Whare Tukutuku

Reimagining an Approach to Alcohol Screening for Whānau Māori

SCOPING REPORT - HAKIHEA 2025

TE RAU ORA

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He Mihi

Tēnā koutou, ngā rangatira o te motu.

E ngā rau rangatira, tēnei te mihi mō o koutou whakaaro nui. No reira e ngā rangatira huri noa i te motu, tēnā koutou, tēnā koutou, tēnā koutou kātoa.

Whare Tukutuku extend our warmest gratitude for your contribution to this research. We acknowledge and thank you, for your diligent thoughts and words of wisdom. To you all, we are privileged by your contribution and time. Once again thank you.

Executive Summary

This report presents findings from a study exploring kaimahi perspectives on alcohol screening for Māori whānau. The research focused on understanding why Māori were screened less frequently than non-Māori, the effectiveness of current screening tools and how culturally appropriate approaches could be developed.

Key Findings

- Tools don't always fit Māori culture: Mainstream screening tools can feel irrelevant or reductionist.
- Relationships matter most: Building trust and explaining questions helps whānau answer honestly.
- Flexibility works best: Using a mix of Māori-led and adapted Western tools meets different needs.
- System issues affect care: Māori services are sometimes treated as a backup, and policies or workload can limit effective screening.
- Co-design improves tools: Involving whānau and staff makes tools more practical and culturally safe.
- Review and adapt: Regularly checking and updating tools keeps them useful and effective.

Limitations

Selection Bias: Participants were purposively selected by the research team, which may limit diversity of perspectives.

Response Bias: Participants' answers may have been influenced by perceived expectations, leading to potential misreporting of behaviours or opinions.

Recommendations

1. Offer a range of screening options: Provide multiple tools and guidance to adapt questions to cultural and personal contexts.
2. Strengthen engagement before screening: Build rapport and explain questions clearly; train staff in cultural safety and trauma-informed practice.
3. Improve referral pathways: Ensure Māori services are primary options, with clear processes and timely follow-up.
4. Co-design tools and processes: Involve whānau and staff to ensure cultural relevance and usability.
5. Ensure practical implementation: Pilot tools in real-world settings to confirm usability and effectiveness.
6. Monitor and adapt practices: Continuously review screening approaches with staff and whānau input.

Introduction

This scoping report is part of a broader project that was commissioned by Health New Zealand Te Whatu Ora at the beginning of 2025 to develop an alcohol SBIRT (screening, brief intervention, refer to treatment) approach for whānau Māori.

There are many existing screening tools and approaches being currently used by the workforce across a range of settings. These range from western tools such as AUDIT – which uses a prescribed set of 10 questions to create a score describing the severity of a person's drinking – through to kaupapa Māori approaches which take a more holistic view of hauora such as Te Whare Tapa Whā.

One existing tool is the alcohol ABC approach (**A**sk, **B**rief Advice, and **C**ounselling) that was piloted by Counties Manukau Health from 2016-2023, based upon smoking cessation tools. The purpose of the approach was to support staff to have "skilled and empathetic" conversations about alcohol use and was trialled by kaimahi in a number of different settings in Counties Manukau including general practices, an inpatient ward, and the emergency department at Middlemore Hospital.

The evaluation for this pilot identified a number of key barriers and enablers to successfully implementing the alcohol ABC approach. The enabling factors included increased kaimahi capacity, strong buy-in from senior leadership, and adaption of the approach across different project environments. Barriers identified included stigma around alcohol use, ethnic biases, and workforce shortages.

As a result of these enablers and (particularly) barriers, the report made the recommendation to develop "a kaupapa Māori model for having conversations about alcohol with patients and whānau". It is this recommendation that Whare Tukutuku have been commissioned to investigate and develop. Broadly, there are two parts to this project: (1) develop an SBIRT approach for whānau Māori, and (2) design a campaign to socialise the approach and to reduce stigma toward whānau Māori who use alcohol.

The purpose of this report is to analyse the first stage of this project. Firstly, the report will discuss the mythology of the study, including the research methods used. It will then look at the findings of the research, identifying key themes and kōrero which have emerged. Finally, it will offer recommendations as to what needs to be done to better support whānau Māori with alcohol use concerns and to what a reimagined approach could look like.

Whare Tukutuku acknowledges the mātauranga and lived experiences of our kaimahi, whānau, and hapori Māori. The insights gathered through this project will play a pivotal role in designing an approach to alcohol screening that fosters aspirations of pae ora across the motu. Furthermore, these findings will provide a valuable lens to better support whānau with alcohol use concerns, helping to reduce stigma and discrimination.

Literature Review

Alcohol-related harm remains a significant public health issue in Aotearoa, with Māori experiencing disproportionately high rates of hazardous drinking and alcohol-related morbidity and mortality (Ministry of Health, 2021). These inequities are underpinned by the enduring impacts of colonisation, systemic racism, and intergenerational trauma, which continue to influence Māori access to culturally safe and effective health services (Came, McCreanor, & Simpson, 2019).

In 2010, the Ministry of Health introduced the ABC approach (Alcohol Assessment, Brief Advice, and Counselling) as part of a strategy to reduce alcohol-related harm in Aotearoa (Ministry of Health, 2010). However, an evaluation of the model's application in the Counties Manukau region has highlighted limitations in the cultural responsiveness and acceptability of the ABC model for Māori whānau (Counties Manukau Health, 2020). Feedback from Māori health providers and communities indicates that the model, as implemented, often fails to align with te ao Māori, lacks a holistic view of wellbeing, and may inadvertently perpetuate deficit narratives about Māori alcohol use (Came et al., 2020).

There is growing interest in developing Māori-centred screening tools and harm reduction approaches that reflect Māori health models such as Te Whare Tapa Whā, Te Wheke, and Pae Ora (Durie, 1998; Ministry of Health, 2014). These models emphasise holistic wellness and interconnectedness, offering culturally relevant pathways for prevention and intervention. Unlike the ABC approach, which tends to follow a biomedical model of behaviour change, these Māori frameworks ground wellbeing in relationships, spirituality, and cultural identity factors essential for the development of any effective intervention for Māori.

Internationally, Indigenous communities have developed culturally grounded alcohol screening tools such as the Indigenous Risk Impact Screen (IRIS) in Australia (Schlesinger et al., 2007), and the Grog Survey App, a mobile tool designed to enhance alcohol screening through culturally appropriate visuals and language (Clough et al., 2019). These examples demonstrate the potential for culturally tailored approaches to improve screening accuracy, community engagement, and outcomes.

This literature review synthesises Indigenous models and frameworks for AOD (Alcohol and Other Drugs) harm reduction and screening to inform the design of a Māori-specific alcohol screening tool. The goal is to support the development of a model that upholds tino rangatiratanga, fosters mauri ora (holistic wellbeing), and enhances cultural safety in the provision of alcohol-related healthcare.

Existing Indigenous Screening Tools

In recent years, Indigenous communities across the world have taken significant strides in creating health screening and intervention tools that are culturally resonant, community-driven, and clinically effective. These innovations reflect a critical shift away from one-size-fits-all models toward approaches grounded in Indigenous worldviews, values, and lived realities. Rather than adapting Western frameworks, many of these tools have been built from the ground up in partnership with Indigenous leaders, health workers, and researchers. They not only address substance use and mental health concerns but do so in ways that promote dignity, cultural safety, and self-determination.

Indigenous Risk Impact Screen (IRIS) – Australia

The Indigenous Risk Impact Screen (IRIS) is a 13-item screening tool that was co-designed through a collaborative effort between Indigenous and non-Indigenous researchers in Australia. Developed in response to the lack of culturally appropriate assessment tools, the IRIS was specifically created to identify both substance use and mental health risks among Aboriginal and Torres Strait Islander peoples (Schlesinger et al., 2007).

Unlike conventional screening tools that often fail to resonate with Indigenous worldviews or lived experiences, the IRIS incorporates culturally informed language, concepts, and delivery methods to ensure

that participants feel respected, safe, and understood during the screening process. The tool's dual focus on comorbid substance use and mental health conditions reflects the interconnected nature of these issues within Indigenous communities, where holistic wellbeing encompassing mind, body, spirit, and connection to land and whānau is paramount.

The IRIS has undergone rigorous validation and has demonstrated strong psychometric properties, including high sensitivity and specificity, ensuring its reliability in diverse settings (Nagel et al., 2014). It has also received widespread acceptability among both health professionals and community members, particularly because it reduces the potential for stigma and supports culturally safe engagement.

Importantly, the IRIS is not just a clinical tool but also a model for how culturally responsive approaches can enhance health equity. It is widely used across both community-based and clinical services, including Aboriginal Medical Services and alcohol and drug rehabilitation centres, and it serves as a practical example of Indigenous-led innovation in health screening

Grog Survey App – Australia

The Grog Survey App is a digital alcohol screening and self-assessment tool specifically designed to assess drinking patterns among Aboriginal and Torres Strait Islander peoples. Recognising the limitations of mainstream screening tools that often lack cultural relevance or sensitivity, this app was developed through a co-design process that prioritised Indigenous knowledge, community consultation, and cultural safety at every stage (Clough et al., 2019).

The app's strength lies in its culturally grounded approach, which incorporates local language translations, visual storytelling, interactive elements, and non-judgmental phrasing, all of which are intended to foster engagement, reduce misunderstandings, and encourage users to reflect honestly on their alcohol consumption. It avoids shame and stigma, which are significant barriers to help-seeking in many Indigenous communities. By offering a private, self-directed, and anonymous platform, the app creates a safe space for individuals to explore their drinking behaviours without fear of judgment.

Beyond individual use, the app is designed for deployment in a range of community and clinical settings, including Aboriginal Community Controlled Health Services (ACCHSs), outreach programmes, and public health campaigns. Its flexibility and adaptability mean it can be used as both a screening and educational tool. Studies have highlighted its effectiveness in prompting behavioural insight and increasing awareness of drinking habits (Clough et al., 2020).

Qungasvik ("Toolbox") – Alaska Native (Yup'ik) Communities

Qungasvik, meaning "toolbox" in Yup'ik, is a culturally grounded intervention developed by and for Alaska Native (Yup'ik) communities. Designed to prevent suicide and alcohol misuse among rural Alaska Native youth, the program comprises a suite of 18 experiential modules based on Indigenous protective factors and relational worldviews (Rasmus et al., 2019).

These modules incorporate traditional practices such as hunting, fishing, drumming, dancing, and storytelling activities that are deeply embedded in Yup'ik culture and known to promote resilience, identity, and intergenerational connectedness. Each module is a guided experience rooted in cultural teachings and delivered by community elders, local facilitators, and youth leaders.
The intervention is dynamic and adaptable, allowing each community to tailor modules to their specific needs and seasonal practices. An evaluation using a control design revealed dose-dependent effects, demonstrating that greater exposure to the intervention resulted in significantly improved outcomes in protective factors related to alcohol resistance and reduced suicide risk (Allen et al., 2020).

Qungasvik exemplifies Indigenous innovation in health promotion by reframing prevention through a strengths-based lens and affirming the central role of culture in fostering wellness. It serves as a blueprint

for other Indigenous interventions worldwide that seek to revitalise ancestral knowledge while addressing contemporary health challenges.

Māori Models and Frameworks for Screening and Assessment

In Aotearoa, several Māori-developed health models offer culturally anchored foundations for screening and assessment, including in the alcohol and mental health context. The Meihana Model (Pitama et al., 2007), an extension of Te Whare Tapa Whā, incorporates six interconnected dimensions—whānau (family), wairua (spiritual), hinengaro (mental), tinana (physical), taiao (physical environment), and iwi katoa (services and systems) to guide clinical assessment with Māori. It promotes a holistic understanding of wellbeing that is relational, dynamic, and rooted in te ao Māori. Another key framework is Hua Oranga (Kingi & Durie, 2000), a culturally validated outcome measure for mental health services that aligns with Māori definitions of wellness across the four traditional dimensions of wellbeing. While not designed solely for alcohol use, these models offer essential guidance for developing screening tools that honour Māori worldviews and support meaningful engagement. Their integration into clinical settings demonstrates a commitment to cultural safety and suggests a clear pathway for designing a Māori-specific alcohol screening tool that reflects tino rangatiratanga and supports mauri ora.

Discussion: The Need for a Māori-Specific Alcohol Screening Tool

These Indigenous models offer compelling evidence of the importance of culturally grounded health interventions. The IRIS, Grog Survey App, and Qungasvik show that health screening and prevention tools are most effective when designed with and for Indigenous communities.

In Aotearoa, the Alcohol ABC model has proven insufficient for Māori whānau. The Counties Manukau evaluation revealed critical gaps in cultural safety, responsiveness, and leadership (Counties Manukau Health, 2020). The presence of ethnic bias, a lack of tikanga-based practice, and inequitable service delivery underscore the urgent need for a decolonised, Māori-led alcohol screening approach (Came et al., 2020).

Methodology

This study employed a mixed-method design using both quantitative (survey) and qualitative (individual interview) data. A survey was developed using Survey Monkey consisting of 17 questions. A total of 84 people completed the survey. For the qualitative component, 8 individual interviews were conducted with kaimahi from across Aotearoa. We gathered a range of perspectives from those with lived experience, kaupapa Māori practitioners, AOD clinicians, policy experts and service managers. Interviews were held online and lasted approximately 45 minutes to an hour. We also held one workshop in Ōtautahi and one online focus group. The findings from the workshop were used to inform both the development of the survey and the interview questions for this research.

Data analysis

Survey data was analysed using Survey Monkey and individual interviews were thematically analysed verbatim from the interview transcripts.

Limitations

Selection bias: the interviewees selected for qualitative interviews were purposely selected by the research team potentially limiting the diversity of perspectives.

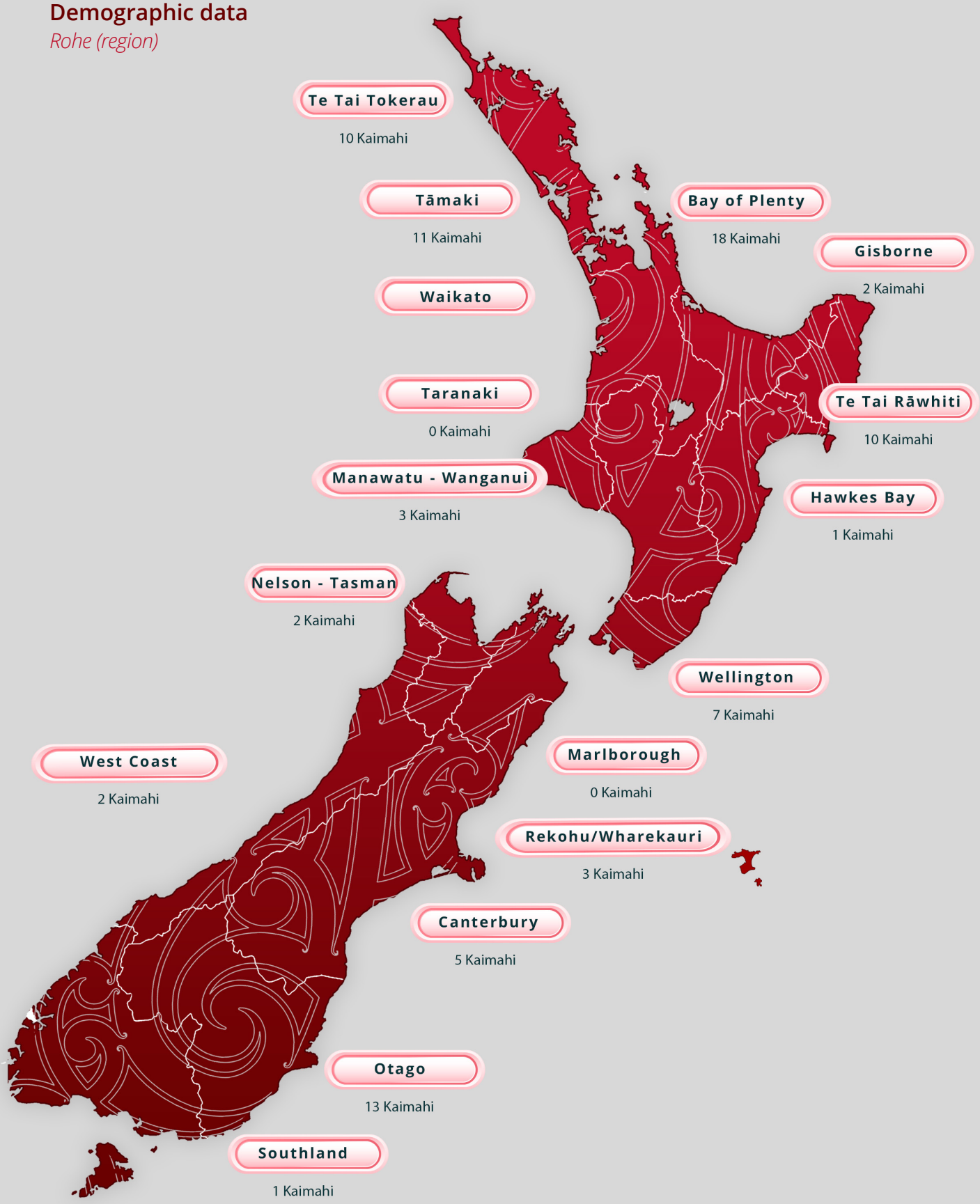
Response bias: our survey relied on self-report data which may not actually reflect actual behaviours and experiences.

Survey findings

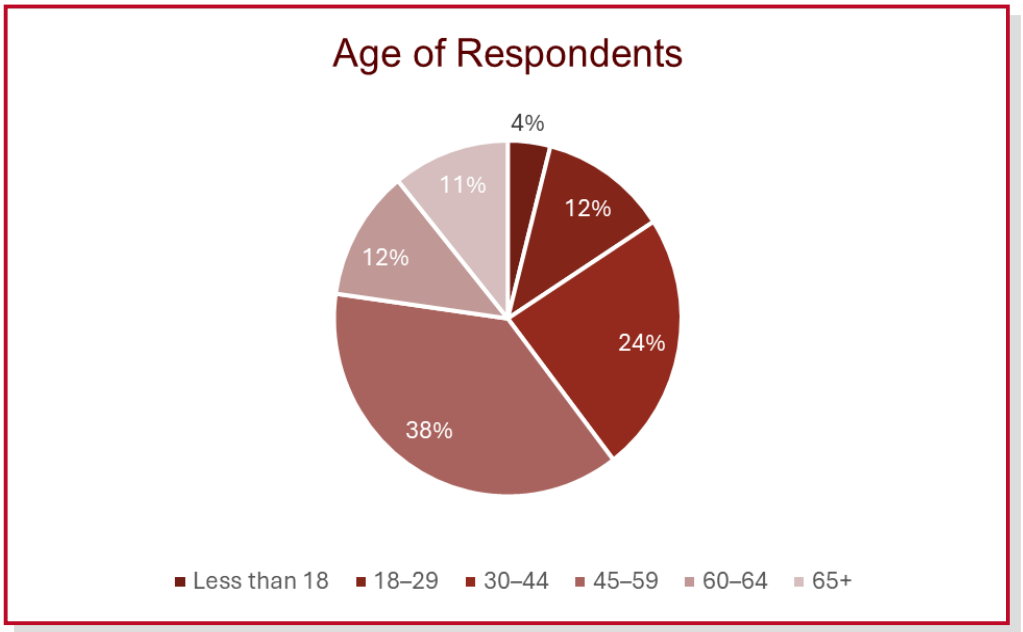
To gain a clearer picture of kaimahi experiences, a survey was undertaken to capture key demographic information and patterns in practice across the regions. The survey incorporated a mix of both qualitative and quantitative data that highlight both demographic and kaimahi experiences across the motu. This context helps to frame the qualitative insights that follow and supports a more comprehensive understanding of the perspectives shared by kaimahi.

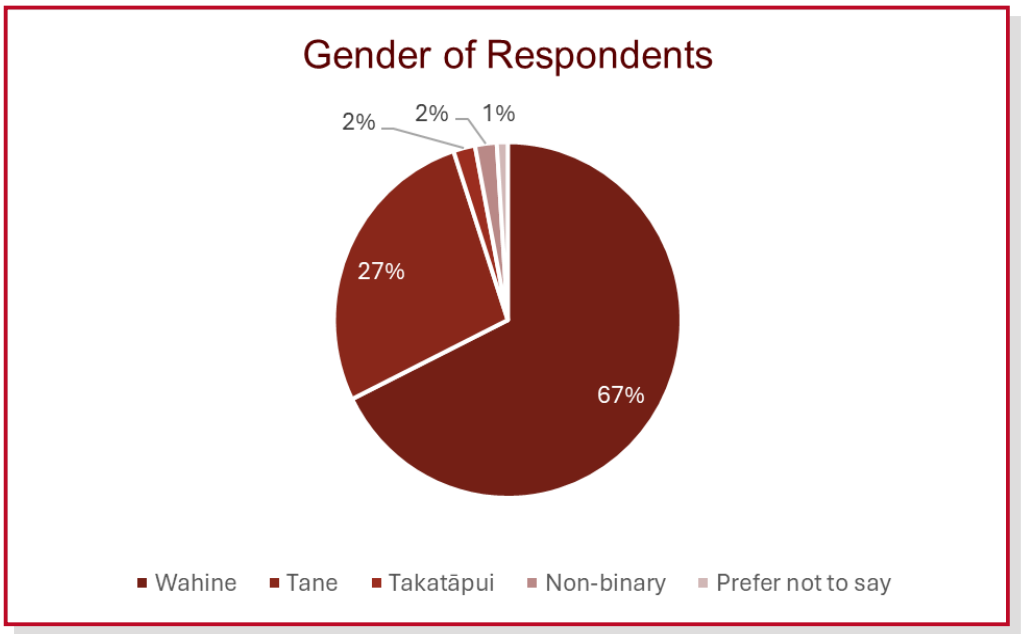
Demographic data

Rohe (region)



Most kaimahi **22%** lived in the Bay of Plenty region, **16.3%** lived in Otago and **13.58%** lived in Tāmaki.

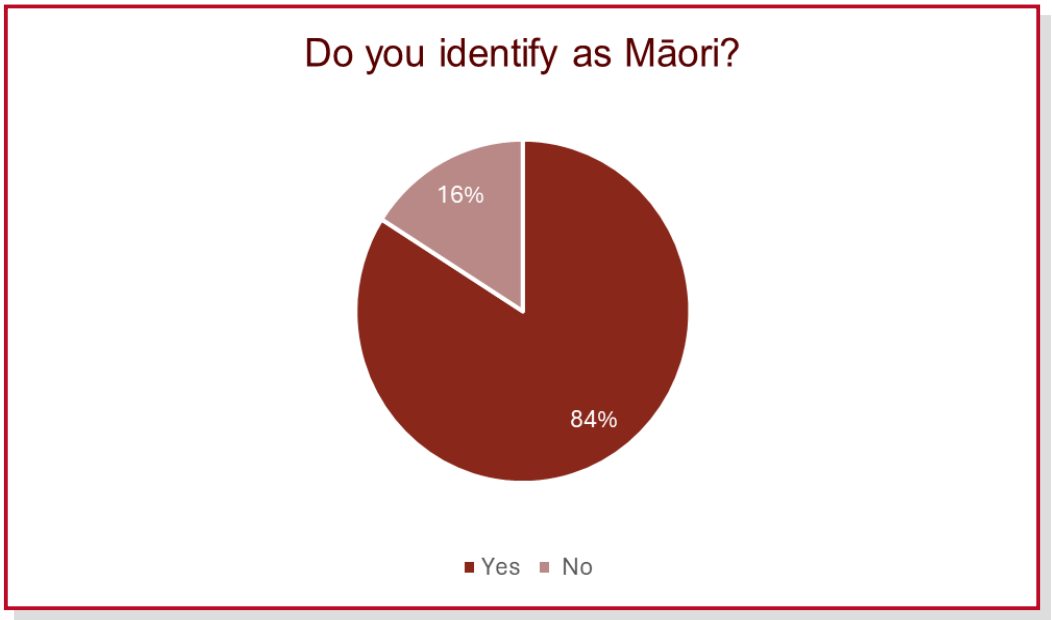




Age and gender

The majority **38%** of kaimahi who completed the survey were aged between 45-59 years old with the second largest age bracket being 30-44 years **24%.** Most kaimahi that completed the survey identified as women **67%, 27%** identified as men, **2%** identified as Takatāpui and a further **2%** identified as non-binary. This is largely reflective of the gender differences consistently found in workforce research that shows that there are more Wāhine working within the Māori health workforce than Tāne.

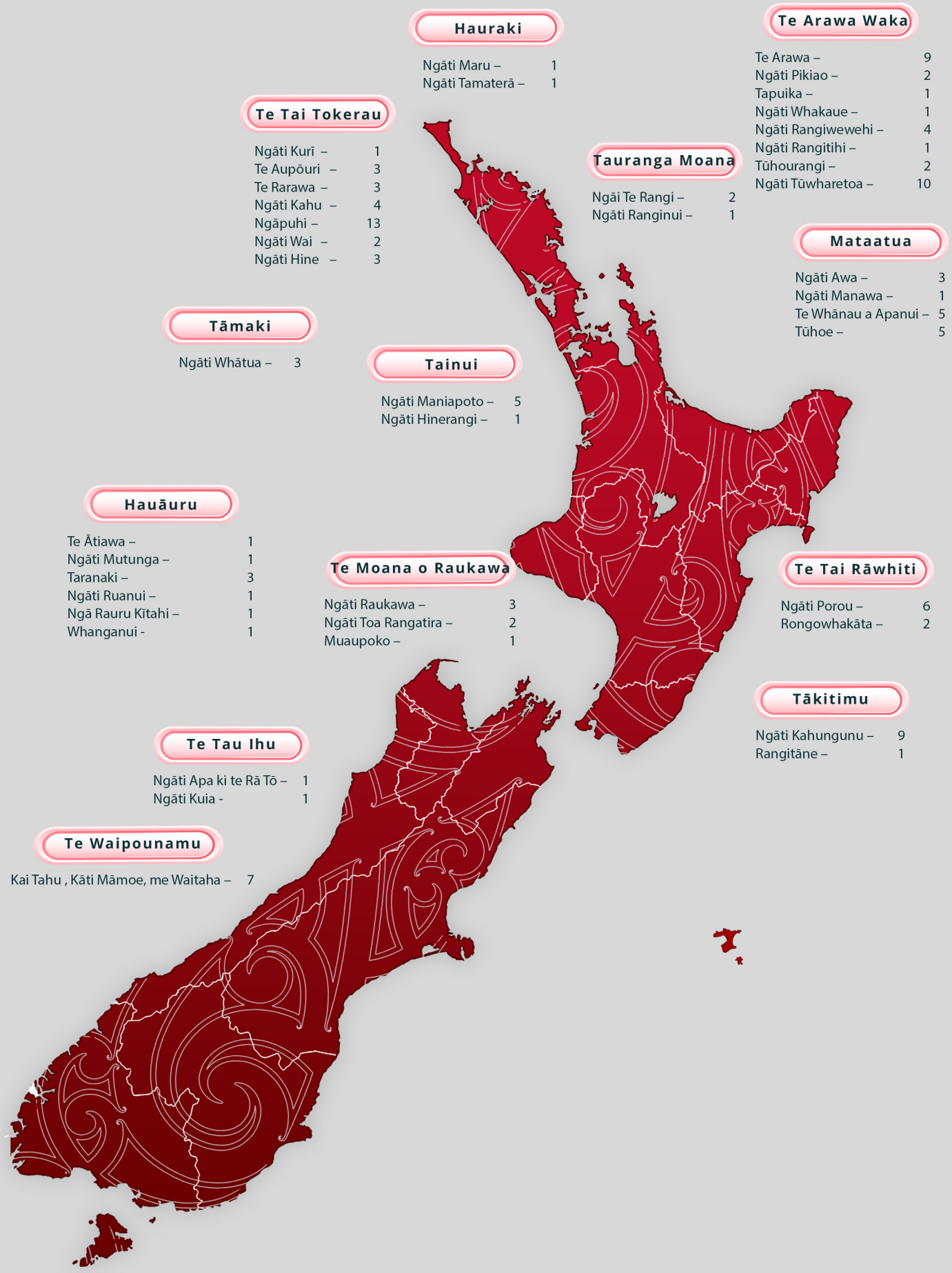
Ethnicity



This survey was open to both Māori and non-Māori kaimahi. **(84%)** of those who completed the survey identified as Māori and **(16%)** identified as non-Māori.

Iwi

The majority of Māori kaimahi who completed the survey were from Te Tai Tokerau



Approaches and tools used to address alcohol concerns

This question explored the key approaches and tools kaimahi use when identifying alcohol-related concerns with whānau Māori. It focuses on the practical methods that guide engagement and assessment, highlighting the core frameworks shaping everyday practice. When asked what approaches/tools kaimahi utilise when working with whānau Māori answers included:

- Te Whare Tapa Whā
- Powhiri Poutama
- AUDIT -C
- ADOM (Alcohol and Drug Outcome Measure)
- Whānau Ora Approach

Many kaimahi emphasised the importance of whakawhanaungatanga and simply having a kōrero when working with Māori whānau.

Barriers and challenges when having conversations with whānau

Kaimahi identified several key barriers and challenges when discussing alcohol use with whānau Māori, with **service access and readiness** and **stigma and shame** emerging as the most prominent themes. Issues of **whakamā**, fear of judgment, and past negative experiences with services were frequently highlighted, reflecting the importance of **trust and cultural safety** in these conversations. Service-related barriers included limited availability of culturally appropriate programs, long waiting times, and the challenge of supporting whānau in environments where alcohol use is normalized. Stigma and shame were reinforced by intergenerational trauma, difficulty articulating experiences, and the absence of safe spaces to discuss alcohol-related concerns. Together, these findings illustrate that conversations about alcohol with whānau Māori are shaped as much by **relational and systemic factors** as by individual readiness.

Service access and readiness

"Confrontation of the addiction and access to service"

"State of whakamā. When they are ready all our residential and detox are mainstream - Waiting for a date and going back to their environment".

"Barriers include stigma, whakamā, and fear of judgement, as well as past negative experiences with services. Without trust and cultural safety, these conversations can be difficult for whānau Māori".

Stigma and Shame

"Intergenerational trauma, stigma, whakamā, whakahīhī"

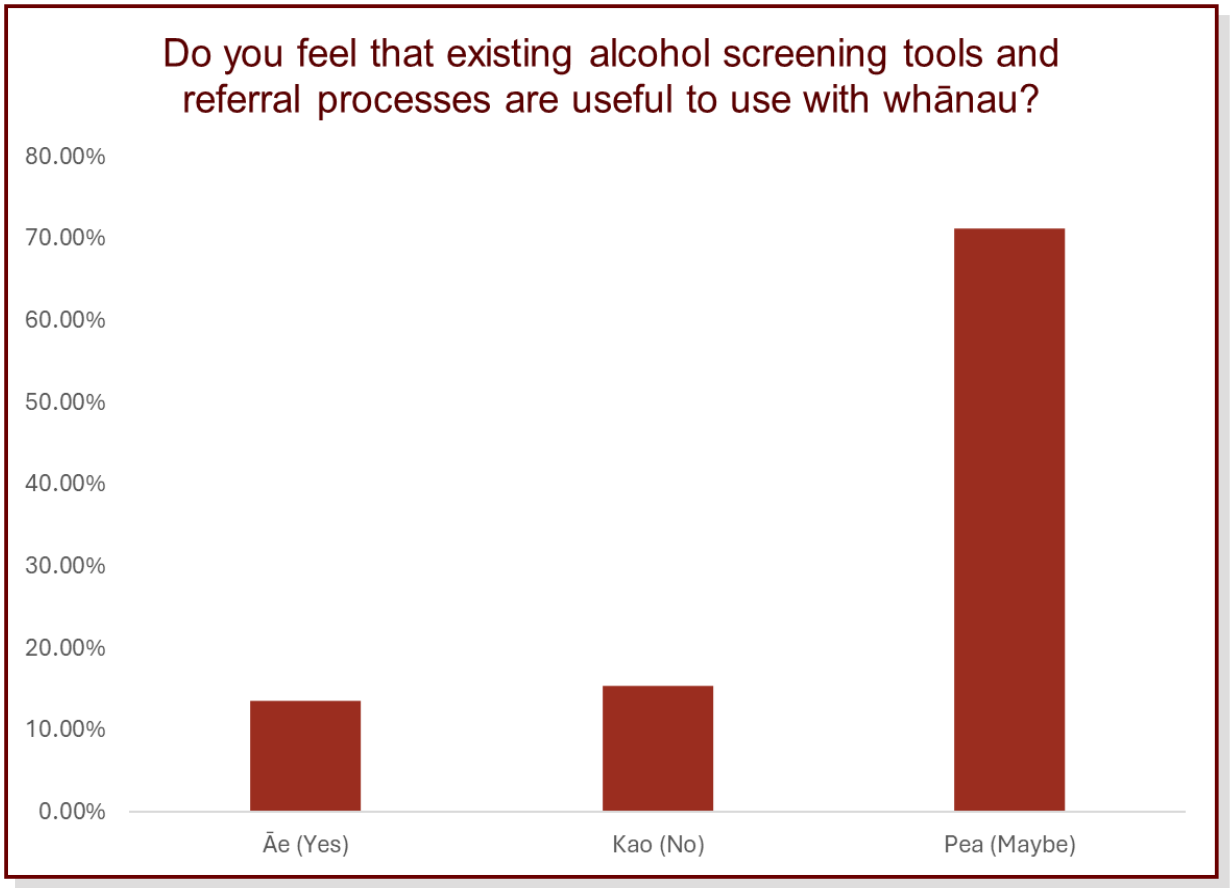
"Shame, education on alcohol harm, familial history, unavailability of safe settings for meetings"

"Whakamā, Unable to describe what is happening to them? Never talked about feelings so this is difficult, drinking is normalized, generational behaviours, trauma, work life balance and taking time for themselves, finding the right person to talk with".

Do you feel that existing alcohol screening tools and referral processes (i.e., Audit-C, ABC, or SBIRT) are useful to use with whānau?

Initial survey results show that most kaimahi feel that existing survey results are somewhat useful for Māori whānau 71.15%. When asked to elaborate on their answers kaimahi said:

- Tools are too individually focused; shame generating and ignore the history and context of addiction among Māori.
- Some tools can be useful for identifying if there are any issues and because they're widely used are less likely to create stigma.
- Current tools are useful for identifying one issue at a time given substance use can stem from various things that also needs to be addressed.
- Tools that focus on summative measurements do not provide opportunity for a full narrative response and the data is often impaired/unhelpful due to a change in circumstance or individual effort prior to seeking support.



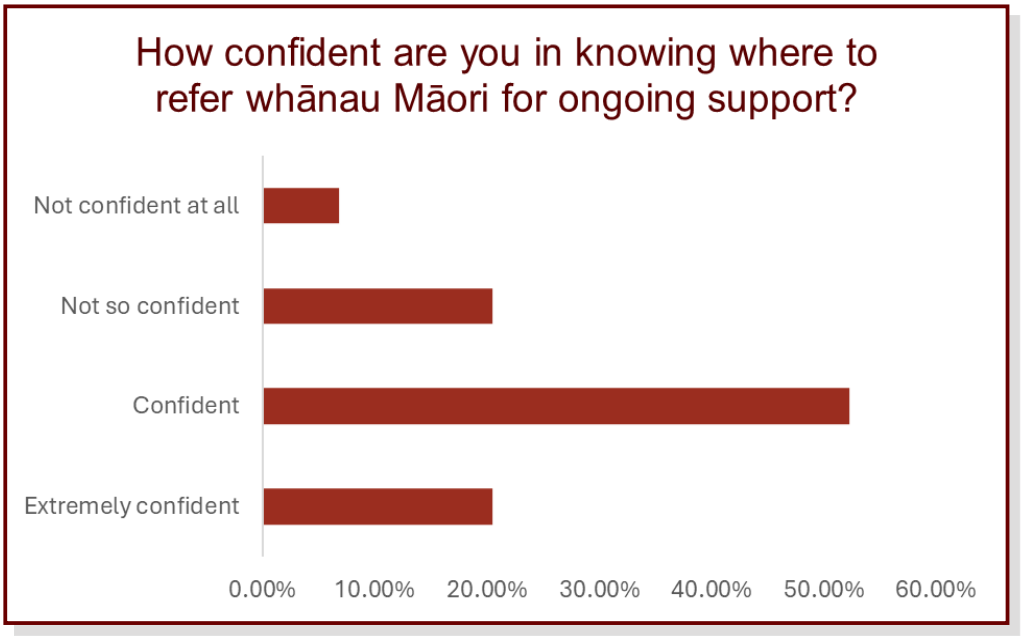
Brief intervention model(s) do you utilise to support whānau Māori

When asked about the types of brief intervention tools and models kaimahi use in their practice, kaimahi described using a range of different models including:

- Te Whare Tapa Whā
- FRAMES
- ADOM
- Trauma informed Cognitive Behavioural Therapy
- Purākau
- Pōhiri Poutama Model

How confident are you in knowing where to refer whānau Māori for ongoing support?

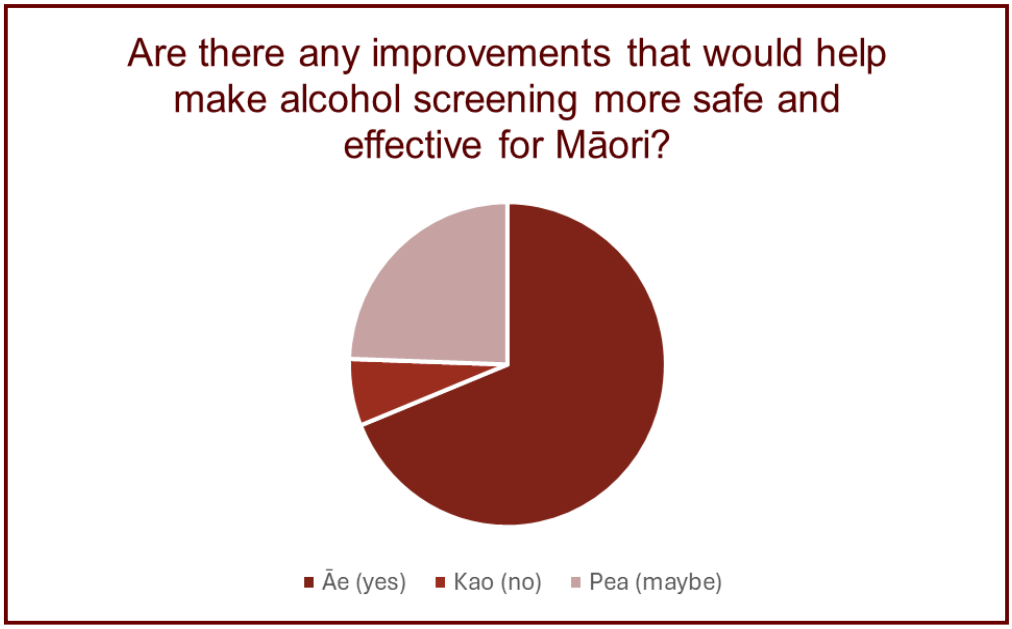
When asked how confident kaimahi were in knowing where to refer whānau Māori for ongoing support, 52% said they were confident in their knowledge of support services, 20% said they were extremely confident, interestingly 20% said they were not so confident. This is concerning when you consider the significantly higher rates of Māori how access alcohol and drug support and the importance of continued care in supporting those with alcohol dependencies.



Are there any improvements that would help make alcohol screening safer and more effective for Māori?

Majority of kaimahi who completed this survey indicated that there were improvements they believe would make alcohol screening a more effective and safe process for Māori. 6.67% of respondents did not believe so and 24.44% thought that there may be improvements that would be beneficial. When asked to explain their answers further, kaimahi suggested that:

- Whaiora be asked about their journey with alcohol and about other addictive behaviours because many patients are self-medicating due to trauma.
- It be ensured that kaimahi have at least a basic understanding of Te Ao Māori and Te Reo in addition to understanding how breaches of Te Tiriti o Waitangi have impacted and continue to impact whaiora and how honouring Te Tiriti can help to achieve equitable outcomes for Māori.
- All kaimahi learn how to build a rapport with whaiora to help normalise non-judgemental conversations where whaiora feel safe to disclose their issues.
- Whaiora experiences of the models/ experiences should be evaluated so we can improve. For example, simply asking whaiora 'how was that for you?".



Approaches, tools and methods kaimahi think work best for engaging Māori in conversations about alcohol use?

When asked what approaches, tools or methods kaimahi thought work best for engaging whānau Māori in conversations about alcohol use, answers included:

- Conducting Māori specific health assessments using Māori models and concepts that are culturally responsive.
- An empathetic, non-judgemental approach where kaimahi focus on whanaungatanga and building connections so whaiora feel safe.

Supports and resourcing kaimahi feel would help them in more confidently applying a kaupapa Māori approach in their mahi

22% of kaimahi said that they felt professional training would support them to more confidently apply a kaupapa Maori approach in their mahi. 13% of kaimahi indicated that having more Māori staff and workforce support would be beneficial. When asked to elaborate further on the survey question, answers included:

- Having more exposure to kaupapa Māori model.
- Making sure we have evidence-based rehabs that work and transition placements back to the community that aren't heavily religion focused.
- Increasing medical literacy for tangata whaiora and their whanau so that they are legally informed about detox and care whilst also retraining medical professionals to rid bias around patients and addiction.
- Kaimahi need more time, many work in time/session restricted services and need permission to work flexibly in different settings/ways where they can properly connect with whānau.

Is there anything else you would like to share about your experiences or whakaaro on developing an appropriate screening tool for alcohol-related support for whānau Māori?

"Whānau voice is critical in this development. Including the workforce working with whānau in this area. Any tool should be underpinned by tikanga and mātauranga māori. Tools must be strengths focused and relevant to whānau."

Qualitative analysis

The qualitative interviews and focus groups provided rich insight into the experiences, values, and realities that shape how alcohol screening is carried out with Māori whānau. Kaimahi spoke openly about the strengths and limitations of current screening tools, the central role of whanungatanga, and the systemic pressures that influence practice. Their kōrero highlighted that while tools can provide structure and clarity, their effectiveness depends heavily on cultural alignment, practitioner skill, and the quality of whanaungatanga established with whaiora. These findings reveal a nuanced picture in which screening is not a technical task but a relational, contextual process embedded within wider structural inequities and Māori ways of caring for whānau.

"The tools weren't designed for us" – Screening tools provide structure but remain misaligned with Māori worldviews

Across interviews and the focus group, kaimahi consistently described screening tools as simultaneously useful and limited. They valued the structure, consistency, and clarity that tools like ADOM or AUDIT can provide yet stressed that these tools often sit uncomfortably within Māori contexts. As one kaimahi explained,

"Limitations of the ABC... drinking behaviours for Māori may not align with common Māori cultural practices. There is a risk of it being reductionist... These tools don't tell us that" (Kaikōrero Tuawhitu).

For many, the issue was less about the tool itself and more about its origin and Kaimahi described how the frameworks underpinning many mainstream tools do not reflect Māori ways of understanding wellbeing, harm, or oranga. Therefore, kaimahi often adapt tools or use them alongside Māori approaches.

Some practitioners chose not to use certain tools altogether, feeling they did not resonate with Māori realities:

"We don't use those tools because they were never made for us... When I got to the service and started to build it they only knew 12-step and I said tough, you'll have to use a 4-step – Whare Tapa Whā" (Kaikōrero Tuawhitu).

Others highlighted that while they appreciate the clarity that tools like ADOM provide:

"I strongly believe in [ADOM]... it's been around for years" (Kaikōrero Tuatahi)

The language and length of western tools can impede genuine engagement. As one participant put it,

"The AUDIT is lengthy cause it's wordy... it becomes repetitive at times" (Focus Group Member; Kaikōrero Tuawhitu).

Across the kōrero, the message was clear: kaimahi valued having screening tools, but only when these tools were flexible, adaptable, and grounded in approaches that align with Māori views of wellbeing.

"It's not the tool; it's the person wielding it" – Engagement, not the checklist, determines effectiveness

Kaimahi repeatedly emphasised that the success of screening depends more on how it is delivered than on which tool is used. As one kaimahi noted,

"Is it the tool or is it the person wielding the tool? ... I think in this case it's the person" (Kaikōrero Tuarima).

Effective screening was described as relational, paced, and grounded in whanaungatanga not transactional or rushed. When screening becomes narrow, checklist-driven, or disconnected from the wider context of a person's life, whaiora can feel judged or overwhelmed.

"When someone attacks one issue at a time, someone can feel very defensive... we are missing physical, social, everything" (Kaikōrero Tuawhā).

This reinforced the importance of holistic engagement and taking time to understand the broader story rather than focusing solely on alcohol use. Kaimahi also described how systemic pressures such as time constraints, workload, or rigid service expectations can undermine the quality of engagement.

"You're fighting a huge machine... you can't deal with the harm unless you deal with the systemic issues" (Kaikōrero Tuarua).

In these contexts, even the best tools become less effective. This recognition led many kaimahi to frame screening as a relational practice rather than a procedural task.

"We're used like a backup service" – Systemic inequities shape referral pathways and access to support

Participants described experiences where Māori services were positioned as secondary options, receiving referrals only when mainstream services were full. One practitioner explained,

"We're viewed as a Māori version of a larger Pākehā service... if the bigger service is full, you come to us" (Focus Group Member).

Although kaimahi worked hard to provide culturally grounded, whānau-centred services, they felt limited by a system that privileges mainstream providers.

This inequitable positioning affects how whaiora enter services and how screening unfolds. Delayed or inappropriate referrals can result in whaiora arriving only once situations have significantly escalated for example, *"when they're there on their 3rd DIC" (Kaikōrero Tuawaru).*

In these cases, kaimahi noted that screening tools alone are insufficient: the relational work becomes even more important, and practitioners often need to prioritise rapport, safety, and manaakitanga over formal tools or processes.

"We should have a Māori version of everything" – Choice, flexibility, and culturally grounded tools matter

Kaimahi spoke about the need for Māori-designed tools and approaches that reflect Māori understandings of oranga. Many emphasised that one model or one tool cannot meet the diverse needs of whānau.

"We should have a Māori version of everything because we deserve options... but just because it's Pākehā doesn't mean it isn't impactful" (Kaikōrero Tuawaru).

Rather than discarding mainstream tools, kaimahi framed choice as central: different whaiora connect with different approaches, and kaimahi need flexibility to respond accordingly.

Some noted that western tools remain useful for certain tangata whaiora: *"Some Pākehā tools can be more suitable and that's okay" (Kaikōrero Tuawaru).*

However, the strongest message was that a kete of tools—not a single prescribed model enables responsive, effective practice.

"If we have the menu of options inside our kete, then we have more effective [screening]... it's not about our own pride, though the tools we use" (Kaikōrero Tuawaru).

For many, Māori tools also embody ways of engaging that are naturally relational such as Te Whare Tapa Whā, Pōwhiri Poutama, and other mātauranga-based frameworks which support the depth of kōrero needed for sensitive topics like alcohol use.

"Whanaungatanga is always a thing" – Relational engagement is the foundation of meaningful disclosure

Perhaps the strongest and most consistent theme across the qualitative data was the centrality of whanaungatanga. Kaimahi described how trust, rapport, and relational safety are prerequisites for honest conversations about alcohol.

"People don't just jump into answering about their drinking… they'll lie to you. I've seen that done and it doesn't work" (Kaikōrero Tuarima).

Without strong relational foundations, screening becomes superficial and whaiora may withhold, minimise, or shape their responses out of whakamā, fear, or mistrust.

Participants also described how whakamā can be amplified when screening is abrupt or poorly explained.

"People get annoyed… 'Why are you asking me this?' … If we've built that this is part of things… then it's easier" (Kaikōrero Tuarima).

This reflects the importance of contextualising questions and explaining their purpose.

Whanaungatanga was not seen as a step but an ongoing process.

"Whanaungatanga is an always thing… it doesn't just finish" (Kaikōrero Tuawaru).

For some kaimahi, the first session was less about formal screening and more about:

"feeling the mauri… have I built a rapport?… the first session is to understand what matters to the person" (Kaikōrero Tuatahi).

They stressed that whaiora often arrive with histories of trauma, judgement, or previous negative service experiences—making relational skill essential.

The relational approach also extends beyond tools. As one participant explained, *"They're here, they're not here to get their groceries… the person is more important than the paperwork" (Kaikōrero Tuawaru).*

"If it's not implementable it sits on a shelf" – Tools must be co-designed, practical, and grounded in real-world contexts

Kaimahi emphasised that any new screening tool whether Māori or western must be practical, usable, and shaped by the realities of frontline practice. Tools that are disconnected from everyday context, or from the experiences of clinicians, whānau, GPs, nurses, and wider communities, are unlikely to be used.

"We could develop something gold standard, but if it's not implementable it sits on the shelf" (Kaikōrero Tuarima).

This was echoed in discussions about the need for tools to fit the populations they serve:

"Design it so it fits the population… the approach is still the same as it was 10 years ago" (Focus Group Member).

Participants highlighted that genuine co-design with whaiora is essential. As one kaimahi noted,

"We met with whaiora... They told us their time was precious... they wanted solutions and options, a clear plan" (Focus Group Member).

This feedback underscores the need for tools that are efficient, meaningful, and able to support clear pathways for action.

For many, Māori processes for designing solutions such as wānanga were seen as the appropriate method for developing new tools:

"We need to develop our own tool... it would take a wānanga to ask what we need to ensure whānau safety" (Kaikōrero Tuatoru).

Recommendations

Based on the findings from both the survey and qualitative interviews we recommend the following:

1. **Provide a range of screening options/ approaches:** Offer multiple tools so staff can choose the most appropriate option for each person. Include guidance on how to adapt questions to different cultural or personal contexts.
2. **Strengthen engagement before screening:** Make rapport-building and clear explanations standard practice before asking alcohol-related questions. Train staff in effective communication, cultural safety, and trauma-informed approaches.
3. **Improve referral pathways:** Ensure referral processes are clear, consistent, and easy to use. Treat Māori services as primary options, not overflow providers. Strengthen follow-up processes to ensure people receive timely support.
4. **Co-design tools and processes with whānau and staff:** Involve Māori whānau and kaimahi in developing and refining screening tools and protocols to ensure cultural relevance, practicality, and acceptability.
5. **Ensure practical implementation:** Pilot and evaluate tools and processes in real-world service settings to confirm usability, effectiveness, and alignment with staff workflow.
6. **Monitor and adapt practices:** Continuously review and refine screening approaches with input from staff and whānau to maintain cultural relevance and responsiveness to changing needs.

Key findings / Discussion

The findings from both the survey and qualitative interviews highlight that alcohol screening for Māori whānau is shaped less by the tools themselves and more by how they are applied, contextualized, and embedded within practice. Across all data sources, several key themes emerged that illustrate the strengths, limitations, and opportunities for improvement in current screening practices.

A key finding is that relationships matter most. Building trust and explaining why questions are being asked helps whānau feel safe to be honest. One kaimahi explained, *"Is it the tool or is it the person wielding it? ... I think in this case it's the person" (Kaikōrero Tuarima).* Strong relationships allow kaimahi to understand the whole whānau situation, not just their drinking.

Flexibility is also important. No single tool works for everyone. Offering a mix of Māori-led and adapted Western tools gives kaimahi options to meet the needs of different whānau. "If we have the menu of options inside our kete, then we have more effective [screening]" (Kaikōrero Tuarua). Adapting questions to fit cultural and personal contexts makes screening more meaningful and easier for whānau to engage with.

Systemic issues also affect how screening happens. Māori services are sometimes seen as a backup when mainstream services are full, which can delay support. Workload, rigid policies, and referral systems can also make it hard for kaimahi to spend the time needed to build trust. *"You're fighting a huge machine... you can't deal with the harm unless you deal with the systemic issues" (Kaikōrero Tuarua).*

Finally, co-design and ongoing evaluation are key. Involving whānau and kaimahi in designing tools ensures they are practical, culturally safe, and useful in everyday practice. Reviewing and improving tools regularly keeps them relevant and effective.

Overall, improving alcohol screening for Māori whānau requires culturally safe tools, strong relationships, flexibility, well-supported staff, fair referral pathways, and ongoing feedback from whānau and kaimahi. Focusing on both the cultural and practical aspects will help whānau engage and get the support they need.

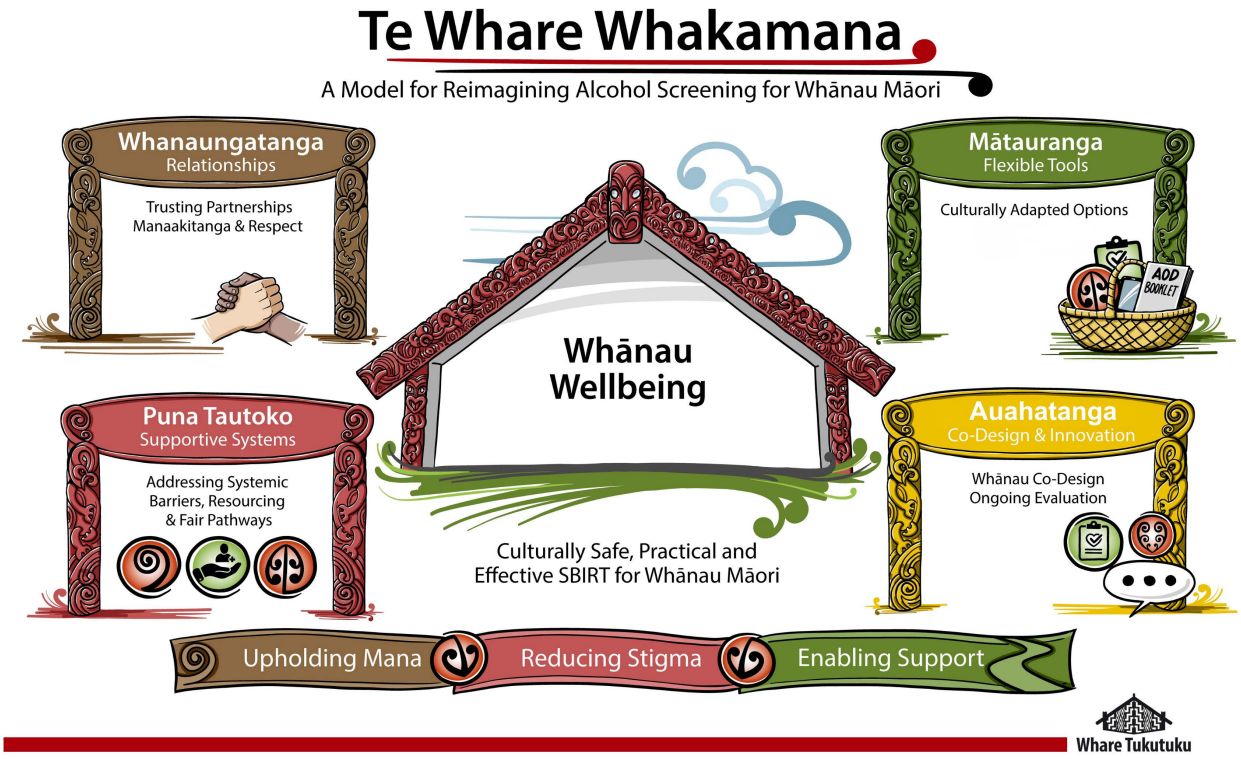
Te Whare Whakamana: A Model for Reimagining Alcohol Screening

The findings of this report demonstrate that alcohol screening for whānau Māori is shaped less by the screening tools themselves and more by the cultural, relational, and systemic context in which those tools are used. A relationship between kaimahi and whānau that is understanding and supportive is likely to result in far better care than any one tool. To be meaningful and safe, an effective screening model must be built around people rather than forms and tools.

The below model *Te Whare Whakamana* has been created using the findings of this report. It offers a reimagined approach to alcohol screening in Aotearoa, that reframes alcohol screening as a relational, culturally anchored process. At the centre of *Te Whare Whakamana* is whānau wellbeing, represented by a whare that can be likened to a familiar model of health, *Te Whare Tapa Whā*. This acts as a reminder that the wellbeing of whānau seeking AOD care should always be central to a care plan. Surrounding the whare are four waharoa – Whanaungatanga, Mātauranga, Puna Tautoko, and Auahatanga – which represent different gateways for whānau and kaimahi to walk through together, to pick up key skills and tools and to champion whānau wellbeing.

When alcohol screening is grounded in *whanaungatanga*, trust, choice, and manaakitanga, conditions are created for honest, supportive kōrero, allowing conversations to move beyond symptoms and toward the aspirations of whānau. Having a range of tools and *mātauranga*, and an understanding of different models of health enables kaimahi to tailor their practice to each person's context. *Puna tautoko* reminds us to be aware and mindful of the systemic pressures that limit effective screening – such as heavy workloads, rigid policies, and inequitable access to services. Finally, *auahatanga* calls for well resourced Māori services and organisational environments that genuinely enable culturally safe practice, to include co-design, quality improvement and innovation in your approach.

By centering whānau wellbeing and drawing on the four waharoa of *Te Whare Whakamana*, AOD care journeys can be strength-based, relational, and aligned with whānau aspirations from the very first point of engagement.



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Rārangi kupu | Glossary

Hapori	*Community*
Hapū	*Subtribe*
Hauora	*Health*
Hui	*To gather*
Iwi	*Tribe*
Kaimahi	*Employee*
Kaumātua	*Elder*
Kaupapa	*Initiative*
Kete	*Basket*
Kōrero	*Discussion*
Kotahitanga	*Unity*
Kupu whakataki	*Introduction*
Mahi	*To work*
Manaaki	*To support*
Mana Motuhake	*Autonomy, self-determination*
Mātauranga	*Knowledge*
Moemoeā	*Dream or vision*
Oranga	*Health, wellness*
Ōtautahi	*Christchurch*
Pātai	*Question*
Pātaka kai	*Community food pantry*
Pūrākau	*Myth, legend, story*
Pūtea	*Money*
Rangatahi	*Youth/young person*
Rangatira	*Leader, chief to be of high rank*
Rohe	*Region*
Rongoā	*Traditional Māori medicine*
Roopu	*Group*
Takatāpui	*Intimate friend of the same gender*
Tāne	*Men*
Tangata Whaiora (whaiora)	*Person seeking wellness*
Te Ao Māori	*Māori worldview*
Wāhine	*Women*
Wānanga	*To gather/ discuss*
Whakaaro	*Thought, opinion, understanding*
Whanaungatanga	*Kinship, relationship*
Whānau	*Family, group, extended family*
Whakahīhī	*To be vain, smug, conceited*
Whakamā	*Shame, embarrassment*
Utauta	*Tools*

Appendices

Appendix 1: Interview guide – Kaimahi Māori – Alcohol Screening Practices

Purpose
To understand why Māori are under-screened for problematic alcohol use compared to non-Māori, by drawing on kaimahi experiences of current screening practices and their whakaaro for better, kaupapa Māori approaches.

Structure (~60 minutes)
1. **Whakawhanaungatanga (5–10 mins)**

Pātai:
1. Can you tell me about your role and how you work with Māori whānau around health and wellbeing?
2. What kinds of issues do you most often see with alcohol use in your mahi?

2. **What's Happening in Practice (10–15 mins)**

Pātai:
a. When you look at your own practice, do you notice differences in how often Māori and non-Māori are screened for alcohol use?
b. What happens when you try to screen Māori whānau using tools like AUDIT-C or the ABC approach? Do whānau engage? Push back? Go along but not fully open up?

3. **Problems with Current Tools (15 mins)**

Pātai:
a. From your perspective, what doesn't work about the AUDIT-C or ABC approach with Māori?

4. **What Might Work Better (15 mins)**

Pātai:
a. If you set the current tools aside, what would a more effective way of asking about alcohol look like for Māori whānau?
   - Would it start with whanaungatanga first?
   - Would it be more kōrero-based rather than a questionnaire?
b. What kinds of questions or approaches would feel safer and more relevant for Māori?
c. How would you know whānau were being engaged properly, not just going through the motions?

5. **Designing Future Approaches (10–15 mins)**

Pātai:
a. Imagine we are building a new alcohol screening approach for Māori – what are the must-haves?
b. What would the process look like, step by step, from the first kōrero to follow-up?
c. How would it feel different from the current tools? (for kaimahi and for whānau)
d. If a kaupapa Māori approach was done well, what outcomes would you expect to see for whānau?

6. **Whakakapi – Closing Reflections (5 mins)**

Pātai:
a) If you could change just one thing about alcohol screening for Māori tomorrow, what would it be?
b) Is there anything else you'd like to add that we haven't asked about, but is important for this kaupapa?

Appendix 2: Survey Questions

1. Which rohe (region) do you live in?
2. What is your job title?
3. E hia o tau? (age)
4. Do you identify as (Wahine (female), Tane (male), Takatāpui, Non-binary, Prefer not to say
5. Do you identify as Māori? (Yes/No)
6. He aha ō iwi (iwi affiliations)
7. What approaches and tools do you utilise when working with whānau Māori to identify alcohol use concerns?
8. What are the barriers and challenges when having conversations about alcohol with whānau Māori?
9. Do you feel that existing alcohol screening tools and referral processes (i.e., Audit-C, ABC, or SBIRT) are useful to use with whānau? (yes/no/maybe)
10. Please explain your answer above
11. What brief intervention model(s) do you utilise to support whānau Māori in your mahi?
12. How confident are you in knowing where to refer whānau Māori for ongoing support? (extremely, confident, not so confident, not confident at all)
13. Are there any improvements that would help make alcohol screening more safe and effective for Māori?
14. Please explain answer above
15. What approaches, tools, or methods do you think work best for engaging Māori in conversations about alcohol use?
16. What kind of support or resourcing would you need to confidently apply a kaupapa Māori approach in your mahi?
17. Is there anything else you would like to share about your experiences or whakaaro on developing an appropriate screening tool for alcohol-related support for whānau Māori?

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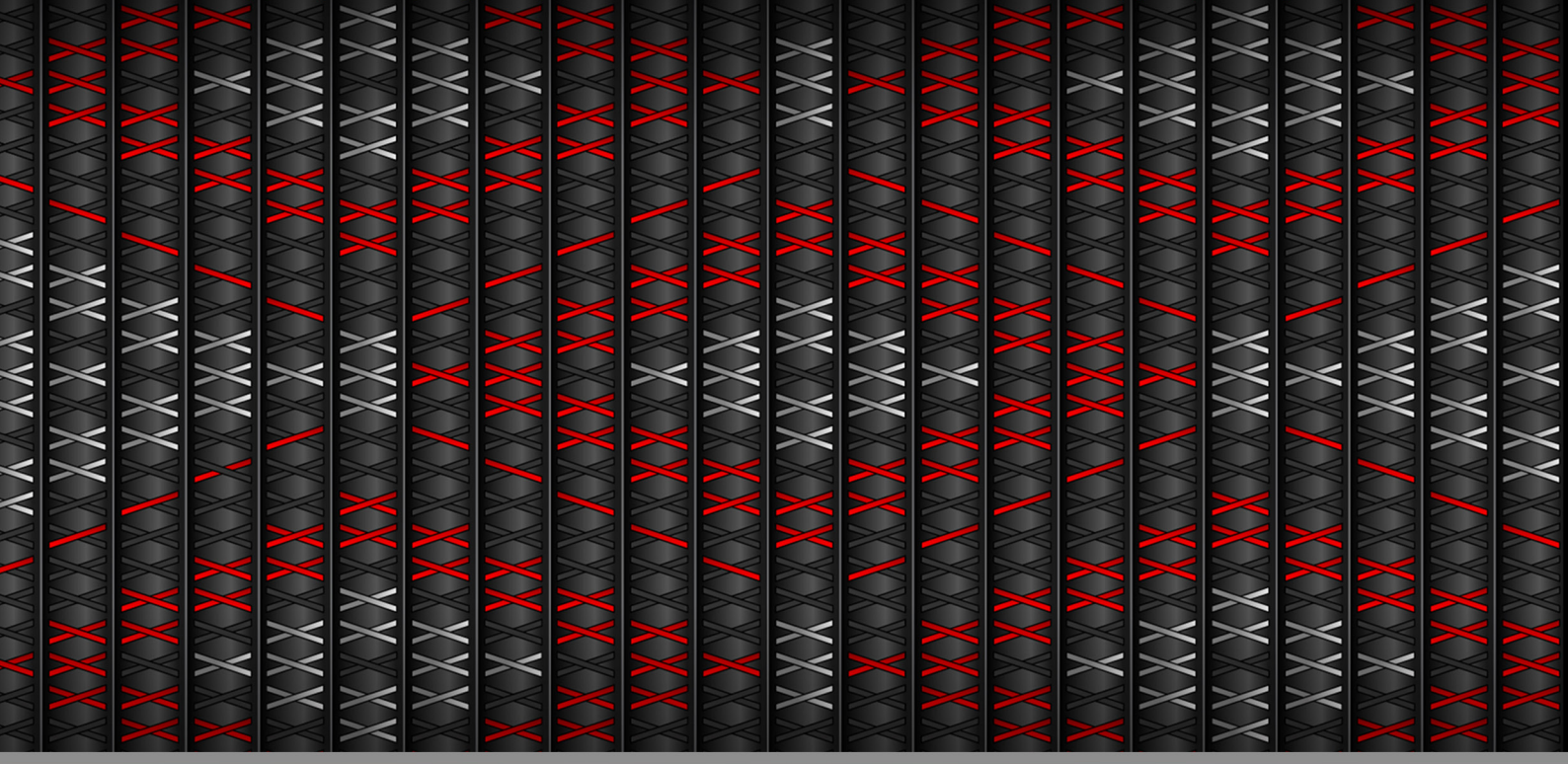

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