

Developing Services in Te Rohe o Ngai Tahu for Maori with Gambling Related Problems

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Although Maori, like other indigenous populations, have been identified as being disproportionately at risk of gambling related problems, there has been limited progress with strategies to address issues in this area. The purpose of the current study¹ was to contribute to the advancement of problem gambling services² for Maori living in te rohe o Ngai Tahu by identifying the capacity and willingness of existing services to engage with such development. Following a review of the relevant literature, information was gathered through a phone survey of local Maori health providers and several non-Maori gambling services. The survey identified a number of salient issues, many not surprisingly relating to recruitment and retention of appropriately skilled staff. A need for increased training of both Maori and non-Maori gambling treatment workers was highlighted, however the presence of some current capacity and a broad willingness to contribute to development of Maori responsive interventions was clearly indicated. The results of the survey along with information from the literature provided the basis for constructing a framework to guide problem gambling service development in te rohe o Ngai Tahu. While the current study was focused on this specific region, it is likely that many of the issues identified would be pertinent to developments in other tribal areas.

Within New Zealand, the last 10-15 years has been characterised by a growth in gambling opportunities and a related increase in the number of people presenting for help with related difficulties (Abbott & Volberg, 2000; Paton-Simpson, Gruys, & Hannifin, 2002). This has paralleled the emergence of gambling related harm internationally as a significant social and health issue (Amie, 1999; Shaffer, Hall & Vander Bilt, 1999; Shaffer & Korn, 2002). In this context, indigenous peoples have been indicated as being at disproportionate risk of gambling related harms (Abbott & Volberg, 1999, 2000; Wardman, El-Guebaly & Hodgins, 2001). Although

there has been a significant increase in literature related to addressing gambling problems generally, there has been more limited development of literature focused on the needs and aspirations of indigenous peoples.

Defining Problem Gambling

The majority of the population are apparently able to engage in 'recreational' gambling with little impact, apart from opportunity cost, however, for a portion of the population such activity is associated with significant harm. Negative consequences for these individuals, as well as their families, friends and wider community have

included financial hardship, relationship difficulties and criminal offending, as well as physical and mental health problems (Abbott, 2001; Productivity Commission, 1999), with an estimated 10-15 people adversely affected for every one problem gambler (Abbott, 2001; Dickerson, 1984, cited in Public Health Association of Australia, 2002).

Like other forms of addiction, a number of factors have been identified in relation to the onset and maintenance of problem gambling (e.g. genetic, psychological, and environmental), contributing to various foci in terms of its conceptualisation (Murray, 1993; Baron, Dickerson & Balczynski, 1995; Walker, 1995). Psychological theory and practice has arguably played a key role, particularly in terms of both aetiological formulation and development of interventions (Draycott & Dabbs, 1998; Lopez Viets & Miller, 1997; Sharpe, 2002). Despite such influence however, the most significant problems in this area have been constituted as 'pathological gambling' within the frameworks of psychiatric disorder, as defined in the DSM VI (Frances, First, & American Psychiatric Association Task Force on DSM VI, 1994). This definition has guided the development of policy, services, workforce and research from 1st July 2004 when the Ministry of Health took on the role of overseeing the funding and co-ordination of gambling services in New Zealand (Ministry of Health, 2004).

Gambling Prevalence for Maori and Other Populations

Gambling activities have increased in a number of countries in the past 10-15 years, along with associated rates of problem gambling (Shaffer et al., 1999; Volberg, 1994). Comparisons between countries, however, should be made with reference to variation in gambling laws and accessibility of gambling venues, as well as differences in policies and practices for addressing potential gambling related harms.

Although problem and pathological gambling prevalence rates appear to have decreased in New Zealand, the number of people seeking help has steadily increased over the past five years (Paton-Simpson et al., 2002). Maori continue to be disproportionately represented, with risk of developing gambling problems potentially amplified for those who occupy low socio-economic status groupings (Abbott & Volberg, 1999, 2000). This mirrors the relatively higher prevalence rates of problem gambling among indigenous people in a number of countries as

identified in Table 1 (Volberg & Abbott, 1997; Abbott & Volberg, 1999, 2000; Spunt, Dupont, Lesieur, Hames, Liberty & Hunt, 1998; Productivity Commission, 1999; Wardman et al., 2001).

A meta-analysis of North American studies indicated that indigenous problem gambling rates were 2.2 to 15.69 times higher than in non-indigenous populations (Wardman et al., 2001). Community surveys of problem gambling conducted among Australian Aboriginal groups also found very high prevalence rates (Abbott & Volberg, 1999; Amie, 1999; Productivity Commission, 1999; NCETA, 2000). National problem gambling prevalence studies conducted in New Zealand in 1991 and 1999 found that Maori had rates that were three to four time higher than non-Maori (Abbott & Volberg, 2000). Other factors, such as the ongoing sequelae of colonisation, including marginalisation and denigration of cultural institutions, which contributes to health disparity may also be implicated.

The available data suggests that, despite comparatively high levels of

problem gambling, Maori and other indigenous populations have not been proportionally over represented in treatment services (Paton-Simpson et al., 2002; Victorian Casino and Gaming Authority 1997, cited in NCETA, 2000). Such findings are not unequivocal however, as one study found Torres Strait Islanders to be disproportionately represented amongst problem gamblers seeking help from counselling services (Productivity Commission, 1999). Thus, while some elements of current gambling services may discourage access by indigenous peoples, this could vary from region to region and service to service. The patterns of Maori service utilisation for problem gambling services however, appear to be similar to those of alcohol and other drug-user treatment services (Te Puni Kokiri, 1996). It could therefore be expected that Maori would present with more severe problems than non-Maori (Abbott, 2001).

While debate continues regarding the potentially causal role of ethno-cultural variables in gambling behaviour, cultural

Table 1: Prevalence of lifetime and current problem and pathological gambling in several indigenous populations (from Wardman et al., 2001)

| Study | Population | Current Prevalence | | Lifetime Prevalence | |
|--|--|--------------------|--------------|---------------------|--------------|
| | | Problem | Pathological | Problem | Pathological |
| Abbott & Volberg, 1992 | New Zealand European adults | 3.0% | 1.7% | 1.4% | 0.06% |
| | Maori adults | 4.6% | 2.2% | 8.7% | 5.9% |
| Volberg & Silver, 1992 | North Dakota Native American adults | 7.1% | 7.1% | 5.8% | 6.6% |
| | North Dakota Caucasians | 2.5% | 0.8% | 1.3% | 0.5% |
| Cozzetto & Larocque, 1996 | Aboriginals within two reservations | | | 12.0% | |
| | Non-Aboriginals in two reservations | | | 6.0% | |
| Volberg & Vales, 1997 | Puerto Ricans | | | 4.4% | 6.8% |
| Polzin, Baldridge, Doyle, Sylvester, Volberg & Moore, 1998 | Montana Native Americans-Flathead reservation sample | | | 6.5% | 2.8% |
| | Montana Native American-household sample | | | 3.8% | 7.6% |
| Abbott & Volberg, 1999 | New Zealand European adults | 1.3% | 0.6% | 0.6% | 0.3% |
| | Maori adults | 2.1% | 1.3% | 3.6% | 3.5% |

affiliation and involvement has been mooted as contributing to the successful treatment of addictive behaviours (Adams, Morrison, McMillan, Orne, Sloan, Tse & Campbell, 2003; Brady, 1995; Durie, 2001; Huriwai, Sellman, Sullivan & Potiki, 2000; Robertson, Futterman-Collier, Sellman, Adamson, Todd, Deering & Huriwai, 2001a). The mechanisms through which this might happen have yet to be documented, however clinical and other anecdotal evidence indicate that such variables need to be accounted for if interventions for Maori are to be effective.

Western Interventions

Like other areas of addiction, psychologists and psychological interventions have been identified as having an important role in addressing addiction problems, including gambling (Oakley-Browne, Adams, & Moberley 2002; Miller & Brown, 1997). While there has been limited controlled research on the effectiveness of the various treatments, modest to moderate clinical benefits have been demonstrated with regard to cognitive behavioural therapies (CBT) (Lim, 1999; Lopez Viets & Miller, 1997; Oakley-Browne et al., 2002). Additionally, CBT has been found to deliver comparable results to more intensive, residential treatment (NCETA, 2000). Interventions in this area have included cognitive restructuring, desensitisation procedures, problem solving, skills rehearsal, self-monitoring and relapse prevention. Recently greater consideration has been given to developing more gambling specific cognitive behavioural treatments (Sharpe, 2002) however, these have yet to be evaluated.

Group therapy/support has been used widely in the treatment of individuals with addictive gambling behaviour, with Gamblers Anonymous (GA) being the most common. Although there have been reports of the effectiveness of GA, there has been no controlled research to verify these claims (Lopez Viets & Miller, 1997). There is however, evidence for the efficacy of a 12 Step based approach for the treatment of alcohol problems, from a large multi site controlled trial in the USA (Project MATCH

Research Group, 1997). In-depth financial counselling has been cited as important for enabling maintenance of therapeutic gains, however there is only anecdotal evidence to back this claim (Connolly, Lockett & Knox, 1995). In addition to psychological interventions, several studies have supported the effectiveness of pharmacotherapies in the treatment of pathological gambling and co-existing psychiatric disorders (Lopez Viets & Miller, 1997; Petry & Armentano, 1999).

The range of treatment options applied in New Zealand has for the most part reflected international trends (Adams et al., 2003). The most commonly utilised approaches have included psychosocial modalities incorporating motivational, cognitive behavioural and group interventions, along with financial advice and adjunctive counselling for relationship, mental health problems and other related difficulties. These have characteristically been delivered within dedicated gambling services, sometimes in conjunction with input from other mental health and addiction services. The few studies that have evaluated multi-modal approaches suggest moderately to significantly successful outcomes comparable with single modality treatments (Lopez Viets & Miller, 1997; NCETA, 2000).

Maori Focused Treatments

While little research has specifically focused on Maori and gambling (e.g. Dyal, 2002; Morrison, 2001), literature on Maori health has provided a context for addressing gambling problems. This has, to a large extent been located around models of wellbeing, based on customary values, beliefs and practices, including *Te Whare Tapa Wha*, *Te Wheke*, *Paiheretia*, *Poutama*, *Pa Harakeke* and *Te Pae Mahutonga* (summarised in Durie, 2001). The models have in common a holistic approach to health, which locate the individual not only within a whanau and wider community, but also within a broader socio-historical and spiritual context. While these have been central to development of Maori responsive interventions, there has been limited published information on their operationalisation (Durie, 2001;

Hirini, 1997; Robertson, Eramiha, Harris, Armstrong, Todd, Pitama & Huriwai, 2001b). A more recent project has more fully explicated the nature of Maori models utilised in the addiction area and supported the importance of these in treatment (ABACUS, 2004). There is also some evidence that Maori focused services and programmes reduce barriers to access, as well as engagement and retention through greater cultural appropriateness and relevance (Huriwai et al., 2000). Much of the above has indicated that effective treatment is likely to include integration of some western practices, although for the most part, clearly contained within frameworks of *tino rangatiratanga*.

Work related to the application of Maori principles and practice in the alcohol and other drug area (e.g. Huriwai et al., 2000; Huriwai, Robertson, Armstrong, Kingi & Huata, 2001; Robertson, Huriwai, Potiki, Friend & Durie, 2002), as well as Maori health in general (e.g. Durie 1998; 2001; 2002) has identified the following points to consider when developing effective interventions for Maori with gambling problems:

- Maori services need to cater for individuals who have a diversity of experience in terms of 'being Maori'.
- Whanaungatanga and inclusion of whanau is central to successful interventions with Maori.
- Maori practices and content contribute to improved access of services, as well as increased retention and satisfaction with treatment.
- Health promotion material that makes use of Maori content in a meaningful way is more effective than non-Maori material.
- Many Maori are willing to engage with non-Maori practitioners and treatment modalities, provided that they are responsive to Maori needs and aspirations.

Summary

The disproportionate risk of problem gambling related harm for Maori is exacerbated by other factors, especially those connected with low socio-economic status and marginalisation. While there is an emerging literature on

Maori and gambling, and some related work on substance use treatment, gambling problems for Maori, individually and collectively, have yet to receive significant attention. With regard to treatment there is a need to focus on the development of Maori focused interventions. This is likely to involve integration of effective western elements, many of which emanate from psychology. However, these clearly need to be extended, both conceptually and in practice, in order to ensure compatibility with Maori frameworks. A key element of the current project was identifying the capacity and willingness of existing service providers to engage in such a process, as well as providing some basis for related development.

Method

Kaupapa Maori Research

Methodologies that validate indigenous experiences and locate Maori knowledge alongside Western research are recommended when addressing topics of importance to Maori (Smith, 1999). Such approaches aim to ensure that researchers are highly accountable to participants and their community, through an overt focus on researcher-participant collaboration. The current project was developed and implemented with specific expectations that it would contribute to an improvement of Maori health status in relation to gambling and that development and implementation of the project were consistent with fundamental Maori values, beliefs and practices. In this context the research team sought to ensure that:

- Data collection was undertaken in a way that maintained accountability to participants and their community and was acceptable to participants.
- Appropriate processes were utilised to build cultural comfort and to provide a safe environment for participants.
- Data was treated with respect and participant's right of review and withdrawal was maintained to allow for joint ownership of data, as well as contributing to researcher accountability in terms of the presentation of results and recommendations.
- Appropriate analytic and conceptual frameworks were employed to

minimise dominant cultural biases and ensure the research did not invalidate the experience of Maori.

The commissioning of the study by an iwi mandated Maori Development Organisation, was central to ensuring that the research was undertaken within a context of accountability.

Participants

Participants were identified through a specially developed database. Three primary groups of participants were identified:

1. Current Maori Problem Gambling Treatment Service Providers in New Zealand (n=4).
2. Potential Maori Problem Gambling Treatment Service Providers, i.e. Maori health providers operating in te rohe o Ngai Tahu (n=20).
3. Non-Maori Problem Gambling Treatment Service Providers operating in te rohe o Ngai Tahu and providing services to Maori (n=7).

Procedure

Potential participants were initially contacted via a letter from He Oranga Pounamu requesting participation in the study. Project team interviewers followed up the letters and confirmed the willingness of participants to take part in this project. If acceptable, a phone interview was then arranged at a time convenient to the participants.

Kanohi ki te kanohi has frequently been promoted as the optimal, or even only, means of gathering information from Maori, in order to ensure maintenance of researcher accountability. It has been suggested however that such relationships can be maintained even if data is not gathered in this way (Cram, 2001). The team was aware from past experience that face to face interviews were not always feasible or preferred by potential participants and that insistence on such by the researchers may limit participation. Within the current project, as well as others carried out under the auspices of Ngai Tahu (Ngai Tahu Development, 2004; Pitama & Ahuriri-Driscoll, 2001), accountability has been supported through a range of interconnections, particularly those already existing within and between the

iwi, runanga and related organisations. Therefore, in a context of multiple lines of accountability, including those of individual team members, a number of advantages were identified in relation to the use of phone interviews to gather data. These included:

- The relative ease with which they could be arranged.
- The convenience for participants.
- The ability to enable wide participation and extensive input.
- The acceptability to most participants.

The majority of participants found phone interviews acceptable for the purposes of the current research, however, two Maori providers requested further discussion about the nature of the research prior to participation and two others requested face to face interviews. One service declined to take part in the study, however the reason for doing so was not clear. Two Maori services identified as potential participants could not be contacted for interviews.

Analysis of Interviews

Structured interview schedules were developed to collect information on service providers' current efforts to respond to the needs and aspirations of Maori, their scope of practice, and willingness to engage with further development of gambling services for Maori. Interview notes were summarised using data summary sheets, which correlated with the structure of the questionnaire. Both quantitative and qualitative data were collated. The quantitative data collected was summarised and reported using basic descriptive statistics. Qualitative data was reviewed using thematic analysis. Specifically, the project co-leaders jointly developed the themes after initial independent examination of participants' responses.

Results

Current Maori Problem Gambling Treatment Service Providers

Four Maori organisations currently providing gambling services, all located in the North Island, were interviewed. All of these programmes were set up in

response to a lack of Maori gambling services and an identified need for such services in their communities. Of three services who were interviewed at length, two had a 100% Maori client base, with the third reporting a roughly fifty-fifty split between Maori and non-Maori. Full time equivalent (FTE) staff numbers ranged from 1-3. All staff were Maori, apart from one non-Maori staff member who was employed in a 0.5 FTE position.

Staff held a range of tertiary qualifications, including, nursing, teaching and social work. In terms of staff development, all interviewees stressed the importance of training that focused on culturally salient material and was delivered within culturally congruent contexts. Two interviewees highlighted the importance of "academic" training, but stressed the need for "getting the balance between academic, tikanga, community and experiential knowledge". Another participant noted the danger of newly qualified and inexperienced workers becoming overly rigid in their approach and not continuing with professional and personal development.

Respondents cited incorporation of Maori practices and knowledge as central to service delivery, although, the differing experiences and needs of individual Maori presenting for assistance was noted. The importance of developing and maintaining relationships with other Maori groups, including mana whenua was identified, though challenges to achieving this were acknowledged. With regard to setting up services, the need for adequate resources, especially in terms of appropriately experienced staff, was strongly emphasised. All interviewees were positive about proposed developments in te rohe o Ngai Tahu and suggested that wide and ongoing consultation would help to avoid 'reinventing the wheel'.

Potential Maori Problem Gambling Treatment Service Providers

The 17 providers interviewed had been delivering services for between 8 months and 18 years. Service development was driven by the health status and specific needs of Maori clients in their area, which were seen

as not being met in the 'mainstream'. Preventative models, whanau based interventions and reinstalling cultural values and practices were favoured by interviewees as modes of intervention. Staff levels varied widely, from 2 to 22 full time equivalent positions (FTE), between 2 and 22 of whom were Maori and 0 to 4 non-Maori. Several services noted the importance of volunteers on their staff.

Staff development was viewed as an integral part of the service, budgetary constraints notwithstanding, with cultural supervision, having access to learning te reo Maori, and attending hui cited as central means of such development. There was a diversity of staff skills and qualifications amongst the providers ranging from diploma courses through to Master's degrees and including courses in health service delivery, business management/administration, mental health, information technology, education and Maori development.

All of the 17 providers worked with Maori as a primary target group. Seven had a 100% Maori client base, seven had between 90-99% and three had between 50-80% of their clients identifying as Maori. All respondents reported that they incorporated tikanga Maori in service delivery, citing examples ranging from the general ("incorporating cultural values" and "cultural policies") to the specific ("karakia", "waiata" and "taking shoes off").

All respondents in this group were positive about participating in some aspect of gambling service delivery and the majority reported some current involvement with addiction interventions. Three cited addiction as their primary focus, ten as their secondary focus and four reported that they referred all clients on for addiction treatment. Addictions models used were primarily focused on Maori principles, e.g. Te Whare Tapa Wha, the Powhiri Model, Whanau Well-being, Te Ngaru, Te Wheke, the Poutama model and Te Pa Harakeke. Some providers also reported that clients were more comfortable with these models and that they worked to assist those clients who were not benefiting from "mainstream" programmes.

Several non-Maori approaches were cited also including the "mainstream model" Alcoholic Anonymous, "harm minimisation" and "abstinence".

Interviewee's commented that they could refer clients who had gambling problems on to a number of gambling services or private practitioners (all but one, non-Maori), but noted that they had rarely done so. The majority of those who did not provide addiction input were unclear about where they could refer clients to. All cited a need for training in the area of gambling, although some expressed an interest only in the health promotion area. An existing high level of collaboration between Maori organisations was evident from responses.

Non-Maori Problem Gambling Treatment Service Providers

The seven non-Maori gambling service providers were all linked to one of two umbrella organisations. These services had been established for between two and 25 years. Respondents were generally unsure of the proportion of Maori clients seen by their service. Of those that did report a proportion, two estimated 1% and "very few", while two others estimated 20-25%. One respondent was unable to identify the current number of Maori, but suggested that five years ago the proportions had been similar to the general population, but did not specify whether that related to local or national figures.

Staff numbers for organisations varied between 1 and 8. Half of the organisations had no Maori staff, with only one service having more than one (four). Staff were identified as having a range of qualifications, including undergraduate and post graduate tertiary qualifications in mental health nursing, psychology, counselling, and social work. "Life experience" and "own values" were cited, as were administration and clerical qualifications.

Respondents were for the most part interested in improving their services for Maori, but most reported limited contact with and knowledge of Maori groups and a wide variation in the level of knowledge of issues pertinent to Maori. While some services reported a range of initiatives to improve their

responsiveness to Maori, others cited minimal development and motivation. Most respondents cited a lack of potential Maori staff as a key barrier.

Discussion

The literature and interviewee's responses suggest that problem gambling remains a significant concern for Maori, despite an apparent decrease in its prevalence in the wider community over the last decade (Abott & Volberg, 1999). All respondents identified the challenges of recruiting and retaining appropriately skilled Maori staff, reflecting concerns raised in other areas of Maori health. The development of an appropriately skilled Maori workforce was identified as a priority if gambling related problems of Maori are to be successfully addressed.

This study found support for the suspicion that narrowly focused treatment would be unlikely to have a significant impact, highlighting a need for comprehensive strategies to address the individual and collective needs of Maori. However, respondents concurred that given the dearth of Maori with specific gambling training, the option of delivering specialised services for Maori by Maori, as suggested in Adams et al. (2003) was limited.

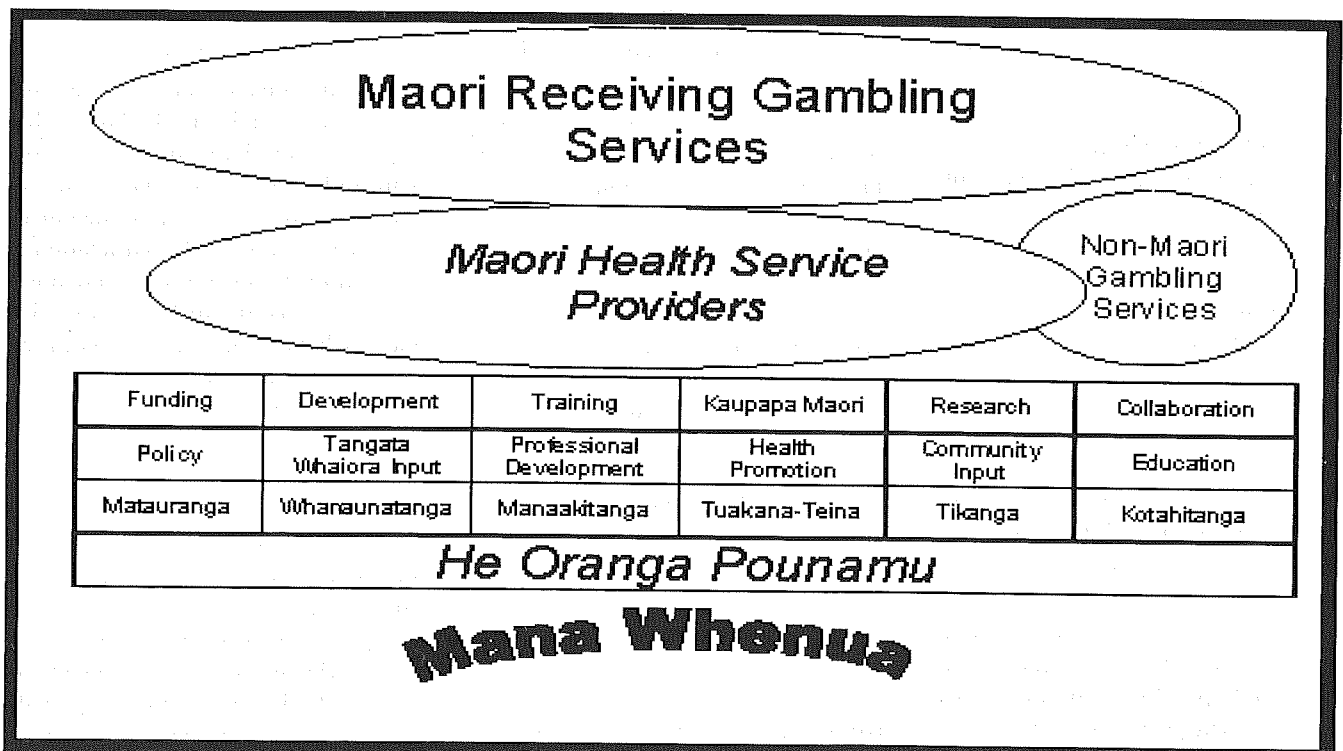
In terms of the training needs of Maori staff, a central question was whether the most appropriate package would comprise mainstream training with a Maori focus or Maori based training. This study supports ABACUS, (2004), Huriwai et al., (2000) and Robertson et al., (2002) who have indicated that approaches which prioritise the values, beliefs and practices of Maori when integrating western approaches are likely to be most appropriate for Maori focused treatment services. Additionally, while the workforce competencies suggested by Adams and his colleagues have identified some fundamental requirements for non-Maori working with Maori, further work is required to extend 'mainstream' conceptual frameworks, including those of psychology so that they are better able to incorporate the needs and aspirations of Maori.

Participants in this study envisaged gambling services being delivered within the broader context of Maori health services, although this question was not specifically investigated. Given the need for upskilling, an interim option could involve collaboration between generic Maori health services and specialist non-Maori gambling services. However, concerns were raised by both

Maori and non-Maori regarding the cultural safety of Maori staff working in isolation within 'mainstream' services. These concerns notwithstanding inter-service collaboration was generally supported by participants and a number of options were suggested, for example, locating a Maori specialist funded by a non-Maori gambling service, with a Maori provider. Alternatively Maori providers could contract appropriately qualified³ non-Maori providers and/or individuals to enable regular referral for specific input. Maori respondents were clear however that such an arrangement would not relieve non-Maori staff or services from obligations to provide a culturally responsive service for Maori who chose to engage with them.

In addition to facilitating development of trust, collaboration would provide an opportunity for respective services to determine the compatibility of models and service delivery formats. As noted above, CBT and other psychologically informed interventions appear to be among the most effective means of addressing gambling problems. While these may be useful for Maori, effective intervention requires development of models which integrate western techniques within the concepts and practices of Te Ao

Figure 1: Model for Development of Gambling Services for Maori in the Ngai Tahu Rohe



Maori. In the short term this may require collaboration with non-Maori services and training providers, in which case the maintenance of tino rangatiratanga is vital to ensure that the needs and aspirations of Maori are not marginalised or tokenised.

In contrast to Maori, whose responses indicated ongoing interconnection between services, non-Maori providers indicated that they engaged with Maori only in relation to specific tasks. Generally non-Maori respondents noted limited contact with Maori providers and Maori community groups able to provide them with appropriate cultural guidance or support. The results suggest that despite the willingness to engage with Maori, limited knowledge and lack of prioritisation restricted development of Maori responsiveness. The non-Maori providers surveyed would need to re-assess their policies and practices for interacting with Maori, if they wanted to ensure they could access support and guidance for their Maori clients

Accurate recording of ethnicity data is important for successful monitoring of Maori health disparities (Reid, 2001). Though ethnicity data was collected by the non-Maori services surveyed, the interviewees from these services had poor knowledge of the data, let alone the implications for service delivery and development. Such a lack of awareness would preclude accountability to Maori clients and the wider community. Specific needs for the Maori client group can not be determined, nor can the requirements for further staff and service development be accurately evaluated within such a knowledge vacuum. Further, lack of awareness of ethnicity data contributed to limiting the perception of the need to work alongside Maori services and communities.

Framework

Maori respondents' endorsed a broad approach to addressing gambling related problems, which included health promotion and education, to enable whanau and the wider community to make informed decisions about gambling. The privileging of Maori values, practices, and beliefs along with the development and retention of an appropriately skilled workforce

were identified as core needs. Given the current make up of Maori health providers, it was apparent that the most feasible model for delivering interventions within te rohe o Ngai Tahu would involve inter-sectoral collaboration within a developmental framework. This would allow for ongoing involvement of various stakeholders as integrated models of service delivery were developed to meet the diversity of needs of Maori requiring assistance with gambling related concerns. The framework outlined in Figure 1 was constructed to guide the development of services for Maori in te rohe o Ngai Tahu, however it is likely that elements and principles highlighted could be applicable in other regions:

- The group at the pinnacle of the model is made up of the individuals and whanau who are the focus of this framework and who ultimately determine its success.
- Maori services are the key providers in this framework, but the place of non-Maori gambling services is recognised, albeit in a significantly less central role than is currently the case.
- The building blocks illustrated were cited as important by key stakeholders in Maori gambling, addiction and health fields, and include key Maori principles and processes. While these are included in commonly cited Maori models of health in the literature, more importantly, they were identified directly through the responses and reported practices of those who were interviewed for this study.
- *He Oranga Pounamu* is located at the base of this model, as it was seen to provide a foundation link across the range of providers and various developmental elements/processes.
- *Mana Whenua* (embracing local runanga/marae and associated organisations) provides the foundation for this model, signifying that the wellbeing of Maori in any rohe is based on fulfilment of the rights and responsibilities of the local people.

In line with contemporary Maori writing (e.g. Durie, 2001; Marsden, 2003; Mead, 2003), participants in the current research identified processes that facilitated wairuatanga as being central to the successful development

and implementation of Maori focused treatment. The framework above does not explicitly identify this element, as it conceptualises maintenance of wairua as the implicit result of the interaction of the key facets of the model, rather than being just another component.

Given the varying levels of development of the potential contributors to the development of gambling services in te rohe o Ngai Tahu, the proposed framework provides for utilisation of the complementary strengths of the various stakeholders. This consideration was central to the identification of the areas in need of further development listed below:

1. **Training** – i) training in the treatment of problem gambling for Maori agencies to enable them to provide specialist services and/or increase collaboration with existing providers, ii) training for non-Maori gambling treatment services to facilitate improved collaboration with Maori providers and increase cultural responsiveness of existing services. The success of such training would be dependent on development of conceptual frameworks able to integrate Maori and western concepts and practice, the privileging of the former notwithstanding.
2. **Data Collection** – Further information is needed to establish the prevalence and nature of gambling problems in the service area and to provide a clearer profile of people likely to access services.
3. **Further Framework Development** – A range of stakeholders should be involved in developing the service framework to fit their region's needs. Prevalence and client profile data, as well as information from relevant literature should be accessed also.
4. **Responsiveness of Non-Maori Services** – Whilst, the responsibility for Maori responsiveness rests with individual organisations, Maori Development Organisations and other relevant Maori stakeholder groups may wish to work alongside non-Maori agencies and/or play a role in monitoring service delivery.

The results indicated the need to develop health promotion and education about problem gambling, including appropriate Maori focused resource

materials. Expansion of policy and research development was also identified as crucial to ensuring the maintenance of Maori responsive services.

Summary and Conclusions

A review of the literature and the results of the current study suggest that gambling problems have a not insignificant impact on Maori, individually and collectively. There is, however, a need to clarify the nature of the impact of gambling problems and to develop more responsive interventions where problems exist. Anecdotal evidence and a relatively small published literature indicate that Maori focused services can improve access, retention and outcome for Maori clients. This study suggests that there is a good base for developing Maori responsive gambling services in te rohe o Ngai Tahu, where there are already several kaupapa Maori health services in operation. Recruitment and retention of skilled Maori staff was identified as a high priority to enable establishment of the means to address gambling problems. While Maori service development was identified as a priority, this study suggests there is support for collaborative approaches involving non-Maori providers. The latter would need to significantly develop their capacity in a number of areas in order to meet the needs and aspirations of Maori clients and enable collaboration with Maori providers. This development could be readily guided by the framework proposed in this paper, which clearly privileges central concepts and practices of Te Ao Maori, as well as providing a structure for relational advancement. It is proposed that service and workforce development could be supported by conceptual frameworks which enable integration of effective western interventions within Maori health models and extension of 'mainstream' paradigms to enable engagement with the central tenets of Te Ao Maori.

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Notes

1. Commissioned by the Problem Gambling Committee and undertaken under the auspices of the Ngai Tahu Iwi Maori Development Organisation, He Oranga Pounamu.
2. The project brief called for consideration of both public health and treatment interventions, however most of the services survey were involved in the latter and information gathered with regard to the former was very limited. Therefore the current article focuses solely on treatment services for gambling related problems.
3. That is, qualified in terms of professional training, as well as the skills, knowledge and relationships to enable them to work effectively with Maori clients.

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