Bicultural Partnerships in Clinical Training and Practice in Aotearoa/New Zealand

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The basis for biculturalism in Aotearoa/New Zealand and the relevance of the Treaty of Waitangi to Maori mental health and clinical psychology training are discussed in this paper. Bicultural clinical training experiences are examined with reference to the clinical programme at the University of Waikato, Hamilton. The importance of cultural inclusion in training and therapy models is outlined. While significant progress in Maori recruitment and retention in the training programmes has been achieved, evidence suggests that Maori trainees are spending longer on clinical training programmes and indicating a preference for employment in Maori-based agencies. Non-Maori practitioners in mainstream agencies are encouraged to recognise the bicultural imperatives consequent on under-representation of Maori in their profession

In 1987 Abbott and Durie (1987) challenged directors of clinical psychology training programmes to increase *taha Maori* (Maori issues) in psychology training, and to increase Maori entry into the profession. Their survey confirmed that there were no Maori academic staff in the university training programmes and only three psychologists of Maori descent who had completed applied postgraduate degrees or diplomas in psychology. Since then, Nathan (1999) has repeated and extended Abbott and Durie's (1987) survey, and found that there were significant increases in *tikanga* (customs) Maori content in two of the six programmes, and the remaining four had made improvements, but these were described as minimal. The improvements included Maori staff appointments, affirmative Maori student intakes, and changes in policy and procedures to recognise bicultural commitments.

The decade of health reforms since 1990 has enacted health legislation which incorporates Treaty of Waitangi (hereafter the Treaty) imperatives and acknowledges *iwi* (tribal) identity and powers (Durie, 1998). These imperatives changed the mental health environment, and the subsequent funding allocations and priorities have encouraged the development of iwi health providers which are often parallel and independent of mainstream services. Affirmative funding is now widely available for training opportunities for Maori and Pacific Island mental health professionals. As a result, the cultural match between *tangata whaiora* (mental health clients) and mental health workers has improved during this time. However, there is still a shortfall of trained Maori professionals. The 1999 Health Workforce survey recorded 3.5% Maori registered psychologists, 91% Caucasian (79% New Zealand born, 12% non-New Zealand born), and 5.5% other ethnicities, against the national population demographics of 14.5% Maori.

Additionally, the mental health statistics for Maori have confirmed that during the 1990's while Maori were becoming mentally ill at a similar rate to *Pakeha* (non-Maori, European New Zealander), Maori were experiencing poorer outcomes during the post-admission phases of treatment. Drug and alcohol related problems as well as 'comorbid' psychotic disorders were the main categories underpinning Maori admissions (Bridgman, 1993). There was also a rising trend for readmission of Maori with serious psychotic illness, and a suggestion that psychiatric diagnoses for Maori presented a distorted picture, with inaccurate assessments and ineffective hospitalisation.

This reflects a similar trend among other minority groups, where psychiatric statistics are less indicative of the levels of psychopathology in the indigenous population and more a reflection of the inability of mental health agencies to understand the social, educational, political, and economic realities faced by many indigenous populations (Fernando, 2002; López & Guarnaccia, 2000; Malgady, 1996; Ramirez, Wassef, Paniagua, & Linskey, 1996; Wing, 1978). Fernando has argued that "the status of psychiatry as a medical discipline and the power of people working in its institutions provide a cover for 'racism' to operate unchallenged" (p. 123). In a landmark social development report, Puao-te Ata-tu, respected *kaumatua* (elder), John

Rangihau, identified three main faces of racism – personal, institutional and cultural (Ministerial Advisory Committee, 1986). Cultural racism, he noted, was the least obvious of these three and was evidenced by the implicit assumption of the superiority of the dominant culture. In other words, the Pakeha (predominantly British derived) culture is "normal" and the Maori culture "a variation from the normal", and an "extra".

Biculturalism and the Treaty of Waitangi

The basis for biculturalism in Aotearoa/New Zealand is the Treaty of Waitangi. Historically, the Treaty existed as an agreement signed by representatives of the (British) Crown and iwi and *hapu* (sub-tribe) in 1840. Kawharu (1989) pointed out that most treaties are merely agreements, but the Treaty of Waitangi specified partnership with trust and co-operation between British settlers and Maori, and protection for Maori fishery and forestry resources and all *taonga* (treasures) necessary for continuing Maori self determination under British governance.

These aspects of the Treaty agreements are defined under three Articles. Article I related to *kawanatanga* (government) provides a national principle of good governance. How that is defined and applied differs over time in accordance with what is acceptable and appropriate to the circumstances, expectations, and demands of contemporary society. Bridgman (1993) stated that in relation to mental health, Article I places a responsibility on the government, representing the Crown, to put in place legislation and public policies that enable people to have access to effective health services and to make good health choices easy choices. Article II described *tino rangatiratanga* (sovereignty) and the principle of self-determination or regulation by iwi and hapu. Parata (1996) emphasised that there is significant variation in iwi and hapu understandings and definitions of full self-determination on matters affecting their well-being. Article III offered *oritetanga*, or citizenship, to all settlers being equality and equity between Maori and non-Maori New Zealanders. Parata (1996) noted that prior to the signing of the Treaty there were no individuals within indigenous society with the same rights and status that British citizenship bestowed under Article III. The key principle of this Article is that of the democratic commitment to one person one vote. At a practical level, in implementing psychology training programmes, Article III recognises that Maori students and staff can function as every other student and staff member. In other words, issues relating to *tangata whenua* (indigenous people) are not automatically applicable in this forum.

Historically it is suggested that in the New Zealand context Maori have lacked status as both citizens and tangata whenua. Until the 1930's, racism and prejudice impacted on citizenship rights (Ballara, 1986; King, 1977; Ministerial Advisory Committee, 1986). Maori participation in Pakeha economic, legal, and political life was regulated and on Pakeha terms. As examples, Maori soldiers in World War I were initially recruited for non-combat tasks (King, 1977), and Maori had no eligibility for Social Security benefits either because a birth certificate could not be produced or it was assumed that the rural Maori community was able to provide for itself with access to traditional fisheries and natural resources (Ministerial Advisory Committee, 1986). Inequities in voting systems such as the New Zealand Constitution Act 1852, gave voting rights to males who owned a small amount of property. The disarray of the Maori electoral rolls following the universal franchise of 1893 meant that Maori women were disenfranchised until the 1940's (Rei, 1993). Researchers have claimed that the nature of the Treaty as more than an agreement was mainly unappreciated by the British who continued with land acquisition and settlement plans regardless of Maori interests. Concerns were aired openly by Sir Apirana Ngata in 1935 (Orange, 1987), but it was not until the urban protests of the 1960's and 1970's and subsequently the passing of the Treaty of Waitangi Act 1975, and its amendment in 1985, that a forum for grievances, and social and economic progress was established. This Act established the Waitangi Tribunal as a body that was able to "*make recommendations on claims relating to the practical application of the principles of the Treaty*" (Orange, 1987, p. 246).

While the three Articles are the original wording of the Treaty, the principles or expressions of these Articles have never been specified and are generally derived from Court of Appeal rulings (Kawharu, 1989). Most commonly, the Treaty principles are known as principles of partnership, participation and active protection of Maori interests. Since 1985, several important social documents have been based on these principles (Ministerial Advisory Committee, 1986; The Royal Commission on Social Policy, 1988; University of Waikato Charter statement, 2002). Under the Treaty of Waitangi, the momentum and responsibility for the implementation for Article I and Article III lie with the wider New Zealand society, both Maori and non-Maori. Article II provides for Maori self-determination. Therefore the principles of participation and partnership are inclusive for Maori and non-Maori. Active protection is distinctively Maori and allows for the way forward in psychology research, theory, training and practice to uniquely reflect Aotearoa/New Zealand society.

Maori Mental Health and the Treaty

Examining the Articles of the Treaty in relation to Maori health confirms that Article II has a solely Maori focus. At a practical level this requires a different relationship with Maori in comparison with the more general bicultural provisions in Article III, which would be typified by fairness, equity and equal access. Article II was seen as all important sovereignty or possession and Orange (1987) noted that that kawanatanga or governance was considered by iwi as a limited concession of power to the British Crown. A number of legal challenges since 1975 have established that intangibles beyond the forestries and fisheries explicitly quoted in the English version of the Treaty (*"o rātou wenua o rātou kainga me o rātou taonga katoa"* in the Maori version; Orange, 1987, p. 257) have been validated and include *te reo* Maori (Maori language), broadcasting rights, health issues, and other Maori identity parameters. This means that Maori have a right to self-determination and control of their mental health definitions and management.

Clinical Psychology and the Treaty

The challenge to operationalise the Treaty and make it meaningful for psychological practice has come from the New Zealand Psychological Society's (NZPsS) National Standing Committee on Bicultural Issues (NSCBI) (1995a), and also from the broader psychological community who are generally responsive and responsible towards diversity issues in Aotearoa/New Zealand. With increasing numbers of Maori now enrolled in university courses (for example, Waikato University recorded 23% Maori in the domestic student roll in 2002) much subject matter now consciously reflects the need for, and interest in, bicultural systems in Aotearoa/New Zealand.

Special recognition of Maori in universities has been referred to by NSCBI (1995a. p.15), which recommended "ensuring cultural safety for Maori" by providing support for Maori staff and students and allowing fair and equal participation on the same basis as other staff and students. In the psychology department of most universities this support for Maori students takes the form of *kaupapa* Maori tutorials, which provide Maori tutors and sessions alongside courses, to support Maori students and address Maori issues.

Although the status and relationships of Maori in Aotearoa/ New Zealand are now more clearly defined within the discipline of psychology, the paradigms and methodologies of psychological theory and research remain almost entirely shaped in the USA and Britain (Hirini & Nairn, 1996; Moeke-Pickering, Paewai, Turangi-Joseph, & Herbert, 1998). Further, because much clinical research has been conducted in the culturally homogeneous context of New Zealand universities, the needs and values of other than the dominant culture have tended to be observed as "variances" (Ministerial Advisory Committee, 1986). Currently it appears that understanding of and incorporating the Treaty in various training arenas has changed many processes and perceptions of clinical issues, but so far has made little change in the content of clinical research and training.

Bicultural Partnership Environment

Organisations and departments with a commitment to establishing a visible and meaningful Maori presence need to consider three stages of development:

1. Understanding the broad history and social background of Treaty of Waitangi relationships and their relevance to a bicultural perspective.
2. Accepting responsibilities and establishing systems to accommodate a Treaty framework and a bicultural perspective.
3. Identifying and implementing practical actions throughout the organisation that are consistent with these views.

The NZPsS initiated Treaty of Waitangi training for the Executive in 1999 and is addressing ongoing bicultural issues though NSCBI. Annual conferences routinely include a bicultural stream or symposium. Professional bodies have commissioned a number of reports. For example, in 2002 The New Zealand Psychologists' Board commissioned reports on Maori participation in the profession of Psychology (Levy, 2002) and a study of cultural safety in psychology teaching and practice (in progress). In December 2002 NZPsS commissioned a bicultural audit on the implementation of Rule 3 (National Standing Committee of Bicultural Issues, 1995b) which outlines a commitment to the Treaty and practical actions relating to active protection, participation, and partnership in psychology research and practice.

Bicultural Partnerships in the Scientist-Practitioner Model

Operationalising the underlying principles of the Treaty provides the foundation for changes in research, training and practice. Examples now in evidence include evolving guidelines for research ethics, most notably the Health Research Council (HRC) (1998), the HRC Maori bursaries and summer studentships, the clinical psychology training programme at the University of Waikato (Herbert, 1998a; 1998b), and practice issues reflected in the values-based NZPsS Code of Ethics (2002).

The protocols that have been established in the clinical psychology training programme at the University of Waikato provide a further example of six key concepts relevant to bicultural understanding. Concepts based on the Treaty Articles are incorporated into the training programme protocols in a way that provides support and understanding for both Maori and non-Maori students:

1. **Biculturalism (Article II) and Maori self-determination (Article III)**: The importance of direct Maori input is derived from the *marae* setting (meeting area) and Maori professionals in other settings (clinical and community psychologists, policy analysts, mental health managers, mental health workers). A range of experiences in the university, in marae (urban and rural), as well as other clinical settings is designed to broaden understanding of iwi self-determination under Article II parameters and Maori bicultural urban development under Article III. Students are encouraged to establish networks with key individuals and groups for guidance, consultation and supervision. Neville, Heppner, Louie, Thompson, Brooks, and Baker (1996) have reported that guest speakers and presentations were consistently rated as the most important event during a multicultural training course.

2. **Equity and equal access (Article III)**: There is formal recognition of the equal partnership status for Maori and their role in relation to the programme. Maori students are accorded fair and equal status with other students as defined in Article III. Maori staff have the responsibility to ensure this safe environment, particularly if there are few Maori students in the programme.

3. **Mana whenua**: Maori community consultation is a specially developed process, and adheres to Article II structures. Maori are consulted as tangata whenua in the appropriate manner and with formal recognition. Since the 1997 Treaty settlement process, the University of Waikato now formally recognises Tainui iwi as tribal landlords of the site and the paramount role of Tainui *kawa* (protocol). The clinical training programme acknowledges this, and also the bicultural responsibilities of representing and supporting staff and students from diverse tribal affiliations. At a practical level this involves contact and introductions to key

local organisations (*runanga* (local council), marae, Maori services) and establishing open communication.

4. **Eliminating cultural racism**: Treaty and bicultural aspects of the clinical course are presented in conjunction with mainstream clinical training not as a contained separate topic area. Coursework and practicum assignments are inclusive of the Maori perspective and not an "extra" (cf. "cultural racism", Ministerial Advisory Committee, 1986, p.25). This requires all staff to take responsibility for inclusion of Maori and bicultural material (Phipps, 2000) and allows comparing and contrasting protocols and discussion of ethical and cultural issues as training proceeds.

5. **Recognising diversity**: Practicum work is undertaken with a focus on understanding the diversity of individuals, whanau and communities so that students and trainees avoid stereotyping. Durie (2001) has drawn attention to the Maori writers and researchers who have helped identify Maori cultural values and psychological viewpoints, but he also noted that there is no single Maori psychological world. I have emphasised aspects of diversity in my own professional and research experiences (Herbert, 2001a; 2001b).

6. **Personal development**: Students are encouraged to seek out and assimilate their own information and experiences as well as to provide resources for others. Appropriate consultation methods are discussed. This develops teamwork and a better awareness of ways of accessing community and Maori groups and organisations. There is a staff responsibility to provide personal support and opportunities for all students to discuss experiences and information as personal development. Examples of support and requests have included non-Maori students seeking guidance on contacting local marae or advice on *koha* (gifts) and thanking individuals and organisations. Maori students are encouraged to value and integrate their own understandings into broader aspects of the training. Experiences have included discussing the significance and *whanau* (family) responsibilities in rebuilding the family marae and *waiata* (song) relating to this, or the ways that Maori students with no regular marae contacts can develop their own supports and consultation.

As these protocols are increasingly recognised and disseminated, psychological researchers will develop theories and paradigms that have a Maori perspective (Article III) as well as an awareness of indigenous theories and paradigms (Article II). Research can validate diverse knowledge bases and acknowledge indigenous protocols and recognise areas of convergence.

The Articles of the Treaty establish that the bicultural focus in Aotearoa/New Zealand extends beyond awareness and sensitivity to the notion of power sharing and self-determination. Friction and problems that arise between different cultures are partly due to differences in ways of seeing and valuing the world and partly due to competition for power in the social system (Metge, 1990). The various *wananga* (places of learning) in Aotearoa/New Zealand, which include Te Whare Wananga o Aotearoa, Te Whare Wananga o Raukawa, Te Whare Wananga o Awanuiarangi, Te Whare Wananga o te Pihopatanga o Aotearoa, have the structures and environment to determine and implement kaupapa Maori perspectives in research and training in the social services.

A bicultural perspective compatible with a university charter can acknowledge a self-determination perspective but cannot implement this approach unless there are structural organisational changes. Clinical psychology training programmes in Aotearoa/New Zealand seek to encourage research which will inform bicultural practice and provide relevant content that will contribute to a better understanding of Maori thinking, feeling and behaving (Durie, 2001). In a bicultural setting the challenge exists to incorporate cultural content into cognitive-behavioural practice.

Cultural Imperatives in Cognitive Behavioural Practice

Assessment and Therapy Issues

Usefulness of cognitive behavioural therapies is predicated on correctly identifying the functions or maintaining factors in problem behaviour. That these problem behaviours have a social and cultural context is widely recognised (Matthews & Peterman, 1998; Tanaka-Matsumi, Seiden, & Lam, 1996). The role and understanding of cultural variables when clinicians are of a different culture has been discussed in both training and practice settings (Yutrzenka, 1995). Zayas, Torres, Malcolm, and DesRosiers (1996) described the strategies that non-minority social workers and psychologists identified when working in a multi-ethnic setting. These clinicians reported that therapists needed to have an awareness of cultural differences, and then should also have some knowledge of the client's culture.

Evans and Paewai (1999) have suggested guidelines for functional analysis where the client is Maori. These strategies have embedded the elements of functional analysis in both the larger Maori context of *tikanga* (rituals), *whakapapa* (genealogy) and *whanaungatanga* (family relationships), and the specific elements of contemporary Pakeha culture. This inclusion of day-to-day activities reflects the truly bicultural status of Maori, and needs to be considered individually for each client. These authors warn against a prescriptive approach, or client stereotyping.

In my own research (Herbert 2001b) I implemented a standard parent-training therapeutic intervention with a Maori parent population and compared this with a culturally adapted parent-training intervention. Key Maori values and concepts of whakapapa, whanaungatanga, and *awhinatanga* (support) were derived from qualitatively analysed interviews and focus groups. Social and cultural validity were explicitly discussed and a multi-dimensional approach recognising the utility of both psychological and cultural imperatives was identified.

Bicultural Competence

Cultural awareness can be seen to exist as a learned or taught component, a 'cultural experience' component, and an understanding of habit or day-to-day behaviours component. The taught component is about Treaty information, policies and procedures, as well as Maori cultural values – the holistic nature of mental health, the Maori identity focus with whakapapa, the extended family connections with

whanaungatanga, and collective roles and responsibilities as awhinatanga, and practices. Differentiating cultural practices and psychopathology requires knowledge and understanding of these historical (Treaty) and cultural issues as well as clinical knowledge and understanding. The question of bicultural competence in Aotearoa/New Zealand includes familiarity with these issues, but may be problematic in assuming cultural practices for Maori psychologists.

Recent literature has confirmed that knowledge of the broader context of the client-group identity and probable marginalisation, as well as the cultural-embeddedness of psychological theory and methods of inquiry are part of cultural competence (Downing Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000). These authors examined a definition of multicultural competence in terms of (a) awareness and knowledge of a culture and; (b) clinical skills necessary to work with diverse groups, and reviewed the literature to identify multicultural competencies related to research and practice domains for professional psychologists. The 12 competencies that these reviewers derived from an extensive list include awareness of one's own heritage, as well as an appreciation of level of acculturation to a dominant culture by a minority group client.

Emphasis on values and sensitivity to diversity is now recognised in the completely rewritten format of the New Zealand Psychological Society Code of Ethics (2002). The revision from a code of prescribed recommended actions to the new values-based code emphasises the nature and broader context of the client-practitioner relationship. Thus the principles outlined in the 2002 Code include respecting personal dignity, advocating responsible caring, requiring integrity in relationships, and recognising social justice and responsibility to society. The first value statement explicitly includes relations between Maori and non-Maori and recommends understanding the Treaty and the principles as a practice implication. *Te Tiriti o Waitangi* as the Maori version of the Treaty is given priority over the English language version to endorse the Article II sovereignty claims.

Cultural Inclusion in Clinical Training

Ideally, clinical training in a bicultural partnership model needs to include components of didactic teaching, relevant clinical experience in delivering a bicultural or kaupapa Maori service, and an empirical component. Comaz-Díaz (1988) noted that the first two components are focused on outward experiences, and the empirical is the inward self-awareness exploring their own ethnic backgrounds and assumptions or stereotypes that they attribute to other ethnic groups. A bicultural model must accommodate and develop training and practice for Maori and non-Maori students so that marae contacts and learning is prepared and delivered with no prior expectations that Maori students have any special responsibilities.

As an example, the first year students in the University of Waikato clinical training programme are welcomed on to a marae at the beginning of the course. This is intended to provide the acknowledgement and balance to the clinical learning and applications, and also to provide affirmation for the Maori clinical trainees. First year assignments focus specifically on Maori themes, and are designed to be fair to both Maori and non-Maori students. While no assumptions are made about the cultural literacy of students, the kaupapa Maori tutors and Maori staff generally work closely with Maori students to ensure that there is sufficient support. Feedback from Maori trainees has shown that the kaupapa Maori support in the department has assisted the retention of several of these Maori students.

Phipps (2000) has reported on outcomes of the University of Waikato clinical training programme. Information was collated from selection interviews and programme tutor support meetings. This feedback reflected an increased interest and awareness by students of the bicultural commitment in the training. In general, students were willing to access a wide range of literature, to develop and respect Maori networks, and to reflect on and discuss cultural awareness in their practice.

Numerically, the numbers of Maori students in the Waikato clinical psychology training programme is continuing to increase. For example, in the decade from 1986 to 1996, there were: 2 Maori graduates from the Waikato clinical training programme. Since that time, the intake of Maori clinical trainees has been: 1997: 0%; 1998: 33% (2 Maori); 1999: 17% (1 Maori); 2000: 50% (4 Maori); 2001: 38% (3 Maori), 2002: 12% (1 Maori) 2003: 50% (4 Maori). From 1997 to 2002 there have 6 Maori graduates. Similar increases have been reported in both the Massey University and University of Auckland clinical training programmes.

Records of student progress in the three-year programme at Waikato University from 1997 to 2000 intakes show that while there has been no dropout among Maori trainees, only 28% of Maori students completed in the minimum three years compared to 81% of non-Maori. This suggests that Maori recruitment and retention in clinical psychology training are being achieved, but to date it appears that Maori trainees are spending longer on the course than non-Maori. Academic requirements are identical for all those accepted on the course and a review of the reasons for Maori and non-Maori students deferring clinical training are also similar. The reasons include time management problems, academic difficulties, health and family and extended family demands. The fact that these problems arise more often for Maori students is cause for inquiry and is described as an ongoing tension by Levy (2002). Levy highlighted the importance of creating a critical mass of Maori participation in psychology to provide mentoring support, role models and to validate and implement relevant Maori content in psychological research and practice.

Validation of process and perception changes for clinical psychology trainees is shown in the annual course evaluations from the University of Waikato clinical psychology trainees 1997–2000, of whom 75% identified as non-Maori. The following comments were in response to the question . . .

How has the course increased your understanding of the Treaty and bicultural issues?

"A great deal. Most importantly, it has made me see that Maori culture has to be integrated into every aspect."

"It was entirely valuable to be introduced to bicultural

issues on different levels – not just academic. This multi-faceted approach has produced many 'aha' reactions."

"Increased awareness and sensitivity. It opened a new perspective for me"

"This has been a rich experience which has enhanced my learning from undergraduate years."

"My understanding continues to deepen."

University postgraduate clinical training programmes have some autonomy to respond to Treaty and bicultural imperatives. Data have been presented that demonstrate student responses to cultural inclusion in training. However, the point has been made that the content of clinical psychology and the critical mass of numbers of practicing Maori clinical psychologists has not yet been achieved whereby a distinctive bicultural elements are routinely incorporated in clinical research and practice.

Cultural Inclusion in Clinical Research and Practice

Academic outcomes show that there is an increase in relevant clinical Maori-focused research being completed (Herbert, 2001b; Rolleston, 2000; Te Huia , 2001; Waitoki, 2000; Williams, 2002), including Nathan's (1999) replication of Abbot and Durie's enquiry (1987) noting changes in the training programmes. The Health Research Council has similarly supported Maori-focused research projects and thesis work relevant to clinical practice.

Analysis of papers published in the *New Zealand Journal of Psychology* from 1987 to 1996 shows that four out of 105 papers (4%) were Maori-focused. This included Abbot and Durie's (1987) paper. In addition there was one editorial outlining the importance of understanding other ethnic groups and outlining lectures in the Psychology Department at the University of Auckland on aspects of the *Foundations of Maori Psychology* (Barlow, 1994) and one paper that included consideration of Maori representation. In comparison to this decade, the papers published in the *New Zealand Journal of Psychology* in following six years 1997-2002 show that six out of 63 papers (10%) were Maori-focused and eight other papers (13%) included Maori ethnicity demographics and/or discussed bicultural implications of research results as relevant in Aotearoa/New Zealand. Current publications are now more often identifying research populations accurately and ensuring that results are not inappropriately generalized to different ethnic groups. Where results are considered generally applicable many authors are more aware of specific Maori and bicultural issues.

Clinicians in Aotearoa/New Zealand who are employed in mainstream health, education, social welfare and correctional organisations are almost certain to be practising in agencies that have comprehensive Treaty polices, at least some Treaty training, and iwi consultation and representation protocols. The Department of Corrections is committed to bicultural therapy models and partnerships with Maori service providers. Maori mental health service providers have generally prioritised employment of Maori caregivers and psychologists, and are committed to Maori workforce development. Barriers and disincentives for Maori psychologists progressing to senior levels and thereby influencing policy and procedures include the lack of critical mass as noted by Levy (2002). Job satisfaction is likely to be lower for Maori working in isolation and working in agencies with no explicit bicultural focus. Maori clinicians have shown a preference to work in their own tribal areas, often in the iwi service if this is feasible. It is suggested that a commitment to Maori and iwi development is a more compatible goal for many Maori professionals than personal achievement and acclaim. This movement by Maori into Maori services highlights the importance of bicultural responsibilities for non-Maori practitioners

Conclusions

Nathan (1999) reported significant improvements in the tikanga Maori content in some of the post-graduate clinical psychology training programmes in comparison to Abbot and Durie's (1987) original survey that showed that psychology had no bicultural course content at that time, and lagged behind medical and social work training. Nathan (1999) had identified Auckland University and the University of Waikato as having implemented the most significant changes. Data from the University of Waikato clinical training show successful Maori recruitment and retention in clinical training programmes with between 33-50% Maori recruitment, and increasing numbers of Maori professionals. Important issues concern the length of time for Maori in clinical training and the current situation of Maori professionals being attracted to Maori and iwi employment. Maori are not progressing to senior positions in mainstream agencies where policy and structural changes can be implemented.

Thus, over the next decade Maori clinicians are likely to continue to be attracted to Maori and iwi health providers. This poses the challenge to non-Maori clinical psychologists to provide accessible, relevant and culturally valid psychological services based in bicultural understanding and adapted for an increasingly diverse but distinctively New Zealand population.

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