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**EVALUATION OF RONGO ĀTEA ALCOHOL AND OTHER DRUG
TREATMENT CENTRE FOR ADOLESCENTS**

A thesis
submitted in partial fulfillment
of the requirements for the degree
of
Master of Applied Psychology
at
The University of Waikato
by
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THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

The University of Waikato

2010

Abstract

Rongo Ātea is a residential abstinence-based Kaupapa Māori alcohol and other drug programme accommodating youth between the ages of 13 and 17. This evaluation investigates the role that staff play at Rongo Ātea along with a number of other factors including the physical environment; stages of change; programme implementation and aftercare. As a Kaupapa Māori programme, the role of how culture and identity can influence positive change is also explored along with the development of a youth-focused approach. I utilised a three phase framework borrowed from the work of Mason Durie (2008) to organise themes. These three phases, which Durie (2008) based on marae encounters, include Whakapiri (Engagement); Whakamarama (Enlightenment); and Whakamana (Empowerment) as they aptly reflect a three phase intervention approach: detoxification and early programme engagement; learning and development through ongoing programme commitment; and post treatment outcomes and aftercare.

The data collection phase of this evaluation took place in 2006 and was initiated by the manager of Rongo Ātea who requested an evaluation to identify programme strengths and limitations from the perspectives of staff and students, and to make recommendations to Rongo Ātea that would assist with further programme developments. I utilised a collaborative and participatory approach (Bishop, 1996; Patton, 1990). Kaupapa Māori research principles were reflected in the use of 'kanohi kitea'— face to face contact (Smith, 1999).

With appropriate training and management support, staff could have a greater influence on programme outcomes. Evaluation findings suggest that drug and alcohol intervention and treatment for young people in New Zealand is significantly under-resourced, particularly in the areas of detoxification and aftercare. To be effective, residential treatment programmes should consist of a three stage programme covering detoxification; treatment; and aftercare incorporating an integrated approach. A greater emphasis on working with whānau alongside the young person is recommended.

Do you really know who I am?
I don't trust you, and I don't care
Do you know that its all just a front
I can't, or won't, really care for anyone
Cause nobody has really cared for me
Love - what the fuck is that
My sister and brother is all I know
that will be there for me until I die
You people think you know me
You know nothing
You don't know my pain, my feelings, my thoughts you think you do and yes I
cry, and don't show anyone
Why? So you can judge me?
Counsel me, when you really don't care, you go home.
Do you know, sometimes I think that I don't belong in this world or exist and
sometimes I think my family, are never there.
My life I have no life
I don't know what love is....
Is it a smile, kindness, warmth, giving or is that all an act
but love to me is like a ball of pain so try to tell me what love is?

*Written by an adolescent as part of her family group conference
plan - from the Youth Court of New Zealand website*

Acknowledgements

First and foremost I would like to thank the young people who commit themselves to their programme of recovery and show enormous courage in doing so, and to staff who dedicate themselves so wholeheartedly to improving the lives of rangatahi.

Heartfelt thanks to my family especially Noeline, Kirsty and Dylan who have supported me with their love and acceptance over this time. Thank you to my wonderful Debra and Hannah who supported and encouraged me, cooked for me and took the dog for walks. I am indebted to Amanda who provided significant practical and emotional support, motivation, and discussion and to Thea who inspired, encouraged and shared her knowledge with me.

Thank you to my university supervisor Neville who demonstrated patience and tolerance in what proved to be an extended process from proposal to completion. Much appreciation goes to Trust Waikato and SPEaR for the scholarships that allowed me take time from employment and fund associated research costs.

Table of Contents

Abstract	ii
Acknowledgements	iv
Table of Contents	v
List of Figures	vii
List of Tables	vii
Preamble	viii
Chapter 1: Introduction	1
Chapter 2: Literature Review	8
Definition of terms	8
Cultural and social context of indigenous drug and alcohol misuse	11
Adolescent substance abuse in New Zealand.....	15
Adolescent treatment	17
Efficacy of treatment.....	20
Retention and engagement	34
Workforce development	36
Aftercare.....	38
Chapter 3: Method	40
Entering the setting	40
Participant observation.....	40
Student interviews	42
Staff focus group and interviews	44
Analysis.....	44
Chapter 4: Te Ao Māori	46
The beginning.....	46
Tapu, noa and mana	48
Whākapapa	50
Te Reo	51
Tua-ātea	51
Marae	52
Chapter 5: Whakapiri	54

Space	55
Boundaries	58
Time	68
Ways of Thinking.....	76
Chapter 6: Whakamārama.....	85
Māori models of health	85
Programme overview	87
Schooling	89
12 steps and NA/AA programmes	92
Abstinence and harm reduction.....	97
Relapse prevention	99
Staff and workforce development	101
Whānau /family intervention	107
Chapter 7: Whakamana	113
Aftercare and follow up.....	113
Chapter 8: Conclusion.....	123
Overview of main findings	123
Reflections	126
Future research.....	128
References	130
Appendix A – Glossary.....	139
Appendix B – Consent Forms.....	140
Appendix C – Participant Information Sheets	143
Appendix D – Interview and Focus Group Schedules Students.....	148
Appendix D –Focus Group and Interview Schedules Staff	152

List of Figures

Figure 1. Te Rūnanga o Kirikiriroa Services	1
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List of Tables

Table 1. Rongo Ātea Student Interview Participants.....	42
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Preamble

My interest in this evaluation stemmed from my previous research undertaken with four other students. We had evaluated a residential facility for children in another city for which the research findings prompted significant programme improvements. At that time I asked myself if I would be prepared to leave my own child in the residence being evaluated. The answer was a definite no. Every child deserves to experience love, encouragement and access to good health and education and I believe our places of care should reflect that as a minimum standard. I do not believe that any intervention will be effective without a safe and nurturing environment that enables a child or adolescent to develop self belief, identity and resilience in a context of caring, respect and acceptance.

My time at Rongo Ātea provided a completely different experience to the earlier evaluation. I was unprepared for the impact that both students and staff had on me. I was moved by the dedication, aroha and manākitanga that staff demonstrated day after day in an environment that was often stressful. Staff were required to implement a programme of change, undertake daily tasks and manage behavioural issues, whilst being confronted with young people whose life experience can only be described as distressing and often heartbreaking. I was heartened to know if ever my son, who was the same age as many of the young people at Rongo Ātea, required treatment, I would have no hesitation in leaving him in the care of the Rongo Ātea staff and for this I am grateful.

Certainly there are improvements that can be made at Rongo Ātea, particularly in the areas of programme and staff development, and clinical intervention. However if the only thing that young people gained from their time in treatment was experiencing an environment that provided safety and security, good nutrition and exercise, routine and boundaries, that is in itself worthwhile. Many of the young people in this programme had lived through abuse, violence, loss and family substance use and the need to provide

young people from chaotic backgrounds respite from those factors, cannot be underestimated. I spent many hours at Rongo Ātea over a seven month period. In that time I witnessed significant changes in the physical appearance of many rangatahi due to good nutrition and exercise. I saw them relax and enjoy themselves, start to build open and trusting relationships with peers and staff in the programme and with family members and friends. Furthermore, I saw them grow from reserved, often unkempt teenagers to confident and proud young adults with a developing self-awareness and self-belief that has the potential to carry them forward. Even if young people did not successfully graduate or maintain the changes after the programme they have the opportunity to experience that something else is possible. This is something that participants can potentially fall back on at any point in their life, whether through return to treatment, attendance at Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings or other social supports.

However, respite in itself is not sufficient to develop sustainable change. Adolescent treatment programmes provide significant opportunities for change with the establishment of long term behaviour patterns assisting an adolescent through the transition into adulthood to develop meaningful and positive experiences. I have attempted to highlight some aspects of the Rongo Ātea programme that would benefit from programme development and suggest recommendations that could make a difference. However, I have also acknowledged the constraints that the Rongo Ātea faces in relation to limited resourcing and attempting to operate a Kaupapa Māori programme within a Western based policy framework.

Chapter 1: Introduction

Rongo Ātea is a Kaupapa* Māori adolescent mental health service of Te Rūnanga o Kirikiriroa focusing on alcohol and other drug treatment. This chapter outlines the structure of Te Rūnanga o Kirikiriroa and provides a description of the treatment programme provided by Rongo Ātea.

Te Rūnanga o Kirikiriroa is a Kaupapa Māori service provider which was established as a Charitable Trust and the Urban Māori Authority for Hamilton under the guidance of the Māori Queen Te Atairangi Kaahu and the former Hamilton city (Kirikiriroa) Mayor Sir Ross Jensen in 1987. The Rūnanga was developed to meet the multi-faceted needs of māta waka within Kirikiriroa. This is fulfilled through a number of advocacy, research, educational and health services, including mental health services for both adults and adolescents (Te Runanga o Kirikiriroa website 2006). Below is a diagram outlining the range of services that were provided by Te Runanga at the time of this research.

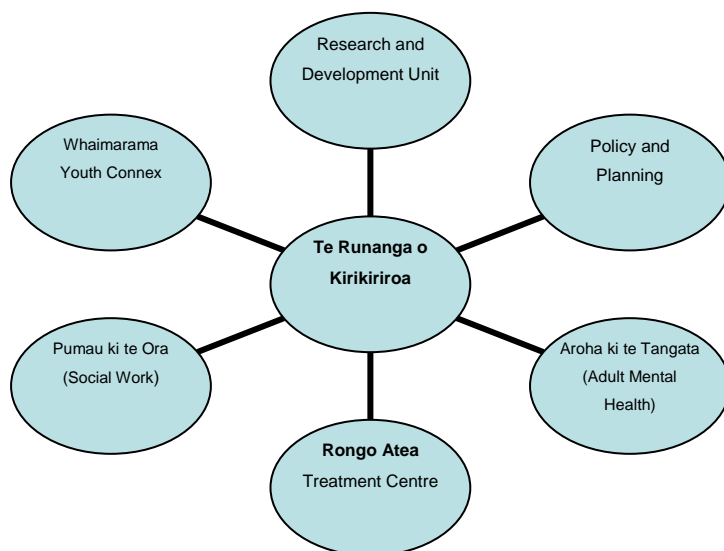


Figure 1. Te Rūnanga o Kirikiriroa services

* A number of words and terms are given in Te Reo Maaori (Maaori language) within the body of this work. A glossary is provided in (Appendix A).

Values stated as being important to Te Rūnanga o Kirikiriroa include Mana Rangatira, Whānaungatanga, Manākitanga and Arohatanga (Te Rūnanga o Kirikiriroa, 2004). According to Barnett and Thompson (2008), a decision was made by the Board of Trustees not to impose the meaning of the stated values on those who worked within the organisation and no specific definition of the values were provided. The reason given for this was an acknowledgement of the multi-faceted needs of māta waka and is based on people interpreting and incorporating the values into their work differently and in a way that is meaningful to them. However, for the purpose of providing some context to readers less familiar with Te Reo, some definitions are provided in the glossary.

Additional values deemed as imperative to the corporate work of Te Rūnanga o Kirikiriroa comprise: the application of Tikanga and Te Tiriti o Waitangi including the principles of partnership in which partners have equal status and are treated with respect, participation (active contribution within forums that make decisions affecting the Māori and Pacific Islands communities). Additionally Te Runanga o Kirikirirao acts as a Kaitiaki in the protection of traditional and urban taonga gender equity, and Mana Māori Motuhake which is reflected in all interaction and practices, and tino rangatiratanga (Runanga o Kirikiriroa website, 2006).

Rongo Ātea is a 24 hour, seven day a week, abstinence based, Kaupapa Māori alcohol and other drug programme accommodating youth between the ages of 13 and 17. Priority for acceptance into the programme is given to adolescents of Māori or Pacific descent but young people from other ethnic groups are not excluded. Pumau ki te Ora[†] is a service that also operated under Te Rūnanga o Kirikiriroa and functions alongside the treatment centre. In addition to providing assessment, support and follow up services to Rongo Ātea, a key role of Pumau ki te Ora was to educate young people on the risks associated with alcohol and drug use and to teach self-responsibility so that

[†] Pumau ki te Ora (PKTO) was disestablished in 2009 as the result of adjustments to DHB funding. Te Hau Ora Waikato now undertake assessments and referrals, which were previously the role of PKTO and Whai Marama, as part of their wider mental health services.

their actions promote a life of continued health and well-being. The aim was to engage young people in open dialogue about their views, and to counteract any 'myths' they may have learned about alcohol and drugs, by providing them with factual information (Te Rūnanga o Kirikiriroa, 2004). This preventative work included delivering presentations to community groups and education courses in schools.

The treatment component of the work Pumau ki te Ora undertakes includes the facilitation of the entry of rangatahi into Rongo Ātea. The staff also support and provide education to whānau on how best to support the young person to maintain a clean and sober lifestyle (Te Rūnanga o Kirikiriroa, 2004). Continuing care and follow up for rangatahi who have completed the programme at Rongo Ātea is also the role of Pumau ki te Ora and this involves 21 days where they remain on the Rongo Ātea roll and then a further three months of follow up which may include phone calls and/or checking in with family and support agencies.

Rangatahi may be referred by an external agency, school, counsellor, family or self. The assessment for identifying substance abuse is undertaken by the referrer or by qualified assessors from Whai Marama Youth Connex which is another service of Te Rūnanga o Kirikiriroa providing outpatient drug and alcohol community based education, assessment and treatment. Pumau ki te Ora social workers assess whether Rongo Ātea is an appropriate placement for the young person. This is done in consultation with the referrer, young person, and the Rongo Ātea clinical team.

There are often other issues in a young person's life interacting with the substance abuse issues that need to be considered in the placement decision and/or the young person's treatment plan. These may include grief and loss, domestic violence, sexual abuse, mental health and behavioural issues. Rongo Ātea may not always be the most appropriate intervention and in all instances substance abuse needs to be a key factor. Guidelines for assessment require following the Diagnostic and Statistical Manual (DSM) IV criteria of substance dependent or clinical use. If specific criteria are not met,

this is discussed in a clinical meeting which generally includes the family. All issues need to be reviewed and substance use needs to present as a key factor and the possibility that current use could lead to dependency – if this is ascertained then the young person may be considered eligible for placement (staff interview, Pumau ki te Ora, 2006).

The residential programme is held over 16 weeks (comprising four week wananga) with an open ended individualised recovery treatment programme. Students may stay longer than the 16 weeks dependent on treatment goals and personal circumstances.

At the time of this study, programme structure was stated in publicity materials distributed to referral agencies and intending participants and their whānau, as including an education programme comprising four wananga (with each wananga intended to be delivered over a four week period). These included a Settling In period (Whakatau - to settle) where young people are encouraged to self reflect, asking the question “why am I here?” and coming to terms with detoxification and addiction. The second stage (Ko wai au -who am I?) deals with self-discovery - “how did I get here?” where young people are encouraged to explore their personal strengths and how personal history and family has an influence on who they are. A third stage (Anei ahau – here I am) aims at building self-development, relationships and trust. Communication skill development and community support are emphasised during this stage to begin preparing the young person for moving out of the residential setting back into the community. The fourth and final wananga (Aku whānau – my family) focuses on goal setting, establishing support networks and designing pathways to new ways of living.

In reality, it was very difficult to distinguish these wananga in any structured or specific way. Certainly aspects of each of the wananga could be identified as making up components of the day to day make-up of the programme in an informal way through conversations between kaimahi and students or the activities that young people participated in during the day. More formal structures included workbooks, goal setting at entry and exit assessments and

the use of daily workbooks. The implementation and impact of the four wananga will be discussed more extensively in Chapter five.

More obvious was the delivery of an AA and NA abstinence based programme as the key method of addressing the substance use or abuse identified as a significant issue for the young people attending Rongo Ātea. This involved daily reflections and review meetings held each morning and afternoon with two morning meetings each week being held as a 'practice' NA meeting on site. In addition, rangatahi attended an NA (or AA depending on whether alcohol or other substances were the young person's drug of choice) meeting once a week outside Rongo Ātea and were expected to find a sponsor who would support them through the programme and post-treatment. As no adolescent or youth meetings existed in Hamilton at the time, rangatahi attended adult group meetings. Kaimahi were only able to attend the meeting with the young person if they themselves were in recovery from drugs and alcohol in line with the AA/NA philosophy. However, whether Kaimahi attended the meetings or not, they escorted rangatahi to and from meetings and were available to provide behavioural intervention or support if required. On occasion, rangatahi were taken to Auckland to attend youth meetings and some students had participated in AA/NA youth camps.

School was conducted every weekday morning from 10.30am – 12pm. A qualified teacher was employed by the Ministry of Education to teach the young people on site. Kaimahi would sometimes provide support throughout the teaching session, although it was observed that they would also use this time to achieve other tasks such as cleaning or administrative work, having very little other time to do this in their working hours, which were mostly taken up with behavioural support and programme delivery. This resulted in the teacher having to provide both educational and behavioural support to students who were at different levels of learning and therefore working from different sets of curriculum and who often displayed limited interest in their study.

Drug and alcohol education is weaved throughout the programme and Tikanga Māori is the foundation of all things undertaken at Rongo Ātea . Tikanga is demonstrated in the way new clients and visitors are welcomed on site with a powhiri, use of karakia and waiata, Whākapapa , whānaungatanga, attending tangi, observing marae protocol, and some use of te reo.

The Rongo Ātea programme facility is purpose built and accommodates up to 16 rangatahi of both genders at any one time. Two accommodation blocks (whare) are located on site, one each for male and female and are overseen by Kaimahi day and night. Kawa, or rules, stipulate that neither gender is allowed in the other's whare at any time. Rangatahi have their own room and share a lounge area within their whare which includes a TV, stereo, lounge suite and dining chairs.

Also located on site is a building which includes a room where Kaimahi and students meet for group sessions, as well as serving as an activity space. The main building located next to the car park, includes the dining area and kitchen as well as staff offices and reception. A basketball court is located next to the dining room, which leads out onto public playing fields, both of which are used for sports. The area between the basketball court and playing fields provides the space for smoking breaks. Rongo Ātea does not allow smoking except for scheduled breaks and on the boundaries of the grounds whilst under supervision. All students are responsible for day to day upkeep of the facility including rostered duties at meal times and ensuring their rooms and whare are clean and tidy. Rongo Ātea is located next to a city based marae which provides health services including a Health Clinic providing professional medical services. The marae Health Clinic was utilised by Rongo Ātea for all student medical needs (unless the student had an otherwise appointed health professional within Hamilton).

This evaluation was initiated as a result of the manager of Rongo Ātea approaching the University of Waikato Community Psychology programme to request an evaluation to identify programme strengths and limitations from the perspective of staff and students, and to make recommendations to Rongo

Ātea that would assist with further programme development. The purpose of this evaluation is to investigate the programme impacts as experienced by rangatahi, and the role that staff play at Rongo Ātea, along with a number of other factors, including the physical environment, stages of change, programme implementation and aftercare. As this is a Kaupapa Māori programme, the role of culture and identity in influencing positive change is also explored along with the development of a youth focused strength based approach. I utilised a three phase framework borrowed from the work of Mason Durie (2008) to organise themes. These three phases, which Durie based on marae encounters, include Whakapiri (Engagement); Whakamarama (Enlightenment); and Whakamana (Empowerment).

Chapter 2: Literature Review

The following review of the literature provides a definition of the relevant terms, informs on adolescent substance use in New Zealand and outlines the cultural context of substance use specifically in relation to indigenous or minority cultures. This is followed by exploring the efficacy of treatment for adolescents, including what is deemed to be successful intervention, retention and engagement, workforce issues and aftercare.

Definition of terms

Adolescent

Adolescence describes a period of transition from childhood to adulthood with 10 - 13 years being ages of early adolescence, 14 -15 year mid adolescence and 16 -19 years later adolescence (WHO, 2002 cited in Schroder, Sellman & Deering, 2007). The New Zealand Ministry of Health's (MOH) definition of youth and young people covers the ages between 15 to 24 and adolescents as specifically between the ages of 10 and 19.

Substance use, abuse and dependence

Schroder et al. (2007) use the *Diagnostic and Statistical Manual of Mental Disorder Fourth Edition, Text Revision (DSM-IV-TR)* (American Psychological Association [APA], 2000) to define substance, which can include an illicit drug, medication or toxin. The substances outlined in the Substance-Related Disorders section of the DSM-IV are grouped into many categories including: alcohol; amphetamines; caffeine; cannabis; cocaine; hallucinogens; nicotine; opioids; phencyclidine (PCP); sedatives; hypnotics or anxiolytics. Other chemical substances which can lead to the development of a substance-related disorder can include heavy metals, rat poison, pesticides, nerve gas, ethylene glycol, carbon monoxide and carbon dioxide. 'Inhalants' (e.g. petrol, paint, glue) are also included where they are used for the purpose of intoxication.

There are distinctions between substance use, abuse and dependence. According to Schroder and colleagues (2007), substance use is not a diagnostic or differentiating term and does not imply that abuse or dependence exists. The DSM-IV uses 'substance dependence' as the primary diagnostic term. Substance dependence, as defined by the DSM-IV is;

a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continued use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug –taking behaviour. (APA, 1994, p. 176)

Dependence can be categorised into mild, moderate and severe, depending on the prevalence of symptoms and impact on life functioning. Substance abuse is the term used when dependence can be excluded and is described within the DSM-IV as “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (APA, 1994, p. 182). The term 'addiction' is often used to indicate moderate to severe dependence and 'substance misuse' can refer to both substance abuse and dependence (Schroder et al., 2007).

Residential treatment and therapeutic communities

The fundamental premise of a therapeutic community (TC) is the use of a peer based residential community to treat substance abuse or dependence and other complex issues by utilising a multidimensional approach to focus on the whole person, not just the substance abuse (Jainchill, Bhattacharya, & Yagelka, 1995; De Leon, 2000). According to De Leon (2000), contemporary addiction focused therapeutic communities can trace some of their history back to the early 1920's with the establishment of long-term addiction focused residential communities. However, the term 'therapeutic community' first appeared in the United Kingdom in the context of psychiatric care in the 1940's and was later applied to addictions focused treatment in the United

States, drawing on some common principles of psychiatric TC models as well as the AA movement, formulated in the 1930's.

The term 'therapeutic community' originally described a residential setting "organized as a community in which all are expected to contribute to the shared goals of creating a social organization with healing properties" (Rapaport, 1960, p.10, cited in De Leon, 2000, p. 12). These communities reflected a shift away from an emphasis on individual focused therapy to an increased use of group therapy methods and were largely developed and run by recovering addicts. Over time, TCs have become more influenced by, and inclusive of various social, psychiatric, psychological and medical practices reflecting a move from an alternative self help approach to a mainstream human services modality, retaining basic principles of shared group goals, responsibility and accountability.

Historically, TCs have provided treatment to clients across a wide age spectrum but with the identification of the unique needs of adolescents, it is becoming more common for TCs to establish distinct youth focused facilities to allow for the provision of an appropriate environment, structure and treatment efficacy. Differences from adult TCs can include shorter lengths of stay, inclusion of family therapy, less focus on life experience and limited use of peer pressure to ensure accountability. It is less likely an adolescent oriented therapeutic community will rely on the more level hierarchical structure that is encouraged in an adult therapeutic programme, as the authority of staff in regards to supervision and decision making is far more appropriate for that age group (Jainchill et al., 1995).

Kaupapa Māori

Kaupapa Māori theory and praxis is an approach by Māori, for Māori that draws on and emphasises a Māori world view (te ao Māori). Within a Kaupapa Māori context, te reo Māori and tikanga are taken for granted as legitimising te ao Māori in which Māori processes are the norm (Smith, 1999). Whilst cultural survival is one vital aspect of Kaupapa Māori, it is inherently about tino rangatiratanga or self-determination (Bishop, 1996; Cram, Smith & Johnstone, 2003; Smith, 1999). As conceptualised by Smith, (1990), Kaupapa Māori is concerned with “the struggle for autonomy over our own cultural well being” (p. 185).

Pihama (2001) places Kaupapa Māori outside of any Western concept of knowledge stating that it is a philosophy or foundation that derives from Māori epistemology grounded in historical knowledge and includes complex relationships and ways of organising society. Citing Nepe (1991), Pihama (2001) uses relationship and organisational complexities to demonstrate that Kaupapa Māori is distinctive to, and exclusively Māori ;

...the concept of the relationship between the living and the dead; life and death; the Māori concept of time, history and development; the relationships between male and female; individual and group; and the implication of such relationships for social power relations. These knowledge types and their functions are the content and product of the interconnection of the purely Māori metaphysical base and Māori societal relationships (p 79).

Cultural and social context of indigenous drug and alcohol misuse

It is widely accepted that societies and groups are the outcome of their historical development and there are specific factors that are significant to a group's development. Patterns of alcohol use are the result of a complex combination of historically specific social and cultural factors (Allen & Clarke, 2003; Durie, 2001; Saggars & Grey, 1999; Skye 2002). Alcohol was a

significant aspect of early colonisation history in countries such as Australia, Canada and New Zealand, used by settlers as a trade item or to bribe indigenous people for employment, sex and even as a principal means for land purchase (Durie, 2001; Saggars & Gray, 1998).

A consequence of many Māori being forced from their lands during the early period of colonisation was the loss of independence through the inability to live sustainably off the land and generate material wealth. Socio-economic theories indicate that there is a correlation between alcohol misuse and inadequate housing, low educational achievement, unemployment, low incomes and poor health (Durie, 2001). A further impact of colonisation was the breakdown of indigenous culture resulting in a disconnection from traditional roles, along with social and spiritual guiding principles (Durie, 2001; Saggars & Grey, 1998).

Durie (2001) argues that a culture of dependence developed among Māori in the same way that it developed amongst the North American and Australian indigenous peoples as a result of the colonisation process. Without the means to generate wealth, and with poor social and health outcomes, Māori became dependent on the state for survival, whilst developing a dependence on alcohol as a means to deal with the humiliating and debilitating effects of displacement (Durie, 2001). Saggars & Grey (1998) assert that if the issues of alcohol and drug abuse within indigenous cultures are to be addressed successfully, then the causes need to be considered along with extensive investigation of specific interventions that have been successful or unsuccessful and the reasons for that. The authors suggest that;

To view the observed patterns of excessive alcohol consumption among indigenous people as simply the sum of individual differences is to tear them from the social context in which they occur. Much of the psychological trauma among indigenous people is a consequence of the continuing legacy of colonialism, and while the trauma requires treatment the underlying causes must also be addressed (Saggars & Grey, 1998, p. 72).

Positive cultural identity and pride have been posited as integral to achieving wellbeing for Māori within culturally based health settings (Durie, 2001; Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001; Saggors & Gray, 1998). Gfellner (1991) cites authors such as May (1983), who asserts that the disconnection of adolescents from both modern and traditional culture interrupts societal integration and sense of belonging and can lead to escapist behaviours such as drug and alcohol abuse. A number of other studies cited by Gfellner (Bissonnette, 1985; Bouchard & Pelletier, 1986; Kueneman, Linden & Kosmick, 1986) presented similar patterns of drug misuse amongst both indigenous and non-indigenous adolescents suggesting that cultural disconnection is not the sole cause of aberrant behaviour. Some of the factors outlined for both groups included culture conflict, boredom, minimal boundaries imposed by parents, and feelings of hopelessness. However, with an over-representation of indigenous youth involved in drug and alcohol abuse, social structural difference appears to be a key variable and several authors place this within a frame of social, political and economic marginality (Durie, 2001; Gfellner, 1991; Huriwai et al., 2001; Saggors & Gray, 1998).

Durie (2001) posits that deculturated adolescents can be prone to alcohol misuse due to the social contact it provides, along with feelings of inclusivity and fun. The loss of cultural identity results in a loss of cultural guidelines that would otherwise impose some form of social control. However, Durie (2001) also challenges lack of cultural identity as a causative factor amongst indigenous adolescents, arguing that alcohol misuse is not always absent when cultural connection does exist and is not unknown even amongst elders who may be steeped in cultural knowledge and practice.

Durie (2001) explores a number of possible factors contributing to drug and alcohol misuse including socio-economic status, mental health risk factors and childhood trauma. Psychological theories applying to Māori include low self-esteem, affect disorders such as depression and personality dysfunction whereby alcohol and drug use helps a person to counter some of these effects (in the short term) through problem defocus, mood elevation and limiting inhibitions that then allow the person to seek more social inclusion.

Where drinking is a response to personal psychological issues, it may also underlie other mental disorders with co-morbid presentations not being uncommon. However, Durie (2001) counters the idea that alcohol misuse can be strongly linked to low self-esteem, especially amongst young Māori where drinking sessions are more about fun and social interaction or an alleviation of boredom rather than a symptom of psychological dysfunction. Saggars and Gray (1998) also stress that the attraction to drug and alcohol use for adolescents can be due to factors deemed by youth as positive, citing O'Connor and Saunders (1992) who state that professionals often ignore the fact that drug use is seen as fun, exciting, rewarding, pleasurable, risky and status bearing.

Durie (2001) states that excessive drinking is common to youth around many other parts of the world and is established as a cultural norm amongst this demographic. In this context, peer influence is perhaps of greater importance than other factors such as ethnicity, cultural identity, socio-economic marginalisation and psychological dysfunction. A binge drinking youth culture is not specific to indigenous groups and a common factor is the need for group belonging and shared risk-taking behaviour. Durie (2001) asserts this is particularly significant within market-oriented societies where there is an emphasis on individual achievement and self-gain, with limited opportunities for social contact through collective achievement experiences.

The state also plays a role in shaping societal expectations and establishing of norms relating to alcohol use (Durie, 2001; McCreanor, Barnes, Kaiwai, Borell & Gregory, 2008). In a study involving interviews with young people, McCreanor and colleagues (2008) found that youth generally enjoyed alcohol advertising and established an association with alcohol as cool, exciting and fun concluding that alcohol advertising creates an intoxicogenic social environment for youth. Durie (2001) states that levels of consumption are influenced by political and economic policies with evidence that prices, locality and density of outlets, minimum drinking age legislation and advertising affect patterns of use. The literature supports a range of factors contributing to excessive alcohol and drug use amongst both indigenous and non-indigenous

youth. Durie (2001) argues that whilst a cultural identity focused programme is useful and recommended for any Māori health intervention, deculturation is not by itself a sufficient explanation of alcohol misuse.

Adolescent substance abuse in New Zealand

Alcohol, cannabis and nicotine are the three most commonly used substances by youth in New Zealand, similar to other Western countries (Adolescent Health Research Group, 2008; Ministry of Health 2002; Schroder et al., 2007).

According to a Ministry of Health report (2002), 79% of New Zealand 14 – 17 year olds consumed alcohol and 10 – 15% of surveyed adolescents tried cannabis at least one time by the age of 15. The Youth '07 project (Adolescent Health Research Group, 2008) in which over 9000 secondary school students across New Zealand were surveyed, reported that 72% of students had tried alcohol, with 61% of those students drinking regularly. Around 5% of students reported using marijuana at least weekly with one in four of the 5% using it before or during school. Approximately one third (34%) of students reported having engaged in binge drinking (five or more drinks over a period of four hours) within the previous four weeks of completing the survey. Such findings are supported by many studies of adolescent substance use in which the majority of young people in mid adolescence report having tried alcohol while around half will have tried an illegal drug such as marijuana (Dunnachie, 2007).

Alcohol was reported as being most commonly sourced from parents (54%) and friends (54%), with 14% of students reporting buying alcohol themselves and 35% getting others to buy alcohol for them. Dunnachie (2007) states that family and peers are major influences in adolescent substance use and abuse particularly where there is the existence of early childhood exposure to alcohol and drugs and peer involvement with substance use. A significant proportion of children are drinking alcohol prior to secondary school age and the proportion of weekly drinking has been shown to increase with age (Dunnachie, 2007).

Results from the New Zealand Youth2000 national secondary school survey in which 1114 Pacific students responded out of a total sample size of 9567, found that more Pacific students (29%) than Pākehā/European students (21%) reported they had never drunk alcohol. Of those students who did report drinking alcohol, there was no difference between Pacific and Pākehā/European students' binge drinking rates (approximately 34%). Pacific students were more likely than Pākehā /European students to report smoking marijuana on at least a weekly basis (9% compared to 5%).

Statistics show that young Māori, particularly young Māori men, have higher rates of substance misuse than non-Māori (Ministry of Health, 2002). Significantly higher use of nicotine, alcohol, marijuana and other drugs was reported from the 2059 Māori students (taitamariki) participating in the Youth '07 project (Clark, Robinson, Crengle, Herd, Grant & Denny, 2008). Around 84% reported having tried alcohol (with 19.5% reporting that they had not had any alcohol in the last four weeks, and 18% having only drunk alcohol once in the previous four weeks). Just over half (50.9%) of young people reported binge drinking and 47.8% reported having used marijuana at least once.

Significant differences have been found between Māori and non-Māori drinking patterns across the age spectrum (Durie, 2001) with Māori being more likely to report being totally abstinent[‡] or not having a drink in the week prior to being surveyed in the 1996/97 New Zealand Household Health survey. However, this study also found that of those who did drink, Māori were more likely to be heavy drinkers, particularly within the youth population. Considerable numbers of students surveyed in the Youth '07 project reported alcohol related issues such as unsafe sex (14%), unwanted sex (7%) and injuries (22%). Alcohol related events are reportedly a leading cause of death in New Zealand youth, including alcohol related motor accidents (Dunnachie, 2007). Māori men were found to be 2.7 times more likely and Māori women

[‡] One third of Maori respondents (out of a sample of 700 households) reported being teetotalers in Te Hoe Nuku Roa, a current longitudinal study over a twenty-year period from 1993 – 2013 (Durie, 2001)

1.6 times more likely to die of an alcohol related issue than their non-Māori counterparts.

Adolescent substance use has also been shown to have high co-morbidity with mental health disorders (most commonly anxiety, affective and disruptive behaviour disorders) and self-harming behaviour (Dunnachie, 2007). Drug and alcohol abuse and psychoses were the primary reason for first admissions to a hospital or psychiatric ward in 1993 and made up 32% of Māori first admissions (Durie, 2001). Additionally, there is a correlation between criminal offending and substance abuse in adolescence (Dunnachie, 2007; Durie 2001). Durie (2001) states that despite Māori comprising only 15% of the New Zealand population, they make up over 50% of the prison population with over 60% of prisoners being shown to have an alcohol or drug problem. Links also exist with family violence, high rates of Māori recidivism, poor Māori health outcomes, school truancy and early leaving rates, demonstrating very high social and financial costs of substance abuse (Durie, 2001).

Whilst drug abuse and dependence problems are much less common than the actual use of drugs and alcohol, about 20 – 25% of adolescents will experience problematic substance use, excluding nicotine, by the end of adolescence (Schroder, 2007). The Christchurch Health and Development Study (Fergusson, Poulton, Horwood, Miln & Sain-Campbell, 2003, cited in Dunnachie, 2007) found that 5.8% of young people at 15 years of age had a substance abuse or dependence issue increasing to 20.8% at age 18. As demonstrated, in New Zealand, Māori males are the most at risk of developing substance abuse issues in adolescence.

Adolescent treatment

Successful interventions for adolescents are likely to have long-term benefits across the life span (Schulenberg, Maggs, Steinman & Zucker, 2001). Very little research exists on the efficacy of adolescent treatment provision within New Zealand (De Valiant, 2004; Schroder et al., 2007). Schroder and colleagues (2007) cite a stocktake undertaken by Ramage, Bir, Towns,

17

Vague, Cargo and Niumata-Faleafa (2005) of child and adolescent mental health services in New Zealand, which found services to adolescents were provided by all district health boards (DHBs) and a number of DHB-funded non-government organisations (NGOs). Whilst the stocktake did not provide a specific overview of adolescent alcohol and drug treatment services in New Zealand, these can be broken down into three levels of health provision – primary, secondary and tertiary. Primary mental health services, including alcohol and drug services, are generally provided by medical centres, community social services or emergency services. Secondary and tertiary services cover a variety of treatment approaches, including residential day or outpatient with the distinction being the level of intensity of service provision.

Schroder and colleagues. (2007) report that outpatient treatment programmes tend to be the most frequent form of alcohol and drug treatment and are generally delivered across a range of organisations utilising diverse approaches, but are most commonly DHB funded services delivering counselling, education, information and pharmacotherapy. Day programmes in New Zealand are usually based on the TC models found in longer-term residential treatment programmes although there are also a number of day and residential adventure based therapeutic programmes operating. These programmes generally offer a three to ten day wilderness adventure supported by counselling pre and post the outdoor programme component. A number of Māori -specific residential services provide treatment incorporating a 12-step approach within a Kaupapa Māori model. Most of the residential treatment programmes work with the TC abstinence focused model with programmes ranging from six to eight weeks to several months or more (Schroder et al., 2007).

A search of the Alcohol Drug Association New Zealand (ADANZ) addictions treatment directory revealed ten services in 2009 providing residential treatment to adolescents. Ages varied for each of the programmes with two of the programmes providing services to young people over the age of 17, three to ages 14 to 19 years, one to ages 13 to 17 (Rongo Ātea), one to ages 12 upwards, one to ages 11 to 16 and two to all ages (with one of these

programmes catering specifically to males). Of these programmes, five were listed as being Kaupapa Māori or having a Kaupapa Māori component, and most programmes purported to have at least one Māori worker.

Not all the adolescent programmes included in the directory provided information on length of stay. The length of the programmes ranged from eight to ten weeks with one programme being an eight weekend residential stay. Number of beds ranged from eight to 16 but not all programmes provided this detail so some programmes may have provided more or less. Interventions varied from programme to programme but included detox, peer support, family intervention, cognitive behavioural therapy, individual counselling, motivational interviewing and Te Whare Tapa Wha. Many of the programmes provided additional services including assessment, education, support groups and some form of aftercare.

Whilst it is recognised that adolescents and adults differ in developmental issues, clinical presentation and history of substance use, many adolescent treatment services in New Zealand have tended to develop from adult models. Very few adolescent services are based on principles that accommodate the broad and complex needs of an adolescent population (Devaliant, 2004; Schroder et al., 2007). Physical and psychological attributes as well as unique environmental challenges may mean that adolescents differ from adults in the extent to which treatment approaches are able to engage and be effective for them. Research indicates that adolescents in treatment for substance use disorders differ in both qualitative and quantitative aspects of substance use behaviour meaning that adolescents differ from adults in relation to treatment engagement and efficacy (Ouimette, Finney & Moos, 1997).

Schroder and colleagues (2007) found that adolescents attending drug and alcohol treatment in New Zealand in 2003 and 2004, both in residential and outpatient settings, presented with a range of issues which included mental disorders, engagement in criminal behaviour, family dysfunction and school disengagement. Compared to those attending outpatient services, those

attending residential treatment tended to present with more complex issues linked to criminality and often tended to have more severe cannabis dependence.

Efficacy of treatment

Despite limited studies evaluating drug and alcohol treatment efficacy for adolescents in New Zealand, the treatment outcome literature that does exist in New Zealand and international contexts suggests that both residential and/or community based treatment is generally associated with positive outcomes (Durie, 2001; Huriwai et al., 2001; Liddle, Jackson-Gilfort, & Marvel, 2006; Schroder et al., 2007).

Consistent across the literature is that young people engaging in drug and alcohol misuse or abuse often present with a range of other complex issues including family dysfunction, disengagement from education, mental disorders and criminality. This complexity needs to be acknowledged through adequate funding and workforce development that supports a broad integrated or multiple therapy approach (Schroder et al., 2007). Durie (2001) asserts that Māori substance abuse will not be addressed by any single approach and maintains that a wide focus is needed to take into account principles of positive Māori development.

Stages of Change Model

The Transtheoretical Change Model (TCM) outlining key stages of change has been successfully applied to various health behaviours including obesity, smoking and sun exposure in adults (Monti, Colby, & O'Leary, 2001). More recent evidence has been provided for its applicability to adolescents (DiClemente & Prochaska, 1998; Prochaska & DiClemente, 1992a; Prochaska, DiClemente, & Norcross, 1992b). A primary objective of addictions treatment outcome research is to establish the efficacy of interventions, yet studies show a high number of treatment clients either do not improve or show a brief improvement and then relapse (Prochaska et al., 1992b). Prochaska and colleagues assert that client factors such as motivation and resistance, or intervention variables such as modality and

relationships do not provide an adequate explanation for lack of therapeutic success.

According to DiClemente (1998), the stages of change model recognises the motivational, temporal and developmental nature inherent to the process of change. Once viewed as a linear multi-staged process with a beginning, middle and end, it is now understood that breaking free from addiction can take a significant amount of time and energy with change being both cyclical and longitudinal, of which relapse is itself a key component (DiClemente, 1999). TCM outlines discrete steps in the process of a persons behaviour change during treatment, thereby allowing assessment of a client's readiness for change. They include pre-contemplation; contemplation; preparation; action; and maintenance (Prochaska et al., 1992b).

Pre-contemplation is the stage where a person is unaware there is a problem and has no intention to change. However, the behaviour is often seen as a problem by others and the person may experience significant pressure from family, friends, employees or the court system to change their behaviour and they may be referred or sectioned for treatment (DiClemente, 1999; Prochaska et al., 1992b). At some point, people can become aware that their addictive behaviour is a problem. This is called the *contemplation* stage where the person starts to think about changing the behaviour but does not make an actual commitment to doing so. Prochaska and colleagues (1992b) state that people can remain trapped in the contemplation stage for a long period of time, but it is at this point that they start to weigh up the pros and cons of the problem and the actions required to resolve it.

The *preparation* stage denotes a period of intention and attempted behaviour change where a person undergoes several unsuccessful attempts to address the problem, although some small gains may be made during this time. Prochaska et al., (1992b) originally referred to the preparation stage as the decision making stage as it does indicate a pre-cursor to the *action* stage. During the action stage, people make an actual commitment to adapt their behaviour and environment in order to address their addiction problems. This

stage can take a considerable amount of time and effort and is most recognisable by others (DiClemente, 1999; Prochaska et al., 1992b). However, the action stage does not equate to change and according to Prochaska and colleagues, others, including professionals, can treat the action stage as behaviour change and not provide the necessary intervention required for long-term maintenance. The *maintenance* stage involves relapse prevention and reinforcement of new behaviours over time. The length of time it takes to ensure behaviour is maintained varies and may range from six months to an indeterminate period of time, and for some, behaviour maintenance is required over the rest of their lifetime (Prochaska et al., 1992b).

Relapse Prevention

Within the addictions field, relapse is considered the rule rather than the exception with very few people ever successfully changing their behaviour at their first attempt (Prochaska et al., 1992b). People tend to relapse frequently and will recycle through the stages of change as they attempt behaviour change. For this reason, Prochaska and colleagues adapted their stages of change model to reflect a cyclical process rather than a linear one, where although it is possible for people to progress through each stage, it is more common that they will relapse and regress to earlier stages. When relapse occurs, individuals can feel demoralised and ashamed and this can result in a return to the pre-contemplation stage. Research suggests (DiClemente et al. 1998, Prochaska & DiClemente, 1984, cited in Prochaska et al., 1992b) that most people who relapse do not endlessly recycle through the stages but that they do learn from their attempts and often reach a period of action and maintenance where they are able to maintain behaviour change over sustained periods of time.

Treatment implications from the stages of change model include the need to understand that low retention rates are not always indicative of inadequate individual or intervention variables but may actually reflect the fact that significant numbers of people abusing substances are not always ready for change (Abrams, Follick, & Biener, 1988; Gottleib, Galavotti, McCuan, &

McAlister, 1990; Prochaska et al., 1992b). This needs to be taken into consideration when measuring treatment programme outcomes particularly where there are high numbers of referrals through the court system or by family and employers and particularly in adolescent settings where young people may not have yet experienced significant negative impacts or 'hit rock bottom', a common precipitator for change.

Processes of change are a second dimension of the transtheoretical model that attempt to explain how change occurs. Prochaska and colleagues, (1992b) describe a number of both covert and overt activities and experiences that people engage in when they are attempting behaviour change and these include a range of techniques and methods that can occur within, between and outside of therapeutic intervention. Pre-contemplators focus on the negative aspects of changing their behaviour and are the most resistant to therapy. Consciousness or awareness raising techniques are most useful for people in the contemplation stage and information and education is the most effective for people in this stage whereby awareness raising can lead to a re-evaluation of their sense of self, their environment and the impact of their behaviour on others (Prochaska & DiClemente, 1984 cited in Prochaska, 1992b).

Utilising cognitive, affective and evaluative processes of change, individuals in the preparation stage start to move towards taking action to modify their behaviour. During the action stage, people tend to develop the belief that they have greater autonomy to change their lives in significant ways. A successful action stage usually incorporates the use of behavioural processes to modify the stimuli that trigger relapse (Prochaska et al., 1992). Both the preparation and action stages can be highly stressful for individuals and Prochaska and colleagues emphasise that significant support and understanding is required during this period. Successful maintenance builds on each of the stages that came before and preparation for maintenance requires detailed individual assessment of the triggers that lead to relapse and the development of alternative responses. A key factor in long term

maintenance is the development of a strong sense of self that is highly valued by the individual and at least one significant other (Prochaska et al., 1992).

Implications of TCM include the need to assess the stage of a client's readiness for change and to target intervention that is appropriate for that stage. Prochaska and colleagues (1992) recommend treatment plans that are efficient and integrative with a specific focus on experiential, cognitive and psychoanalytic methods during pre-contemplation and contemplation stages, and existential and behavioural methods during action and maintenance.

12-Step, Abstinence and Harm Reduction Approaches

A 12-step abstinence based programme is one of the most widely used drug and alcohol interventions for adults internationally (Ouimette et al., 1997). Traditional 12-step approaches developed from a self-help approach and arose out of the therapeutic community movement and combine the elements of AA and NA with long term abstinence. The 12-step approach emphasises a disease focused model of addiction. A fundamental assumption is that substance abuse is the result of an underlying biological or psychological susceptibility resulting in dependence on substance use. Individuals involved in 12-step treatment are required to accept the disease model of addiction with abstinence as their treatment goal and ongoing participation in 12-step activities including attendance at 12-step meetings such as AA or NA, obtaining a sponsor and working the steps (Ouimette et al., 1997).

Whilst studies generally support the efficacy of a 12-step approach for adults (Miller, Ninonuevo, Klamen, & Hoffmann, 1997; Montgomery, Miller, & Tonigan, 1995; Moos, Finney, Ouimette, & Suchinsky, 1999) the success of this treatment modality for adolescents is less well substantiated (Passetti & White, 2008). However, some evidence suggests that the more severe the substance abuse issues and the higher the motivational factors the more effective 12-step programmes are likely to be (Kelly, Myers & Brown, 2002). The majority of day and residential treatment programmes for both adults and adolescents in New Zealand are based on therapeutic community abstinence based models of treatment. A critique of the application of 12-step

programmes adolescents is that they have been extrapolated from an adult oriented model without consideration of developmental differences (Kelly, Myers & Brown, 2005).

Group meetings are central to the practice of working the 12-Step programmes, with the intention of providing ongoing support through identification with peers and the creation of a sense of belonging (Twelve Steps & Twelve Traditions, 1953, cited in Kelly, Myers, & Brown, 2005). Kelly and colleagues highlight that an issue with many AA and NA groups is that they are largely made up of adults and so the opportunity for adolescents to identify and develop a sense of belonging is hindered and tends to have a negative impact on attendance. An AA Membership Survey (2001, cited in Kelly et al., 2005) revealed that the average age of people attending AA meetings was 46 years with only 2% under 21 years of age. Adolescents can have difficulty identifying with issues that are relevant to adults attending groups including the extent of the impact of their substance use on areas such as employment, finances, relationships and imprisonment, and for this reason therapeutic benefits may be minimised (Kelly et al., 2005; Passetti & White, 2008).

However, there is evidence to suggest that adolescent involvement in AA and NA groups can reduce the frequency and severity of relapse (Kelly et al., 2005). Heish (1998, cited in Kelly et al., 2005) found self-help groups comprising adolescents of similar age correlated with higher attendance and affiliation along with greater reductions in substance use post treatment. Whilst there is not yet sufficient evidence to make a definitive judgement, Kelly and colleagues suggest that the affiliation that adolescents have with other peers at group meetings may have even more influence on behaviour than peers in other settings such as school, as a result of greater identification and support. It appears to be important for treatment providers to ensure that adolescents have access to AA and NA groups that have a significant youth make up and focus to ensure ongoing attendance and good treatment outcomes.

Passetti and White (2008) state that there is minimal research into how adolescents perceive and interpret a 12-step approach that was developed by and for adults. An examination of adolescent interpretations of the 12 steps revealed that some steps were regarded as daunting and confusing (e.g. the moral inventory and making amends), with others seeming complex and conceptual (e.g. higher power and hitting rock bottom). Passetti and White recommend communicating the steps to young people utilising various learning methods including both reading and talking and assert that robust discussion about the steps is required to assist young people to develop an understanding and increase their acceptance of referrals to 12-step groups.

Some researchers still question whether abstinence is a realistic objective that can be maintained over the long term for many young people (Allen & Clarke, 2003; Devaliant, 2004). Allan & Clarke cite a World Health Organisation (WHO) report that suggests programmes designed for adolescents with a goal of abstinence do not tend to produce high rates of long term behaviour change. Harm reduction, on the other hand, seeks to provide a range of strategies to mitigate the potential risks involved with excessive alcohol and drug use.

Green (2002) argues that harm minimisation initiatives (prevention, treatment, and education) do not apply a one-size-fits-all approach to either the populations using drugs or the substance being used but instead allow for the development of multi-layered interventions. In a society that sanctions the use of alcohol, abstinence-based messages of treatment can lose credibility amongst a target youth audience, especially if they are existing users. Additionally, a sole focus on abstinence may result in a loss of opportunity to deliver harm reducing messages to those young people who will not give up drug use or view it as an unsustainable goal (Allen & Clarke, 2003; Devaliant, 2004; Green, 2002).

Saggers and Gray (1998) cite authors (Single, 1995; Wodak, 1995) who assert that harm reduction strategies that acknowledge the reality of drug taking seek to minimise harm associated with excessive or inappropriate use.

Assumptions of harm minimisation include acceptance, but not necessarily approval of drug and alcohol use, and attempt to destigmatise the user and regard them as self-responsible for their choices and actions whilst equipping them with tools to achieve short term achievable goals.

Allen and Clarke (2003) maintain that abstinence should be provided as an option for young people but harm minimisation does allow for the reality that drug and alcohol use is not likely to ever be eliminated from society. A harm minimisation approach takes care not to condone illicit drug use and does highlight the harmful legal and social consequences such as fines and prison sentences as well as behaviour that is potentially harmful to self and others. In essence it is an approach that is opposed to illicit drug use but aims to avoid a punitive response to prevention and treatment whilst purportedly enabling realistic and achievable goals.

Cultural Approaches

Māori health perspectives tend to differ from traditional Western models of treatment in that they generally encompass a more holistic approach with a focus on the integration of mind, body, and spirit within a context of social collectivity (Huriwai et al., 2001). Conversely, Western approaches take a more individualised approach with a tendency to concentrate on pathology without taking into account wider contextual factors (Huriwai et al. 2001; Siggers & Gray, 1998).

Māori wellbeing has always been located in the context of whānau , hapu, and iwi and with environmental, spiritual, cultural and physical elements needing to be in balance for good health to be present. This focus is reflected in some contemporary Māori health models such as Te Wheke, and Te Whare Tapa Wha (Huriwai et al., 2001). Māori health encompasses tinana, hinengaro, wairua and whānau and is contextualised within te whenua which provides a sense of identity and belonging, te reo, te ao turoa and whānau ngatanga. Cultural beliefs and practices, such as tapu, noa, tangi, powhiri, karakia and ritual around food are integral to the concept of wellbeing within a Māori world view (Cram, Smith & Johnstone, 2003; Durie, 2001).

Bishop and Glynn (1998) assert that the imposition of a model that does not reflect the experiences and values of the recipient will inevitably fail. Spooner and Sullivan (cited in Huriwai et al., 2001) state that the “highest level of success is when a client who has experienced whānau, hapu and iwi alienation feels comfortable about returning to their tribal roots” (1990, p.1036). According to Durie (2001), it is well evidenced that Māori wellbeing is attained when achievement is experienced in both the Māori world and wider society, with participation in the Māori world being linked to a strong cultural identity and sense of belonging. A link between a strong sense of ethnic identity and low levels of substance use is supported by some overseas literature (Liddle & Dakof, 1995; Monti, 2001). McCormick, Kalin, and Huriwai (2006) respond to research undertaken by Adamson, Sellman and Deering (2006) in which it was found that those retained in community based treatment after an initial assessment are more likely to be female, non-Māori, opioid users, despite Māori males being over represented in the drug and alcohol abuse statistics. However, it was found that Kaupapa Māori services did have better retention rates of Māori clients.

Community based treatment became the preferred policy oriented treatment model in 1998 and there has been a reduction in the number of residential treatment programmes in NZ since that time (McCormick et al., 2006). McCormick et al. (2006) emphasise that substance dependent clients come from diverse backgrounds and present with complex issues including underemployment, limited education, family dysfunction, abuse and criminality. Therefore, a range of rehabilitative contexts need to be provided including more intensive treatment such as residential services. The better retention rate of Māori in Kaupapa Māori services signaled by Adamson and colleagues (2006) indicates that Kaupapa Māori services need to be readily accessible to Māori and further development of such services should be encouraged and supported (McCormick et al., 2006).

Durie (2001) asserts that health services need to have well developed policies and procedures in order to deliver culturally appropriate services to Māori, implementing cultural values, whānau inclusion, use of Māori language and

tikanga, a professionally and culturally competent Māori workforce, and with outcome measures that reflect the goals and aspirations of Māori. Advantages of Māori specific services is that they enable the option of ethnically matched and culturally proficient health workers which can lead to increased service accessibility and improved treatment outcomes (Durie, 2001; Huriwai and colleagues 2001; Robertson, Haitana, Pitama, & Huriwai, 2006; Saggars & Gray, 1998). A Kaupapa Māori approach is by Māori, for Māori meaning that Māori health professionals are best suited to working with Māori clients (Durie, 2001; Huriwai et al., 2001).

Tensions can exist between traditional Western models of treatment and Kaupapa Māori service delivery. Assessment processes often focus on a diagnosis without taking into account a wider context and clinicians may regard Māori perspectives as being too broad, impractical and lacking a strong evidence base (Durie, 2010). However, Durie (2001) asserts that this tension can be overcome when the limitations of each approach are acknowledged and ways are sought to provide a specific treatment process in parallel with a more healing focused approach that incorporates a Māori world view. Cram and colleagues (2003) iterate that a Kaupapa Māori theory and practice does not necessarily exclude the use of various non-Māori methods, but it does ensure that those methods occur within a context of cross-cultural reliability and endeavour to provide best outcomes for Māori.

Whilst some general health services attempt to incorporate a bicultural approach into their practice, many Māori employed within health services do not fully trust such an approach due to the continuing marginalisation of Māori interests and minimal impact on the power relationship that exists between professionals and clients (Durie, 2001). Specifically tailored Kaupapa Māori health services are more able to locate Māori values at the centre of their practice and as a result implement strategies and processes that empower Māori development, whilst working with a diverse range of healing and treatment approaches.

Durie (2001) supports a recommendation of the Mental Health Commission,

that calls for the establishment of Kaupapa Māori specific services based regionally according to population. Kaupapa Māori services extend beyond a presentation of a Māori perspective providing a treatment environment that is based on Māori cultural values and practices. Durie (2001) states that mental health practice should not be distinguished from personal values, beliefs and cultural identity and cites Huata (1998) in regards to 'healing the person', rather than 'treating the disease'.

According to Durie (2001) practical activities running alongside both clinical and formal tikanga practices can be useful forms of intervention, including toi Māori such as painting, flax weaving, wood carving, kite making and flying, bone carving, sports, singing and musical instrumentation. Activities such as these can be particularly useful within adolescent settings, providing access to te ao Māori for young people who may have limited experience in the Māori world. Furthermore, non-verbal cultural activities may assist with creating effective communication. Rangatahi may be more comfortable expressing themselves with a guitar or piece of artwork than articulating how they feel in words or face to face communications (Durie, 2001).

Whilst literature on culturally specific interventions for adolescents is limited (Liddle, Jackson-Gilfort & Marvel, 2006; Skye, 2002) cultural and youth specific approaches have been found to provide meaning within adolescent rehabilitative contexts in overseas settings. One example is a study undertaken with African American adolescents in which it was found that facilitating therapeutic access into the world of the young person through music and other relevant themes such as religion and sport, resulted in increased intervention opportunities and engagement (Liddle et al., 2006). When working with African American adolescent males, Liddle and colleagues (2006) stress that therapists need to consider the various and intersecting contexts that make up an adolescent's life, highlighting three key areas; the mainstream culture, the minority cultural experience (and the associated oppressive and racist beliefs young people are exposed to) and the traditional African American culture. However, these three areas also exist within a youth subculture, which for African American youth largely manifests as street

culture.

Studies undertaken by LaFromboise and Bigfoot (1998) with Native American adolescents revealed that interventions addressing multiple cultural and social contexts for young people and their families have a positive impact on therapy outcomes and reduction in substance use. Liddle and colleagues (2006) cite a number of researchers (Duncan, Brooks-Gunn & Kelbanov, 1994; LaFromboise & Bigfoot, 1998; Luster & McAdoo, 1994; Stevenson, Reed, Bodison & Bishop, 1997) claiming that when young people from minority cultures experience a strong cultural identity, family and community connection and have positive bicultural socialisation they are less likely to engage in substance abuse and other negative or harmful behaviour.

Integrative Family Therapy Approaches

Despite mounting evidence emphasising the importance of family involvement in adolescent treatment, services still generally focus on the individual with minimal inclusion of family or significant people in the adolescent's life (Liddle, 2004). Family-based treatment is one of the most extensively investigated treatment modalities for adolescent substance abuse with some specific approaches showing significant promise such as Multisystemic Therapy (MST) and Multidimensional Family Therapy (MDFT) (Sexton & Alexander, 2007).

Multisystemic Therapy is a model that aims to provide sustainable solutions to families dealing with youth with serious behavioural problems. MST is an intensive family and community based treatment that utilises a multi faceted approach and frames an individual within a context of interconnected systems such as family, school, peers and community. Intervention is targeted by identifying the strengths within the various components of a young person's world and empowers families with skills and resources to facilitate change (MST New Zealand). MDFT is a family-based treatment that incorporates substance abuse prevention for adolescents with drug and behaviour issues. Like MST, MDFT utilises a multidimensional approach focusing on decreasing negative behaviour, including substance abuse and enhancing protective

factors and pro-social development. This treatment also works on family empowerment through enhancement of the parent-adolescent relationship, facilitation of parental commitment, communication, peer relationships, school engagement and community participation (Liddle, 2002).

Integrative approaches have been shown to be effective with families presenting with a range of issues and across diverse ethnic and cultural groups. Family based interventions are integrative both in method and approach and extend beyond an individual clinical focus and instead viewing the person as a relational system comprising multiple relationships and contexts (Liddle, 2004; Sexton & Alexander, 2007).

Consistent with an integrative approach, evidence suggests that self-concept and family functioning, both of which have been identified as key factors in the success of substance abuse intervention, should be treated relationally for best treatment outcomes, rather than in isolation from each other (Liddle, Dakof, Parker, Diamond, Barrett, & Tejada, 2001; Waldron, Slesnick, Brody, Turner, & Peterson, 2001, cited in Henderson, Dakof, Schwartz, & Liddle, 2006). Henderson and colleagues (2006) support a combination of family and individual therapy sessions, developing adolescent self-concept and self-esteem whilst creating a supportive family environment as part of an effective treatment intervention.

Integrating a whānau approach into health intervention is particularly important within a Kaupapa Māori framework. Mead (2003) attributes the fragmentation of hapu and whānau resulting in a lack of Māori leadership and authority and isolation of families to some key social issues, such as substance abuse. He asserts that tikanga and cultural reconnection can pull whānau together and provide a foundation for the development of Māori aspirational fulfilment. Durie (2001) emphasises the need for whānau inclusion in health treatment of an individual in order to develop a secure identity and asserts that whānau development is one avenue to building good health with another being whānau healing. According to Durie, whānau

healing addresses not only the interests of the individual but of the whole group. Primary aims include resolution of whānau pain and the restoration of healthy relational patterns utilising processes of appraisal, confrontation, deliberation and reconstruction of whānau values. Durie (2001) distinguishes whānau healing from family therapy;

Unlike family therapy, which often leads to a concentrated examination of micro-communication and the elaboration of underlying feelings and attitudes, the energy in whānau healing flows outwards, away from intensity and raw emotion towards shared ownership of whatever problems are unearthed (p.206).

A process of healing suggested by Durie (2001) has some commonalities with other forms of family therapy but also some distinct differences. Whānau healing includes identifying key issues, confronting inappropriate behaviour and facilitating group processes. However, it also includes the incorporation of Māori practices such as: whakatau, karakia and formal introduction to set up collective participation; whakawhānaungatanga, whereby whānau bonds and linkages are recognised and reciprocity and mutual obligations are acknowledged; whakataatari, which outlines problem identification and analysis and seeks to establish new guidelines that assist with strengthening the family; and finally whakaoranga is the step towards restoration and healthy whānau development, a conversion of pain and dysfunction to hope, identity and collective capacity. Durie (2001) states that it is imperative that whānau healing is facilitated by someone well versed in both whānau dynamics and Māori culture and capable of understanding process and the spiritual and cognitive dimensions of whānau healing.

There is little emphasis on whānau therapies in health intervention in New Zealand (Durie, 2001). Where it does exist, such as in Child, Youth and Family Services (CYFS) family group conference, the intervention is driven by a government department and focuses on the needs of the individual and providing a solution to an immediate problem, rather than on the healing of

the whole whānau system. A barrier to the implementation of multisystemic and whānau approaches within treatment programmes is the associated financial cost. Henderson and colleagues (2006) acknowledge that the cost-effectiveness of an intervention is an important outcome measure and highlight the social and economic costs of delinquency are excessively high in comparison to the costs of intervention citing the financial expense of criminal incarceration and recidivism as examples of areas where dramatic cost saving can occur.

Retention and engagement

Treatment retention has been found to be the most consistent predictor of treatment outcomes for adolescents receiving treatment in residential settings (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003; De Leon, 2000; Dembo, Livingston, & Schmeidler, 2002; Devaliant, 2004; McWhirter, 2008; Merrill, 1998; Reisinger, Bush, Colom, Agar, & Battjes, 2003; Schroder et al., 2007; Stevens, Arbiter, Mullen, & Murphy, 1996; Stevens & Morral, 2002).

A correlation has been shown to exist between longer treatment stays and dynamic client characteristics as well as programme-related variables (Schroder et al., 2007). Dynamic client characteristics include internal motivation to attend treatment, willingness to engage in treatment goals, and the expectation of positive outcomes. Programme related variables include the relationship between the programme participant and key staff, experience of being involved in the treatment process as well as in decision making and in goal setting, and the sense of belonging and having fun whilst attending the programme (Schroder et al., 2007). Schroder and colleagues emphasise the importance of programme related variables, particularly the relationship between staff and participant, and notes the high attrition rates of staff within New Zealand as a major concern that needs to be addressed in order to develop more successful outcomes.

Schroder and colleagues. (2007) found that participants were more likely to drop out of treatment early if they reported less motivation and higher external pressure (family; legal system) to engage in treatment, did not include

abstinence as a set goal, and did not have a high expectation that treatment would assist with making significant changes in their lives generally or regarding their substance abuse. Additionally, participants were more likely to drop out of treatment if they felt they had not been involved in treatment goal setting, did not report a safe and supportive relationship with staff and did not experience having fun during the programme.

Reisinger and colleagues (2003) look further at the concept of engagement and explore the differences between engagement and negotiation. They assert that completion, a measure of retention, can give a false indication of success as some programme participants learn to negotiate a programme to complete a requirement (such as a court order and/or avoidance of penalties such as fines or convictions), without actually learning or integrating changes in their self-concept or lifestyle. Engagement, on the other hand results in positive change. Retention may measure how long someone stays in a programme and whether they complete, but does not indicate whether someone is engaging with rather than negotiating with the programme.

Reisinger and colleagues (2003) suggest that in some instances, a person who engages with the programme but for some reason leaves the programme prior to completion, may have initiated more longer term positive change than someone who stays the full length of a programme because they are required to do so, but does not fully integrate change into their lives. This is not to negate the general finding that those who stay longer in treatment tend to benefit more from doing so, but rather that retention is not necessarily synonymous with engagement, with engagement being a key to long lasting outcomes.

Adolescent residential treatment centers serve a vulnerable population who can be challenging to engage in services (Schroder et al., 2007; Smith et al., 2008). Engagement goes beyond day to day participation in treatment activities. Client engagement involves clients having established an effective relationship with staff, a commitment to working on issues and an acknowledgment of some personal responsibility in achieving treatment goals.

They express a level of commitment to working on problems, which they acknowledge, and for which they accept some responsibility (Reisinger et al., 2003; Schroder et al. 2007; Smith et al. 2008). Smith and colleagues (2008) state that engagement covers three dimensions, these being attitudinal, relational and behavioural. The attitudinal dimension is characterised by the concept of 'readiness to change' (Prochaska & DiClemente, 1984) where a young person recognises their issues and is prepared or motivated to work on them. The relational dimension is represented in the young person's relationship or therapeutic alliance with staff, and the behavioral dimension is reflected in programme participation and willingness to work with staff on treatment goals.

Workforce development

There is a growing amount of literature on Māori and indigenous mental health and addition workforce development over recent years as a result of identified ongoing health and social disparities for indigenous people internationally (Robertson, Haitana, Pitama & Huriwai, 2006). Like other indigenous populations, Māori are over represented in the mental illness and substance disorders statistics but underrepresented in the mental health professions (Robertson et al., 2006; Kia Puaawai Te Ararau (2005-2010).

Primary recommendations of Kia Puaawai Te Ararau (2005-2010) include growing the size of the Māori mental health workforce and upskilling staff to ensure both clinical and cultural competence in order to work effectively with Māori within the mental health sector. Dual clinical and cultural competency-based training is crucial for the Māori mental health workforce in order to adequately integrate knowledge, skills and experience with cultural expertise and their application within mental health settings. Durie (2001) asserts that by increasing the cultural as well as clinical competence of practitioners, the proportion of misdiagnoses and poor treatment outcomes will be reduced. Furthermore Māori mental health practitioners are crucial to building services that develop cultural identity, re-establish links with whānau and Māori communities and provide professional and effective practice resulting in improved mental health outcomes (Durie, 2001). This requires

acknowledging the existing expertise of Māori which enables them to better meet the needs of tangata whaiora and whānau.

The Werry Centre for Child and Adolescent Mental Health Workforce Development Report (2008) states that whilst Māori and Pacific people have high youth populations experiencing mental health and addiction issues, access to treatment is limited due to low numbers of Kaupapa Māori and Pacific services and clinicians available for adolescents. The Werry Report (2008) espouses the development of by Māori for Māori solutions and effective recruitment strategies such as targeting high school populations, career promotion, provisions of financial training assistance, culturally safe learning environments, indigenous mentoring programmes and enhancing relationships between tertiary education providers and child and adolescent mental health services. These recommendations are supported by Robertson and colleagues (2006) who propose capacity building through robust recruitment strategies, improving remuneration, promoting 'professional' roles in addition to support roles and developing clear career pathways.

According to Robertson and colleagues (2006) whilst career promotion in schools is encouraged, there is also the need for a diverse workforce and they caution that recruitment should not just focus on the youth population but should also target mature populations with relevant and desired skills and experience. Cultural elements are also viewed by as imperative to workforce development with a particular focus on use of Māori language and processes, inclusion of Kaumatua, tohunga, whānau and greater participation and ownership by Māori in policy and programme development (Robertson et al., 2006).

Staff retention is also an issue. Contributing factors for Māori leaving their jobs in mental health are stress and burn-out as a result of low staff to client ratios; the inability of community based providers to offer secure employment due to short term funding contracts; complex client issues; the stigma of working in mental health; regular restructuring of the health sector and high

levels of audits and investigations (Kaahui Tautoko Ltd, 2001 cited in Kia Puaawai Te Ararau 2005-2010). Kia Puaawai Te Ararau (2005-2010) also cites Maxwell-Crawford and Gibbs (2003) who discuss job retention within the mental health sector being linked to job satisfaction, the opportunity to make a difference, and remuneration. Maxwell-Crawford and Gibbs (2003) emphasise that where these elements are lacking, staff attrition will be high. Kia Puaawai Te Ararau (2005-2010) cite Kaahui Tautoko (2001) to suggest that Māori are attracted to Kaupapa Māori workplaces where they are able to practice in a Māori way and gain recognition for their skills resulting in considerable satisfaction and reward from their mahi;

Maximum gains in whānau ora can only be achieved through a wider workforce that is well equipped to detect and understand mental health need. Our collective goal must be achieving positive outcomes for whānau. Our people knew the advantages of working as a collective unit. We work within the framework of whānau, hapu and iwi. We understand the power of the collective and its ability to strengthen, nurture and heal. We know that as a collective we can achieve great things. (Te Rau Tipu Conference, 2004; p. 20, cited in Kia Puaawai Te Ararau (2005-2010))

Aftercare

Follow up or aftercare is crucial to ensuring sustainable recovery and long term outcomes (McCormick et al. 2006). Whilst there is evidence to support the effectiveness of adolescent treatment, longer term outcome studies indicate that continued substance abuse is common after three months of discharge (Garner, Godley, Funk, Dennis & Godley, 2007). Adolescents attending residential treatment as opposed to community treatment, generally tend to present with severe and complex issues including family dysfunction. Schroder and colleagues (2007) found high rates of family disconnection exist for many young people in treatment and emphasises the need for adequate aftercare services to provide support and a source of connection. Better treatment outcomes are associated with continuing care and reduced environmental risk factors such as reduced peer pressure, with many

researchers advocating for the increased application of aftercare services (Garner, 2007; Kelly, 2000; Schroder et al., 2007).

Citing Garner, Fortney, Booth, Blow, Bunn, and Cook (1995), and Schmitt, Phibbs, and Piette, (2003), Garner (2007) identifies two common barriers to aftercare support are being discharged from treatment without successfully completing a programme and not being located near a treatment facility post discharge. Schroder and colleagues (2007) state that the lack of post treatment support in New Zealand appears to be due to a lack of funding for aftercare services for youth. Given the high rate of adolescent relapse that adolescents experience post-treatment, the role of aftercare services cannot be underestimated (Garner, 2007; Kelly, 2000).

The main findings of this literature review indicate that a multisystemic whānau oriented approach is important for producing successful outcomes in both mainstream and Kaupapa Māori adolescent treatment contexts. Evidence suggests that young people benefit from intervention that incorporates both a youth and a cultural identity focus. Furthermore, Kaupapa Māori programmes benefit from the provision of an integrated clinical and cultural approach. Funders, policy makers and services need to understand the cyclical nature of change and ensure ongoing supports are available over the long term.

Chapter 3: Method

A qualitative evaluation was undertaken to explore concepts of how change occurs and to gain insight and understanding utilising a collaborative and participatory approach (Bishop, 1996; Patton, 1990). As a Kaupapa Māori programme, Rongo Ātea would ideally benefit from Kaupapa Māori research, which requires research to be undertaken by Māori for Māori representing the perspective of a Māori world view (Cram et al., 2003). As I am a Pākehā researcher, this was not possible. However, I sought to reflect Kaupapa Māori research principles by demonstrating respect and avoiding trampling on the mana of people, through the employment of kanohi kitea (Smith, 1999), collecting staff and student views (Cram et al., 2003) along with spending time at Rongo Ātea with staff and students, listening and participating in daily activities and feeding back findings.

Research information was gathered from a number of sources including undertaking a review of New Zealand and international literature, participant and programme observation, interviews with students, staff focus group and interview including Kaimahi, social workers and management staff. Following is a description of each of the methods undertaken.

Entering the setting

When I first started as a researcher at Rongo Ātea, I was greeted with a pōwhiri and was able to explain to students who I was and why I was there. Previous to this I had attended a staff meeting along with my supervisor and met with the programme manager and staff to discuss programme objectives and process. I was assigned a space within the main office area where I had access to a computer, files, and daily log book and programme information.

Participant observation

I spent around 220 hours at Rongo Ātea between May 2006 and December 2006, participating in and observing the programme. This included being present in groups (9am reflections and 3pm review), during meal times, sports

activities (korikori tinana), off site outings, schooling, unstructured time, pōwhiri, staff meetings and staff training.

My practice was to participate in the programme for either the day or several hours at a time and then write up observations afterwards. This time was invaluable and assisted me to establish a rapport with both staff and students whilst developing an understanding of the structure, kaupapa and kawa of the programme. At times it did become difficult to balance engaging with the programme and maintaining a level of objectivity. However, I do believe this component of data collection enriched my experience and understanding of the programme. Patton (1990) writes

...getting close to a program through firsthand experience permits the evaluator to access personal knowledge and direct experience as resources to aid in understanding and interpreting the program being evaluated. Reflection and introspection are important parts of field research. The impressions and feelings of the observer become part of the data to be used in attempting to understand a program and its effects. (p. 205)

Part way through observation and data collection, Rongo Ātea went through a major restructuring of the programme and staff, including a change in management. The influence of this restructure was captured in my own observations and also in the interviews with both staff and students. This did have a significant bearing on my ability to explore the impact of the programme on the participants, and also meant the loss of my main contact within the programme. The changes in staff and programme resulted in some difficulties for me in negotiating time with staff and students and sourcing information. However, key components that remained unchanged over the duration of data collection, or that were considered to be useful in any reshaping of the programme itself, have been highlighted in the research.

Student interviews

Students were formally introduced to the research and interview process as a group, provided with a written panui and allowed to ask questions. I did not seek consent straight away as I also wanted to give students the opportunity to talk with their Kaimahi about their participation as they had a trusted relationship with them. I had asked students to hand in their consent forms (Appendix B) to the Kaimahi if they wished to take part.

Initially eight (out of a possible ten) students signed consent forms. However, two of those consenting chose to leave the programme soon after. The whānau worker and manager gained consent from whānau for the young people to participate. In all instances, students who participated were still under the care of whānau which simplified the consent process. Another two students asked to be interviewed at later stages of the programme.

Of the eight interviewees, three were female and five were male. Five participants identified as Māori (four male and two female) and three participants identified as Pākehā (one male and one female). Ages ranged from 14 to 17 years (age indicates age at time of first interview).

Table 1. Rongo Ātea Student Interview Participants

Participant [§]	Gender	Age	Ethnicity	Referral	Interviews
Connor	Male	14	Māori	Family	2
Jason	Male	14	Māori	Counsellor	1
Stuart	Male	15	Māori	Court	2
Jonathan	Male	17	Pakeha	Family	2
Joseph	Male	16	Pakeha	Court	1
Emma	Female	15	Māori	Court	1
Alicia	Female	16	Māori	Court	1
Talia	Female	17	Pakeha	Counsellor	1

[§] All names are changed to protect anonymity

Three participants provided a second interview. One of these students (Stuart) had graduated from the programme by the time of the second interview and had been living at home for three months. The other two students (Connor and Jonathan) gave interviews on the day of their graduation. Jason had agreed to do a follow up interview when returning for a friend's graduation but then chose not to as he wanted to spend the time with his friends as was the case with Emma. Joseph gave his first and only interview at the end stage of data collection, as he asked to participate and was reasonably new to the programme at that point. Talia had given an interview whilst returning to the programme for a short time after having graduated previously. Alicia had left the programme of her own volition and against the advice of the staff at Rongo Ātea, after having been in residence for nearly a year, but not yet graduated from the programme.

Interviews were generally between 30 minutes and one hour and were audio taped with the student's permission. Interviews were semi-structured. That is, a set of questions was constructed as a guideline prior to interviewing. However it was made clear to the student that I was interested in their experience of the programme and we did not have to conform rigidly to the questions. Questions (Appendix D) included demographic information (age, gender, and ethnicity), whether the young person was court referred or other, drug of choice, how long the young person was using previous to treatment, family and school situation, self-perceived reasons for use, perceptions and experience of the Rongo Ātea programme. Interviews did not include extensive questioning around the reasons why the young person participated in drug use or their family history as the focus was on their experience of their programme. However, client records, accessed with permission from management and students, revealed complex issues for all interviewed and non interviewed students including traumatic family histories (e.g. violence, abuse, family break down or death of a parent/s, drug and alcohol use or abuse), disengagement from school, run-ins with the police or actual criminal activity (reflected in numbers of court referrals), dual mental health diagnoses (e.g. conduct disorder), teenage pregnancy and gang affiliation. Such

complex presentations are consistent with the literature on adolescents in drug and alcohol treatment.

Staff focus group and interviews

A total of seven staff participated in interviews or focus groups. This included three staff from Pumau ki te Ora (the Social Work service of Te Rūnanga o Kirikiriroa), of whom two were interviewed at one time and then a third, who was employed at a later date was also interviewed; three Kaimahi, two of whom were also case managers and an acting manager.

Other informal discussions were held with the outgoing manager and manager of Mental Health services, and other Kaimahi on duty during periods of observation.

Analysis

All interviews and focus groups were audio recorded. I then transcribed each interview verbatim. This allowed me to re-familiarise with the interview and to start to get a sense of the ideas and concepts included. Information from the transcripts, literature review and observations, was organised into a number of recurring themes relevant to the research questions (Patton, 1990).

Mason Durie's key phases of intervention from Māori Concepts of Wellbeing (2008) were utilised as a framework under which to group each of the theme areas. Durie (2008) contextualises the key phases of intervention within a marae based encounter. He asserts that less than half of all Māori regularly participate on marae and with research suggesting that stronger links to cultural identity result in better health outcomes for Māori (Durie, 2001), an examination of encounters on a marae provides useful insights that might assist in therapeutic interventions (Durie, 2008). The key phases of health intervention that Durie maintains are required for successful outcomes for Māori include whakapiri; whakamārama; and whakamana. I borrowed these three phases from Durie to use as a framework for this study because they allowed me to define three categories that arose from the research analysis,

being whakapiri which captured themes around engagement and retention of rangatahi participating in the Rongo Ātea treatment programme; whakamārama focusing on the programme structure and impacts on participants; and whakamana which provided for an examination of post-treatment factors and ongoing support. More explicit meanings of the three phases of the intervention are provided as prefaces to the next three chapters of findings and discussion. However, it is important to have some understanding of te ao Māori in which to frame the discussion and provide context. The next chapter provides a brief overview of te ao Māori, highlighting some key concepts relevant to the findings and discussions.

Chapter 4: Te Ao Māori

In the words of the late Professor James Ritchie, “in the Māori world I am an outsider, a visitor and always will be” (Ritchie, 1992, p.51). My limited experience with te ao Māori tells me that as Pākehā, I will never fully understand the profound depth of Māori cultural concepts. However, if I am to engage in processes and research affecting Māori, it is integral that I develop some understanding and context in which to frame my engagement and discussion. This chapter does not provide a comprehensive study of te ao Māori but attempts to outline some key concepts and principles to provide context for the following chapters.

The beginning

To understand te ao Māori, it is necessary to go back to the beginning. Whilst there are some variations in the story of creation, according to Shirres (1997, p.25), the best known story is the one written down in 1849 by the Arawa chief Wiremu Te Rangikaheke;

Here indeed is the origin of the generations of human beings. There is one ancestor of the Maori people, Rangi the sky who stands above, and Papa the earth who lies below. According to the Pakeha, the human race, and heaven and earth, and all things were made by God. According to the Maori, heaven and earth were themselves the source. Originally the sky and the earth were dark, and the children of Rangi and Papa considered that human beings had multiplied and become many, but it was still not light – all was still dark. Then those children considered their great plan, to kill their parents. Then one of their children said: “Don’t kill them, just separate them, one above and one below”. And they all agreed to that.

The separating of Rangi and Papa facilitated the birth of atamai and āhua, shape and form, which was infused with hauora, the breath of life which some believe came from the Supreme Being Io (Shirres, 1997). From atamai and

āhua, came wā and ātea, time and space. Time and space provided the structure for the emergence of Rangi and Papa from the te ao wairua, or the world of spirit. Māori have a particular concept of time distinct from the Pākehā construction of time, describing the past as ‘the days before’ and the future as ‘the days after’, reflecting a world-view in which Māori look to the past as a guide for the present and the future (Ka’ai & Higgins, 2004).

The story of Rangi and Papa is part of a much bigger narrative of creation that is made up of multiple layers of concepts and understandings woven together to portray complex but meaningful patterns and relationships. Some of these layers involve the physical elements experienced in the world including the sky, wind and storms, the earth, trees, birds and plants, and the ocean and rivers. Another layer is the spiritual dimension in which the children of Rangi and Papa, who were created out of the nothingness, are known as spiritual powers. Shirres (1997, p. 26) is careful not to refer to them as gods, which he states is a Western imposition, but rather each of the atua is a created spiritual power that is identified with, and responsible for, a specific area of creation such as Tānemāhuta, the trees and birds; Tangaroa, the sea and marine life; Rongomātāne, cultivation and custodian of the kūmera; Tāwhiri-mātea, the wind; Tūmatauenga, war; haumiatiketike, fern roots and uncultivated plants; Rūaumoko, volcanoes-eruptions and seasons (Ka’ai & Higgins, 2004; Shirres, 1997).

Within te ao Māori, the physical and the spiritual dimensions are not separate, but rather the spiritual world permeates the physical world in which every person is linked to all living things and to the atua (Ka’ai & Higgins, 2004; Shirres, 1997). Waetford (2007) cites Henare (2003) and Wolfgramm (2007) to highlight the dynamic view of te ao Māori in the way meaningful relationships with ancestors, atua, whenua, and taonga, are generated to confirm identity and a sense of the eternal while transcending distance, space and time. According to Henare (cited in Waetford, 2007) te ao Māori is;

found in rituals, ceremonies, religious objects, sacred places and sites, in art forms and carvings, in songs and dances, proverbs, wise

sayings, and riddles, in the naming of people and places, in myths and legends, and in customs, beliefs, and practices (Henare, 2001, p. 16).

Tapu, noa and mana

According to Ka'ai and Higgins (2004) there are three primary cultural concepts, from which all other cultural concepts can be understood. These are tapu, noa and mana.

Tapu has its source in the mana of the spiritual powers (Shirres, 1997). Every part of creation is tapu because it is linked with other spiritual powers and the ultimate source of creation.

Underpinning the Māori model of the universe is the realisation of the worth of every part of creation, a worth which comes from the very fact of its 'being' and from the link of each part of creation with particular spiritual powers. This is expressed with the word *tapu*, 'being with the potentiality for power' (Shirres, 1007, p.18).

A complex system of customs and ritual has been created around tapu to protect the tapu that belongs to all of creation. These customs and ritual, which are generally restrictive, are in themselves tapu due to the connection to atua and ancestors (Ka'ai & Higgins, 2004; Shirres, 1997). Those who participate in ritual associated with tapu must be made noa before they are free to move anywhere they want. Noa does not negate tapu, but rather allows a person to be free from the restrictions associated with ritual (Shirres, 1997).

Tapu also protects the mana of a person or thing, whether it is inanimate or inanimate. Tapu is closely linked to mana with a distinction based in the difference between existing and being. Something has tapu when it exists (potential for power), but it has mana when its full power is being expressed, or is in the fullness of 'being';

The difference between tapu and mana is also related to 'being'. A thing has its full *mana*, is fully powerful, when it has its full 'being',

when it is fully alive, fully active. Mana is the power of being, a power that is realized over time (Shirres, 1997, p.37).

Shirres states that all the mana of a human person can be seen as coming from three sources and including mana whenua, associated with the land, mana tangata, as a result of connections to people, and mana atua, derived from the connection with the spiritual powers and the source of creation (Shirres, 1997, p.18). According to Mead (2003), mana is also related to the position that a person holds within the social structure. Maori society is hierarchal with rank and leadership being based on seniority of descent from Atua, ariki, tohunga, rangatira taurekareka, tuakana, and teina (Mead 2003, Kai'ak & Higgins, 2004).

Mana is derived as a birth right due to a direct lineage from nga ātua. The first born in the senior line holds great mana and usually is the Āriki and more tapu than anyone else. This also fits for firstborn female known as ariki tapairu. The younger siblings normally fulfil rangatira roles (Mead, 2003). There are strict tuakana and teina observations when it comes to who has more mana and who takes the roles of leadership such as speaking rites and karanga. At the same time, also observed is the strengths or gifts each brings to the collective and sometimes the roles may reverse depending on the situation.

Mana is also gained over time through the actions of a person and in this sense, mana is both granted and respected by the people. A Chiefs mana was dependent on their ability to manāki people and sustain cordial and strategic relationships. Mana was enhanced by the integrity and strength of the Chief's people and their mana was enhanced by deeds and strength, but particularly by their lineage.

Utu is also closely tied to mana and deals with concepts of reciprocity and balance. Utu is sought when there is a breach of tapu or an increase or decrease in the mana as the result of a group or individuals actions (Ministry of Justice, 2001). Utu is not so much about revenge as about balance and is also a reciprocation of generosity between one person or group, and another.

There is an appropriate time and place for utu. Utu can be deferred, sometimes for a few generations, but it is not forgotten (Ministry of Justice, 2001). The interweaving of time and space to create balance is understood. There is a place in the healing process in moving from the darkness to the light and this balancing is a natural progression that can take time but will eventually happen, denoting the need for faith in the balance of all things through time.

Whākapapa

Ka'ai and Higgins (2004) describe Māori customary concepts as being interconnected through whākapapa which links the spiritual and physical aspects of te ao Māori. Whākapapa is the basis of Māori social structure, defining the kinship system and genealogical lines comprising ariki, rangatira, tūtūa, tuakana, teina, and atua. In this sense, whākapapa establishes identity and belonging within the tribal structure of iwi, hapū and whānau (Ka'ai & Higgins, 2004; Mead, 2003). Whākapapa connects all Māori back to the primary source of creation in which Rangi, the sky, and Papa, the earth were still dark when their children, nga ātua, decided to separate them and created light. People are descendents of the nga ātua and whākapapa extends beyond human relationships to include the physical environment and the universe (Ka'ai & Higgins, 2004).

To be a person is not to stand alone, but to be one with one's people, and the deeper the oneness the more we are truly persons and have that mana tangata (Shirres, 1997, p.53).

Whanaungatanga is related to whākapapa in that it encompasses whākapapa but can also include extended relationships that are not always kin based but rather developed through shared experiences or other kin like connections (Mead, 2003). Whakawhanaungatanga is the process of relationship building through establishing connections and commitment to others (Bishop, 1996) and can often lead to enduring relationships from generation to generation.

Te Reo

Te reo Māori is also an essential strand in the woven interconnectedness of te ao Māori. Te reo and tikanga are intertwined. Ka'ai and Higgins (2004) refer to te reo as the life blood of Māori culture, acting as a link between knowledge and meaning, a woven strand that connects customary concepts to each other and through time. Smith (200) also talks about te reo Māori and Kaupapa Māori knowledge as being inextricably tied and cites Nepe (1991) to depict this interweave and how it's influence on Māori;

Kaupapa Māori knowledge has its origins in a metaphysical base that is distinctly Māori. As Nepe states, this influences the way people think, understand, interact and interpret the world. For Nepe, Māori knowledge is esoteric and tuturu Māori. It validates the Māori worldview and is owned and controlled by Māori through Te Reo Māori. Te Reo Māori is the only language that can access, conceptualise and internalise in spiritual terms this body of knowledge. (Smith, 2000, p.3)

Tua-ātea

Tua-ātea is the world beyond any space-time framework, and it is infinite and eternal (Shirres, 1997, p. 18). Ritual, including pōwhiri and karakia provide the access to Tua-ātea (Shirres, 1997). Participation in Māori ritual connects people to each other, the ancestors and the atua and involves taking part in the dynamic movement of creation 'from the nothingness, to the night, to full daylight (Shirres, 1997). Karakia is a practice that acknowledges the world beyond space and time through identification with people both living and passed on.

Ritual such as pōwhiri and karakia provide ways for the people to connect with each other, the ancestors, and the atua to develop oneness;

This oneness extends right back into te kore, the 'nothingness' of the beginning of creation. They truly find who they are, they become who they are. Then one with the spiritual powers, with their mana, we take

our part in bringing creation out of its darkness into the world of light. In this way, we are not just men and women of this world as we know it, but men and women of the whole universe, of the cosmos (Shirres, 1997, p.90).

Marae

Identifying of oneself with one's people and one's history is a major reason for the marae (Shirres, 1997, p.54). To walk onto a marae is to walk onto a place which is beyond space and time, a place where people connect to the ancestors and to the family wherever they are (Shirres, 1997, p.56). Marae also signifies the connection to land and to one's roots in the earth. Whenua is the Māori word for both land and afterbirth denoting a strong connection to the earth as mother, Papatūanuku (Shirres, 1997). Marae is tūrangawaewae, a refuge, a place to stand, a place of nurturing and manākitanga (Tauroa, 1986).

Waetford (2007) outlines functions for both the literal and the metaphorical marae, citing Salmon (1990) who portrays the literal marae as the gathering place for the practice of traditional rituals and customs, an encounter between tangata wheuna and manuhiri, the living and the dead, a place of boundaries and frontiers transcending time and space. Henare (2003) and Wolfgramm (2007, cited in Waetford, 2007) posit marae as a metaphor for making sense of spiritual and ritualistic customs and concepts within te ao Māori and where spiritual elements, arts, practices, symbols and behaviour can be learned and expressed. Waetford writes;

As individuals move from one scene to another, their behaviour changes in patterned ways as they adapt to a new set of rules and take up different roles. As scenes alter in a patterned sequence, one can more nearly appreciate the true rhythms of life in that culture. One can envisage the Māori cosmology as coming most sharply into focus on the marae. (2007, p. 36)

The marae, whether literal or metaphorical provides a space for a myriad of encounters, and an opportunity to develop cultural identity through immersion in te ao Māori.

Chapter 5: Whakapiri

To be a person is not to stand alone, but to be one with one's people, and the deeper the oneness the more we are truly persons and have that mana tangata (Shirres, 1997, p.53).

To walk onto a marae is to walk onto a place which is beyond space and time, a place where people connect to the ancestors and to the family wherever they are (Shirres, 1997, p.56). The emulation of a marae space for Rongō Ātea is intentional. The marae is tūrangawaewae, a refuge, a place to stand and belong, to speak what is felt whilst respecting others and being respected (Tauroa, 1986). For Māori, the marae is the wāhi rangatirama, wairua and iwi and is designed to enhance dignity and provide a place in which manākitanga and tikanga Māori is able to be expressed (Mead, 2003; Tauroa, 1986). Tikanga and kawa help to establish clear boundaries along with expected ways of behaving and relating.

Durie (2008) identified three phases of health intervention required for successful outcomes for Māori within treatment settings that are based on marae encounters. These include whakapiri which addresses processes of engagement; whakamarama which is the development of knowledge and understanding; and whakamana which is the empowering of people to move beyond a place of knowing to action and sustainability.

Whakapiri, is the first of three key phases of health intervention with Māori categorised by Durie (2008). Whakapiri includes initial contact and establishing connectedness which allows for a readiness and willingness to engage in a therapeutic programme over a period of time. When engagement is unsuccessful, non-compliance is likely. It is well understood that successful engagement leads to better treatment outcomes (Battjes et al., 2003; De Leon, 2000; Dembo et al., 2002; Devaliant, 2004; McWhirter, 2008; Merrill, 1998; Reisinger et al., 2003; Schroder et al., 2007; Stevens et al., 1996; Stevens & Morral, 2002). A New Zealand study focusing on retention of adolescents in drug and alcohol treatment programmes (Schroder, 2007)

found that where young people experienced connection and a sense of belonging in the programme, and were involved in the setting and implementation of their personal treatment goals along with feeling supported by staff, there was a positive trend in programme retention.

According to Durie (2008) for whākapiri to be enhanced within a framework of marae encounters, attention must be given to space, boundaries, time and ways of thinking.

Space

Time and space provided the structure for the emergence of Rangi and Papa from the te ao wairua, or the world of spirit (Shirres, 1997), moving from the darkness into the light. Physical and negotiated space influences the ability of people to engage in treatment and move into phases of whakamarama and whakamana.

In a treatment setting, sense of belonging is vital to attain engagement and first impressions are important in establishing engagement. One of the questions asked of rangatahi was in regards to their first impression of Rongo Ātea and whether it was what they expected. All interviewees responded by saying their expectation was that it was going to be a lock up facility and were surprised to find that it wasn't.

When I was coming up I thought there was going to be bars on the window, or it would be like an old hospital, people would be psycho and stuff like that. I didn't expect it to be like, just normal people like me. (Stuart)

Nah, oh I had had a visit before that to see what it was like. I was really surprised. I thought it would be close to what a lock up was but it was all good. (Emma)

Nah – it was better than I expected. I thought it was going to be like jail or something. I thought they were going to be all like Māori and hard out. (Jonathon)

Rongo Ātea is designed to be welcoming as well as functional, and reflects many principles of the marae in both the physical set up and established kawa. A courtyard runs between the whare kai and the whare nui, acting also as a marae ātea during pōwhiri, which is undertaken at each intake. Pōwhiri is the opportunity for clearing tapu restrictions, establishing the purpose for tangata whenua and manuhiri being brought together, establishing boundaries and developing relationship. According to Durie, the pōwhiri has implications for healing. Pōwhiri provides an encounter that reduces time and space between groups and beings the process of relationship building (Durie, 2001).

Pōwhiri acts towards building group cohesion whilst acknowledging the different identities within a group and creating a balance between unity and difference. The process of pōwhiri can itself be therapeutic. Durie states “for a visitor whose life has been one of exclusion, or whose identity has never been valued, the pōwhiri can be a profoundly healing encounter” (Durie, 2001) p.176).

Rangatahi entering Rongo Ātea are able to bring whānau and/or support people to the Pōwhiri.

On my pōwhiri, I was nervous as. But it was OK cos I came in with (another new student). So at least I wasn't alone. But yeah, it was alright. (Emma)

Emma expressed the fear of being alone and this is a common experience for many rangatahi entering the treatment programme, leaving their families to be with people they don't know in an unknown setting. From a te ao Māori perspective, no-one ever comes alone as they bring with them their ancestors and atua (Shirres, 1997). The pōwhiri beings the journey of discovery of self, Whākapapa , and whānaungatanga.

At the conclusion of the pōwhiri and sharing of food and space, Kaimahi take the new student to their room. Bag searches are undertaken at this time and the student is made familiar with their surroundings. This is the beginning of rapport building for the student with their Kaimahi and case manager and can

set up the student's inclination to start to engage with the programme. Most of the rangatahi interviewed had not undertaken any detoxification prior to being admitted to the programme. For many the first day at Rongo Ātea was also their first day 'clean'. Students reported finding this initial period of treatment where they were experiencing withdrawal, as difficult and stressful.

I can't remember coming in. Until I woke up the next morning – it's all blurry. I kinda remember getting stuff searched. After that it's just a blur. (Stuart)

I had always thought about it (stopping use) but when I tried I stressed out too much and just went back to drugs, and um being here the first two weeks I stressed hard. But I'm ok now; still crave though. (Emma)

When you first come in its hard to cope, cos you're detoxing. Yeah it was hard to get used to it that fast. It was hard to stay here, everybody was saying how it sucks here and all that but I just didn't want, didn't want to go back out cos, oh, I don't know it just wasn't right – it just didn't feel right. (Connor)

I had stopped for like a day. Because I didn't know I was coming in cos I got told like, on a Sunday and I was coming in on a Monday. And I wasn't feeling too well cos I had food poisoning and that was my last day of drinking, the Sunday. (Joseph)

In terms of a young person's ability to develop relationships and engage with the programme, the period of time that they spend detoxing must be taken into account. Rangatahi entering the programme may have been using one or a range of substances including alcohol, marijuana, methamphetamines or other. Detox experiences can vary dependent on when they last used and what they had been using. It is important to note that Rongo Ātea is located beside Te Kahao Health, a Māori health service and so had ready access to clinical services. For this reason, rangatahi may require more intense supervision and support in the initial period of the programme. Several students talked about how after a couple of weeks they were able to think

clearly and this was in fact the first thing they noticed as a result of coming off alcohol and/or drugs.

After a couple of weeks I was more focused onto stuff, more focusing. I started thinking about things I had been doing. Yeah, yeah I was like fuck that was mean or something, or au, that was stupid, all letting my family down and stuff. I started thinking more. (Connor)

This quote from Connor demonstrates how the first few weeks in treatment, coming off drugs and alcohol is an intense period of time for the young person. Not only are they dealing with the physical effects of withdrawal but also the emotional effects and often realising the impact of the lifestyle they had been leading up to that point. The young person must be provided the space and the support to come to terms with the physical and emotional adjustments they are experiencing in that initial period prior to even contemplating the idea of long-term change. Boundary setting and relationship building are important in moving the young person into an ongoing state of engagement or whakapiri.

Boundaries

Boundaries provide safety, honesty and mutual respect. Conflicting messages in regards to boundaries result in unsafe and high risk situations. According to Durie (2008) boundaries within a marae context help to distinguish relationships and establish lines of honesty and respect as well as social control. Tikanga, kawa, Whākapapa and whanaungatanga are some of the ways in which boundaries can be established.

Tikanga and kawa

Tikanga and kawa are established for the protection and safety of mauri and mana and to ensure social controls are maintained. Established kawa existed within the Rongo Ātea programme and noted by the young people as making a significant impact on their ability to engage.

Well, its good, even though I don't like it, I reckon its pretty good how they keep us on site, keep us on a straight routine, so you don't get mucked around or anything, you just follow your routine, get up at 7.30 in the morning, get to shower as quick as you can so you don't have to wait. Your cigarettes last longer cos you only have nine a day and you have more money to spend. (Jason)

Yeah, it's pretty good. Like the shoes and hat when you go into someone's house. Treat them with respect and you get respect. (Joseph)

Stuart expressed the strongest dislike for the kawa in his first interview.

I don't think there should be smoke times, like they kinda treat this place like a primary school, and we should be able to smoke when we want because it's so hard giving up drugs and when they're limiting your cigarettes and that's the only thing that can keep you calm.

Stuart believed that the manager did not like him, favoured girls over boys and had it in for him, which he evidenced by the number of times he had had to appear in the manager's office and made to do 'workforce' (given as consequences to behaviour);

Oh, cos there's thing called a workforce...and like, you just, maybe do it in a period of time, like in the evening or afternoon, lawns, garden and shit. It's like the ... especially in the afternoon about 3 o'clock when the suns coming out, it's hot as and I've had the most of them in the history of Rongo Ātea.

Stuart returned to Rongo Ātea for several days three months after his graduation, to support two of his peers graduating whilst the programme was still in a state of change. It was interesting to note Stuart's viewpoint on kawa after leaving the programme and returning several months later;

Have you noticed any changes in the programme since being back?

Heaps. All the rules – none of the old rules are here any more – this place used to be strict as. They're loosening up on a lot of things.

What rules specifically?

Posters – you weren't allowed no guns or women. Now they've got it easy, rappers in bikinis and shit, and I remember I had one picture of this girl standing next to a car, wearing clothes and I got a four hour workforce. You've got people walking into here with their hats on inside and stuff and just being told to take them off. Heaps of shit aye. People just abusing the place and stuff – there are like no rules around here and stuff.

Do you think it's a good thing or not a good thing?

Not a good thing. I think there are some rules that they should loosen down on, that I agree with but some they shouldn't.

So you think the kawa is important?

Back then I hated it. But when you get out you realise what some of them are for. Some of them are just stupid and I never understood but then I finally clicked on about a few months ago I was sitting there I was wondering why I didn't do that – those rules are there to see if we can follow those rules. One thing (the previous manager) had was she was strict and that was good in a way cos that keep this place tidy, you know meshed together – now its just slowly falling apart.

It is important to note that, as already stated, Rongo Ātea was going through a time of change at this stage that did result in some perceived chaos. However, there was a commitment from management and staff to develop a strong and effective programme. The point of including these observations from Stuart is that clearly the kawa, despite his initial disapproval, had a big impact especially post treatment when he began to realise the role discipline played in his own life and his ability to refrain from substance abuse. It also highlights how tikanga and kawa provide boundaries that enhance a sense of safety and protection. Consistency of kawa was also something that was raised by rangatahi as being an issue at times.

Um, when I break the kawa, they help me fix it, like what I have done wrong. Some of them make their own rules up. I'm not saying that we're not naughty sometimes. Other kaimahi (the ones that keep me on board) stick to the kawa here – and that's frustrating. (Alicia)

She doesn't make it fair. Sometimes I feel sorry for (name) cos she's real nice to ... she's nice to me but like, just stupid things like, she'll go and take my stuff off the clothes rack when its wet and she'll stick it in the dryer but (name) will ask her and she'll go "what's wrong with the clothes rack"? (Jason)

Some of them have different views about shit, like recovery and that... like someone said that they wouldn't use this programme – you should get yourself clean, and do it yourself. And then someone said you can't do it alone. (Jonathan)

Several of the boys expressed their perception that they were treated differently than the girls.

Yeah. And the girls get the better treatment ... they just like, they like get a girls night and get movies and they get pizza and shit. And then the boys asked and we had to get straight 10's (reward points) all week and then we didn't even get it in the end. The girls they get oh yep and they get it, like the Kura as well, if they want to go in there they go in there, if we want to go in there its like no, the girls are in there. (Jonathan)

I think there should be more equal treatment. Like there were these two girls, they brought drugs into here. They made paraphernalia and smoked drugs in here. They ran off site, they ran away and came back. Not one of them got a workforce. One fella stole half a tin of some other fella's wax – he got put into isolation for four days and got a formal charge laid against him. One fella also wore someone else's

jacket while they were on home leave and he got chucked out – girls wear other people’s shoes and they steal clothes and stuff – they get asked to take them off. (Stuart)

Whether the gender bias in regards to staff treatment was real or perceived, it does highlight the need for staff to be adequately skilled in behaviour management and demonstrate consistency in their application of kawa and other tikanga.

Another boundary that was established during the initial stage of treatment was a no contact policy which was intended to assist the student to focus on their new environment and their treatment plan. However, staff emphasised that once the initial no-contact period was passed and students were settled into their new environment and routine, contact with whānau was important.

I think part of our policy is to isolate the kids first. What happens in the first few days is not even have contact with their whānau. I think the way we do it, no contact with whānau is important (during that time). If you’ve got whānau involved initially, there is not a heck of a lot of changes. No contact is heart wrenching, but it is good. We do make allowances though; they have phone passes to whānau once a week. But I think as they get closer to graduation they should have more contact with their whānau. (Staff focus group)

The no-contact policy in the initial stages of treatment provide an example of boundary setting which is enforced to allow rangatahi to settle into their environment and adapt to a new set of rules and expectations. Rangatahi need to develop new relationships with staff and peers to get the most out of their programme.

Whākapapa

Whākapapa links the spiritual and physical aspects of te ao Māori (Ka’ai & Higgins 2004). As the basis of Māori social structure, defining the kinship system and genealogical lines, whākapapa establishes identity and belonging within the tribal structure of iwi, hapū and whānau (Ka’ai & Higgins, 2004;

Mead, 2003). Whakapapa is an effective social tool in which an individuals identity is defined through their relationship with others (Mead 2003) Rangatahi attending Rongo Ātea are encouraged to identify their whakapapa if they don't already have this knowledge prior to attending. Sharing of whakapapa takes place in group meeting fostering a sense of collectivity and creating opportunities for discovering connections and links and mana.

It teaches me more about um, like it gives you more understanding about your ancestors, like you're descended from a line of Chiefs. And they speak to you in Māori and they tell you and then you get to understand what they say. I knew a bit about it. I knew how to respect the Māori ways, cos my Mum teaches me all that. (Jason)

As a result of students being encouraged to discover or acknowledge their whākapapa, Jonathan, a non-Māori, was also motivated to explore his own family history which was a new concept for him;

Just how it is - the rules and stuff. I dunno, it's just different. Powhiri – ten songs for one person (laughs) and then they speak and sing back.

Has that impacted on you as a non Māori person - positively or negatively?

Yeah, it's probably made me more open. I kind of used to be like a skin head sort of. I was never like a racist as one.

Has it helped your with your own identity?

What, like who I am and where I come from? Yeah, kind of. I found out where I came from and all that. I asked my family and that. I just asked when I went home (on home leave).

This suggests that rather than the Kaupapa Māori context of the programme excluding non-Māori, the focus on development of identity and whākapapa opened up a space for all students to explore who they were and where they came from.

Whānaungatanga

Whānaungatanga is about connections and relationships and is a relevant context for discussing relationships between staff and rangatahi. It is also related to manākitanga in that whānaungatanga is about establishing relationship where manākitanga is about nurturing and maintaining those relationships. Firstly, I will give a breakdown of the staff roles to provide clarity.

A number of roles existed on-site within the Rongo Ātea programme. The programme manager was responsible for the training needs and management of the staff, reporting to Te Runanga management and governance, programme development, and decision making around intake and exit of programme participants. Case managers and kaimahi had a shared role of supporting the rangatahi in their day to day participation in the programme. This consisted of behavioural management, supervising group sessions and workbooks, completing daily logs, escorting rangatahi to medical and clinical appointments, supervising chores, undertaking additional domestic tasks, and implementing daily programme activities. Case managers had the additional responsibility of ensuring the young person's treatment goals were being met. This included meeting with the young person regularly to discuss and record progress, supporting the young person to find a sponsor, liaising with family, social workers and relevant community support, schools and training providers or employers.

All students interviewed emphasised the relationship with their kaimahi and case managers as being integral to success. All interviewees stated they felt respected and supported by most kaimahi although they were also quite open about which kaimahi they preferred over others. They knew they could talk to their case manager if they had a problem. The relationship with the kaimahi was deemed by the young people to be very important both in regards to choosing to stay at Rongo Ātea and the extent to which they felt they engaged in the programme.

Students are case managed and supported and there is a strong commitment amongst staff to act as a team. Whilst case managers generally had some form of qualification, including youth work, counselling, psychology and nursing, no staff with clinical expertise were located on site. Counselling may be identified as a need in the young person's treatment plan and the young person will either attend sessions off site or the psychologist or counsellor would come into the programme to provide this service. In this regard, for many of the students the key interventionists are the Kaimahi. They are the person rangatahi tend to seek support from if they are feeling down or need someone to talk to. It was clear in interviews and observations that Kaimahi were a strong factor in retention and engagement.

Kaimahi are with rangatahi at all times in a supervisory, support or therapeutic role. Alicia stated that the only thing that kept her in the programme at times were the Kaimahi and the support they gave her. She spoke about another student who she had become quite close to in the programme running away and how she had also been tempted to go but her relationship with Kaimahi kept her there - "without them, I wouldn't be here". Research undertaken by Schroder and colleagues (2007) found that young people need to feel connected to the programme whilst also experiencing it as fun, and highlights the staff/client relationship as a key factor in retention.

Towards the end of 2006, Rongo Ātea underwent significant restructuring of both staff and programme, mainly due to funding constraints, but also in an attempt to find ways to ensure the programme was delivered efficiently and effectively. At this time, the position of whānau worker was removed and the work previously undertaken by the whānau worker was devolved to social workers from Pumau ki te Ora and to case managers. Staff reported that they experienced significant increases in their work loads and an inability to adequately meet the needs of young people in the programme.

Funding for numbers of staff on the floor is tied to numbers of students on the programme at any one time (or number of beds). This system does not recognise the role that staff play in retention and engagement. Not only are

Kaimahi required to manage difficult and sometimes extreme behaviour, they must also meet the needs of rangatahi relating to daily care whilst delivering the treatment programme. Staff ability to undertake programme delivery was often compromised, particularly if care or behaviour demands of young people were high.

It is important to note that adolescent alcohol and other drug use requires a different approach than adult treatment due to developmental issues, differences in values and belief systems, environmental consideration, peer influence and educational requirements (Substance Abuse and Mental Health Service Administration, 2005). Whilst the impact of the shift changes could not be known to be either detrimental or beneficial to the way the service was run, it did result in some staff feeling dissatisfied with the changes and there were a number of staff who either resigned or were restructured out during 2006. The point in raising this here is that staff must be treated as a key resource in any adolescent treatment programme.

Case managers manage the young person's treatment plan as well as work alongside Kaimahi with behaviour management and programme implementation. At the time of restructuring, case managers appeared to be struggling with the time it took to focus on a student's individualised treatment plan, updating records, and being on the floor supporting the young people. Very little time is allocated to staff to undertake paperwork and there appeared to be no designated time for staff to discuss their caseloads with other staff or with managers. When staff meetings were held they were often rushed with only the staff rostered on that day attending.

It's been hard working with so many young people and so little staff on the floor. Our staffing was cut from five to four, along with the whānau worker so we got their job load too. The main issue for me was when we had the staff numbers on the floor we could spend quality time with the young people – we could do the one on one or the one on two. We could break the groups up and do various things; we could do the

sports together because there was such a large group of people. (staff focus group)

Staff reported, which I also observed, that the staff and programme changes were having a significant impact on the behaviour of the rangatahi in the programme. Staff felt a lot of their time was being taken up with trying to manage increased volatility and conflict amongst some students. The focus on behaviour management, whilst necessarily a part of any treatment programme for young people, minimised the amount of time staff were able to spend on the treatment programme and individualised treatment plans, as well as their ability to keep up with case management and the paperwork required;

Yeah, I've noticed some of that behaviour. I think what has happened is their behaviour is quite natural, due to programme and staff changes. Who is doing the anchoring? It is the institution that drives the kaupapa. When the institution isn't solid, the foundation from which they gain their learning, and they can visibly see it is not solid; it is natural to see this kind of behaviour. They are doing this because they have seen the changes, they've seen staff come and go. (Social worker interview)

Staff emphasised the need for relationships as key to the success of the programme;

I think all the disruptions can be put down to personnel change. Systems frameworks have their place but from a Kaupapa Māori perspective, from a human perspective, when you are dealing with youth like these, relationships are the key foundation in any programme. (social worker interview)

Whilst some disruption can be expected during a time of change, it will be an ongoing challenge for Rongo Ātea to ensure that staffing adequately meets the needs of rangatahi attending the programme. Given the impact of staff on engagement, it is imperative that adolescent treatment programmes such as

Rongo Ātea, and funding bodies, are cognisant of the role staff play and ensure structures are in place to support staff in their ability to support young people. According to Schroder and colleagues (2007), it is a concern that staff attrition is so high in adolescent treatment services in New Zealand as staff play a vital role in the success of youth treatment programmes particularly in the area of retention.

Relationships are key to engagement of young people in treatment programmes. Kaimahi working at Rongo Ātea play a vital role in the ability of a young person to engage in their treatment plan. Acknowledgment, training, and retention of staff must be a high priority for any service provider.

Time

Māori have a particular concept of time that differs from that of the Pākehā. Māori describe the past as *ngā raa o mua*, meaning 'the days before'. By contrast, the future is described as *ngā kei muri*, meaning 'the days after'. This reflects a world-view where Māori move into the future with their eyes on the past. This attitude looks to the past a guide for the present and the future (Ka'ai & Higgins, 2005, p.9). Exposing rangatahi to the concepts of space and time based in te ao Māori provides access to creation stories, connection to whakapapa and also the world beyond space and time.

Tua-ātea is that world beyond the space and time which is infinite and eternal, (Shirres, 1997, p. 18). Rangatahi participate in ritual including pōwhiri and karakia which provide the access to Tua-ātea and represents moving from darkness into light (Shirres, 1997). Participating in, but also understanding the reasons for ritual and the layers of meaning behind practices, gives young people greater access to te ao Māori reinforcing their sense of identity and connection to atua and ancestors. In the context of a 12-step programme, understanding the world beyond space and time could potentially provide some context to some of the 12-steps, which many of the young people struggled to understand and find meaning in, including the idea of a Higher Power.

In regards to treatment, a seamless continuum of care is required whereby the goals and aspirations of the young person and the whānau that are set at the onset of the young person treatment programme, and then carried throughout the programme and through to their exit and beyond. In this way the past, or the goals already established to live into, acts as a guide throughout treatment.

When talking about marae encounters in relation to health intervention, Durie (2008) suggests that treatment needs to be allocated the time that is required. Time has an impact on engagement in that sufficient time must be allocated to meet client-centred needs and priorities. TCM would also support the notion of allocating time appropriately along with being aware of the cyclical, rather than linear, nature of change. Prochaska and colleagues (1992) outline discrete steps in the process of a person's behaviour change during treatment and thereby allowing assessment of a client's readiness for change. They include pre-contemplation, contemplation, preparation, action, and maintenance. According to Di Clemente (1999), the Stages of Change recognise the motivational, temporal, and developmental nature inherent to the process of change. Once viewed as a linear multi-staged process with a beginning, middle and end, it is now understood breaking free from addiction can take a significant amount of time and energy with change being both cyclical and longitudinal, of which relapse is itself a key component (DiClemente, 1999; Prochaska et al., 1992a; Prochaska et al., 1992b).

According to McWhirter (2008, p.176), "treatment intervention should be designed to be congruent with an individual's stage of readiness to change". This will be discussed further in the next chapter on programme intervention, but the stages of change can also be viewed in the context of time, retention and engagement. Engagement is enhanced when adolescents feel involved, and experience choice at all levels of their treatment (McWhirter, 2008; Schroder, 2007). Matching treatment intervention to treatment readiness enhances an adolescent's sense of choice and participation in their own progress. By utilising the stage of change model, appropriate intervention can

be matched to the particular stage the young person is at and prepare them for moving through the stages whilst enhancing their experience of choice.

Alicia described her sense of choice when deciding not to go home at the end of her first 16 weeks in treatment. She also identified her own sense of preparedness in regards to being out of the programme and being able to abstain from alcohol.

That was the end of my first programme. I knew I was going to do another set of 16 weeks. And then I thought about it ...um, cos it was my family's choice (to come into the programme). And then I rang my Mum last week and said I was going to stay longer. And she asked me why and I told her because I don't want to come out and use and get wasted and scrap all the time. (Alicia)

Jonathan perhaps best demonstrates the cyclical nature of the change process and how relapse plays a key role. At age 18, he was on his second stay at Rongo Ātea, having spent sixteen weeks in treatment at age 16. He talked about the experience of changing and being clean whilst at Rongo Ātea resulting in him feeling healthier and how he thought that when he left he would be ok drinking alcohol as long as he didn't take other drugs. At first, this did not pose significant problems in Jonathan's life but eventually he found himself increasing his use and then again turning to other substances.

Yeah. Oh, but I always had that in my head that, oh, it's all good, I can just drink. Yeah, that's how I ended up back in here again.

So after you left here the first time you thought you could just drink and not take drugs – and that became problematic for you?

Yeah, and then... Like I drank as soon as I got home and then I just started, occasionally I'd have a puff and then started using drugs more and more. I was drinking quite a lot. I probably went worse than before.

What was interesting about Jonathan was that in the first interview he had stated that he had realised he could not tolerate any drugs or alcohol and his new goal was long-term abstinence. However, by the time of his graduation from his second round of treatment, Jonathan had changed his mind and intended to socially drink. He was asked what had changed his mind on this.

Yeah, cos, I didn't really think about drinking a little bit. I just thought I can drink heaps instead of doing drugs.

What has made you decide you could drink socially?

From my own experience and from talking to people. People that I've talked to reckon when you grow up a bit you sort of try that, and you do that anyway – its sort of a stage that you go through.

The intention to drink socially was not uncommon amongst the young people interviewed and some of their peers. This will be discussed in both of the next chapters in relation to programme intervention and in post-treatment follow up. The point of using Jonathan's interview in this chapter is to highlight the non-linear process of change. There may be an expectation, particularly from funding bodies that an adolescent enters a programme and outcomes are achieved within a specific period of time.

Individualised treatment goals need to be realistic and time must not be allowed to dictate the change process of the young person. Of the eight students interviewed, Talia and Jason were the only two to have completed a 16 week programme without rolling over for an extended period of time (although Joseph was part way through his first 16 weeks so it was too early to tell if he would extend his time or not). Both Talia and Jason differed from some of the other students in that both had engaged in some form of treatment prior to entering Rongo Ātea. Talia was interviewed on a five day visit to Rongo Ātea after having earlier completed the programme. She stated her reason for returning was to provide herself with some ongoing support but also to awhi others in the programme (a good example of manākitanga and reciprocity), particularly those she had known from her time in treatment.

Talia did in fact have some clean time of several weeks prior to entering the programme and so did not spend any time detoxing after entry. She had been seeing a counsellor some time prior to entering treatment.

This was also the case for Jason, who had been seeing his school counsellor and had also participated in a school based programme called 'smashed and stoned'. In his interview, Jason stated that the 'smashed and stoned' programme was 'useless' and that he felt he didn't learn anything. However, it is interesting to note that he, more so than some others, engaged relatively quickly with his treatment and achieved his stated goals within one treatment round. It is possible that both Jason and Talia moved through the pre-contemplation, contemplation and preparedness stages of change due to the work they were already doing prior to entering treatment and were able to move quickly into the action stage. Talia was interviewed some months after graduating from treatment, and whilst not formally interviewed, Jason also returned to visit Rongo Ātea several months after completing to attend the graduation of several of his peers. Both Jason and Talia had remained abstinent post-treatment and were therefore successful, at least over a period of months, in maintaining their intended goal in this regard. It is also important to note that Jason's school counsellor had taken a great deal of interest in him and had supported him into and throughout treatment, including attending his graduation;

And I had a drug counselor at school, he used to talk to me every day, and he um enrolled me here – I'm going to ring him tonight.

Jason returned to school post-treatment where the support of his school counsellor continued to be available to him.

Most young people in this study were clearly either in the pre-contemplation or contemplation stage of change at entry and therefore it should be expected that their engagement with the programme would take longer. Another way of looking at engagement is in relation to navigation as put forward by Reisinger

and colleagues (2003). Navigation is the propensity to do the time required without fully engaging in the programme. Just because a young person (or adult) completes a programme does not mean that they have achieved treatment goals that will have a long term impact on their lives. This is particularly relevant for people who are referred through the court system or pressured by family, school or counsellor to attend. Often the focus of the young person is around what they need to do to get through the programme. This is distinct from those who focus on how they can get out of the programme as soon as possible and voluntarily leave, often by running away without consulting with programme staff or whānau. Rather, navigation is undertaken by those who have something to get out of staying for the entire period (to avoid the consequences of court action or appease family, for example) but intend to go back to the original lifestyle of substance use.

I didn't really want to come, but my Mum and Dad told me to come up here. Otherwise I'd end up with 24000 dollars worth of fines and a conviction. (Joseph)

Traditional outcome measures generally focus on straightforward measurement such as programme completion and abstinence during the programme and long term. However, the relationship between outcomes and experience are a lot more complicated than quantitative measurements allow for. When engagement is measured through retention, completion by a young person who navigates their way through the programme could be assessed as a successful outcome without really capturing the extent to which change has occurred.

Reisinger and colleagues (2003) also discuss how those working with adolescents in treatment talked about 'planting seeds' in the mind of adolescents.

Thus, they recognise that change may be an incremental process resulting from the accumulation of treatment and other life experiences.

Treatment can prepare clients to benefit from subsequent experiences, teaching them concepts that they in turn apply to their life situations now and in the future. In addition, the clients may need to return to treatment to receive more support and guidance in applying the concepts. (p. 792)

This idea that the treatment programme was just one step in the process of change for a young person was reflected in comments made by staff.

The more I have thought about graduation, compared to that stepping out, I think so many of our young people deserve to step out, but not to graduate, and I think we should make it stepping out because there are so many connotations to 'graduating'. (staff focus group)

Yeah, it's not like 'I'm fixed'. Stepping out means you've got a new challenge. Because I think the people we are graduating or moving out, are stepping out, they've got a new challenge. (staff focus group)

An advantage of navigation is that it provides an opportunity for those working with the young person to draw them into engagement. If a person is navigating the programme they are generally committed to staying for at least the time they are required to complete otherwise they face consequences (Reisinger et al., 2003). Alicia talked about how she spoke with Kaimahi and senior staff at Rongo Ātea about her decision to stay longer and was supported in this. She was empowered in her ability to choose for herself, with support from adults around her. This was different to when she first entered treatment as a result of court action, and provided Alicia with the opportunity to think about her long-term goals rather than just doing her time.

Nah, I just wanted to do my time and then get out of here, and get wasted again. Then I am having second thoughts – like staying here. (Alicia)

Alicia moved from a state of navigation to one of engagement, which she attributed to her relationship with Kaimahi and the opportunities to be engaged in her own goal setting within the programme and hence giving her 'second thoughts' about leaving the programme before she achieved her goals.

Stuart also talked about how he first came into treatment as a result of a court referral. His idea at the time was that he would do the 16 weeks that were required of him by the court and then leave.

Oh, yeah. At first I thought I would come in and spend a bit of time and get a bit cleaner and stuff. (Stuart)

Unlike Alicia, Stuart did not express the same degree of autonomy or inclusion regarding the decision to continue on in treatment after completing his initial 16 weeks. When asked whether it was his decision to roll over his period of treatment, Stuart responded that it was a decision made by the management of Rongo Ātea. However, it was also clear that Stuart was engaging with the programme rather than just navigating to get the time done.

Do you think your relationship would have happened with your Dad, if you hadn't come here?

Nah. I don't think it would have happened. I think I'd be six feet under by now if I hadn't come here.

Did you know that when you were using?

I didn't care.

Do you care now?

Yeah

Staff were able to identify that Stuart had not yet met his treatment goals and worked with him to increase his level of actual engagement with the programme. Both Alicia and Stuart demonstrate how navigation can provide access to engagement. The challenge, as emphasised by Reisinger and

colleagues (2003), is for those working with young people to move participants from navigation to engagement. Staff at Rongo Ātea appeared to achieve this effectively in that five of the seven young people interviewed could be identified as coming into the programme with the intention of navigating but moved through to a point of engagement. Two students, Talia and Jason, could be viewed as being already engaged in the process of change prior to entry.

The idea that change is dynamic and non-linear, even though it can be conceptualised as a stage based process, highlights the need for young people to gain a positive experience in their first contacts with alcohol and drug treatment (Prochaska & DiClemente, 1998; Reisinger et al., 2003). Reisinger goes as far as to say that this may in fact be the one most important result for a young person even if little else appears to be achieved in that initial experience.

By recognising where people are at in the process of change and by being aware of the cyclical nature of change, the young person can be supported according to the stage they are at and provided with the tools to motivate them to move forward. Engagement can be further enhanced through involving the young person in their treatment plan and empowering them in their sense of choice and control. It is also necessary for funding bodies to be mindful of the different stages in which people enter treatment, and that the process may be cyclical once they are in treatment. It makes sense to allow a person to extend their period of treatment to ensure they have the time to do the work they need to do in a supported and therapeutic environment.

Ways of Thinking

Durie (2008) examines ways of thinking from a cultural perspective and asserts that within te ao Māori, understanding comes from larger contexts and wider relationships. This has relevance in terms of what it means to be a Kaupapa Māori programme and how this affects the ability of young people to engage with the programme.

Young people's drug use is shaped by social, cultural and economic contexts (Allen & Clarke, 2003; Durie, 2001; Saggars & Grey, 1999; Skye 2002). Positive cultural identity and pride have been posited as integral to achieving wellbeing for Māori within culturally based health settings (Cram et al., 2001; 2003; Durie, 2001). Huriwai et al. (2001) assert that barriers to access, engagement and retention due to cultural inappropriateness and irrelevancy would be reduced by dedicated Māori services, increased Māori cultural content in existing services and increased cultural competence of clinicians. "Dedicated Māori services primarily serve Māori clients, have a Māori philosophy, and have as an integral part of the programme a cultural component(s)" (p. 1036).

Rongo Ātea operates within a Kaupapa Māori framework, incorporating values such as manākitanga, mana rangatira, and arohatanga. Day to day practice includes powhiri, Whākapapa , waiata, karakia, use of te reo, and culturally defined kawa such as respecting elders and peers, removing hats and shoes before entering a building, and utilising spaces appropriately and respectfully.

Developing an appropriate cultural context within a Kaupapa Māori treatment programme poses significant challenges. Young Māori enter Rongo Ātea with various cultural understandings and sense of identity. Furthermore the programme also caters for non-Māori and attempts to provide relevance for all participants, whilst maintaining the commitment to Kaupapa Māori. Finn (1996 cited in Huriwai et al., 2001) suggests that the settings of treatment services and client/counsellor matching contribute to improved responsiveness and relevance for clients. This was reflected in the employment practices at Rongo Ātea with a strong focus on recruiting Kaimahi and managers with a good understanding of Kaupapa Māori principles and tikanga.

I think it's that family – Kaupapa Māori family based – the way Māori people are with each other. I believe Māori people are caregivers – it

comes out in that way. We relate to these young people as if we were at home – still remaining professional but there is just that whānau based relationship that we have at home – and you can see it around here in the way that we relate to each other. (staff focus group)

I prefer working in a Kaupapa Māori setting because it is what the young people relate and respond to. From working in other places, it is what young people relate to the best. I've worked in other settings and they're just not the same. (staff focus group)

For me there is pride ... to be able to work in a place that gives me access to my culture and identity whilst working in a professional and educational role. (social worker interview)

Many of the young people articulated an appreciation of the Kaupapa Māori principles incorporated into the programme and were able to articulate new leanings around Whākapapa.

When admitted to Rongo Ātea, Stuart had an estranged relationship with his father who was Māori and did not identify with his Māori heritage. In his life prior to treatment he had actively denied that part of himself which he expressed as a 'skin head'. Over the course of the programme, Stuart started to develop a sense of pride in his whākapapa and made efforts to learn about tikanga and te reo, including giving a mihi at his graduation at which his father was present.

Yeah, it was good learning. Before coming here I was a skinhead. I didn't know anything about the Māori side of me. When I was in here I changed my mind.

What made you change your mind?

I guess coming to a Māori based rehab... oh actually I left the skinheads about a month before I came in cos it just started getting out of control. When I first came in I didn't want to learn. I wasn't racist or

anything, I just didn't want to know about it, wasn't ready. I'd just finished being a skin head. I wasn't ready to get straight into that. Just wanted to kick back. But yeah, it makes me feel a bit more stable.
(Stuart)

The non-Māori students also felt like they also gained value from the Kaupapa Māori components of the programme.

Yeah, learning a bit of Māori and that, how to speak it. How to look after yourself when you go and flat and stuff. They have pōwhiri and speak Māori – I like learning to understand what they are saying.
(Joseph)

Alicia appeared to find it difficult to articulate her experience of the Kaupapa Māori component of the programme. Her expressed understanding of kawa was limited to rules such as no spitting, swearing or gang insignia. This suggests that the programme could be more explicit in how protocol and kawa are developed and the role of kawa in the provision of social control. When understood, kawa not only serves a role within the treatment programme itself but can potentially equip young people in how they act and respond in te ao whanui once they leave.

Alicia stated that for her, people are all the same no matter where they are from, although she did make a joking, but perhaps pertinent comment that demonstrates a possible expectation that she may need to defend herself in a relationship of cultural difference;

Some people here are from my tribe. But some are from other tribes – but basically we are all the same.

Is it good having Kaimahi who are Māori ?

Yep. Oh, and Pakeha, it doesn't bother me. If they get smart I'll get smart back (laughs).

An interesting dialogue ensued when Alicia was further questioned in regards to the Kawa within the programme.

What do you think of the kawa?

They're pretty fucked up aye. You're not allowed to spit. I don't know why we aren't allowed any gang shit here – um, swearing.

What kind of gang stuff?

Like black power and mongrel mob. West side, east side. But I tried to tell (*the manager*) and I said I thought this was a drug and alcohol treatment centre not a gang thing ... and she goes ... this is supposed to help you on the outside. I go what the fuck has a gang got to do with this shit.

I don't know much about gang culture, but I guess I'm thinking gang culture can be a lot about drugs and alcohol but are you saying its not?

Nah. Well, alcohol, some people become patch members cos they got no family – or they are born into it, and they're prospectors and all that. Some bad shit though ... like bad as. I was brought up with gangs since I was born.

So is that something that you are going to have to go back to when you go home?

Yeah probably.

Is it about surviving without drugs and alcohol in that environment?

Yeah. Oh, some of them back there don't use – most of them do.

So in terms of the kawa you don't agree with not being able to talk about gang stuff, is that what you are saying?

It's bullshit.

Cos you don't think it's related to drug and alcohol use?

Oh, (laughs) ... yeah I reckon it is. It's worth it. Cos they had other girls in here that were the opposite colour to me and that stopped them in their shit and I told them enough about it and they haven't did it since.

So why do you think it shouldn't be part of the kawa?

Cos some of us were raised with it and I will never ever give it up.

This interaction with Alisha demonstrates a need to address multiple components of a young person's life. Even though Alisha was learning about valued parts of her culture, what was most important to her was her connection to the gangs, as that was what she was raised with and where she gained her sense of belonging and family.

Alicia remained in treatment for over a year. Part of the reason for her not going home sooner was that home was not deemed safe for her and staff had not been successful in finding a safe environment for her to return to. Alicia had at some point chosen to stay for a second treatment period but as time went on, her engagement with the programme gradually decreased to the point where she left without graduating. Alicia's interview indicates that part of her disengagement could possibly be attributed to her inability to talk about those things that mattered to her. Whatever others views of gang culture are, to Alicia there was great meaning and sense of belonging. Alicia experienced a lack of understanding of her links to the gang and inability to express herself in this way. Obviously it was appropriate for rules to exist within the programme preventing swearing, spitting, and gang insignia. However, components of a young person's life that are extremely important to them, even if they have a negative influence, can provide a point of access for programme engagement and assisting the young person to move beyond such influences.

Research supports the view that youth culture needs to be acknowledged as part of any treatment programme to ensure engagement (Liddle, Jackson-Gilfort, & Marvel, 2006, p.127). Alicia's reference to gang culture, although not specifically youth related, demonstrates the need to meet young people where they are and utilise what is important to them as a way of engaging them in the treatment process.

During the time of this study, Rongo Ātea had a practice of censoring music and videos allowed on-site. Many of the young people expressed a strong

interest in music, particularly hip hop and gangsta rap. They often expressed their view that this censoring was unfair. At one particular group meeting, they attempted to convey to staff how important this music was to them and how they felt they should be allowed to listen to more of the music they were interested in. Whilst the meeting had been instigated by staff to hear the student's views as they had been consistent in their complaints over some time, the end result was that things would continue as they were, with the students being told that the music they wanted to listen to was inappropriate and would have a negative influence. Instead of the students feeling acknowledged as had been the intention of the meeting, they continued to express their resentment and felt that the staff did not understand. Liddle et al. (2006, p.128) state that;

Where relevant, discussion of music, particularly gangsta rap artists, and related topics helps therapists to make overt and substantial (in terms of time spent on the topic, use of the topic as a window into the teen's life, values, beliefs, behaviours and goals) the therapeutically crucial topic of important life influences.

Whilst not condoning the inclusion of content that may negatively influence rangatahi or provide messages inconsistent with the aims of treatment, it is important to find ways to acknowledge the youth influences and multi-dimensionality of young people's lives as a way of a building relationship. Utilising a strength-based approach that takes into account a young person's interests allows access into their world and can enable those working with that young person to begin to work with those influences in a positive way and thereby strengthen the young person's engagement with the programme.

How young people relate with each other is also a significant factor in engagement. A range of views were expressed in regards to this with some rangatahi, such as Jonathan, revealing that they found other rangatahi a hindrance to their ability to engage.

What is it like sharing your recovery with other young people?

Oh, it can be a bit frustrating. Cos, you know it's sort of like the opposite of support, like "I'm going to go and use" and just like ... there's heaps of other shit like behind the back shit and all that.

When people talk about using – is this just in the early stages of being here or is something that carries on into their programme.

Oh, for some of them, but some of them never change.

Alternative views were expressed by others, like Jason, in that having other young people participating in the programme made it more fun and relevant.

How helpful do you find it being here with other young people?

Makes it more interesting, more fun; you're around people of your own age group so you're in the same decade as them.

Does it help you in your recovery knowing you are around people going through the same thing as you?

Yeah, they support you.

Connor also talked about the camaraderie between his peers;

Help each other? Oh, yeah. We all support each other, do weights, get some muscles.

Weight lifting was a popular activity amongst the boys. At the time of this research, there was no equipment provided for use until one of the staff members brought in his own gym equipment which the boys embraced with enthusiasm. The exercise equipment was kept in the boy's whare which meant the girls were unable to use it. Access to weights and exercise equipment has since increased with the inclusion of a small gym located at Te Kahao Health located at the front of Rongo Ātea and which can be accessed by all the students. Ensuring the programme remains fun and relevant for

young people is an important factor in both engagement and retention (Schroder, 2007).

Engagement is a salient factor in the success of any treatment programme. All students interviewed said that they wanted to leave the programme at some point. Some of the reasons they provided for not leaving included not wanting to let family down; renewing relationships with significant people in their lives and wanting to keep them intact; just feeling like 'it was the right thing to do', expressing a sense of responsibility towards some of their peers in the programme; and recognising the harm being caused to themselves and other through their substance use. Awareness of reasons why young people choose to stay in treatment is necessary for any programme provider in regards to shaping the programme environment, structure and content. The next chapter will look at how the programme structure and content of Rongo Ātea assists rangatahi to gain understanding and knowledge, or whakamana (enlightenment) in relation to their substance abuse and overall wellbeing.

Chapter 6: Whakamārama

To be a full human being is also to be at the centre of the universe, beyond space and beyond time.

To be a full human being is to be one with the human race, the people of the past as well as the people of the present.

To be a full human being is to be one with the universe and to take part in the whole movement - I te kore, ki te poo, ki te ao mārama, from the nothingness, to the night, to the full daylight'. (Shirres, 1997, p.119)

Whakamārama is the second key phase of a health intervention with Māori as proposed by Durie (2008). Durie talks about whakamārama as 'switching on the light' or gaining understanding and emphasises that information, procedures and advice are not always processed in the same ways. Domains of whakamārama include spiritual, intellectual, emotional, physical and social elements, and may be experienced through any or more of these means (e.g. spiritual awareness, emotional catharsis, positive relationships, acquisition of knowledge). The concept of whakamārama is utilised in this chapter to discuss the content of the Rongo Ātea programme, and the impact as perceived by staff and rangatahi.

Māori models of health

Contemporary Māori models of health seek to widen our understanding of the meaning of health and attempt to challenge the monocultural assumption that health means the same thing for all people.

The domains of whakamārama are reflected in Durie's Te Whare Tapa whā model (Durie, 1994). This model outlines four interdependent components of health (as in four walls of a house). Each of the components is dependent on the other in order to sustain good health. If disharmony is present in one component, then there is an imbalance of wellbeing. Te Whare Tapa Whā includes *te taha wairua*, spiritual health representing faith and relates to unseen and unspoken energies; *te taha tinana*, the physical aspects of health representing the capacity for physical growth and development; *te taha hinengaro*, the emotional and psychological wellbeing of the whānau and of

each individual within it with mind and body as inseparable; and *te taha whānau*, the social environment in which individuals, their whānau and communities live and act, denoting the capacity to belong, to care and to share. Within the context of *te taha whānau*, individuals do not function in isolation but are part of extended social systems. Cram and colleagues (2003) expand on these four domains as being contextualised within *te whenua*, *te reo*, *te ao turoa*, and *whānaungatanga*.

Durie (2008) also talks about enlightenment and miscommunication which may result from a different experience of encounters, the spiritual understanding versus intellectual comprehension, the intellectual message versus the emotional impact of the message, and the individual focus versus the group involvement. For this reason, it is imperative to acknowledge that not all information or knowledge is processed or experienced in the same way. A Māori view of health is holistic and focuses on whānau health and wellbeing rather than solely the health of the individual. This view is consistent with the fundamental premise of a therapeutic community in regards to treating the whole person, not just the substance abuse. Key components of a holistic approach to Māori health include cultural concepts such as *tapu* and *noa*, *tangihanga*, *karakia*, *waiata* and practices around food, exercise and illness (Cram et al., 2003).

Examples of cultural pathways to *whakamārama* (Durie, 2008) include the spiritual domain which could involve *marae* participation, *tangihanga*, *karakia*, and *waiata*; the intellectual domain espoused by *te reo*, metaphor and symbolism; the physical domain reflected by activities such as touch rugby, weight lifting, *waka ama* and good nutrition; and the social domain including whānau occasions, relationship building with peers, group sharing, and *kapa haka*. In addition to incorporating *Kaupapa Māori* principles into the programme, the *Rongo Ātea* treatment programme emphasised contemporary models of Māori health such as *Te Whare Tapa Wha*. The adoption of such models into treatment are supported by the likes of Huriwai and colleagues (2001, p. 1035) as there is an emphasis across a number of personal (e.g. family), environmental (e.g. community), cultural and spiritual dimensions.

Programme overview

In 2006 Rongo Ātea was attempting to implement four programme components which were Whakatau, the settling in period; Ko Wai Au, discovering self identity through personal and family history and identifying personal strengths; Anei Ahau, developing trust, communication, relationships and community support; and Aku Whanai which involved goal setting, establishing support networks and designing pathways to a new way of living. In addition, Rongo Ātea ran an abstinence based 12 step programme that included practice NA meetings held on site and attendance at adult AA or NA meetings, held outside of Rongo Ātea once a week. Rangatahi were encouraged to enlist a sponsor from these meetings who could provide support both during and post treatment.

The key components as outlined in the Rongo Ātea programme reflect Durie's stages of intervention – whakapiri (whakatau); whakamarama (ko wai au; anei anau); and whakamana (aku whānau). The treatment programme is contextualised within a Kaupapa Māori framework embracing use of te reo, karakia, waiata, pōwhiri, whānaungatanga and application of appropriate kawa and protocol.

Each of the young people entering the programme were assessed by qualified drug and alcohol professionals either prior to referral (and as a result of the assessment recommendation) or through Whai Marama Youth Connex, another youth service of Te Rūnanga o Kirikiriroa providing health and counselling services to young people. Referrals were made by agencies, schools, counsellors, whānau and the youth court. All referrals were managed through Pumau ki te Ora, the social work arm of Te Rūnanga o Kirikiriroa, also providing educational and prevention services to Hamilton schools and community outside their role with Rongo Ātea. Pumau ki te Ora social workers played a pivotal role in facilitating the relationship between the referral agency, whānau, rangatahi and Rongo Ātea including the development of a treatment plan for the young person entering treatment.

At the time of this study, there had been a recent change in the role requirements of the social workers in regards to overseeing the implementation of the individualised treatment plan with the overall responsibility being passed on to case managers. The social workers worked alongside the case manager, keeping updated on their client's progress and gathering information to inform the continued care plan (for post-treatment).

Pumau ki te Ora staff reported that they had advocated for this change as they found that when the social worker was based on site, there was a tendency for them to be handling both case management and whānau work. They felt this had become unmanageable and wanted to see the whānau work and case management split and for the case managers based at Rongo Ātea to take on more case management.

The Pumau ki te Ora staff did recognise that the recent reduction in staff numbers on site raised some issues around the ability of staff to deal effectively with case management and leading shifts. Case managers provide some supervision for both kaimahi and rangatahi and with the level of daily care, behavioural support and monitoring required, case management was often difficult as staff were frequently required to fill in for insufficient staff on the floor or deal with difficult behaviour. However, Pumau ki te Ora staff also made the point that the programme was going through significant changes and needed time to adjust, along with the development of effective systems and processes.

Hopefully getting more people settled in, things will change; but the key thing is, what has to be in place is that treatment programme. When you talk about chaos – the kids can get away with a lot of things. Two of the things I have seen is staff turn over and a lot of organisational knowledge was lost when (the last manager) left. (staff focus group)

In observing the programme, it was difficult to identify a clear structure and often staff and students were unsure what was happening from day to day. The young people were given workbooks to work through that outlined each

of the stages but there appeared to be no obvious connection to the rest of the programme. The workbooks themselves occurred as additional work that both the young people and the staff completed at the end of the day more as a matter of having to, rather than emphasising a key aspect of the programme and the young person's development;

Are you working through your workbook?

Yeah

Do you do that with your case manager?

Oh, it was with our case manager but now we are meant to do it with our sponsors.

And have you got a sponsor at NA?

Nah, I just lost them last week. (Jonathan)

Whilst the workbooks did not seem to provide a great deal of meaning for rangatahi in terms of working through the 12-step programme, they did appear to be useful as a communication tool, where young people would sometimes write things down about how they were feeling that assisted the staff to support them or respond to a request. During the restructuring, staff often did not know what the programme was going to be for that day, which led to a sense of disorder and confusion for both staff and rangatahi, who would query what was happening. However, there was an acknowledgement by staff that structured programme development was necessary;

I think that the main strengths of RA are the people themselves, the staff that are left. I think it is clear that the current framework is undergoing change but the people that they have left are the drive for a new direction. There's a real commitment. (Social worker interview)

Schooling

Schooling took place between the hours of 10.30am and 12pm with all young people attending at this time. Teachers were provided by the Ministry of Education. When I was located at Rongo Ātea in 2006, three teachers were employed during the time I was there. The first one had been teaching for

several years and left due to retirement, but the two teachers employed in the second half of 2006 left within several months. Staff did report that it had been difficult to find teachers. This was possibly due to the limited hours but they also felt it was because it was a challenging position.

Schooling appeared to be unstructured and somewhat disorganised and did not always last the full hour and a half, seemingly due to unruly behaviour and the inability of the teacher to hold the attention of the group. What was observed was the teacher eventually working with one or two students whilst others did their own thing or wandered off. Staff felt this was due to the teacher's approach;

With our teacher at the moment, it's not going too well. He's kind of a teacher that talks down to them. And our young people already have issues with authority. And I think it's leaving a big gap for those students who are meant to be returning to school and they're not keeping up with the curriculum. (staff focus group)

These young people need to be assessed first and they need an individualised programme with a focus on numeracy and literacy and they should be doing what they are meant to be doing in school. A lot of time is being taken up on doing work sheets just to fill in the time slot. The classes start at 10.30 and by 11 everyone is out of the room. (staff focus group)

However, it was noted that the teacher appeared to receive very little support from Kaimahi during a teaching period. It was observed during one class, that a member of staff sat alongside students and drew pictures with them and made distracting jokes whilst the teacher was attempting to teach. Other Kaimahi took the opportunity to undertake other chores that they found difficult to fit into the rest of the day, such as cleaning and recording notes.

I didn't like school. The teacher treated us like primary kids, like we were handicapped or something. The other guy was good. This guy

just came in and didn't listen to you, didn't listen to what you wanted, and we weren't even really demanding but he would still come in everyday and read some crap baby story, and then say it was about learning and shit and then asking us questions out of form one maths books and stuff. That's why I didn't like him. (Jonathan)

The teacher who had been in place at the beginning of 2006 after a period of several years was held in high regard by the staff;

He was awesome – he had that good rapport with them and spoke to them at eye level. Others have talked to them looking down on them – I'm the teacher and you're the pupil. (staff focus group)

Our original teacher, I don't know if he assessed them and did individual programmes but he did work with them individually, he worked with them at different levels; he worked at getting some of them back to school. He looked into polytech and he had their interests in mind – so for me, it goes back to the person because if a young person is going to relate to you then you can work with them – they need to find the right person. (social worker interview)

After the resignation of the third teacher in 2006, staff resorted to implementing their own educational programme whilst waiting for a replacement teacher.

Since the last teacher, staff have implemented a learning programme and I think we've done a great job cos we've implemented things that they are interested in – going off site – library, museums. Short worksheets and then move on – simple and short. (Staff focus group)

We have set our own assessments and you don't go past that until they are competent at it. I think that their learning needs to be monitored –

it's very hard for a teacher to come in his own and fill in an hour and a half slot. (Staff focus group)

Given the significant learning needs of many of the rangatahi attending treatment, a strong educational component of the programme could potentially assist with increasing literacy and numeracy and supporting the transition back into school, training programme or employment. Furthermore, a successful educational programme could provide a sense of achievement and efficacy thereby enhancing treatment outcomes. Care needs to be taken with recruitment, ensuring that the right person is in place. More support needs to be available to any teacher through the provision of a distraction free space and kaimahi backing with behaviour management and learning assistance.

12 steps and NA/AA programmes

The 12 step programmes are a key part of the Rongo Ātea abstinence programme. From observations and interviews, this is an area that many young people found difficult to relate to. Several students stated that they found the language difficult to understand and were often not sure how to apply it. Even those students who felt they were able to apply the steps and get value from them, and who had found themselves a sponsor during and post treatment, said that they felt it would be beneficial to have an NA group for teenagers that was easier to relate to. Some strong responses were elicited when rangatahi were asked about their experience of support groups.

Oh, I hate that too. I hate the NA stuff. (I hate) being there. Its all old fella's stuck in their past. (Connor)

You have to be brainy to understand that stuff (Jason)

I don't believe in the 12 steps. I don't like them. I reckon it is all to do with yourself. I just sit in there and count the time and wait for it to finish (Stuart).

Yeah. But what I don't get, with the 12 steps, is all that higher power shit. Cos I don't really have a higher power. Yeah, yeah. But some people work it. Some of it I can (relate to) but some of that, you know, 'we told ourselves bla bla bla' (laughs) it just sounds, like I can understand it but I don't want to understand it. (Jonathan)

Others, such as Talia and Alicia, did express some understanding of the 12-steps and were able to apply them;

(The steps) help me focus. It helps me not use and shit when I go on home leave. Being powerless over your addictions and stuff. And step 6 - honesty, I use that one. I used to talk a lot of bullshit. I'd lie to my friends and shit like that cos I was wasted all the time. Now I tell the truth. (Alicia)

In the initial interviews, half the students stated their intention to keep using socially once they left the programme. They could not imagine a future being completely abstinent from drugs or alcohol. This was also a common finding by Devaliant (2004). Interestingly, this did not change over time for those students who were interviewed a second time. In fact, in the case of Jonathan, who had identified in his first interview that he realised he could not safely take drugs or alcohol at all, this changed to his believing that if he was careful he could still use socially. When asked what had changed his mind about this he said it was from talking to family and others on the programme and believing that he just had never been careful enough in the past.

Other students expressed a desire to use but felt this wouldn't be right for them. These were students who had completed more than the initial 16 week programme as they identified this as an indicator of their not being ready to leave the programme;

I don't feel like I could be around a drink and not pick it up. I think I need to stay here until I don't feel that way anymore. (Alicia)

Staff expressed their concerns about the AA/NA not being overly accessible to youth as well as their own limitations in being able to deliver the concepts effectively;

Our particular young people and other young people out there doing it think ... it needs to be youth friendly with words that they understand. We read one yesterday, and every second word we had to break down – like what does uniqueness mean, and unless they understand they are not going to get it so I would like to see more youth friendly resources in the age groups that we work with (under 18). (staff focus group)

Adult's readings – all about jail, wives, children – it's not relevant to them yet – it's what's coming if they don't stop but they don't think of the future. Jails, institution and death - that means nothing to them. Or they think it's cool. It's attractive because of their rebellious side, the wild side. (staff focus group)

Cos quite often, they are laughing at the people at the NA meetings, they think they are a joke. They think they are losers too. They'll come back here and they'll laugh at what they've said. We see where these older people have been and we can say to these people, carry on along that line you're going to end up like that one day – they cannot see that far – they can only see today and tomorrow. (staff focus group)

There is nothing for them to relate to in the moment in the day, and you'll notice, they just read it out and when it comes to sharing, well even I don't understand it. (staff focus group)

It became clear from conversations with staff that they had limited understanding of the 12-step programme, which resulted in difficulty with implementing the steps in an effective and relatable way. For example, when I mentioned that many of the young people seemed to have problems

grasping the concepts, one staff member, who was acting in a management role at the time, responded by saying “don’t worry, none of us can understand them either”. This lack of understanding was also reiterated by staff in the staff focus group along with a variety of problems relating to rangatahi understanding of 12-step concepts including difficult language, complex concepts, and literacy issues,

and a lot of them, they see the cards and they get frightened, they see all these big words – oh nah, and they close up then. Literacy issues – then having to read and understand. Even the whole listening thing sometimes, twiddling fingers and thumbs, they’re bored. They have only got so much of an attention span, so you’ve got to keep it moving, and you’ve got to keep it interesting. (staff focus group)

It’s a lot harder to get people who have been here longer to share. I think they may be bored. Maybe they’re not seeing why, maybe they’re not seeing the therapeutic effects of what they are doing. I think its important but I think they don’t share a lot of the time because - you know as adults, a lot of us have been there and done that, and then in NA or AA we’ve got to the bottom of the barrel so we don’t mind telling everybody where we’ve been and we’ve done because we’re ready to. These young people haven’t accepted where they are so they are not going to share anything. (staff focus group)

We should in our mahi, let them know what these meetings are about. Let them know what to expect. Cos quite often we get these young people in – off we go to these meetings and these kids don’t even know what it’s about. I think it’s good that they do all go but they need that understanding of what it is all about rather than just throwing them in at the deep end – informing them more. (staff focus group)

Kaimahi and managers talked about how they would like to adapt the daily reading cards to be more youth friendly along with developing youth oriented

support groups but felt constrained by time and not knowing if it was something they were able to do;

Where does it say we can't set it up, we could be the beginning of a new era of these young people cos there's a lot of them out there and when we take these young people out to the NA and AA meetings, you just have to look around and they are just rolling their eyes cos these are old fuddy duddy's and that's not us, wouldn't it be awesome if they had their own and then starting attracting others in. (staff focus group)

As part of programme development, management were looking at exploring commonalities between a Kaupapa Māori approach and the 12-step programme. One of the social workers explained the view that whilst the 12 steps originated in the United States and utilised a prescriptive and stepped approach, there was an underlying spirituality that it was felt could be aligned with a Kaupapa Māori framework. Some common elements that were identified included a collective response, group support, sense of togetherness, higher power and building group cohesiveness. Others, some of which have been outlined earlier, include whakapapa, reciprocity and the world beyond space and time.

The social worker above also expressed a belief that the reason buy in from rangatahi to the 12-step programme was minimal was due largely to the state of change the organisation was undergoing which had resulted in reduced social controls in the form of kawa, boundary setting, and decreased clarity around programme implementation and goal setting.

I think what has happened is their behaviour is quite natural if you look at the 12-step programme from the anchor analogy. So who is doing the anchoring, that's RA - when they anchor starts moving, that is when the buy in decreases. It is the institution that drives the Kaupapa. When the institution isn't solid, the foundation from which they gain

their learning, and they can visibly see it is not solid; it is natural to see this kind of behaviour. (social worker interview)

Connection with a sponsor and AA/NA is meant to be a critical aspect of recovery with the Rongo Ātea programme and post-treatment support. Several of the rangatahi interviewed expressed a limited understanding of the steps and how to apply them meaningfully in their lives. Sharing in groups was constrained and staff appeared to have some difficulty in both conceptualising the steps for themselves, and communicating them to programme participants. Very few rangatahi had successfully gained a sponsor and there seemed to be insufficient encouragement for them to do so. An opportunity exists for Rongo Ātea to look at how the 12-steps are delivered to rangatahi including ways to make the steps more relevant to adolescents, further training for kaimahi/case managers in implementation of 12-step principles and linking of those principles across all aspects of the programme.

Abstinence and harm reduction

The Rongo Ātea programme promotes abstinence not only for the duration of the programme but also over the long-term. Several rangatahi expressed their desire to continue to use socially. This was not only raised in the one-on-one interviews but was also overheard in general conversation between the rangatahi especially before a period of home leave;

Yeah, cos, I didn't really think about drinking a little bit. I just thought I can drink heaps instead of doing drugs. People that I've talked to reckon when you grow up a bit you sort of try that, and you do that anyway – its sort of a stage that you go through. (Jonathan)

I'm abstinent while I am here and that is a good thing. I don't tell my Mum and Dad this (laughs), but I will drink socially when I get out of here. Just as long as I stay out of trouble. That was the problem before, getting into trouble. (Emma)

Others were clear about their intention to remain abstinent.

Yeah, I think if you, if you're an addict who has gone through recovery and if you pick up a bottle of beer, or if you have a toke on a joint or anything like that, you'll probably get back into the same routine that you were. (Alicia)

It stuff up your head, your head gets clogged up and you can't see properly. Like, it makes you look sick. Like, I've had people say "you look healthy now that you're not using". I'll continue to do that (remain abstinent). (Jason)

Staff expressed varying views but most were supportive of an abstinence based model of treatment;

There are at least 24 different models and approaches to treatment. The 12-step programme has credibility and has been deemed effective. What is important is that staff have the ability to facilitate and translate the 12 step programme in an effective way. This would be reflected in staff korero, individual treatment goals, and programme activities. Identified as an area where staff require training. (social worker interview)

I think (abstinence) is a strength. However, that's because there isn't any other choice here. But I totally believe in abstinence. How do we get them to keep that whakaro when they go home? (staff focus group)

When asked if they felt there were more appropriate Māori models of treatment, two staff responded that addiction is a white person's disease that needs to be treated with a white person's model of treatment. However, these staff also emphasised the need for staff and young people to acknowledge and work with the effects of colonisation.

Some staff stated that there need to be more of a focus on abstinence over the long term and that the emphasis had been lost with some of the restructuring;

I think with the changes there has been a shift, not purposefully, from abstinence (under the previous manager) but I don't think that message has carried on in the same strength – no fault of anyone I don't think but I don't think that message has carried on in the same strength. It's a shame because we are meant to be operating under that umbrella and that is what we should be advocating as staff, whether we believe in it or not, that is what we should be saying so I think that's been an issue. Personally, if a person can drink and keep themselves safe then that's also great. But it's about giving the young people all that information and at the end of the day it's their choice.
(staff focus group)

Relapse prevention

Change is viewed as a dynamic process and people undertaking change often relapse to unhealthy behaviour patterns several times before ultimately succeeding. This knowledge has enabled professionals to reframe the concept of relapse from one of failure to one of progress. People can learn from the relapse, using the experience to identify their high-risk situations, to discover current strategies for change that are not working for them, and to come up with new plans that might work for them (Monti et al., 2001).

Relapse prevention was acknowledged by staff and managers as being integral to recovery from substance abuse and purported to be a part of the Rongo Ātea programme. However, some staff felt that there needed to be more focus on relapse prevention to assist rangatahi with their home leave and ongoing support post treatment.

It's (relapse prevention) always at the end – in fact it should be right from when they step in the door. That's what we should be working on,

but usually its prior to them going home on home leave or before graduation and it's not enough time. (staff focus group)

I think we've missed out on a strong top person who can give that strong message that it's not ok to use when you go home. I don't think that message has been told clear enough. I don't think its coming from us as much either because we're missing the time as a team to talk about these things. (staff focus group)

They'll go back on home leave and they'll go home with a sentence that we'll not use. When (the last manager) was here – that message was reinforced – what she said to these young people went. Young people and staff are getting away with more. I say that sadly. (staff focus group)

Rangatahi had limited phone contact and were ineligible for home leave in the first 30 days of their stay at Rongo Ātea. The purpose of limited contact was to help them settle into their programme and start to focus on their self development. After 30 days, rangatahi became eligible for home leave which involved a weekend at home approximately once a month. Home leave was generally scheduled for all rangatahi to take at the same time. Some of my observations when attending the programme included hearing rangatahi talking about the opportunity to use when they were on home leave. Whilst relapse prevention was purported to be an integral component of the programme, there was in fact minimal relapse prevention education delivered during my period of observation. Inevitably, many of the rangatahi would use whilst on home leave and this seemed to compound some of the informal conversations heard about using socially once they graduated.

If abstinence is to remain a fundamental premise to the Rongo Ātea programme, then it is important that adequate support is in place for rangatahi to develop abstinence based goals and be equipped with relapse prevention knowledge and techniques. Whilst it is well understood that relapse is to be expected as a part of recovery from drug and alcohol use, relapse should be viewed as an opportunity to learn and should decrease over time as new

behaviours are learned, rather than become the norm. Equipping staff with a good knowledge of relapse prevention and the ability to effectively educate programme participants would greatly benefit rangatahi in their abstinence based goals and having the tools to deal with the temptations and pressures they experience when returning back to their home environments. It is important to ensure that relapse prevention education is a key component throughout the programme with particular emphasis prior to home leave and graduation.

Staff and workforce development

Workforce development was reported to be a key issue for some staff, with awareness that the needs of rangatahi were quite distinct from those of adults in treatment and the ability to have specific youth work skills was important. Staff talked about how easy it can be to have 'your buttons pushed by young people' and therefore it was deemed important to learn detachment, have clear boundaries, and to be consistent in their approach. Staff reported specific skills that they thought should be prioritised for development, including knowledge of addictions and effective intervention; behaviour management; empathy; tolerance; openness; resilience; implementing boundaries/being fair; working as a team and risk management. Staff from Pumau ki te Ora expressed a view that case managers and kaimahi would benefit from attending Al-anon^{**} meetings which they thought would provide an effective form of supervision and training in 12-step principles.

It was also stated in interviews that respect is vital to successful intervention with all staff consistently implementing kawa and working cohesively and as a team. Kawa assists with boundary setting in which intervention can occur and young people need boundaries and structure to provide a sense of security. It was felt that some staff needed to balance the need for boundaries with the need to be liked and to be a 'friend' to the young person they were supporting. It is important that staff understand how, when and why kawa exists and that it

^{**} The Al-Anon Family Groups are support groups for relatives and friends of alcoholics who share their experience in order to solve their common problems. <http://www.al-anon.org.nz>

needs to be delivered in a consistent manner by all staff. Staff expressed the belief that if there is a strong understanding of kawa from staff then it is more likely to be implemented;

Consistency is a problem but I think it's mainly around personal kawa not necessarily around personal whakaro. We all strive for the same thing but physically we might do it different. (staff focus group)

We all know what the kawa is: it's how we enforce it? Cos like, I know if we are all on kawa that day, the kids are going to know and its going to be quite easy but if the kids are getting mixed messages from kaimahi, we have to bring it back. Every now and then we have to bring it all back. We have to say this is it, we can't move from this. (staff focus group)

A staff handbook was provided, but some staff felt there needed to be greater emphasis on staff applying the handbook guidelines and that it should be regularly reviewed. Some staff suggest that there should be greater emphasis on staff having to demonstrate that they understand and support the principles and kawa outlined in the handbook. Some staff reported that there needed to be greater clarity around staff roles and responsibilities.

Staff also reported that there needed to be an acknowledgement of the energy and commitment required by staff working in the adolescent treatment environment and that staff need to be valued and nurtured in their roles. Shift work can take its toll and staff stressed that this needs to be managed effectively with debriefing and supervision available on a regular basis.

Different ways of relating to the young people because they are not all the same ... but as our numbers dwindle, it is becoming a harder job. I believe what's vital to this service is staff. And what I've seen, and I've been here three years, is that those that are good at are still here,

unless they have found something else and moved on. (staff focus group)

I think it's the ability to relate quickly to a young person, and create that rapport with the young person. Do the walk, spend quality time with the young person and be genuine about it. (staff focus group)

And when you're working here its about capturing that time and knowing when to go in ... spend that time and notice when that young person needs some support – go over there spend some time with them and see what happens. (staff focus group)

When questioned about qualifications, support staff reported that they thought it was more important for a Kaimahi to be a hands on youth orientated person with well developed empathy skills than to have a specific professional qualification;

If something happens, like if one of the boys need support or gets upset about something, sometimes a clinical approach isn't appropriate – you've got to be able to read them. Sometimes it's just leaving them, or approaching them in a more informal way. You've got to be able to read them. The important thing is you have got to be able to build that relationship; usually it will happen straight away – when they first come in and then gauge it from there. If that doesn't happen, if you're always going to be coming at them clinically, then they don't want to know. (staff focus group)

Whilst staff emphasised the importance of practical and youth focused skills, they recognised that clinical knowledge and expertise were also needed at Rongo Ātea. The lack of such expertise was especially felt with the loss of a previous manager who had professional qualifications and experience in addictions;

I think it is a definite issue. Especially for staff who need to give specialist advice. I think we really lack that now. Some of us have a basic knowledge but I think we definitely need a professional – more for the kid's sake.

When (previous manager) was here it was good to have someone with the right knowledge to bounce off – that's lost now.

Upskilling of staff working in the mental health field, to include both cultural and clinical competence is a recommendation of Kia Puaawai Te Ararau (2005-2010). Durie (2001) asserts that an increase in the cultural and clinical expertise of staff will result in enhanced treatment outcomes.

As part of their recruitment strategy, Rongo Ātea did require case managers to have a tertiary qualification that was deemed relevant in some way. At the time of my observing the programme, qualifications held by staff included degrees in psychology, nursing, social work and counselling. The manager at the time I entered the programme, had extensive experience working in drug and alcohol settings and was also completing specific addictions training at the time. However, this manager resigned to take up a position in another organisation during 2006 and no staff remained with specific training in addictions (although this may have changed since). This became an issue in regards to implementing an addictions focused programme and Rongo Ātea would greatly benefit from recruiting new staff with specific training and experience in addictions, whilst also providing relevant training opportunities to existing staff.

Cultural knowledge

A further requirement for recruitment of staff at Rongo Ātea was having knowledge of and respect for Māori tikanga and there did appear to be a reasonable level of awareness and knowledge amongst the staff. Staff demonstrated the implementation of tikanga in daily practices such as karakia, waiata sessions, supporting pōwhiri, using te reo, acknowledging

whākapapa and observing basic protocols such as taking hats and shoes off before entering the whare kai or whare nui. Staff also supported rangatahi to attend tangi as appropriate.

During 2006, a parent of one of the rangatahi died whilst he was in treatment. Other rangatahi demonstrated a great deal of empathy and caring at this time which was encouraged and supported by staff. Several kaimahi, and the majority of rangatahi travelled to the home of the boy whose parent had died to show their love and support. They met family and participated in rites. I recall on the drive home listening to one of the rangatahi question a kaimahi about the stories of the mountains that we passed on the way. This demonstrated an informal but meaningful sharing of knowledge that could only happen because the staff had an understanding of te ao Māori. However, there were very few structured opportunities for young people to learn in depth cultural concept and this is something that be more effectively integrated into the programme.

Restructuring

Case managers and kaimahi spoke a lot about the impact of restructuring and having fewer staff on the floor. They felt that there had been little opportunity to be involved in the decision making and that where they had had the opportunity to communicate with management, they weren't listened to. According to the staff, these changes had had a significant impact on their ability to adequately support young people and undertake planning, programme implementation and case management.

(In the past) we could monitor them (rangatahi) effectively – never leave them on their own. These young people have to be monitored constantly. We've had to leave them on their own sometimes because we couldn't be in two places at once. We've had to rely on these young people being honest and true so we can leave them on their own. (staff focus group)

Even the behaviour of the young people, I've never seen so much defacing and vandalism – I go off site and there is gang stuff going on. And I believe that has to do with the staffing because we can't spend that time with them. (case management) has got a side stepping too. When we could – a good five minutes here, ten minutes here, if we could manage it. The main concern for me is burn out. We don't even get our lunch or dinner breaks. (staff focus group)

Pumau ki te Ora staff had also noticed the impact of reduced staffing on programme implementation with case managers, whose role it was to provide implementation of individual case management plans. Case managers were often required to provide monitoring and supervision to relieve some of the pressure on Kaimahi. The lack of a treatment plan meant that there was sometimes no plan to manage, which was attributed to lack of capacity in staffing and the ability to balance case management with the direct needs of rangatahi.

Three or four kids might not seem a lot but when they are doing the whole Kaimahi stuff – when do you get time to sit down with them, talk to them about what some of their issues are. (social worker interview)

Any process of change will result in some form of disruption and so it is hard to measure the long term impacts of the restructuring. Certainly there was awareness by staff and management that there needed to be more of a focus on planning and programme structure and implementation.

Informal training and team collaboration

Staff expressed the view that there was not enough time given for staff collaboration during shift crossovers, or to discuss case management along with programme planning and implementation. Even staff meetings were not viewed as being conducive to discussion or planning and staff felt that they were rushed due to needing to be working with rangatahi. Only staff who were scheduled on the day of the staff meeting could attend unless they were

willing to attend in unpaid staff time. Several of the staff actually did do this, as they believed that communication and information sharing was paramount.

Really staff meetings, although they shouldn't drag on, they shouldn't be hurried and a lot of the time we'll be hurried because we'll be thinking come on we got to get out of here. And you'll only get the staff that are on shift. And you don't get everybody that is on shift because some people are left out on the floor. I would like a day set aside, a day or two every month (expression of agreement from others). That's for team building and going over programme staff. (staff focus group)

Rangatahi are sent on home leave generally once a month. I was advised by a manager that the two days that the majority of young people were away provided a good time for training. However, in reality, the training consisted of one half day with less than half of all staff attending. It was communicated that training took place over the Christmas period, but in 2006 there was in fact no training at all over this time which was taken up with several days of cleaning before staff went on their break.

I think it is really important that we have team building. We are an awesome whānau – just imagine what team building would do. We'd all have wings, we'd be flying, and we'd be wonderful. We get on really well now and we need that opportunity to be together rather than at the end of the year cleaning together.

Whānau /family intervention

Despite significant evidence highlighting the success of family therapy in health interventions including adolescent treatment (Durie, 2001; Liddle, 2004; Schroder, 2007), services still tend to focus on the individual with only peripheral involvement from family members or significant others.

Māori wellbeing has always been located in the context of whānau, hapu, and iwi (Durie, 2001; Huriwai et al., 2001) and whānau involvement should be deemed essential within a Kaupapa Māori treatment programme. Whānau involvement is a difficult matter as Rongo Ātea is not currently funded to work with whānau other than inclusion at entry and exit through Pumau ki te Ora. Prior to rangatahi being admitted to the programme, whānau and/or caregivers are provided with information on the service. Social workers from Pumau ki te Ora attempt to engage whānau or caregivers to participate in programmes or activities such as Al-anon, so they are able to support their young person in recovery.

Family members choose whether and how they engage, and in many circumstances the whānau themselves experience issues with drug and alcohol addiction and may require more intensive support than what Rongo Ātea or Pumau ki te Ora are able to provide. This also raises issues of ensuring the young person has a safe place to return if the family is not able to support them in their commitment to decrease or abstain from alcohol and/or other drug use.

There could be room for more contact with whānau, but a lot of whānau aren't safe. We have to try to find whānau that are safe and get them on board. (staff focus group)

With those young people that have their whānau behind them, and doing what they need to do, it may take longer than the 16 weeks but you do see changes. (staff focus group)

In some instances, the young person and their whānau are being supported by an external agency such as Whai Marama Youth Connex in Hamilton, Hauora O Ngati Haurua in Morrinsville, or Te Korowai Roopu Tautoko in Taupo, which may also be the referral agency. Such agencies may continue to work with the family whilst the young person is in treatment. This issue will be explored further in chapter seven when discussing post treatment care and support.

Staff working with students and whānau identified in their interviews that no matter what has happened in the whānau, whether it be family violence, familial drug and alcohol issues, or relational difficulties not uncommon to teenagers and their parents, young people are responsive and keen for support from whānau members. This was supported in the interviews with rangatahi.

My higher power is my Mum. She helps me stay here as well. She tells me to stay or I know what will happen. She makes me feel better every time I'm upset. I was never close to my Mum. But we're close as now. (Alicia)

Stuart was very clear that his family was the main reason for his commitment and success in the programme. He had been estranged from his father prior to entry into the programme.

When I started first using drugs, me and my father, we didn't talk for a few years, and um, me and, it was just me and my Mum and then when I was in here I called him. He has my brother and sister, and they're like my reasons, and they're still the reason that I'm here and why I want to stop my drug offending and they're the reason why I want to stay clean. (Stuart)

Stuart attended home leave visits with his father during the programme and his father also attended Stuart's final graduation along with his stepmother and younger siblings. Whānau provide the sense of belonging and self-worth imperative to a young person's sense of self and is a motivating factor in programme engagement (Liddle, 2006). Every student who was interviewed stated that whānau was the main reason for attending or staying in the programme. This was also observed in group settings where young people would commonly refer to their whānau in their story telling or sharing.

At admission into Rongo Ātea, rangatahi are asked to name the person who they most trust to support them in the programme. If they are having a difficult time, they are encouraged or supported to call their identified support

person. This can also assist with relapse prevention during home leave and on returning home after completion of the programme. The support person is often a parent, relative or professional, such as a teacher or counsellor who has supported the young person pre-treatment. When interviewed, Pumau staff stated that they found rangatahi are often very honest about who that person is. Jonathon had identified an aunt who was willing to undertake Al-anon groups so that she could support her nephew during and after completion of the programme. Jonathan felt that he still had a lot of ground to make up with his immediate family to earn their trust back, this being his second time in treatment and feeling like he had let them down with his substance abuse and associated impacts.

Has your relationship with your family improved?

Slowly – it will in time. First I need to pay some money off. I just need to give it time and prove that I can do it – just get myself a job and that.
(Jonathan)

Staff acknowledged that the best outcomes for young people are achieved when whānau are engaged in the process and so encourage whānau to function as part of a team as much as possible. Pumau ki te Ora involve families in entry and exit planning but beyond that there is little opportunity to work directly with them.

Definitely a barrier – one of those barriers, is having the capacity to work with families. That is very much limited by our contract, what we are supposed to do. In saying that, that is one of the challenges of being in a contractual environment, trying to operate a Kaupapa Māori system. One of the things is Whānau Ora – family health. Part of that is being given the capacity to work with families as well. Particularly in the last phase of their treatment when we are looking at seriously integrating them back into society, especially where they are living and getting the family on board.

Lack of whānau involvement is an ongoing issue for Rongo Ātea and as long as funding for individuals rather than family systems remains a priority, then it will continue to be so. Rongo Ātea attempts to work with families within the constraints they have and utilise the Pumau ki te Ora social workers to undertake a lot of this contact especially during entry and exit. Whilst there was some expectation from Pumau ki te Ora staff that Rongo Ātea case managers would also make some whānau contact during the treatment period, in reality, this was extremely difficult for case managers due to time constraints and the need to work directly with rangatahi.

A further barrier to working with whānau was proximity. For rangatahi to be eligible for DHB funding, they were required to be residing in the Waikato. However, many rangatahi came from outside of the Waikato especially those who were referred by the youth court, most likely due to limited places to refer in the area of residence of the young person. This posed a significant barrier to working not only with whānau but also with other relevant community supports that might assist the young person post treatment. This will be discussed further in the next chapter.

The domains of whakamārama including spiritual, intellectual, emotional, physical and social elements are exhibited throughout the Rongo Ātea treatment programme including a focus on tikanga; schooling; sports activities; group therapy and sports and field trips. A lack of resourcing for activities including arts and music results in staff providing some of the materials provided. Staff are key to the implementation of the programme and staff development needs to be a priority along with ensuring sufficient time for programme planning, staff meetings, training and case management. In particular there is a strong need for staff development in an abstinence based model of treatment including the 12 steps to adequately support young people in understanding how to apply the steps and seek ongoing support from a sponsor and NA or AA groups. Staff also need to have a depth of understanding of Māori cultural concepts including tapu, noa and mana; te

reo; and whākapapa to ensure effective development of cultural connection and development of identity for rangatahi.

Chapter 7: Whakamana

Ko maiea. Maiea ngaa atua. Maiea ngaa patu. Maiea ngaa taangata, Ko maiea.
We emerge with all acknowledged and satisfied. The atua are satisfied. The
weapons are satisfied. The people are satisfied. We emerge with all acknowledged
and satisfied.

The third stage of Māori health intervention is whakamana which is the empowering of people to move beyond a place of knowing to action and sustainability. Durie (2008) states that all intervention should ultimately lead to empowerment as a result of successful whakapiri and whakamārama. Aspects of whakapiri include self-control and capacity to manage behaviour, emotions and adaptation; sense of dignity and integrity, self worth, secure identity, strong social support systems; and knowledge, including being well informed and aware of risks and pathways to wellbeing (Durie, 2008). Whakamana provides people with the ability to participate in both te ao whanui and te ao Māori through the establishment of supportive relationships and supports.

Aftercare and follow up

Within te ao Māori, the past is viewed as a guide for the present and for the future. This highlights the need for a seamless continuum of care, as defined by several of the Rongo Ātea staff and highlighted in this chapter. Effective transition from a treatment programme into te ao whanui relies on effective goal setting, engagement, successful programme delivery and knowledge building, as well as the provision of ongoing supports to ensure the sustainability of recovery.

The treatment period in which an individual demonstrates a commitment to behavioural change is not necessarily change itself and the challenge of treatment is how to effect goal maintenance over the long term (Kelley et al., 2000; Prochaska et al., 1992b). The maintenance period within a stages of change model, can take an indeterminate period of time, in which relapse prevention and ongoing support is imperative (Prochaska et al., 1992b).

Treatment centers in New Zealand are not well funded for aftercare services (Schroder, 1997).

At the end of a young person's treatment period a meeting is held involving the young person, their Rongo Ātea case manager, the clinical team and the young person's whānau or caregivers. In some instances, the young person is under the care of CYFS, who have the challenge of providing an appropriate placement, which may not always be back in their family home if that is deemed an unsafe environment. When rangatahi graduate from Rongo Ātea, they remain registered with the service for 21 days before being referred back to Pumau ki te Ora for three months follow up. The 21 days are designed to be a settling down and readjustment period for the young person (Staff Communication, 2006). The social workers instigate contact at the end of the 21 days. The amount of contact Pumau ki te Ora have depends on how things are progressing or not progressing, or whether the young person is regressing.

When asked what constituted success for rangatahi attending Rongo Ātea, social workers stated that they expected to see that the young person stays in treatment as long as they can to get as much clean time as possible, make connections with people who can support them, make reconnections with whānau and/or other significant people in their lives, and that they understand they have a choice to abstain. Social work staff communicated that they do attempt to take a holistic approach by looking at education, social networks, the goals of the young person and support structures such as continuing AA or NA meetings, identifying a sponsor, or undertaking ongoing counselling so they can continue to maintain the changes they have started to make in their lives. Staff stressed how important it was to have a seamless continuum of care in which maintenance goals were linked back to their reasons for being in treatment in the first instance.

What this requires is some way to capture data and then feed back and evaluate the efficacy of treatment. That is what I would like to see, a seamless programme. At the moment, we are still in a state of change

but one of the ideas I would like to see driving forward is that we link in with the continuing care back into a quality assessment type framework, because we can use this tool to evaluate the efficacy of this treatment programme. A seamless continuum of care is needed – there must be a component that addresses the issues that brought them in the first place.

Pumau ki te Ora provided entry and exit services, with Rongo Ātea staff running the day-to-day treatment programme itself. Social workers emphasised the need for Rongo Ātea case managers to capture appropriate data and document the information required to inform discharge planning. Concern was expressed by the social workers that data collection and communication between case managers and social workers was limited in this area.

Whilst social work staff were clear they were responsible for aftercare support they did express a lack of clarity around roles at the point of discharge in regards to whether it was Rongo Ātea staff or Pumau ki te Ora staff who were responsible for contacting whānau, facilitating discharge meetings and undertaking exit planning. Social workers stated that there was a blurring of roles at the point of discharge particularly in regards to whose responsibility it was to contact whānau and arrange meetings. Whilst there was an expectation that case managers would be the point of contact for family, they were often on shift work, resulting in the hours not always being conducive to being available for CYFS workers or whānau.

The implementation of a seamless continuum of care, is consistent with a stages of change model in which Prochaska and colleagues (1992b) state that successful maintenance relies on each of the previous stages. Maintenance preparation requires detailed assessment of the triggers that lead to relapse so that alternative responses and appropriate support can be developed.

At the centre of our (Pumau ki te Ora) relationship with Rongo Ātea is the treatment plan. Unless we have a plan, we are all over the place. So we will be passionate that this is our treatment plan – this should inform our contacts with the whānau. Because we admit them in but the strength of our admission is how they get looked after and how they get what they need. The challenge is to drive the seamless continuum of care.

One social worker from Pumau ki te Ora talked about the challenge of establishing maintenance goals that were appropriate to the young person, including abstinence or harm reduction goals, that would most assist them over the long term and how this required an adequate treatment plan beyond what was currently being provided. The social worker reported finding it difficult to juggle the philosophical divide between abstinence and harm reduction within an abstinence based programme and needing to really focus on the continuing care plan which often just consisted of a number of phone calls over a period of three months.

As long as it remains in its current form, it (continuing care plan) will never contribute to the development of the programme. It will just be an add on that we do. I think it should be a key component.

Part of the discharge process was to meet with the whānau to develop a way to continue to achieve and maintain goals and the positive behaviours rangatahi have learned in treatment. An issue confronting staff regarding some young people was where to send them once they were discharged from Rongo Ātea. Staff were aware that after a period of treatment, in which the young person had experienced some new routines and learned new behaviours, they would then be going back to the same environment they had come from, which, in many cases had contributed to their substance abuse.

Challenges – yeah, it's more, for me, managing the ethical dilemmas doing the exit planning. When they graduate, we work on the

assumption that we have brought them to a certain level where they have the tools necessary to address the issues that brought them here in the first place. That is what we want to do – reintegrate them back into society. The challenge is when the family haven't kept up as well. Because the challenge for me is finding out the family dynamics, the environment, what kind of environment are they going back to.

Some young people were retained at Rongo Ātea for periods much longer than the original 16 weeks, not solely because they hadn't yet achieved their treatment goals but also because there was no safe environment in which they could be placed. CYFS guidelines were utilised to make that assessment along with a notification to CYFS if an appropriate alternative could not be found.

The importance of a safe and supportive whānau environment was emphasised in the interviews with rangatahi where several identified family as their primary support post treatment.

What will help you stay clean?

Oh, just staying home, really.

Do you have a sponsor

Yeah but I don't call her

What support do you have when you leave

Oh just my family (Connor)

Emma, Talia, Jason and Stuart also all talked about their family being key supports on their return to home. Family of these rangatahi had also played a role in supporting their referral to treatment, maintained contact with staff and been involved in entry and exist assessment and establishment of goals. Jason stated that he had support from his mother who had abused drugs and alcohol in the past but had been in recovery for some time and was extremely supportive of his treatment. He also talked about the involvement of aunties

and uncles who were still using and had been influential in his initial use of marijuana, but did express support of his attempts to stop.

Who do you find supportive?

My family. They say, you shouldn't be using drugs. The ones that use, they say "look at me, do you want to turn out like me?" (Jason)

In some instances where support was not available from the primary caregiver, others in the family had been identified to provide ongoing support as demonstrated by Jonathan;

I'm going back to Wellington and living with my aunty. She has gone to NA meetings and knows what it's all about. She knows if I am getting out of hand – she thinks I can do it.

Alicia, on the other hand, was someone who stayed for an extended period in treatment of almost 12 months. Residential periods can be rolled over for rangatahi if it is deemed they have not yet reached their goals and would benefit from further treatment as was the case for Stuart. Alicia did choose to stay for a second treatment round but beyond that the main reason for her not leaving was due to an unsafe whānau environment, largely influenced by gang culture. Pumau ki te Ora social workers were working with CYFS to identify alternatives but were unsuccessful by the time Alicia decided to release herself from treatment prior to graduation and return home, a decision that was not supported by Rongo Ātea staff. Staff had shown a great deal of concern for Alicia over this time and stated that they believed Alicia actually stopped engaging and benefiting from treatment the longer she stayed and would have like to have seen her supported to move into a safe living situation at an earlier stage.

Rongo Ātea Kaimahi and case managers appeared to have less assurance that rangatahi would maintain their goals long term, perhaps because they were less involved in the post treatment support than the social workers from

Pumau ki te ora. One staff member in the focus group stated that in her three years at Rongo Ātea she had only ever seen one person really commit to their treatment goals and embrace the 12-step concepts and apply them fully, including ensuring she had set herself up with a sponsor to provide ongoing support. This was Talia, who in her interview revealed a significant amount of contemplation and preparation had occurred prior to treatment and an expression of real commitment to achieving her goals long term. Talia demonstrated a strong self-awareness around what was required to maintain her goals.

Kaimahi from Rongo Ātea also stated that although they were discouraged from doing so, they would have liked to have more input into aftercare support. Staff confessed to giving some graduates their contact numbers and telling them to ring if they needed someone to talk to. Staff expressed a hope that young people got *something* out of the programme that they could take away and at the very least that they knew that treatment and/or support groups were an option that they could fall back on at any time.

But with all the various things that we do, such as NA, reflections, it's not so much about teaching young people, it's about hoping what they are going to catch. Because sometime, something - they are going to go (clicks fingers). I think that is a general rule of thumb for young people, its very hard to teach them if they are not willing to be taught, but then hopefully down the track, however long that may be, something may come back to them, they may attend an NA meeting, they may ring someone to get support. (staff focus group)

They do know those things are here. Because prior to coming here, they had nothing but being here, go from here, they do have some tools. They may not always use them but they do know they are here. (staff focus group)

Research suggests that most people who relapse do not endlessly recycle through the stages but that they do learn from their attempts and often reach a period of action and maintenance where they are able to sustain behaviour change over sustained periods of time (DiClemente et al. 1998, Prochaska & DiClemente, 1984, cited in Prochaska et al., 1992b). Rangatahi expressed various views about their ability to abstain from alcohol over the long term with many seeing relapse as inevitable.

Yeah, I just try not to look at as like, I'm going to relapse kind of thing. Just try and stay off them. I hate thinking of myself as a drug addict. If I think about that it makes me want to use. Just don't bother about drugs. Hopefully I should stay away. But I know I'm going to use some time later, like every addict. But I'm not going to plan the day or anything, I'm just going to avoid them. Not at this time. Probably at New Years. That'll be a biggie. Probably will relapse on New Years. I'll be drinking with my mates. But you know, I probably will on New Years, but I am going to try not to even if I do, well, it's New Years, buggar it. (Stuart)

Oh yeah. Oh probably when I get out I'm going to stop smoking up, but keep on drinking probably. (Connor)

Within integrative models such as MST and MDFT, a number of dimensions of an adolescent's life are recognised as playing a role in their ability to sustain positive behaviour change. Rangatahi identified peers as being a key challenge to goal maintenance;

It's out of it. Cos you know I haven't been around so many teenagers at once. You've got like 16 people here (Rongo Ātea) and then you go into a school that has like 1000 kids and at lunchtime there's all these kids running past – its pretty freaky aye. They (kids who use) usually go off and do their thing. I just hang out with the smokers. Some of those do drugs and shit but they know I'm trying to stay clean

so they go off and do it. A few times I've sat there and watched people doing it – and I could smell the smoke and see them doing it, so I just went for a walk. (Stuart)

Whilst tikanga is present in many of the processes and activities at Rongo Ātea, there could be a much greater emphasis on teaching cultural concepts that build resilience of rangatahi through the establishment of a strong cultural identity. This would include an expanded focus on whākapapa and te reo Māori, along with teaching important cultural concepts, such as tapu, noa and mana that allow for a greater connection with te ao Māori and the responsibility of being part of a collective.

Other supports that were identified by rangatahi as being helpful to achieving their treatment goals included reintegration back into school, career development and participation in areas of interest such as sports and music. All rangatahi expressed an interest in either returning to school or developing a career. Stuart had returned to school after his graduation and in a period of three months had achieved several credits in maths and English and was planning to carry on to the next year. Jonathan had been unable to express any kind of career goal in his first interview but by the end of his treatment he had aspirations of being a personal trainer and had researched what he would need to do train for this role. Emma and Alicia, who had developed a strong friendship whilst attending Rongo Ātea had attended open days at Wintec and talked about their interest in hairdressing.

The activities that rangatahi participated in whilst in Rongo Ātea also provided some ongoing strategies for them to apply when leaving. Boredom was a common response when asked why they chose to use drugs and alcohol and the treatment programme exposed them to alternatives that provided them with a sense of achievement and feeling good about themselves. Several of the boys, who had shown a keen interest in weight lifting and guitar whilst in the programme talked about continuing these activities post treatment.

I never had anything I was good at or I stuck at except for drugs and so every time I would start something I would give up. So I noticed with my weights and guitar, I notice I'm getting better. (Jonathan)

Family support, ongoing participation in meaningful activities and career aspirations were all identified by young people as being important to their ability to maintain their goals long term. Having at least one person believe in their ability to achieve, whether it was a counsellor or relative also appeared to be important to young people. Whilst AA/NA group therapy and utilising a sponsor were all encouraged as part of their goal maintenance, very few rangatahi expressed an interest in utilising these supports once they left the programme. Rangatahi would need to see the value and how the principles of AA and NA would work in their own lives, something they did not get to experience whilst in treatment.

Many of the young people talked about their intent to use, albeit socially once they left the programme. If Rongo Ātea is to continue to offer a 12-step abstinence based programme, there needs to be a greater emphasis on relapse prevention, ensuring the 12-steps provide value and meaning and supporting rangatahi to access a sponsor. Alternatively, and perhaps concurrently, there may be a need to look at harm minimisation strategies to assist young people who intend to continue to use drugs and/or alcohol to keep themselves safe over the long term, with abstinence provided as a choice. Whilst tikanga is evident in the day to day running of Rongo Ātea, there is room for more emphasis on teaching cultural concepts that build resilience of rangatahi through the establishment of a strong cultural identity. Multidimensional approaches that include intervention incorporating family, peers, school and community, are recommended to ensure long-term maintenance of behaviour change.

Chapter 8: Conclusion

Overview of main findings

This thesis has explored the Rongo Ātea treatment programme as experienced by rangatahi, the role that staff play at Rongo Ātea and a number of other factors including the physical environment, stages of change, programme implementation and aftercare. It is important to have an awareness of te ao Māori to understand the context in which Kaupapa Māori programmes are developed and implemented. The three phases of health intervention; whakapiri, whakamārama, and whakamana, which Durie (2008) states are necessary to produce successful outcomes for Māori, provided a framework for exploring programme structure and effects.

Whakapiri highlights the need for effective engagement within a treatment programme. Rongo Ātea provides a space that is welcoming and attractive allowing for the development of a sense of belonging and being valued. The physical structure emulates the marae space and fosters the inclusion of Māori tikanga and kawa that helps establish clear boundaries and relationships to assist with learning and retention as well as access to the world beyond space and time. Retention rates are a key treatment issue and have been associated with positive treatment outcomes (Schroder et al, 2007). Participants are more likely to engage in treatment if they feel involved in goal setting, experience a safe and supportive relationship with staff, and have fun during the programme. Interviews with rangatahi indicated that their relationship with kaimahi significantly influenced their willingness to engage in treatment and the decision not to leave the programme when things got hard. This supported the findings of Schroder and colleagues (2007) in regards to staff and participant relationships being essential to retention and positive treatment outcomes.

Low retention rates in adolescent populations may be indicative of young people not being ready for change, as suggested by the transtheoretical stages of change model (Prochaska et al., 1992b). Variables that negatively influence retention rates in adolescent treatment programmes include low motivation and high external pressure, exclusion of abstinence as a set goal and low expectation of treatment (Schroder et al., 2007). Rangatahi based at Rongo Ātea demonstrated the various stages of readiness in response to their treatment and many of them indicated a reluctance to remain abstinent over the long term. Readiness for change needs to be taken into account when measuring treatment programme outcomes along with an understanding of the cyclical nature of recovery in order to develop intervention appropriate to various stages.

Whakamārama denotes enlightenment and the gaining of knowledge and was used to explore programme implementation and impacts on rangatahi attending the programme. Generally, adolescent drug and alcohol treatment centres are modelled on or developed from adult programs and do not sufficiently accommodate the wide-ranging and complex needs of an adolescent population (Devaliant, 2004; Schroder et al., 2007). Rongo Ātea incorporates youth oriented components including sport, art activities, schooling, and field trips, although it was noted that many of the resources required for activities such as gym equipment, art and music supplies were provided by the staff themselves. A more youth focused orientation to programme implementation is needed, particularly in relation to the 12-Step programme and inclusion of AA and NA support groups. Both young people and kaimahi expressed their limited understanding of the 12-steps and the inability to relate with the associated concepts and language. Whilst adolescents can have difficulty identifying with issues relevant to adults attending AA or NA support groups, research implies that adolescents do benefit from access to support groups that have a considerable youth focus (Kelly et al., 2005). Delivering the 12 steps and establishing support groups that are relatable and youth friendly is crucial to the successful implementation of this treatment mode.

Māori wellbeing is located in the context of whānau, hapu, and iwi with environmental, spiritual, cultural and physical elements needing to be in balance for good health to be present. When young people experience a solid cultural identity, family and community connection and experience positive bicultural socialisation they are less likely to engage in negative or harmful behaviour (Durie, 2001; Liddle et al, 2006). The lack of whānau inclusion and community integration in the Rongo Ātea programme presented as a gap in the treatment approach during this research. A number of factors contribute to this gap including limited funding, deficient programme development and inadequately resourced and trained staff. It would be useful for management of Rongo Ātea to develop more integrative approaches and to work with funders and external agencies to find innovative ways to incorporate greater whānau involvement in the programme.

Workforce development is a key component of effective Kaupapa Māori service delivery and dual clinical and cultural competency-based training is crucial for staff in order to adequately integrate knowledge, skills and experience with cultural expertise (Durie, 2010, Kia Puaawai Te Ararau, 2005-2010, The Werry Centre, 2008). Whilst tikanga is present in many of the processes and activities at Rongo Ātea, there could be a much greater emphasis on teaching cultural concepts and strengthening identity. This could include an expanded focus on whākapapa and te reo Māori, teaching significant cultural concepts and developing stronger links with the 12-steps.

Whilst there was a requirement for case managers at Rongo Ātea to have a relevant qualification, clinical expertise was limited in the Rongo Ātea programme with a reliance on off-site professionals and external AA and NA adult support groups. The programme would greatly benefit from an at least one on-site appropriately qualified clinician with the ability to practice in a culturally appropriate way.

Whakamana denotes empowerment and in the context of health intervention relates to the sustainability of recovery over time. Follow up or aftercare is crucial to ensuring successful long term outcomes (Garner, 2007; Kelly, 2000;

McCormick et al. 2006; Schroder, 2007). Rongo Ātea, like many other treatment programmes in New Zealand, is insufficiently resourced to deliver long-term, effective follow-up treatment. Greater alignment with external adolescent mental health agencies, schools or training providers and whānau along with extended periods of follow up and support can assist with long-term treatment outcomes.

Reflections

A limitation of the research was the restructuring that occurred within the programme and how this impacted on my ability to engage with management and staff in regards to the research and to access various resources that might have been useful. In hindsight, it would have been beneficial to develop stronger relationships with the Te Runanga o Kirikiriroa research staff and management early on the research process rather than relying on my relationship with the Rongo Ātea manager as when she left, so did much of the awareness and buy-in of the research being undertaken. Staff and management were very focused on the restructuring process and in many ways the evaluation felt like an imposition during a difficult stage of programme development. This hindered my ability to access staff for interviews and to access filing systems and record databases which may have assisted with a greater understanding of internal processes and recommendations for development.

A further limitation of this research was my being Pākehā within a Kaupapa Māori setting. Smith (1999) argues that being Māori is an essential criterion for carrying out Kaupapa Māori research supporting the self-determining concept of 'by Māori, for Māori'. However, she also states that non-Māori may be involved in research providing they position themselves as non-indigenous. This includes going beyond merely acknowledging personal values and assumptions but also asking questions around who gets to define the research, what impacts the research has, what knowledge and outcomes will be gained from the study and what processes are in place to support the

researched and the researcher. It was important to continue to ask these questions throughout the research process to ensure that the not only was my practice appropriate to my position as non-Māori , but that the questions being asked to inform the study were culturally relevant and shaped by the intention to produce the best outcomes for Māori. Rongo Ātea staff were included in the research design and planning, including developing processes for ongoing feedback throughout the research, face to face contact and researcher participation in the day to day running of Rongo Ātea. Part of my initial research plan was to establish a whānau group to oversee the research throughout the evaluation period.

In reality, I found that my ability to connect and sustain relationships outside of staff and students based at Rongo Ātea, was limited. This was partly due to high staff turn over during this time, including the departure of the onsite manager who had requested the research initially. Another factor was my lack of experience and confidence in appropriate relationship building and tikanga. Peace and Roorda (2009) identified that non-Māori evaluators tend to start research with strong intentions of observing best practice guidelines but often fall short in the implementation with a number of complex challenges contributing to a failure of practice. Whilst I have some understanding of Māori tikanga and am able to confidently participate in pōwhiri, waiata and other cultural observance, I have learned from this experience that my depth of cultural understanding is lacking. Māori and Pākehā have distinct world views. Many Māori concepts may in fact not be accessible to Pākehā by virtue of not being Māori. Ka'ai & Higgins (2004, p.8) cite Pēwhairangi (1992, p.11) who states;

I know there are a lot of Pakeha who would love to learn, not only the language, but the Maori heart. And it's a thing one can never teach. Quite a number of Pakehas are sincere about it. This is part of the Maori they want to learn: respect nature, respect for anything Maori, how they should come on to a marae, how they should come into a meeting house, and how to learn to speak like an orator. But anyone

can speak on a marae once they've been shown the proper procedure. This is just scratching the surface. Maoritanga goes deeper than that and I don't think Pakehas are aware of this. They think that because they've been to university and studied the language and the culture, they've mastered it. To me listening, it sounds as if there is no depth there at all, especially as far as tapu is concerned. There is so much tapu connected with the whole culture and I don't think Pakehas can absorb it.

Interestingly, much of my learning of Māori cultural concepts took place towards the end of my thesis journey whilst trying to make sense of the discussion and findings and having my work critiqued. I believe this limitation in understanding shows in the surface questioning regarding the Kaupapa Māori nature. In future I would at the very least, ensure that a whānau group is established prior to the initiation of the research process and my knowledge and experience of Māori cultural concepts strengthened for any research that I was undertaking with Māori .

Future research

Rongo Ātea would greatly benefit from Kaupapa Māori specific research to investigate programme effects and development from te ao Māori particularly in regards to the integration of clinical and cultural approaches. Smith (1999) asserts that Kaupapa Māori research enables Māori self-determination, providing a vehicle for autonomy over cultural well being. Furthermore, it is connected to Māori philosophy and principles whilst legitimising Te ao Māori including the importance of te reo Māori and cultural concepts. Durie (2001) strongly recommends the establishment of Kaupapa Māori specific services based on Māori tikanga and located regionally according to population. Rongo Ātea is one of only a few Kaupapa Māori specific services for adolescents in New Zealand and caters not only to the Waikato but takes a number of referrals from other areas, providing a valuable and unique service.

A recent article in the Youth Court of New Zealand newsletter *Court in the Act* (November, 2010) outlines an article by Marie (2010) challenging the view that lack of cultural identity plays a role in Māori offending and purporting that cultural identity strategies are not successful in rehabilitation. This is however, a simplistic view, negating significant international research supporting an integrative approach to intervention of which cultural identity is a part (Bishop & Glynn, 1998; Cram et al, 2003; Durie, 2001; Gfellner, 1991; Huriwai et al., 2001; Liddle & Dakof, 1995; Liddle et al., 2006; Monti, 2001; Saggars & Gray, 1998). It has been found that Kaupapa Māori treatment programmes have achieved higher rates of retention for Māori than mainstream programmes (McCormack et al, 2006). As stated by Cram (2003) and Durie (2001) Kaupapa Māori theory and practice does not necessarily exclude the use of various non-Māori methods, but does ensure that methods occur within a cross-cultural context and endeavour to provide best outcomes for Māori. This continues to be an area for further research within a New Zealand context.

Finally, it has been said that a society can be judged by how it treats its most vulnerable. Our children and adolescents deserve to be treated with care and provided with opportunities to develop strong identities and healthy lives. At a time when we invest more in prisons than ever before, we need to be willing to make the same investment in young people and their families, through adequate resourcing of evidence based and culturally appropriate early intervention, prevention and treatment. Rongo Ātea is at once both an example of the sort of programme in which we should be investing and an example of the sub-optimal outcomes which are likely if such investment is not at a sufficiently high level.

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Appendix A – Glossary

Unless otherwise indicated, definitions have been sourced from Mead (2003).

Arohatanga	love, respect, compassion
Hinengaro	the mental element
Kanohi kitea	face to face ^{††}
Kaitiaki	guardian
Māta waka	kinship groups outside their traditional rohe
Mana Rangatira	sovereignty, self-management, leadership
Manākitanga	hospitality, caring, generosity
Mauri	life force
Pōwhiri	welcome ceremony
Rangatahi	youth
Te ao turoa	environment
Te ao whanui	wider society
Te whenua	land providing a sense of identity and belonging
Tohunga	priest; skilled spiritual leader; expert
Taonga	highly prized object
Tinana	the physical element
Tikanga Māori	Māori knowledge and practice
Tino Rangatiratanga	self-determination
Tuakana/teina	eldest and younger
Utu	reciprocity, balance
Tūrangawaewae	place to stand, home
Wairua	spirit
Whenua	land
Whānaungātanga	relationships

^{††} Smith, 1999

Appendix B – Consent Forms

WHANUA/CAREGIVER CONSENT FORM

PARTICIPANTS COPY

Research Project: Evaluation of Rongo Atea Drug and Alcohol Treatment Programme

Name of Researcher: Helen Paki

Name of Supervisor: Neville Robertson and Bridgette Masters

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the change to ask any questions and any questions have been answered to my satisfaction.

As the Caregiver responsible, I consent to _____ participating in this research.

If I have any concerns about this project, I may contact the convenor of the research and Ethics Committee (Dr Robert Isler, phone: 07 838 4466 ext. 841, e-mail r.isler@waikato.ac.nz).

Caregiver's Name: _____ Sign: _____
Date: _____

=====

RESEARCHER'S COPY

Research Project: Evaluation of Rongo Atea Drug and Alcohol Treatment Programme

Name of Researcher: Helen Paki

Name of Supervisor: Neville Robertson and Bridgette Masters

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the change to ask any questions and any questions have been answered to my satisfaction.

As the Caregiver responsible, I consent to _____ participating in this research. If I have any concerns about this project, I may contact the convenor of the research and Ethics Committee

Caregiver's Name: _____ Sign: _____
Date: _____

University of Waikato
Psychology Department

STUDENT CONSENT FORM

PARTICIPANTS COPY

Research Project: Evaluation of Rongo Atea Drug and Alcohol Treatment Programme

Name of Researcher: Helen Paki

Name of Supervisor: Neville Robertson and Bridgette Masters

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the change to ask any questions and any questions have been answered to my satisfaction.

I _____ consent to participating in this research.

If I have any concerns about this project, I may contact the convenor of the research and Ethics Committee (Dr Robert Isler, phone: 07 838 4466 ext. 841, e-mail r.isler@waikato.ac.nz).

Name: _____ Sign: _____ Date: _____

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RESEARCHER'S COPY

Research Project: Evaluation of Rongo Atea Drug and Alcohol Treatment Programme

Name of Researcher: Helen Paki

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I have received an information sheet about this research project or the researcher has explained the study to me. I have had the change to ask any questions and any questions have been answered to my satisfaction.

I consent to _____ consent to participating in this research. If I have any concerns about this project, I may contact the convenor of the research and Ethics Committee

Name: _____ Sign: _____ Date: _____

Appendix C – Participant Information Sheets

Participant Information Sheet For Whānau or Caregivers of Students

Evaluation of Rongo Atea Alcohol and Drug Residential treatment Centre: Te Runanga O Kirikiriroa Trust

The Research

I am undertaking an evaluation of the Rongo Atea Treatment programme to find out how it works, what works best, and what might work better.

The research will focus on student's experience of the programme and how change happens for young people who are in a residential treatment programme. The research will also try to identify unplanned effects of the programme – what else comes up for people during their participation besides their alcohol and/or drug use, and how these things get dealt with over the course of the programme.

The Rongo Atea programme is unique in that it uses a Kaupapa Maori model and it will be interesting to find out how this is experienced by the adolescents undertaking the programme. It is hoped that this research will help those people making policy and funding decisions to better understand what is required for young people to assist them through this process. It will also help the Manager and staff of Rongo Atea identify the strengths of the programme and areas for improvement.

The research is a course requirement for my Masters degree in Psychology from the University of Waikato. The University Supervisors of the research are Neville Robertson and Bridgette Masters of the Psychology Department.

I will be taking part in day-to-day activities including outings, meal-times, classes and groups. This will help me to understand more about the kind of activities that make up the programme and how they work.

Your adolescent has indicated they are interested in being involved in one-to-one interviews.

The one-to-one interviews are an important part of the research. I will ask you things like how things are going in the programme so far? What were your attitudes to drugs/alcohol before the programme and what are they now? How (and if) this has changed over the course of the programme and what do you think has made the difference? How do you feel about exiting the programme and what do you think you need to make this successful for you?

Researcher – Helen Paki

I am a student at the University of Waikato completing my Masters in Psychology and a post-graduate diploma in Community Psychology.

I have a 15 year old son who is at High School and we have lived in Hamilton for most of the last 14 years. Previously to that we lived in Rotorua and

Auckland. I also have a job at the Waikato Institute of Technology (Wintec) where my role is to assist students with disabilities who are studying there.

Interview Process

The interviews will take place at Rongo Atea and will take about an hour. There will be between one and three interviews with you depending on how long the student has already been in the programme. This is so I can get a good idea of how things change along the way.

I will ask some general questions to guide the interview but mostly I am interested in the student's experience. Whilst I will not be probing about anything deeply personal, if something comes up for the student that is uncomfortable they are able to go and talk to their case manager. They are also welcome to have a support person with them at the interview. This could be a staff person, whānau or another student that they are comfortable with.

The interviews will be taped with the student's permission. I will write up notes from the tape and will meet with the student to go through it to see if there is anything they want to change or add.

Right to Withdraw

Participation in this research is voluntary. The student has the right to:

- Withdraw from the research at any time
- Refuse to answer any questions
- Ask questions about the research and have them answered

Results of the Research

When the report is written up I will send a summary of the research if to the student. A completed copy of the research will be provided to Rongo Atea and copies of the completed Masters Thesis will be held at the University of Waikato and at the Ministry of Social Development.

Ethics

This research has been approved by the ethics committee of the psychology Department of the University of Waikato. The researcher will adhere to the ethical guidelines provided by the New Zealand Psychology Society Code of Ethics. Confidentiality will be maintained throughout the research process and no identifying information such as names or personal details will be used.

No-one else will get to listen to the tapes or read the transcripts, and they will be destroyed at the end of the research.

Contact details

My email is hmp2@waikato.ac.nz

My phone number is 07 855 3704

The University Supervisors are Bridgette Masters and Neville Robertson and they can be contacted at the University on 07 856 2889.

Participant Information Sheet Students

Evaluation of Rongo Atea Alcohol and Drug Residential treatment Centre: Te Runanga O Kirikiriroa Trust

The Research

I am undertaking an evaluation of the Rongo Atea Treatment programme to find out how it works, what works best, and what might help it to work better.

The research will focus on your experience of the programme and how change happens for young people who are in a residential treatment programme. The research will also try to identify unplanned effects of the programme – what else comes up for you during your participation besides alcohol and/or drug use, and how these things get dealt with over the course of the programme.

The Rongo Atea programme is unique in that it uses a Kaupapa Maori model and I want to know what you feel about this. It is hoped that this research will help those people making policy and funding decisions to better understand what is required for young people to assist them through this process. It will also help the Manager and staff of Rongo Atea identify the strengths of the programme and areas for improvement.

The research is a course requirement for my Masters degree in Psychology from the University of Waikato. The University Supervisors of the research are Neville Robertson and Bridgette Masters of the Psychology Department.

I will be taking part in day-to-day activities including outings, meal-times, classes and groups. This will help me to understand more about the kind of activities that make up the programme and how they work.

The one-to-one interviews are an important part of the research and if you choose to participate I will ask you things like how things are going for you in the programme so far? What were your attitudes to drugs/alcohol before the programme and what are they now? How (and if) this has changed over the course of the programme and what do you think has made the difference? How do you feel about exiting the programme and what do you think you need to make this successful for you?

Researcher – Helen Paki

I am a student at the University of Waikato completing my Masters in Psychology and a post-graduate diploma in Community Psychology.

I have a 15 year old son who is at High School and we have lived in Hamilton for most of the last 14 years. Previously to that we lived in Rotorua and Auckland. I also have a job at the Waikato Institute of Technology (Wintec) where my role is to assist students with disabilities who are studying there.

Interview Process

The interviews will take place at Rongo Atea and will take about an hour. There will be at between one and three interviews with you depending on how long you have already been in the programme. This is so I can get a good idea of how things change along the way for you.

I will ask some general questions to guide the interview but mostly I am interested in your experience. Whilst I will not be probing about anything deeply personal, if something comes up for you that is uncomfortable you are able to go and talk to your case manager. You are also welcome to have a support person with you at the interview. This could be a staff person, whānau or another student that you are comfortable with.

The interviews will be taped with your permission. I will write up a transcript of the tape and will meet with you to go through it to see if there is anything you want to change or add.

Right to Withdraw

Participation in this research is voluntary. If you choose to participate you have the right to:

- Withdraw from the research at any time
- Refuse to answer any questions
- Ask questions about the research and have them answered

Results of the Research

When the report is written up I will send you a summary of the research if you are interested. A completed copy of the research will be provided to Rongo Atea and copies of the completed Masters Thesis will be held at the University of Waikato and at the Ministry of Social Development.

Ethics

This research has been approved by the ethics committee of the psychology Department of the University of Waikato. The researcher will adhere to the ethical guidelines provided by the New Zealand Psychology Society Code of Ethics. Confidentiality will be maintained throughout the research process and no identifying information such as names or personal details will be used.

No-one else will get to listen to the tapes or read the transcripts. Data will be kept under secure conditions for up to five years as preparation for publication of academic articles. At the end of five years, all raw data will be destroyed.

Contact details

My email is hmp2@waikato.ac.nz

My phone number is 07 855 3704

The University Supervisors are Bridgette Masters and Neville Robertson and they can be contacted at the University on 07 856 2889.

Appendix D – Interview and Focus Group Schedules

Student Interview Schedules (semi-structured)

Demographic details

How long have you been in the programme? (note roll-overs and intention to roll over)

Age when you started drinking/using drugs

Circumstances under which you started using

People involved in alcohol or drug use (friends, family)

What were the circumstances that led you to treatment

Did you want to attend treatment – why?

If not, who referred you and why?

What was it like when you first came to Rongo Atea?

What did you expect treatment would be like?

What do you hope to get out of time here?

Interview one and follow up interviews (as appropriate)

Expectations

What is it like for you here now?

Is the programme meeting your expectations?

What are you learning from the programme?

What is your experience of:

Group sessions

School

Individual session

Daily activities – outings, chores, mealtimes, socialising, personal time

Staff

Peers

Staff Focus Group and Interviews Schedules (semi-structured)

Kaupapa Maori

What has it been like working within a Kaupapa Maori setting?

Do they think they would get the same benefit from a programme that was not Kaupapa Maori? Why? If not, why not?

Abstinence model

What are their thoughts about the abstinence model?

Twelve step programme?

Are the principles of the abstinence model and 12 step programme ones that you will be able to or want to apply when you leave here? Why/why not?

Unintended effects

What have you learned about yourself while you have been here?

Have you felt supported to explore things about yourself and your life while you are here? How/how not?

Have you ever thought about leaving the programme? Why/why not?

Programme Strengths and Weaknesses

What has most helped you in this programme?

What do you think is lacking in the programme and why?

What do you think about the length of the programme?

What has it been like not using drugs or alcohol?

What are your views on using drugs and alcohol now?

Post treatment

What do they think it will be like when they leave and go back to their life outside Rongo Atea?

Prompts – friends, family, social supports, school, future aspirations

What tools do you have that you didn't have before to support you in your life?

What do you think you need to support you when you leave here?

Other

Is there anything else you think is important to talk about?

Appendix D – Semi-Structured Focus Group and Interview Schedules (Staff)

**Evaluation of Rongo Atea Alcohol and Drug Residential treatment
Centre: Te Runanga O Kirikiriroa Trust**

The Research

I am undertaking an evaluation of the Rongo Atea Treatment programme to find out how it works, what works best, and what might work better.

The research will focus on student's experience of the programme and how change happens for young people who are in a residential treatment programme. The research will also try to identify unplanned effects of the programme – what else comes up for people during their participation besides their alcohol and/or drug use, and how these things get dealt with over the course of the programme.

The Rongo Atea programme is unique in that it uses a Kaupapa Maori model and it will be interesting to find out how this is experienced by the adolescents undertaking the programme. It is hoped that this research will help those people making policy and funding decisions to better understand what is required for young people to assist them through this process. It will also help the Manager and staff of Rongo Atea identify the strengths of the programme and areas for improvement.

The research is a course requirement for my Masters degree in Psychology from the University of Waikato. The University Supervisors of the research are Neville Robertson and Bridgette Masters of the Psychology Department.

I will be taking part in day-to-day activities including outings, meal-times, classes and groups. This will help me to understand more about the kind of activities that make up the programme and how they work.

The staff focus groups are an important part of the research and if you choose to participate I will ask you things like what is your experience of working as a staff person at Rongo Atea? What changes do you see occur for students over the course of the programme? What do you attribute these changes to? What are the strengths of the programme? What do you think could be done differently? Do you feel equipped as staff to provide the care provided? Why/why not? Does Rongo Atea have good links with community agencies? Why/why not? Do you think the social supports area adequate for youth? What concerns do you have for students post treatment (if any)?

Researcher – Helen Paki

I am a student at the University of Waikato completing my Masters in Psychology and a post-graduate diploma in Community Psychology.

I have a 15 year old son who is at High School and we have lived in Hamilton for most of the last 14 years. Previously to that we lived in Rotorua and Auckland. I also have a job at the Waikato Institute of Technology (Wintec) where my role is to assist students with disabilities who are studying there.

Focus Group Process

The focus groups will take place at Rongo Atea and will take about an hour. As staff work at different times and it is difficult to get together at the same time, I will be scheduling 3 – 4 groups at different times based on rostering. Time may also be made available in the staff meeting. I will set up the time for focus groups with the approval of the Rongo Atea Manager.

I will ask some general questions to guide the focus group but mostly I am interested in your experience. The interviews will be taped with your permission. I will write up a transcript of the tape and will meet with you to go through it to see if there is anything you want to change or add.

Right to Withdraw

Participation in this research is voluntary. If you choose to participate you have the right to:

- Withdraw from the research at any time
- Refuse to answer any questions
- Ask questions about the research and have them answered

Results of the Research

I will be providing feedback about the research as it develops by regularly attending staff meetings. You may also contact me at any time if you want to know how things are going or if you have any questions or comments.

When the report is written up I will send you a summary of the research if you are interested. I will also be providing a brief presentation at Rongo Atea on completion of the research which you will be most welcome to attend. A completed copy of the research will be provided to Rongo Atea and copies of the completed Masters Thesis will be held at the University of Waikato and at the Ministry of Social Development.

Ethics

This research has been approved by the ethics committee of the psychology Department of the University of Waikato. The researcher will adhere to the ethical guidelines provided by the New Zealand Psychology Society Code of Ethics. Confidentiality will be maintained throughout the research process and no identifying information such as names or personal details will be used.

No-one else will get to listen to the tapes or read the transcripts, and they will be destroyed at the end of the research.

Contact details

My email is hmp2@waikato.ac.nz

My phone number is 07 855 3704

The University Supervisors are Bridgette Masters and Neville Robertson and they can be contacted at the University on 07 856 2889.

Semi-Structured Focus Group and Interview Schedules (Staff) Programme Effectiveness

Discuss kaupapa of the programme;

Kaupapa Maori

Abstinence

12 Step recovery

Relapse prevention

Behaviour modification

Post care

Youth specific education

School

Sexual health

Life Skills

How do each of these kaupapa contribute to the effectiveness of the programme?

What changes do you see occur for students over the course of the programme?

What do you attribute these changes to?

What are the strengths of the programme?

What do you think could be done differently?

Unintended effects

What unintended effects of the programme do you witness? How does this happen and how is it accommodated within the context of the programme?

Whānau /caregivers

What contact is there with whānau during the course of the programme – staff and students?

Are whānau expected to undertake any form of change or therapy?

If so, how are they supported in this?

How important is whānau involvement in the overall treatment of the adolescent?

Community Agencies/support

What are the factors (social, economic etc) that you perceive as contributing to youth drug and/or alcohol abuse?

Does Rongo Atea have good links with community agencies (and is that important)? Why/why not?

Are there adequate social supports for youth with drug/alcohol issues? How can adolescents be better supported?

Post treatment

What concerns do you have for students post treatment (if any)?

What do you perceive as the value of residential treatment centers as opposed (or in relation to) to non-residential treatment and preventative programmes?

Staff experience

What is your experience of working as a staff person at Rongo Atea?

Do you feel equipped as staff to provide the care required? Why/why not?

Do you believe you have the training/supervision you need?

Comment on recent staff changes

Anything else you would like to discuss