems in engaging in collaborative practice. The responses to these barriers reinforce the indigenous beliefs of the participants around individual wellbeing coming from collective relationships, and that healing comes through making connections between service users, the community and the environment – a process of connection guided by culturally competent practitioners.

Discussion

This research project set out to identify the unique experiences of practitioners from a range of health and social services that are engaged in collaborative relationships for and with Māori with substance use and related problems in a predominantly Māori rural community in New Zealand. Qualitative data were collected from two focus groups involving a total of 21 participants. Participants predominantly self-identified as Māori, female, with a significant service history of working in the geographical area. These participants were in the most part engaged in direct client contact in whānau/ family support roles. A limitation of the current research project was that there were no mental health or primary care general medical practitioners that were available to attend the focus groups. This reduced the input of two particularly important sectors involved in collaborative practices with those with substance use and related problems.

The focus group methodology, guided by tikanga (practices informed by Māori values) provided the opportunity to see how cultural processes such as a whakatau (settling) contributed to an atmosphere of safety and unity, a necessary foundation for open discussion within the focus groups, an activity in itself which is collaborative in nature. The findings from the study identified three broad themes. The first of these revealed that collaboration was viewed by participants through the lense of Māori values, that is, viewing collaboration as relationship guided by values such as aroha (love), tika (doing what is right) and pono (honesty). These values were also proposed to be interrelated to spirituality and Māori holistic and socially mediated views of wellbeing. Collaboration was proposed to be a preferred model of practice that contributed to benefits for practitioners such as strength in numbers, shared responsibility, and shared resources. These benefits were proposed to in turn contribute to better outcomes for whānau.

Whanaunga (relative) or kupapa (traitor)? revealed a unique set of experiences under-reported in the literature, that is, the benefits and challenges of living in a predominantly Māori rural community. Participants revealed how working, and in some cases living, in a small rural community increased the likelihood that service users and staff would be either related or have interacting community roles. As a result some service users avoided local service providers due to fears of confidentiality. In a reciprocal nature, these shared relationships were proposed to place staff in a precarious position of kupapa, that is, a potential traitor due to holding information that may be beneficial or harmful to one or more of the groups or persons that they have relationships

with and in some instances responsibilities too (i.e., whānau or employers).

Healing through whanaungatanga (relationships) also highlighted the shame and embarrassment that some whānau (family) experience when talking about their problems, further complicated by fears of confidentiality. Several barriers to working with people with substance use and related problems were identified in addition to confidentiality concerns. Some of these were related to rural realities, such as lack of service options and difficulties in attracting qualified staff, and people moving into the area with little social or cultural connections in the area; whereas other barriers related to the impact of the negative experiences of staff working with people with chronic and complex substance use and related problems.

The strategies to respond to several of these barriers were in many ways found in the location of the barriers, that is, through relationships. Acknowledging the sensitive nature of substance use and related problems with whānau, and the underlying fears associated with confidentiality and past negative experiences with services, was argued as a first step in working towards collaboration. Reconnection through whanaungatanga (relationships) reflected what Huriwai and colleagues (2001) called 'the path to wellness'. Knowledge of community resources, whakapapa (genealogy), and tikanga (practices influenced by Māori values) were argued to be important skills that enabled practitioners to connect people that have moved in from outside of the area to make cultural connections to the area, and to reconnect people with whānau (families) and community based activities that can contribute to wellbeing.

Of particular note in this research was the observation that the host Iwi (tribe) organisation had staff from a range of services participating in the focus groups, including social workers, educators and addiction therapists. This organisation reflected Māori models of health, taking a holistic approach, one focused on the broad needs of whānau. The staff also had long histories of working in the area, increasing the likelihood that staff were in tune with the social and cultural context their clients lived in.

The findings of this research can assist agencies and practitioners working with Māori experiencing substance use and related problems, and those working in rural communities to understand some of the unique barriers to collaboration, and culturally relevant responses to these barriers. This research project provides a platform to further explore, understand and interpret key factors associated with collaboration for and with Māori with substance use problems in rural communities. Areas that warrant further exploration include: the strategies used to increase the awareness, knowledge and skills of non-substance abuse specialists in working with people with substance use problems; the strategies used to increase the awareness, knowledge and skills of practitioners in working with Māori; the strategies used to develop shared inter-agency understandings and processes in relation to working with the privacy code when sharing information; and the perspectives of those with substance use and related problems and their whānau of collaboration with health and social services.

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Note

[1]In this statement the Māori term 'take' is used with reference to an 'issue or problem' as oppose to the English term take.

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