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An Evaluation of an
Impaired Driver Treatment Programme

Facilitated by Tūhoe Hauora,

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
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at
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by
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Abstract

Driving while impaired is a substantial issue in Aotearoa. It has the potential to result in loss of life and cause significant health and economic strain on society. Recidivist impaired drivers are major contributors to this problem. Countermeasures of impaired driving have previously included liquor licencing, drinking age restrictions, health promotion campaigns and health rehabilitation therapies. The Ministry of Health offer an Impaired Driving therapy throughout Aotearoa as countermeasure to this issue. The programme is administered through the funder-contract system. Participation is compulsory for those mandated by court order.

This study evaluates an Impaired Driver programme facilitated by Tūhoe Hauora; a kaupapa Māori mental health and addiction provider based in Taneatua, Eastern Bay of Plenty. The course is delivered once weekly over a period of ten weeks to a group of twelve or less recidivist impaired drivers or first time offenders who were convicted of driving with excessive levels of breath alcohol.

The evaluation draws from a community psychology paradigm in exploration of the lived experiences of programme participants, in the context of course 2 of the 2014 Tūhoe Hauora Impaired Driving course.

The experiences of five individuals were explored using in-depth face to face interviews and presented using a case-by-case approach. Participant observation, document review, evaluation visits and participant surveys were used as supplement methods of inquiry. The findings illustrated that Tūhoe Hauora met contract requirements by addressing impaired driving recidivism to date of interview. The evaluation also found the course

actualising the mission of Tūhoe Hauora which was to address the holistic well-being of programme participants. The research did present areas in the programme that could be improved particularly pertaining to the referral process and a need for agency collaboration. Recommendations were formulated in attempt to address the programme gaps and discussion is offered in addressing the multi-layered oppression that was experienced throughout the evaluation process by both Tūhoe Hauora and the evaluation participants.

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Preamble

When I entered the doors of Tūhoe Hauora as a new employee, my world changed. I found a special place there. The people who welcomed me did not judge me on the disconnect with my language or culture. They accepted me with open arms for who I was. They showed me that my values were valued. That I was enough. The people of Tūhoe preserve what it is to be humble, caring and open. That is something that needs to be shared and emulated throughout Aotearoa. You bring something special to those who meet you. I hope I can do the same for others one day.

Chapter 1: Introduction

This research is an evaluation of the Ministry of Health funded Impaired Driving treatment programme that was administered by Tūhoe Hauora; a non-Government *kaupapa*¹ Māori² mental health and addiction organisation based in Taneatua, Eastern Bay of Plenty.

I was in my second year working as a Quality Management coordinator and Personal Assistant to the General Manager for Tūhoe Hauora when I reached the research phase of my masters degree. Tūhoe Hauora were experiencing a phase of change. A new manager had been appointed and several external audits had taken place highlighting a need for administrative improvements and continual self-evaluation at varying levels of the organisation.

During these audits the organisation expressed frustration at how the methods used to evaluate and monitor their practice, failed to consider, reflect and report their unique use of *kaupapa* Māori methods and general existence working as Tūhoe for Tūhoe. Instead, the organisation were perceived by their funders based on how many boxes were ticked using predominantly quantifiable measures.

¹ I have chosen to italicise Māori words and terms throughout this evaluation and define each in the glossary section. Although this runs the risk of making Māori look like the ‘other/minority’, I believe that providing a point of reference may support those readers less familiar with a Maori world view and language to understand the content of this thesis.

² I use the term ‘Māori’ in respect to *tangata whenua*; indigenous people of *Aotearoa*. *Tangata whenua* is referenced in the glossary. I have chosen not to italicize the word Māori for this reason. I also have not italicized direct quotes that define Māori concepts to save repetition.

I approached the General Manager requesting that I undertake an evaluation of the organisation. I believed it would give me much needed research-evaluation experience and the organisation an opportunity to have an assessment against their practice using techniques appropriate to the *kaupapa* of the organisation. Importantly, this would be with freedom from the strong audit culture which had become commonplace for them as perpetuated through the funder-contract system. The manager allowed me to pitch a proposal during a management *hui*. It was here the Clinical Team leader and the General Manager placed their trust in me and gave me the go-ahead to begin an evaluation.

I had initially requested an evaluation of the culturally embedded and *marae* based *wahine* and *tane tikanga* programmes that were funded by the Department of Corrections. Due to the several risks and barriers associated with evaluating that programme, the manager offered opportunity for me to evaluate their newest programme that both she, and the Clinical Team leader were facilitating. This was the Impaired Driving treatment programme. As I had helped undertake general administrative tasks for this course, I held a fair idea of the course purpose, content and structure and considered this an excellent but complex learning opportunity. This evaluation therefore draws on predominantly qualitative fields of inquiry from a community psychology paradigm, utilising my experience as a previous member of Tūhoe Hauora. This is an analysis of the lived experiences of five individuals who participated in the course delivered between 16 September - 18 November 2014.

This project identifies health outcomes experienced by programme participants and determines aspects of the Tūhoe Hauora facilitated course

that contributed towards those health outcomes. The evaluation further aims to provide Tūhoe Hauora with feedback for purpose of acknowledging effective practice and providing recommendations where needed for purpose of programme improvement, so that the organisation can meet and exceed the Impaired Driving contract requirements and ensure the programme is actualising the mission of Tūhoe Hauora.

Chapter two presents relevant literature that was reviewed in refining this research project. This chapter explores the Māori health landscape, the definition of health used for purpose of this evaluation and how best to evaluate a *kaupapa* Māori programme that is conceptualised through a mainstream lens. Chapter three presents the background, purpose and rationale of this evaluation. Chapter four discusses the approach and methodology of the evaluation.

Chapter five analyses each of the research participants using a case study approach. Each case study explores the alcohol and drug background of the participant, including the self-reported health outcomes as a result of the programme. The conclusion of each case study analyses the information in reference to the evaluation aims. Chapter six summarises the evaluation findings and references these against broader community psychology concepts.

Chapter 2: Literature Review

The following chapter discusses prominent themes arising from the literature that was reviewed and considered in designing, contextualising and analysing this evaluation. The purpose of the first section, Māori health, is to ensure that I have considered the wider socio-political and historical landscape of Māori health in fair analysis of the Tūhoe Hauora Impaired Driving programme.

Māori Health

The health deficit between Māori and non-Māori in *Aotearoa* is widely documented. A review of New Zealand health reports illustrated that in 2016, these disparities continue to be substantial. For instance, the Ministry of Health website reported that Māori are overrepresented in areas of heart disease, stroke, diabetes, high blood pressure, chronic pain and arthritis, smoking, obesity, unmet healthcare needs and oral health issues (Ministry of Health, 2013b).

Māori also have higher rates of experiencing mental illness in comparison to non-Māori. For instance, The Ministry of Health (2009) outline that 4938 of every 100,000 Māori accessed a mental health and addiction provider between the year 2007 and 2008. The Ministry of Health (2009) further determined that Māori have higher rates of hazardous drinking, cannabis use and drug associated disorders than non-Māori.

Health

Early psychological frameworks attribute health outcomes to individual choice and behaviour (Hodgetts, Stolte & Rua, 2014). However, modern community and social psychologies pay attention to wider influences

affecting the human condition. For instance, social determinants of health are viewed as moderators of well-being. Social determinants consider “fundamental determinants of human functioning across the life span” (American Psychological Association Task Force on Socioeconomic Status, 2007). It is defined as:

The conditions in which people are born, grow, live work and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves shaped by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and unavoidable differences in health status seen within and between countries (World Health Organisation, 2012).

From this perspective, control over life, social affiliations, socio-economic status, education, employment, poverty, housing, access to resources (such as health services) and general standards of living attribute to health and well-being. This perspective comes from the work of the World Health Organisation (WHO) resulting from the Ottawa Charter for Health Promotion (1986) which ascertained that people should have control over determining their own health. The WHO believe that control over individual health can be actualised by ensuring that every individual has access to

- peace,
- shelter,
- education,

- food,
- income,
- a stable eco-system,
- sustainable resources, and
- social justice and equity (World Health Organisation, 2012).

These broader factors are needed to ensure that any one individual has ability to reach a complete state of mental, emotional, physical and social well-being. The WHO practice to ensure health is “used as a resource for life” rather than structuring life with aim of becoming healthy (World Health Organisation, 2012).

Similarly, Maui Pomare, the first western trained Māori doctor of *Aotearoa* who graduated in 1899, was the first to formally communicate to ‘western’ practitioners and academics that “Māori health does not take shape in the human body alone, but within the trials and opportunities which make up human journeys” (in Durie, 1999, p.1). He made many advancements in addressing health beyond the physiological state. Despite his harsh criticism of a Māori health perspective, Pomare advanced the notion that culture and health were interrelated (Durie, 1999).

A great amount of work has taken place since Pomare’s death. For example, Māori health was officially defined in 1994 during the *Hui Te Ara Ahu Whakamua*, organised by *Te Puni Kōkiri* (Rochford, 2004). It was here Māori representatives, health professionals, community organisations and tribal leaders set a strategic direction for Māori health. They defined what is meant by ‘a healthy Māori’, how this should be measured and policies that need to be set for this to be achieved. It was here that the

importance of culture and identity was affirmed including that Māori involvement at various levels of society was needed for Māori health progression (Rochford, 2004). Since the *hui*, several Māori models of health and health promotion have evolved.

Te Whare Tapa Wha

Professor. Mason Durie (1998b) created *te whare tapa wha* framework which has now become embedded in health policy throughout *Aotearoa* (Pitama, Robertson, Cram, Gillies, Huria, Dallas-Katoa, 2007). The framework encapsulates the importance of taha tinana (Physical), taha hinengaro (psychological), taha wairua (spiritual) and taha whanau (social) as determinants of health.

Each dimension represents a pillar of a *whare*. Each pillar is said to be needed for the *whare* to remain balanced and standing strong. Interpreted, this means individual health is reliant on the balance of the spiritual, physical, mental and emotional facets of health. Neither one facet is more important than the other, yet the state of one dimension of health can drastically impact and affect another.

Te Wheke

Te Wheke (The Octopus), developed by Rangimarie Rose Pere, is a model used to represent how health of self is entwined with *whanau*, *hapu* and *iwi* health (Love, 2004). It illustrates that the mind and spirit have a human connection with *whanau* and the physical world. The head of Te Wheke represents *whanau* and each other tentacle represents;

- *waiora*, total wellbeing for the individual and family;

- wairua tanga, spirituality;
 - hinengaro, the mind;
 - taha tinana, physical wellbeing;
 - whanaungatanga, extended family;
 - mauri, life force in people and objects;
 - mana ake, unique identity of individuals and family;
 - hā a koro ma, a kui ma, breath of life from forbearers; and
 - whatumanawa, the open and healthy expression of emotion
- (Ministry of Health, 2015).

More recently, the Whetu (Star) framework has been developed to ascertain the importance of mind, body, spirit, *whenua* and *whakapapa* towards Māori health (Mark and Lyons, 2010). Each framework embodies that health must be seen from a multifaceted perspective, for health to be addressed. Well-being cannot be fully achieved when any one area is lacking.

For this study, I have adopted the framework of *te whare tapa wha*. This is because participants were educated on this model during the Impaired Driving course, and could articulate their health experiences per the four dimensions of *te whare tapa wha* during the interview process. The concept of social determinants of health are also commonly used throughout this project in respect to community psychology concepts.

Important Concepts

From a social perspective, social and health disparities are widely argued to be the result of power inequalities (Nelson & Prilleltensky, 2005). In the case of *Aotearoa*, Māori were viewed as inferior to the coloniser. This led

to oppression of Māori culture and world views impacting, on large scales, Māori health.

Oppression

Oppression is one of the most important concepts in community and social psychologies and is used often throughout this thesis as it describes the ongoing experience of Māori and other indigenous cultures. I have therefore chosen to define it. Oppression is described Prilleltensky and Nelson (2002, p.12) as “A state of domination where the oppressed suffer the consequences of deprivation, exclusion, discrimination, exploitation, control of culture, and sometimes even violence”. Oppression is the evident at various levels and structures of society. In terms of the Māori experience, at the societal level, the colonisers re-structured social and economic institutions, rearranged power and privilege and considered some less than human. This oppression caused a social, cultural, political and health divide between Māori and the European settlers.

Minoritization

Minoritization is also important to mention in terms of health deficit. The concept is described as the socio-historical processes where one group becomes dominant over the other through social interaction. Minoritization works by favouring and privileging one group which is “manifested in systems and structures that perpetuate privilege” (Pratt, Burman and Chantler, 2004, p.33). Those with the dominant cultural and political power become known as the majority. Those without power are known as the minority. As a result of colonisation, indigenous groups throughout the world have become a minority in their home land as policies, legislation and

social values shifted to favour western ideologies thereby suppressing indigenous ways of life and knowing. Māori are now considered a minority in *Aotearoa*.

Urbanisation

Urbanisation has also played a major role in the widening of health inequity between Māori and non-Māori. As Māori sought out employment opportunities internal and external migration took place. Thus, access to *hapu*, *iwi* and wider *whanau* supports became non-existent for those experiencing urbanisation. Urbanisation led to a loss of language and familiarity with *marae* and cultural customs, and lack of wider *whanau* support. This led to a complete value shift for those Māori living in urban communities (Durie, 1998a).

Historical Trauma

Social and liberation psychologies consider indigenous health disparities within its broader historical context. Historical trauma connects the historical socio-political climate with the symptoms of psychological issues. Experiences of historical trauma are described as “locking the colonized into a present reality of being perceived as subservient, weak, backward, and evil” (Watkins & Shulman, 2008, p.114). It is perpetuated by the coloniser who exercise racism, discrimination and eurocentrism, also known as the ‘colonial psychology’, and augmented by oppressive processes such as the unequal sharing of benefits, taking of resources and eurocentric legislation.

Experiences of colonisation and oppression is said to have a negative psychological impact for the victims. At an individual level, these impacts include unexpected bodily pain, anxiety, loss of sleep, depression, tension and disabling fears (Shulman & Watkins, 2008). At a collective level experiences of trauma can cause entire groups to re-experience trauma in new ways; intrusive thoughts, recurring nightmares, physiological reactions, feelings of fear and of being overwhelmed, insomnia, difficulty concentrating, hypervigilance to make sure trauma is not revisited, confusion over boundaries between past and present, silences, eruptions of emotions, and impossibility of completeness; to name a few (Shulman & Watkins, 2008).

Oppressive events are characterised by a forget and denial ‘Colonial psychology’ perpetuated by the coloniser. This means that oppression and historical trauma are often ‘forgotten’ in the making of government policy and legislation. An argument exists that to overcome the colonial psychology, the context and history of health disparities needs to be considered before they are discussed and addressed (Moewaka-Barnes, Gregory, McCreanor, Nairn, Pega, & Rankine, 2004). Shulman & Watkins (2008, p.63) propose that health must be viewed through a “wider historical landscape, marked by tragic dismissals and assaults levied by one group on another, which has shaped the societal context in which our individual personalities have been formed”. Current health deficit therefore, cannot be viewed without acknowledging the psychological damage forced upon indigenous societies through the colonisation process.

Acknowledging the Experience of Tangata Whenua

Many factors can be viewed as influencing a Māori health deficit. These include Māori history, Māori demography, economic reform, state restructuring and wider national and international indigenous development (Durie, 1998a). I have chosen to focus on two of these influencers specific to this evaluation. These are the health sector reforms and examples of Māori experiences with the Crown.

Māori and the Crown: Some examples

New Zealand's legislation is particularly evident of the Crown's 'colonial psychology'. The Crown's attitude was that of "bringing civilisation to the savage" (Te Hiwi, 2008, p.2). It is characterised by eurocentric thinking that disenabled Māori to live by Māori values and traditions and placed limitations as to how effectively Māori could navigate the westernised system. For example, the New Zealand Constitution Act of 1852 laid foundations for the New Zealand colony and determined voting rights. It ascertained only freehold property owners or leaseholders were able to vote. This excluded the majority of Māori who lived communally resulting in only 100 Māori men voting in the first general election of 1853 (Atkinson, 2012). Māori continue to have less political influence than their non-Māori counterparts.

Land loss and current Māori health deficit are also clearly linked. Ebbett & Clarke (2010, p. 217) state, "The Native Lands Acts (1862 and 186) meant communally owned land could be sold and owned by individuals. European purchasers found individuals who wanted alcohol or goods, and would supply them on credit to create debt". As a result, land was confiscated in

order to clear debt. As Durie puts it, for Māori, “Loss of Land is Loss of Life” (1998b, p. 115). Loss of land and access to land of heritage affects the ability for Māori to form a cultural identity (Ebbett & Clarke, 2010). Today there is little Māori multiple-owned land left. This means there is limited access to land of heritage, opportunities for home ownership, communal living, and opportunities for economic, horticultural and agricultural development for Māori by Māori.

Despite the Crown’s treaty promise of “te tino rangatiratanga” (State Services Commission, 2005, p.7), the 1907 *Tohunga* suppression Act was implemented throughout New Zealand (Woodard, 2014). This act outlawed the use of *Tohunga*. Māori were therefore forced to practice health within a western paradigm and spirituality by western religions. Today, western frameworks of health remain dominant over indigenous health approaches. Māori health practiced is currently viewed as the ‘alternative’. Furthermore, just under half the Māori population surveyed in 2013 affiliated with the Catholic, Anglican, Ratana or Christian religions (Statistics New Zealand, 2013).

Furthermore, the Native Schools Act 1867 decreed “that English should be the only language used in the education of Māori children” (Calman, 2012, p.3) outlawing use of Māori language in schools. This led to multigenerational loss of Māori language and cultural identity. As explained later in this chapter, identity is viewed by Māori health scholars as a key factor towards Māori well-being (Nikora, 2007).

From a physiological perspective, accounts from New Zealand’s early settlers illustrated that Māori were once a physically healthy race (Timu-

Parata, 2009). It was the contact with early *pakeha* settlers which saw a decrease in physical health for Māori. New arrivals brought with them influenza, measles and tuberculosis (Pool, 2015). Māori had no previous exposure to such diseases and held little immunity against the sicknesses. Despite the Crown's effort to control contaminated ships arriving to *Aotearoa* shores, these diseases led to the death of many Māori (Pool, 2015).

Early settlers also brought with them alcohol which was a major contributor to a disconnect of mental, spiritual and emotional health for Māori.

According to Huriwai (2002) alcohol and subsequent drug use was non-existent for Māori pre-contact. For instance Wright-St.Clair (1969) quotes Captain James Cook in description of his 1796 visit:

. . .nor did I see any signs of any other liquor being at all known to them, or any method of intoxication, if they really have not, happy they must be allowed to be above all other nations that I at least have heard of Other accounts support the claim Māori were alcohol free before experiencing colonisation (Hutt & Andrews, 1999, p.5).

It is widely agreed that water was drink of preference for Māori and that Māori viewed alcohol adversely for some time before assimilation took place. Tobacco use by Māori on the other hand was widely documented illustrating that initially, Tobacco was the first drug contributing to negative Māori health outcomes as a direct outcome of European influence (Ebbett & Clarke, 2010; Hutt & Andrews, 1999).

The Health Sector

New Zealand's health sector history is characterised by the government's want for assimilation of Māori rather than presence and expression of Māori culture and identity. This worsened the Māori health deficit. Significant health movements began with the Social Security Act introduced in 1938 by the first New Zealand labour government (Lavoie, 2004). Financed through general taxation, the Social Security Act introduced free primary, specialist, hospital, maternity and other medical care and prescriptions to all New Zealanders (Gauld, 2001). However, the National government of 1949 to 1957 introduced policies which allowed the private sector to play a large role in the health system.

By the late 1960's National had raised health care costs, decreased efficiency of the health system and increased dominance of Doctors within the health sector (Gauld, 2001). Because of this, the Department of Health undertook a review in 1969 which identified that General Practitioners continued to charge patients therefore were failing to meet the Social Security Act obligations of ensuring free-public health to all. This resulted in the creation of a dual private-public healthcare system (Gauld, 2001).

The late years of the 1970's and 1980s was characterised by sector fragmentation as public, primary and secondary health services were funded in differing ways. It was during this time Māori found their voice. Māori began to argue of the important relationship between culture and health, and that increased Māori participation throughout the health sector was pivotal in addressing Māori health need. The government at the time rejected this argument under the belief that all people were to be treated the same (Lavoie, 2004; Timu-Parata, 2007).

The early eighties saw two pilot Area Health Boards introduced (AHB's) (Gauld, 2003). By 1989, Fourteen AHB's were implemented across *Aotearoa*. AHB's were responsible for local health funding and health service delivery (Gauld, 2003). The 1990 Health Minister, Simon Upton, released a Green and White paper outlining major health reforms that were soon implemented under that National government (Miller, 2003). This is commonly known as the health reforms of the early nineties.

Neo-liberalism heavily framed the health reforms of the 1990's drawing from the idea that previous government spending on health was the cause of all health sector problems. Upton ignored Government funded reviews that recommended against causing market-like conditions and policy changes (Gauld, 2003) and continued to implement health reforms that separated 'the role of providers and purchasers' (Finlayson, 2002, p.163). The reforms were described as 'a highly ambitious and far reaching programme of structural change in a very short time frame' (Finlayson, 2001, p.158), based on a 'range of ideological, philosophical and economic considerations' (Boston, Dalziel & St John, 1999, p.11).

The health reforms led to the implementation of four Regional Health Authorities (RHA's) that replaced previous AHB's (Lavoie, 2004). RHA's took on the roles of AHB's with further responsibility to purchase services from independent providers. These providers were considered 'the market' (Gauld, 2003). Market like landscapes saw the health sector become unstable. This caused growing disparities between Māori and non-Māori especially evident during the late eighties and early nineties (Durie, 2003).

The response to health disparities highlighted Māori resilience and reflected a step towards self-determination. Durie (2003) refers this era as the years of Māori health development. RHA's encouraged 'by Māori, for Māori' approaches. (Gauld, 2003, p.206). At this time, the *te-reo Māori* movement and return of lands under the *Treaty of Waitangi* were also taking place (Timu-Parata, 2007). Previous Māori Affairs Minister, Koro Wetere and Chief Judge Eddie Durie, Māori leaders in their fields, emphasised a need for strengthening Māori identity for Māori development to be successful (Durie, 1998a). As a result of this awareness, the Department of Māori Affairs was replaced in 1992 with The Ministry of Māori Development (Lavoie, 2004). This department supported Māori to address and take part in the development of education, economic and health sectors. The Māori Health Directorate was soon introduced allowing Māori to be involved in health policy and Treaty centred advice (Lavoie, 2004). Between 1993 and 1998 the number of Māori health, non-government organisations grew from 23 to 240 (Ministry of Health, 2000). Māori also started to develop their unique systems for health "in the context of mainstream funding and devolution of services to *iwi*" (Timu-Parata, 2007, p.1).

The 'reforms of the reforms' took place in the late 1990's (Gauld, 2001). During 1997, RHA's were changed to the Health Funding Authority (HFA). With the introduction of a Labour government, this again developed in the year 2000, from HFA's to what is currently in place as twenty-one local District Health Boards (DHB's). The Ministry of Health was also implemented as the overreaching policy adviser with responsibility of

monitoring national health systems and planning and funding of DHB's on a per capita basis (Lavoie, 2004).

DHB's were responsible for ensuring the input of Māori and local communities. Legislation was implemented to ensure that at least two people identifying as Māori were represented on every DHB Board (Gauld, 2003). This system, described as a system that is governed by contracts (Lavoie, 2004), remains in place today. Māori health providers are described as preferred 'mechanisms to address health inequalities' (Lavoie, 2004, p.10). Durie (2003), suggests this system allows for better access to health providers for Māori and an increased ability to implement Māori and *iwi* specific methods of health delivery. However, despite the movement forward for Māori development, health disparities continue to exist as the current health system struggles to provide equity for all.

The Crown's answer to address Māori health using the funder-provider system has been to foster partnership approaches with Māori organisations and *iwi* drawing from the principles of *Te Tiriti o Waitangi*. The reality is that partnership between the contractor and the contracted using this system is limited. This is effectively explained:

In relationships where one partner places emphasis on dollar value, and the other places value on outcomes for the community, there is a high likelihood of failure, and, given the different power and resource positions, it is clear that the losing partner will be the one with the less power and fewer resources. (Masters-Awatere, 2015, p.36).

Māori health providers reliant on Crown funding are subject to exist at the power-less end of the funder-provider system despite having main responsibility of addressing Māori health needs. Current statistics are evident of the continuing divide between Māori needs and the lack of efficacy of Crown implemented historical, socio-political and systemic approaches to addressing Māori health disparities.

Overcoming Deficit

Despite the attempt for assimilation by the coloniser, Māori continue to hold tight to their unique culture. As Nikora puts it, a “Māori world exists in parallel with mainstream New Zealand society. Māori accommodate to ordinary New Zealand culture yet maintain an equivalent and parallel reality within the Māori world” (Nikora, 2007, p.81). Mainstream society is characterised by a denial psychology which forgets that a violent colonial history exists. Yet, Māori seek transformative change in reach of equity (Te-Aho & Liu, 2010). A need and want is therefore evident for further development so that Māori equity is accepted and nurtured within the context of mainstream health.

According to liberal psychologies, three phases are needed to overcome historical deficit, immobilise oppression and ascertain that Māori reality. These are systemic and socio-political level analysis, transformative change and lastly, overcoming of internalised oppression (Moane, 2008). The following discusses the prominent themes emerging at each of these phases.

Internalised Oppression

The highlighting of historical trauma and health disparities have shaped how social psychologists approach research and practice. A search of key words using ‘transformational’ and ‘transformative’ change for literature review brought out an abundance of articles referring to the phenomenon of consciousness raising which is said to be the point in which change occurs at an individual level (Moane, 2008; Nelson & Prilleltensky, 2005).

Paulo Freire developed the idea of conscientisation in reference to cultural action, which leads to transformative change. His book explores the relationship between humans and how they understand their reality therefore their relationship with the world. Freire believed that when man can challenge the reality they live in, a point of conscientisation has been reached. Conscientisation takes place when one can recognise their conditioning and question the dominant structures around them (Freire, 1998; Nelson & Prilleltensky, 2005). Also known as personal empowerment, this is said to be the starting point of cultural change.

Smith (2003) challenges Freire’s idea as to where conscientisation sits in the scheme of change. Smith argues that conscientisation is not necessarily needed before a person can be involved and contribute to change. That is, change is not a linear process. Smith (2003) uses the example of parents enrolling their children in *kohanga reo* of who, without realising, becoming agents of change through this simple act. Parents become knowledgeable and aware of the socio-political structures involved in reaching *te-reo* Māori revitalisation through interacting with the *kohanga reo* organisation.

For Māori, the forming of a cultural identity is highlighted as tool to overcome internalised oppression. Research has shown that strong cultural identity leads to well-being and aides in overcoming mental illness associated with alcohol use, abuse and dependency (Ebbett & Clarke, 2010). This is because for Māori, identity and psychological well-being are interrelated (Durie, 2001). It is argued that a sense of cultural identity results with good health by building “strength, pride, support, and a sense of belonging” (Ebbett & Clarke, 2010, p.215) whereby “the social, cultural and economic resources of the Māori world will lessen feelings of estrangement, lead to an increased sense of belonging, and ultimately improve mental health” (Ebbett & Clarke, 2010, p.223). For one to develop cultural identity, access to *whanau*, *iwi*, *marae*, and land is essential whereby cultural expression can take place (Durie, 1998b).

Transformative change

Social psychologies also often refer to decolonisation alongside transformative change. Decolonization refers to reclaiming of an indigenous identity for those who have experienced colonisation (Lang, 2005).

Decolonisation in the context of health, is proposed to manifest through transformative change practiced through transformative paradigms.

A transformative paradigm is “a framework of belief systems that directly engages members of culturally diverse groups with a focus on increased social justice”, where transformative practitioners, practice cultural and self-awareness (Mertens, 2002, p.470). This is augmented using reflexive practice where the researcher challenges the normally accepted social power systems that arise while conducting research (Capone & Petrillo;

2013Mertens, 2002). In this context, researchers are seen to have the responsibility to encourage conscientisation by driving oppressed groups to have “direct participation” (Capone & Petrillo, 2013, p.112) in overcoming their own oppression. They become what is termed an agent of change. At a societal level, transformative change occurs when agents of change encourage an increase in community involvement, augmented through clear goals, effective relationships that recognise power dynamics and power sharing between stakeholders (Greenaway and Witten, 2005; Watkins and Shulman, 2000). An example of this is illustrated in the study by Hess, Isakson, Githinji, Roche, Vadnais, Parker, & Goodkind (2014) who explored transformative change at an interpersonal level. Their study paired ‘privileged’ undergraduate students with refugees for two years in effort to elicit mutual learning and advocacy. The overreaching research objective was to empower refugees by “raising their consciousness” and “increasing their understanding of structural forces affecting them” (Hess et al., 2014, p.349). The study found that the ‘privileged’ undergraduate students reported an increased understanding of their social position and the impacts this has on health and social justice. Refugees also reported finding their voice against adversity. In essence, both had experienced consciousness raising.

Much of the literature reviewed ascertain the need for creating a space at the interpersonal level, in creation of transformative change. This was effectively summarised by Smith (2003) who proposed that transformative change within an academic setting must have:

A capacity to make 'space' for itself to be sustained in a context of unequal power relationships with the colonizer and the critique that

will inevitably be developed as such indigenous theorizing often contradicts and challenges the existing and accepted ways of knowing, doing and understanding in the Academy” (p.6).

An example of creating space is that of Linda Nikora, who is an agent of change. Nikora, alongside likeminded scholars, developed a Māori Psychology Research Unit at Waikato University. This has allowed the institution to develop a Māori psychology. This space validates Māori world views, challenges positivist disciplines of psychological practice and has increased Māori graduate psychology student success rates (Levy, 2007). Through this space, students, at a personal level, raise their consciousness, thereby overcoming internalised oppression, and are armed with the tools to become self-aware practitioners who raise social consciousness through professional practice at wider societal levels.

Systemic and Socio-political Analysis

Social Psychologies concentrate on the need for involvement and change at systemic and political levels. This aligns with an ecological perspective. Nelson and Prilleltensky state ecology as “the interaction between individuals and multiple social systems in which they are embedded” (2005, p.71). The human condition here is said to be influenced by the personal (micro), relational (meso) and collective (macro) levels (Nelson & Prilleltensky, 2005) of society where power structures exist and are interconnected. It is believed that change on any one of these levels of society impacts the human condition therefore health.

For health deficit to be overcome, considerations at the macro levels needs to be achieved. As Nelson & Prilleltensky put it “failure to think and

practice ecologically reproduces the dominant cultures emphasis on individualism and encourages the tendency to engage in victim blaming” (2005 p. 34). This is supported by Durie who recognised the relationship between systemic and political changes and its influence on health deficit. He states “progress will not come from the health sector alone but from a range of policy areas. Unlike non-Māori mortality rates, Māori rates have not declined over the period 1980-99, and the widening disparity coincides with major economic and structural changes in New Zealand during that period” (Durie, 2003, p.408). As I have already outlined, historic health sector changes and legislation had a direct impact on Māori health deficit. Overcoming this, would mean all facets of policy and legislation are cognisant of te Tiriti o Waitangi and a Māori world view.

When Māori reach a point of power equality there is chance they can create oppressive power struggles for their own *iwi* and *hapu*. This is known as the role of colonized as oppressor (Memmi, 1991). Te Aho and Liu (2010) use the examples of Māori leaders prioritising money over collective need and disallowing women to talk in authoritative roles. Such actions could pose possible risks for Māori becoming oppressors of their own people. A transformative process would need to take place for *hapu* and *iwi* leaders to ensure kinship and Māori health is of paramount consideration over western priorities such as financial and political gain.

Te Tiriti o Waitangi

The Treaty of Waitangi is of importance to Māori health and development (Levy, 2007). Signed by 40 Māori chiefs from various *iwi* of *Aotearoa* on February 6th 1840, the *Treaty of Waitangi* is described as New Zealand's founding document. Its purpose was to construct a partnership between Māori and the Crown with intention to ensure the well-being for all at collective and individual levels (Levy, 2007). However, widespread debate over the articles has risen since the inception of the treaty. Although these will not be discussed in depth here, the prominent issue is that discrepancies existed between the English and Māori versions of the document (State Services Commission, 2005).

Due to limitations in translation of language and cultural concepts, the Māori version, signed by *iwi* Chiefs, simply did not represent the intentions of the Crown as outlined in the English version. In accordance with *Te Tiriti o Waitangi*, referred here forth as the Treaty, the following points outline the agreement:

- Article 1: Gave governance to the Crown. Here, Māori gave the crown the complete government over their land. The term *kawanatanga* was used to determine this, instead of the more appropriate word of *mana*. Therefore, Māori do not always accept that Crown have full control over *tangata whenua*.
- Article 2: Gave Māori sovereignty or chieftainship. Here, Māori were guaranteed 'te tino rangatiratanga', translated as the unqualified exercise of their chieftainship over their lands, villages, property/ treasures.

- Article 3: Ensured equality and citizenship for all. Here, the Crown assured Māori would have the Queen's protection and rights equal to the British (State Services Commission, 2005).

Much work has been undertaken to advance the fair application of the Treaty. For example, principles of the Treaty were created in answer to the discrepancies between treaty versions, and in ease of application to policy (Kingi, 2007; State Services Commission, 2005). These principles are a representation of the spirit of the treaty. References to each can be found throughout government and scholarly health documents. The principles in their simplest form, pertaining to Māori health are:

- Partnership – Māori work in partnership with the crown.
- Protection – Māori well-being is protected and a commitment is guaranteed by the crown to ensure the health deficit is decreased.
- Participation – Māori are involved in all levels of the health sector from frontline health staff to policy makers (Kingi, 2007).

These principles are critiqued as overly-simplified. Health policies that refer to Treaty principles are viewed as insufficient in relation to addressing Māori health needs. It is argued that a Treaty specific health policy is needed for Māori to make true advances within the health sector. This can be augmented by using the Treaty as a framework for Health development. This would result in a change of the current funder-provider framework (Kingi, 2007; Lavoie, 2004).

Another issue found with Treaty implementation in health practice is with consistency. Māori groups are said to rely on enthusiasm rather than expertise in implementation of the treaty principles. As enthusiasm can

only go so far, these organisations seek external consultants. This has resulted in a clear variance in the implementation of Treaty matters across organisations (Masters, 2003). These points need to be considered given the well-being for Māori has not been attained as promised through the Treaty.

The Impact of Impaired Driving

Statistical data clearly illustrates the severity of impaired driving as a social issue within *Aotearoa*. Put simply, impaired drivers have caused significant rates of road death and injury. For instance, alcohol or drugs were a factor in 62 fatal crashes and 336 serious injury crashes in the year 2014 alone (New Zealand Transport Agency, 2016). In 2010, impaired drivers alone were responsible for the deaths of 142 individuals (Matua Raki, 2012). A blood sampling review spanning the years of 2004-2009 found that 48 percent of drivers killed in car accidents during this time, showed some level of alcohol in their blood with a total of 35 percent of those drivers having both alcohol and another substance present in their blood (NZ Police, 2010).

Based on data collected from 2002, Māori made up twenty-three percent of those involved in fatal car crashes (Ministry of Transport, 2013). Moewaka Barnes (2000) elaborates on this, explaining that Māori are overrepresented in terms of alcohol related car crashes resulting in both morbidity and mortality. For example, Māori made up eighteen percent of those involved in serious injury resulting from car crashes, and fourteen percent of minor injury resulting from car crashes (Ministry of Transport, 2013). Morbidity and mortality results in major implications for the individual and wider *whanau*. In terms of morbidity, individuals can experience a loss of quality of life and shift in life function to meet treatment needs and recovery time.

They also must consider “loss of work and productivity” (Matua Raki, 2012, p.31). The general well-being of the wider *whanau* is also greatly implicated when the life of a loved one is lost.

The impacts of impaired driving are not limited to injury and loss of life. From a financial perspective, impaired driving comes at a significant cost. For instance, the concept of social cost is predominantly used throughout impaired driving literature to indicate the economic impact of impaired driving accidents. It is defined as “a measure of the total cost of road crashes to the nation. It includes: loss of life and life quality; loss of productivity; and medical, legal, court, and property damage costs” (Ministry of Transport, 2013, p.1). The average social cost of just one fatal crash in *Aotearoa* is over \$3.850,000. A non-fatal crash resulting in serious injury averages at just over \$409,000 while one crash resulting in minor injury averages at just over \$21,000 (Ministry of Transport, 2013). Given the statistics, the societal and economic impact of drug and drunk drivers in *Aotearoa* is apparent.

Statistics and wider implications associated with impaired driving specifically pertaining to the Eastern Bay of Plenty area are scarce. Considering the geography and nature of open roads, the Eastern Bay of Plenty can be viewed as a high-hazard impaired driving zone for first time and recidivist impaired driving offenders. As of Monday 22 August 2016, a total of 22 road deaths had occurred in the wider Bay of plenty region since the beginning of the year (New Zealand Transport Agency, 2016). Those already identified as high risk drivers attributed to 34% of fatal vehicle crashes. Sixty-one percent of those crashes are linked to alcohol use.

According to the Ministry of Transport (2013), the Bay of Plenty region has the second highest rates of this occurring in New Zealand.

Drinking environment, location and source of alcohol consumption influence impaired driving (Usdan, Moore, Schumacher & Tabott, 2005).

This is can be projected to the Eastern Bay of Plenty. For instance, McCreanor, Lyons, Moewaka Barnes, Hutton, Goodwin, and Griffins (2016) found that for financial reasons, home drinking and pre-loading (drinking at home before clubbing) is common and this almost always involves people travelling to and from the home where the drinking is taking place. It is important to consider this in relation to the current study.

The Tūhoe Hauora service area consists of small rural towns where the nearest night clubs are between a 15 minute and 45-minute drive away.

Despite attempts at reducing these road-statistics, recidivism rates for impaired drivers in *Aotearoa* “appear to be increasing” therefore current approaches to solve the issue are viewed as “ineffective” (Matua Raki, 2012, p.9). According to the Matua Raki Impaired Driving guidelines (2012), alternative interventions to reduce these statistics are needed. But this is complex. Several factors are said to influence rates of impaired driving. These include learned family behaviours, social networks, rural positioning, legal drinking ages and other licencing and liquor outlet legislation (Ferguson et al., 1999; Huckle & Parker, 2014). It is therefore evident that addressing the issue commands a multifaceted approach from various government and non-government agencies.

Evaluation

My aim in terms of this section of the literature review is to ensure I have considered the issues and ways to mitigate issues that could implicate my evaluation. However, this is very complex given several evaluation paradigms need to be considered. These are mainstream perspectives, *kaupapa* Māori perspectives and how to best approach programmes administered by a *kaupapa* Māori organisation that are conceptualised from mainstream perspectives.

Kaupapa Māori Research Theory

It is argued that dominant research methods have “misinterpreted Māori understandings and ways of knowing by simplifying, conglomerating and commodifying Māori knowledge for “consumption” by the colonisers. These processes have consequently misrepresented Māori experiences, thereby denying Māori authenticity and voice” (Bishop, 1999, p.1). The way in which research was conducted, interpreted and narrated by westerners has skewed perception of Māori culture for both Māori and non-Māori (Bishop, 1999; Jones et al., 2006).

In response to the negative impact of western research approaches, academics forged a space to undertake research that validated a Māori world view. Academics argued that in accordance with *tino rangatiratanga*, Māori had the right to ascertain Māori world views, authority and control including reaching a point to which these world views become the norm (Moewaka Barnes, 2009). Here arose *kaupapa* Māori research theory.

Kaupapa Māori research theory is described as “the philosophy and practice of being and acting Māori” (Smith, 1992, p.1) whereby “Māori are defining

the process, doing the research for and about Māori, with the eventual outcome being meaningful to Māori” (Thompson & Barnett, 2007, p.1). As a philosophical framework, it has several different principles developed by differing scholars. These principles challenge the status quo to normalise Māori world views. Rather than go in depth of each principle, the following provides a brief snapshot of the *kaupapa* Māori principles as outlined by Smith (2003):

- Tino Rangatiratanga - the principle of self-determination;
- Taonga Tuku Iho - the principle of cultural aspiration;
- Ako Māori - the principle of culturally preferred pedagogy;
- Kia piki ake i ngā raruraru o te kainga - the principle of socio-economic mediation;
- Whānau - the principle of extended family structure;
- Kaupapa - the principle of collective philosophy;
- Te Tiriti o Waitangi – honouring the principles of the treaty of Waitangi; and
- Ata - the principle of growing respectful relationships.

The relevant aspect of *kaupapa* Māori theory here is that Māori self-determination is at the fore. Research epistemology lay in the idea that research should be based on mutual investment and transparency for benefit of Māori. Here is where the forming of *whanaungatanga* or relationships between the researcher and researched is viewed as integral in the success of *kaupapa* Māori practice. Unlike western approaches, the researched are the ‘knowers’ therefore subjective fields of inquiry are favoured. Participants

are viewed as key informants of research and drivers of interviews (Bishop, 1999; Masters-Awatere, 2015).

In terms of a practical research approach, Moewaka-Barnes summarises best practice within this paradigm as:

It covers: A respect for people; he Kanohi kitea (importance of meeting with people face to face); titiro, whakarongo, korero (looking and listening to develop understanding from which to speak); Manaaki ki te tangata (collaboration and reciprocity); kia tupato (being politically astute and culturally safe); kua e takahia te Mana o te tangata (don't trample the Mana of the people) and kia ngakau mahaki (being humble in your approach) (2009, p. 5).

It is important to note two points here. A *kaupapa* Māori research approach is one that is practiced by Māori for Māori. Second, *kaupapa* Māori research in its context of Māori development often corresponds with overcoming health deficit. On the contrary, *kaupapa* Māori practice aims at existing beyond the point of reaching equity as an infinite space for Māori to research and practice (Levy, 2007).

Accountability is dominant theme emerging across *kaupapa* Māori literature. Māori practicing within *matauranga Māori* have a unique accountability to stakeholders, *whanau*, *hapu* and *iwi* (Bishop, 1999; Masters Awatere, 2015). Given *kaupapa* Māori practice can only be undertaken by Māori, Māori researchers have a unique level of accountability not greatly explored, understood and experienced by non-indigenous academics.

However, assuming Māori are homogenous group, and all will respond to culturally embedded practice is somewhat risky, especially for those who have experienced enculturation (Durie, 2001). It is here that variances between cultural identity need to be acknowledged. Te Hiwi (2008, p.6) states, “Acknowledging the multiple realities of being Māori is a necessary part of the claiming of space, whether in psychological research or practice”. Accepting that Māori are not a homogenous group because of instances such as urbanisation and enculturation must be considered before determining best methods to research and practice by Māori for Māori.

Evaluating a Mainstream Programme

A good starting point to consider in discussion of evaluation is to define it. After browsing over several articles and books, I sought further investigation in to the *Aotearoa* New Zealand Evaluation Association (ANZEA) website given they are New Zealand’s leading evaluation body. In their introduction guide, evaluation is defined in its simplest form as “the systematic determination of the quality, value and importance of something” (Mc Kegg & King, 2014, p. 5).). That ‘something’ tends to be a programme, policy, organisation or initiative where health or social research is concerned (Davidson, 2005; Mark, Donaldson & Campbell, 2011).

Evaluation research differs to research in general, in that general research is conducted with aim to acquire new knowledge whereas evaluation looks at how “effectively existing knowledge is used in practice research” (Dahlberg & Mc Caig, 2010, p.16). Evaluation determines if something is good or not, evaluates how good that something is, and clearly justifies those conclusions

(McKegg & King, 2014). How these conclusions are made are context-dependent.

Evaluation is not a new phenomenon. We as human beings are natural evaluators (Davidson, 2005; Mc Kegg & King, 2014). For instance, we decide every day what products to buy. In this process, we weigh up usefulness, effectiveness, cost and quality in deciding what to buy and in justifying why we purchased it. In terms of research however, evaluation draws on theoretical frameworks and methodologies to achieve a piece of robust research that can conclude the value, quality and importance of whatever it is that is evaluated (Mc Kegg & King, 2014).

The key in any form of evaluation, whether this is research or through daily activity, is the process of determining value (Davidson, 2005). Programme evaluation then, is the systematic process of determining the quality or value of a set of coordinated activities that are designed to achieve beneficial outcomes for the participants (Davidson, 2005). Mc Kegg & King (2014, p. 13) quote the following as necessary process in undertaking robust evaluation practice. A good evaluation practitioner:

- Asks, answers and questions about the quality and value of things;
- Decides on what's important, in context;
- Gets to the heart of what quality and value mean for people - from different worldviews and perspectives, about the outcomes that matter, and the processes that contribute to these outcomes;
- Reflect and incorporate these 'values' in the criteria that are used to judge how 'good' the services, and outcomes, are;

- Gather a range of valid and credible evidence (qualitative and quantitative) about the thing being evaluated (the evaluand);
- Synthesise this evidence using evaluative reasoning to reach valid, defensible, unambiguous conclusions about the ‘goodness’ and ‘value’ of the evaluand;
- Present these conclusions explicitly so that the evaluative conclusion is transparent and open to challenge;
- Argue the case for the doing something useful with the results; and are
- Culturally responsive and competent.

Programme, policy and practice evaluation research is now very much influenced by social and community psychologies. This is said to be the resulting influence from Kurt Lewin who developed formative evaluation (Mark, Donaldson & Campbell, 2011). However, this was not always the case. Evaluation has developed from positivist paradigms therefore scientific, objective fields of inquiry were and continue to be favoured (Masters-Awatere, 2015). Masters-Awatere (2015) argues that given Māori are over-represented in health and social issues, Māori tend to be participants in Crown funded programmes and initiatives that are evaluated. Given the strong mainstream influence on evaluation measures and frameworks, evaluation measures tend to favour mainstream perspectives therefore unfairly measure stakeholders identifying as Māori.

Evaluating a Kaupapa Māori Programme

Nelson and Prilleltensky (2005) explain that research and analysis is constructed around its epistemological; the relationship between the researcher and the researched, and its ontological roots; the way the

researcher believes reality is constructed. It is within these philosophical boundaries that social researchers, such as those favouring *kaupapa* Māori paradigms, challenge dominant forms of knowledge in seeking ways to fairly evaluate indigenous stakeholders.

For instance, positivism and post-positivism practice within the ontology that one external reality exists therefore objective research methods are validated. Here the researcher takes a neutral stance separate of the researched (Nelson & Prilleltensky, 2005). Within these paradigms clinical and naturalistic sciences are founded as health was considered a physiological issue and health outcomes measures quantifiable (Masters, 2002).

Social constructionism on the other hand validates subjective forms of inquiry under the belief that the world is constructed of individual realities. Therefore, research methods are used to inquire the lived truths of the individual thereby favouring qualitative and subjective forms on inquiry (Nelson & Prilleltensky, 2005). Dominant forms of social knowledge stem from positivism and favour objectivity. Here in lies the issue in terms of effective evaluation research methods for Māori.

The devolution of services to DHBs and an increase in Māori health providers saw a need to evaluate Māori based organisations administering contracted health services. To receive funding and renew contracts, non-government organisations (NGO) needed to justify their decisions and measure health changes and service outcomes (Masters, 2002). Measures of health success therefore are expected to be quantifiable (Masters, 2002).

The argument from a Māori health perspective is that outcome and

accountability measures should be context specific as measures using a western lens is not a fair way to evaluate *kaupapa* Māori practice (Masters, 2002). Crown funded research and accountability measures have been more so often than not, financially oriented, favoured agendas external to the community being researched and were culturally blind (Bishop, 1999; Masters-Awatere, 2015). *Kaupapa* Māori practice on the other hand, as discussed earlier, places Māori self-determination and well-being to the fore. Essentially it is culturally embedded (Master-Awatere, 2015). The two views we have discussed exist at the extreme ends of the research spectrum. My question is, how do I go about evaluating an Impaired Driving programme, that is administered by a *kaupapa* Māori organisation but is conceptualised from a predominately mainstream lens? The following introduces the themes emerging from the literature that helped me decide my evaluation framework and approach.

Methodology

Māori evaluators experience dual roles when practicing between the two extreme spectrums (Masters-Awatere, 2015). Masters-Awatere states that “being caught between the two promotes cultural distress for evaluators when culturally normative practices are followed (p.282)”. Masters-Awatere’s argument for evaluation of Māori based programmes favours practice that can analyse and interpret from a Māori world view. But how can this be applied in the practical world?

Use of culture-friendly methodology was often an answer found in literature concerning indigenous research. Hoffman & Coffey (2008) for instance offer a simple answer to address evaluation of contracted services. Their

experiences researching the homeless concluded that “accountability measurements and statistical outcomes offer information about numbers served, but they do not contribute data on the quality of that experience” (2008, p.219). The researchers suggest qualitative measures should be used by policy makers to construct better ideas of the outcomes which are being experienced by those using funded organisations. Although this approach is limited, it is a starting point.

Frameworks

Use of appropriate evaluation frameworks was another way to look at how best to approach this evaluation. For instance, Moewaka-Barnes (2009) Māori evaluation manual was very helpful in introducing such frameworks. Frameworks such as He Taura Tieke: Measuring Effective Health Services for Māori and The Consolidate Earlier Experience, Holistic framework and Interactive (CHI) audit model were regarded as effective tools for evaluators working with Māori. Both frameworks are designed to ensure competence of the practitioner.

He Taura Tieke, developed in 1995 by the Ministry of Health, was designed with purpose to ensure technical competence of evaluation practitioners. This included the need for cultural safety, working within legislation, best practice guidelines, meeting contractual obligations and monitoring of procedures (Moewaka-Barnes, 2009).

The CHI, developed in 1993 by Mason Durie was similar in its framework with the difference being that it was specifically designed as a tool for cultural audit of provider contracts. Key features included “Māori development; health gains for Māori and Māori cultural beliefs and values,

and includes cultural safety and intellectual property rights” (Moewaka-Barnes, 2009, p. 7). The key theme in both models is that evaluators working with Māori for Maori must be competent culturally, ethically and legislatively.

Evaluator Awareness

Evaluator awareness is needed in evaluating a *kaupapa* Māori programme that is based on western terms. Penehira, Doherty, Gray & Spark (2008) discuss the importance of being aware of external contexts when engaging with Māori. For instance, a need to acknowledge that working within a by-Māori-for-Māori space is not isolated, but rather “exists in a context somewhere along the continuum of colonized *Aotearoa*, which exists in a Neoliberal world. We do not act in isolation of any of that “(p.5). This means Māori researchers need to be aware, accepting and navigate beyond the space of a Māori lens while working for Māori needs. This idea is extended by Masters (2015) who states (2015, p. 26):

In my view a critique of the context of colonisation and racism (within the broader context and critique of our history) is seriously lacking. The absence of such a critical lens has imposed a white hegemonic agenda of entitlement on Māori people that immediately constructs a deficit environment when applying evaluation measures.

Thus, in the construction of evaluation measures of Māori, the historical context needs to be considered and cognisant of power structures perpetuating adverse health upon that community.

Masters-Awatere (2015) explored the concept of cultural confluence. A culturally confluent researcher describes those who through their evaluator

role, navigate the dual worlds experienced by Māori evaluators. This is actualised by being a culturally engaged practitioner, using culturally appropriate evaluation frameworks, involving the people being evaluated, and ensuring the process contributed to positive Māori health outcomes. Māori evaluators were also found to be responsible, and at most parts expected by stakeholders to participate in Māori cultural processes such as *whaikorero*, *whanaungatanga*, *hui*, *waiata* and *karakia* on *marae* and through this, their work became increasingly accountable to those they worked with, especially so when stakeholder and evaluators shared *whakapapa*. Evaluators were also responsible to meet the same western expectations such as meeting contractual obligations.

Durie (2005) suggests Māori psychologists exist at an interface position, rather than extreme ends of *kaupapa* Māori research or science spectrums. The focus of the evaluator is primarily to bridge the divide between both worlds utilising knowledge from both paradigms for benefit of Māori.

Evaluator values

Acting for the benefit of Māori was the central theme in working with Māori. It seems a clear variance exists between practitioners' knowledge bases and what constitutes someone considered as an evaluator working by-Māori-for-Māori. Levy (2007) explained that some Māori researchers who faced a dual role did not consider themselves *kaupapa* Māori practitioners because they lacked fluency in *te reo Maori*, *tikanaga* and knowledge of *matauranga Māori*. From Levy's perspective, these people are still leaders of *kaupapa* Māori psychological practice given they are practicing in a way which improves Māori health and development. The researcher-held value

of wanting to benefit Māori health was equally pivotal as those working in culturally embedded paradigms. An effective way to practice the dual role is to ensure values are aligned with the want of Māori well-being.

Multi-levelled engagement with stakeholders

Moewaka Barnes (2000) promotes the concept of appropriate engagement with Māori. Her study was conducted with a Māori organisation in evaluation of a drunk-driving programme. The study was predominantly controlled by the Māori organisation being evaluated. Barnes (2000) found that the collaborative framework used, which ensured Māori stakeholders were involved at every level of the evaluation process, was the success factor to the study. In a later paper, Moewaka Barnes (2009) further states however, that “sometimes you cannot keep your integrity and please all parties. If this is the case, processes need to be in place to ensure that, even if there are differing views, each voice has an opportunity to be heard and considered” (p. 12). In terms of engagement, if Māori involvement cannot be reached at every level of the evaluation process, at the least, the evaluator must ensure stakeholder voice and needs are determined and clearly conveyed throughout the evaluation process.

It seems, regardless of who is evaluating a *kaupapa* Māori programme, the project will prove a difficult task. The best way to work within a dual role for Māori, is to practice in a way that ensures power structures are acknowledged, and Māori well-being is placed at the fore so as to contribute to Māori knowledge and development. The importance lay in using participant oriented research frameworks with open and collaborative relationships with Māori for Māori.

Chapter 3: Programme Background

Definition

An impaired driver refers to a person who drives a vehicle after consuming alcohol and or other drug substances while under the influence of those substances (Matua Raki, 2012; Waters, 2012). Drugs in this thesis refers to both illegal substances and over the counter medications that cause impairment. A recidivist impaired driver therefore, is the term used to describe a person who commits the offence of driving while impaired having previously been convicted of impaired driving in the past (Matua Raki, 2012).

Repeat impaired driving offenders are considered high risk drivers given they disproportionately contribute to road and driving trauma. They are more likely than first time offenders to be involved in fatal crashes, refuse breath alcohol tests, have high blood alcohol concentrations and are also more likely than others to drop out of impaired driving therapies (Lapham, Kapitula, C'de Baca & McMillan, 2006).

Effects of Substance Use

There is no shortage of impaired driving literature relevant to developed countries. International studies highlight that impaired drivers are becoming increasingly prevalent. This has become a substantial issue because alcohol and drugs affect the psychomotor and cognitive functioning needed for safe driving (Dubois, Mullen, Weaver, & Bedard, 2015; Matua Raki, 2012).

Effective psychomotor skills are needed for hand-eye and foot-eye coordination, reaction time and vision. Effective cognitive skills are needed for interpreting the traffic environment, making decisions, short term memory, vigilance, being able to multitask and most importantly, attention and concentration (Matua Raki, 2012). When alcohol or drugs are consumed by a driver, many of these skills are inhibited causing risky driving which has proven to lead to injury or death of road users.

How skills are affected by drug and alcohol intake vary across individual and are dependent on many variables. Research shows this includes but are not limited to the demographic, attitude, personality and behaviour of the individual driving (Ferguson, Sheehan, Davey & Watson, 1999). Research has further shown that those more likely to drive while under the influence of alcohol and drugs will tend to be:

- Male;
- 18-24 years;
- From a low socio-economic background;
- Single or divorced;
- In a blue-collar occupation;
- Have low education/literacy level;
- Have low self-esteem;
- Have low ability to deal with emotions (stress, anger, frustration, depression);
- Have a deviant attitude to alcohol;
- Have a criminal history; and
- Have a drug or drinking health problem, such as abuse or dependency (Ferguson et al., 1999).

Contrary to these denominators, literature also shows that impaired drivers tend to be heterogeneous, in that there is no one common factor other than substance consumption contributing to any one instance of impaired driving (Ferguson et al., 1999; Waters, 2012). Therefore, rather than delve in to the relationship between these influencers of impaired driving, I have chosen to illustrate the issue in terms of the most prevailing substances found in impaired drivers.

Prevalent substances

Alcohol was found to be the single most prevalent drug responsible for road injury and death in Canada, the United States and New Zealand (Dubois et al., 2015). This is a major issue given alcohol is readily available in communities; yet it drastically affects driving by slowing reaction times, causes an inability to multi-task, distracts and sedates the driver, impairs judgement and causes impulsivity (Matua Raki, 2012). It also increases driver risk taking (Laude & Fillmore, 2015). The extent that alcohol causes these effects varies depending on individual and alcohol intake.

International studies have found relationships between drinking characteristics and rate of drink-driving. These are described as a “range of demographic, lifestyle and criminal characteristics that predispose some individuals to the risk of drink driving” (Ferguson et al., 1999, p. 14). For instance, those who self-reported binge drinking once a month were five to six times more likely than others to drive while intoxicated (Zakletskaia, Mundt, Balousek, Wilson, & Fleming, 2009). Those presenting with high levels of hostility (Ferguson, 1999) and young males are also viewed as high

risk alcohol impaired drivers (González-Iglesias, Gómez-Fraguela & Sobral, 2015).

Similarly, cannabis is the most common illicit drug found in impaired drivers (Hartman, Brown, Milavetz, Spurgin, Pierce, Gorelick, & Huestis, 2016). It affects critical thinking, attention and cognitive performance. This is particularly evident in occasional users (Wright & Terry, 2002). In layman terms, this results in “slower driving, an increased tendency to drive below the speed limit and increased following distance” (Hartman et al., 2016).

The impact of cannabis use on road trauma is wide-reaching and varies between context and driver. Prevalence of cannabis impaired driving is influenced by socio-political factors. A study in the United States of America found increase in cannabis related driving accidents correlates with the legalisation of medicinal cannabis use (Hartman et al., 2016). In the *Aotearoa* context, research has shown that it is more likely than not, those who have consumed cannabis, also have alcohol present in their system (NZ Police, 2010). This is concerning given studies have found that those with both substances in their blood were more likely to make driving errors than those intoxicated by one substance alone (Dubois et al., 2015).

Substances other than cannabis and alcohol, although less studied, also contribute to road trauma by altering cognitive and psychomotor functioning (Matua Raki, 2012). The most prevalent drugs in *Aotearoa* include but are not limited to opioids, amphetamines, benzodiazepines and prescribed medication (Matua Raki, 2012). The impacts of these substances on drivers include an inability to pay attention to tasks, an inability to visually search

and scan, and an inability to estimate time and judge distance (Lococo & Tyree, 2010). However, like alcohol and cannabis, the extent to which these substances affect an individual depend on a multitude of personal, context specific and socio-political factors.

Countermeasures

Strategies to reduce impaired driving are categorised as general and specific interventions (Ferguson et al., 1999). General interventions are intersectoral and target the community where the behaviour is occurring; what would be considered macro-level intervention. This includes punitive measures, liquor licencing, drinking age restrictions and health promotion campaigns. Specific interventions are health focussed and include specialised therapy for those who are convicted of impaired driving (Ferguson et al., 1999). These would be considered micro-and meso level interventions. The following outline two of the most important generalised strategies currently employed in *Aotearoa* to address impaired driving.

Law enforcement

The New Zealand justice system ensures perpetrators are accountable by law for those driving while impaired. This began with the introduction of alcohol-limits in 1969 (Ministry of Transport, 2015). At present, the New Zealand Police are responsible for measuring alcohol limits using breath and blood measurement tests.

Breath tests “measure the number of micrograms of alcohol (mcgs) per litre of breath” whereas blood tests “measure the number of milligrams of alcohol (mgs) per 100 millilitres (mls) of blood.” (Health promotion agency, 2016). Tests are undertaken on those found to be driving carelessly, those in

an accident and through random checkpoints (Matua Raki, 2012). The current legal blood alcohol limit for driving in New Zealand is no more than 50 milligrams of alcohol for every 100mls of blood or 250mcg of alcohol per breath for those over 20 years of age. The Institute of Environmental Research website (2015) explain, in layman terms this is equivalent to three standard drinks over two hours for men and two standard drinks over two hours for women. For drivers under the age of 20, the limit of alcohol consumption while driving is zero (Ministry of Transport, 2014).

In 2009 an amendment was made to the Land Transport Act which made it illegal for people to drive under the influence of any drug on the roads in New Zealand (Matua Raki, 2012). This included driving while under the influence of prescription drugs (New Zealand Transport Agency, 2015). As a measure to regulate drug-drivers, the New Zealand Police were given the right to test those who were suspected of driving while influenced by a drug using an impairment test. An impairment test asks the driver to walk in a straight-line heel-to-toe, stand on one leg and includes pupil dilation assessment (Ministry of Transport, 2016). A blood sample is further required to examine the level of intoxication of those drivers who fail a drug impairment test.

Recidivist impaired drivers are commonly expected to attend an assessment centre, usually a contracted organisation, whereby counselling or other forms of therapy are undertaken (New Zealand Transport Agency, 2014) ahead of having their licence reinstated. In other circumstances, alcohol interlock suspensions are issued. Here, convicted drunk-drivers may only use vehicles that are fitted with an alcohol interlock device (New Zealand

Transport Agency, 2014). While punitive measures play a vital role in addressing impaired driver issues, health promotion and therapies also have their important place.

Advertising Campaigns

Health promotion activities vary across government agency and Non-Government providers(NGO) depending on audience and objective. The New Zealand Transport Agency (2016) have a prominent role here. The agency currently have several health promotion initiatives aimed at reducing instances of impaired driving. For example, ‘the thoughts campaign’ is a string of advertisements aimed at challenging ideas of driving while under the influence of marijuana. ‘The limits campaign’ is a drink driving advertisement aimed at resonating with those in their 30’s or 40’s who believe in sober driving but have developed their own limits on drinking and driving due to the lack of health promotion targeting throughout the 1990’s and 2000’s. ‘The legend campaign’ (New Zealand Transport Agency, 2016) is aimed at rural drivers which is where most high-risk impaired driver accidents occur. These advertisements aim at encouraging sober drivers to offer rides to those at risk of drunk-driving.

Best Practice for Impaired Driving Rehabilitation

An abundance of international literature exists ascertaining that intervention and community education programmes and therapies have positive impact on general recidivism rates (Love, 1999; Woodall, Kunitz, Zhao, Wheeler, Westerberg & Davis 2004). However positive outcomes are dependent on many factors. Meeting these factors will increase programme efficacy by

50 percent (Love, 1999) but this may vary depending on context.

According to Love (1999), these Factors include but are not limited to:

- how reconviction rates are defined;
- the type of programme;
- the follow-up period;
- the category of offence;
- the offender characteristics;
- the problems treated; and
- the programme integrity.

Programme integrity is described by Love (1999) as the key factor towards reducing recidivism. Programme integrity consists of adequate referral time; resources and facilities; qualified, experienced and trained staff; appropriate assessment, selection and matching of offenders to programme; programme design and structure, cognitive-behavioural principles and consistent delivery of the intervention.

Furthermore, continuity of care is a determinant of recidivism rates. As Walker states “a final challenge for many treatment services is providing suitable after-care, as once treatment is complete clients are rarely motivated to maintain contact and check-in with services” (Walker, 2014, p.14).

Alternatively, research has shown programme drop out is less related to programme content but most often attributed to lack of motivation, scheduling issues, and convenience (Maltzman, 2008).

In *Aotearoa*, addressing recidivism rates is pertinent for those identifying as Māori. This is because Māori are disproportionately represented in the justice and corrections system. For instance, a Department of Corrections

review of recidivism rates showed that within two years release from prison-based sentences, 41.6 percent of those Māori were re-imprisoned and 61.1 percent re-convicted. Similarly, within 2 years of starting a community based sentence, 14.1 percent of those Māori reviewed were re-imprisoned and 45.6 percent re-convicted (Department of Corrections, 2005).

Key concepts associated with effective impaired driving interventions very much reflect that of generalised recidivism therapies. This is effectively summarised by Maltzman (2008, p.107) who paraphrases the quote from Sir William Osler's aphorism which effectively describes how to best address impaired driving recidivism; "You must treat the person rather than the disease." If the needs of the participant are not met, impaired drivers will continue to drive while under the influence. Given impaired drivers present complex mental health and addiction issues, impaired driving therapists have many factors to consider in the screening, design, facilitation and implementation of impaired driving programmes.

Screening and Assessment

Screening refers to questionnaires that determine whether a drinking and drug problem exist. Assessment refers to comprehensive assessment undertaken if drug and alcohol problems are found to exist through the screening process (Waters, 2012). Studies propose that screening and assessment of impaired drivers prior to sentencing is necessary in assuring that appropriate modes of treatment are used to meet offender needs (Love, 1999; Mullen et al., 2015; Waters, 2012). This is because offenders need to be matched to their treatment for the treatment to be effective (Love, 1999).

The underlying issue here is that recidivist impaired drivers tend to present with drug, alcohol and associated mental health problems; more so often than not, co-existing problems exist (Freeman, Maxwell & Davey, 2011). Studies have found that when underlying substance and mental health issues are not addressed, the likelihood of impaired driving re-offending increases (Mullen, Ryan, Mathias & Dougherty, 2015). As Freeman et al., (2011, p. 39) conclude “the effective screening of the DUI population at the earliest practical point after apprehension would appear to provide a range of clear benefits at both an individual level as well as for the community in regards to road safety”.

The implication here is that two components are necessary to achieve appropriate assessment and screening. These are comprehensive assessment tools and experienced and qualified practitioners (Freeman, Maxwell & Davey, 2011). Assessment tools must be able to identify and predict potential risk and “appropriate cut points to define risk groups” (Ferguson et al, 1999, p. 9) whereas the facilitator must have the skill to interpret, analyse and apply this information effectively.

Cognitive Behaviour Group Therapy (CBT)

CBT therapy has many positive impacts for impaired drivers and health agencies. It is favoured by providers given it is cost effective and efficient (Matua Raki, 2012). However, the health impact CBT techniques have on impaired drivers are far reaching. For instance, impaired drivers become recidivists because of their low response to countermeasures which are found to work with the general population (Terer & Brown, 2014).

Practitioners have therefore become heavily reliant on CBT in addressing impaired driving statistics because CBT is particularly beneficial for

offenders who are considered recalcitrant and hard to treat (Quinn & Quinn, 2015).

Cognitive Behavioural therapy is described as brief psychotherapy with intent to teach participants adaptive coping mechanisms and strategies for managing the issues faced in day-to-day living (Quinn & Quinn, 2015).

CBT also helps address those with substance issues by helping them recognize that heavy drinking has negative impact on themselves and their *whanau* lives. This often leads to further substance focussed therapy.

An example of how CBT attributes to impaired driving recidivism is evident in the Back on Track (BOT) programme evaluation. The BOT programme utilised education cognitive behavioural therapy. The evaluation reviewed 22,277 follow up interviews that took place several months after programme commencement and assessed against substance use and outcome measures. The evaluation found that the programme had decreased impaired driving behaviours and implicated wider health outcomes in that many participants had decreased their consumption of substances, and the negative experiences associated with substance use. Many of those interviewed also reported becoming substance free (Stoduto, Mann, Flam-Zalcman, Sharpley, Brands, Butters, Smart, Wickens Ilie, & Thomas, 2014).

Studies have also found that incorporating motivational enhancement techniques and interviews in to impaired driving therapy has a positive effect on programme efficacy (Brown, Dongier, Ouimet, Tremblay, Chanut, Legault & Ying, 2012). Motivational enhancement techniques concentrate on the differing aspects of “motivation at various points along a continuum of behavior change. The MI approach has been developed to deal with the

resistance, ambivalence, and lack of objective self-assessment that are common, particularly among those in the earlier stages of behavior change” (Naar-King, Wright, Parsons & Frey, 2006, p.3). It is therefore used primarily to improve engagement with treatment especially for those presenting with complex issues (Matua Raki, 2012) by enabling them to identify their “personal strengths, balance the pros and cons of specific behaviours, and set goals for behavior change” (Hennessy & Tanner-Smith, 2016, p. 472). An example of its impact is in the study undertaken by Brown et al., (2012), who explored the effects of motivational interview sessions on those who were convicted of driving while under the influence. The study revealed that motivational interviews ahead of driving CBT helped address alcohol misuse issues. The factors of motivational enhancement found particularly beneficial in treating impaired driving are the facilitators ability to express empathy, being non-confrontational and developing discrepancy, rolling with resistance and supporting self-efficacy (Matua Raki, 2012). This is augmented by facilitators’ use of open-ended questions, affirmations, reflective listening and summarising themes arising from therapy (Matua Raki, 2012).

Significant social rewards have also been found for the participants through the use of CBT group sessions. The social impacts from such therapies are said to benefit overall well-being of participants. For instance, Maltzman (2008, p. 84) states:

A high level of sociality maintains a high level of endorphins. The neurochemical brain state in part determines behavior, which reciprocally modifies the brain state along with social behavior.

These results and their interpretation have obvious implications for

risk factors contributing to the development of alcoholism, and for its treatment and prevention.

Group therapy therefore has a substantial role to play in addressing social issues for recidivist impaired drivers. Social affiliation and support provided by group therapy augments a sense of comfort for its participants. This allows participants to become active members of group therapy by shared expression of their emotions. This reduces stress and improves emotional well-being (Maltzman, 2008). Participants also tend to maintain contact with one another following programme completion (Maltzman, 2008).

Another way participants become willing to contribute to group therapy is by connecting through a shared experience. Given participants have shared experiences, it is likely that they can talk in a way which will not cause peers to become defensive or resist participation (Matua Raki, 2012). This shared experience encourages others to participate in group based activities and learn through the process of a community of practice (Wenger, 2000). Community of practice is the term used to describe the social learning process which takes place within a community. Community of practice occurs through the processes of joint enterprise, where participants share an understanding of the group to contribute to it; mutuality, where all participants engage, interact and form trusting relationships with one another; and shared repertoire where the group develops their own language, tools and stories unique to that community (Wegner, 2000). When participants have spent some time together, they learn from one another, building social norms and identities, expecting each to become accountable

and contribute to learning within that community through direct social participation.

Shared experiences however do not always result in a positive outcome for programme participants. Research has found that antisocial people tend to 'find' antisocial peers resulting in and encouraging antisocial behaviour (Handwerk, Field, & Friman, 2001). When these people are grouped for therapy reasons, peers often promote deviant behaviours. This is referred as iatrogenic effects (Lochman, Dishion, Powell, Boxmeyer, Qu, & Sallee, 2015). Thus, group therapy is not always seen as best way to treat participant needs (Handwerk, Field and Friman, 2001). Studies by Handwerk et al., (2001) highlighted that for troubled youth, the use of normalized and family environments, constant positive interaction, close monitoring, treatment tailored specific to the youths need and opportunities for relationships building with facilitators can mitigate antisocial behaviours. However, Powell et al., (2015) believe ways to mitigate such issues happening are far too under researched. It is therefore pivotal to consider that these findings cannot be applied to wider groups of people.

Course structure is viewed as a moderator of impaired driving group programme efficacy. For instance, this is highlighted in Vaucher, Michiels, Lambert, Favre, Perez, Baertschi & Gache (2016) ten year randomized control impaired driving programme evaluation. The study showed that short 2 hour lectures over a long series, as opposed to day long programmes over a longer series decreases impaired driving recidivism by 25 percent. The limitation being, that the effects of short session programmes have little to no effect 2 years following programme commencement.

Matua Raki (2012) also consider relapse prevention planning as important role within CBT specifically for impaired drivers. This is supported by Wilson, Sheehan, Palk, & Watson (2016) who state, “planning plays an important role in drink driving rehabilitation and should be a focus of early intervention programs aimed at reducing drink driving recidivism following a first offense” (P.702). Wilson et al (2012) further explain that part of prevention planning consists of addressing self-efficacy as improved self-efficacy can reduce impaired driving behaviour.

Facilitation and Delivery

Facilitators are expected to ensure that programmes are well run, systematic and delivered effectively. These factors are said to moderate the success of programme outcomes (Hennessy & Tanner-Smith, 2016; Matua Raki, 2012). Facilitator ability is therefore viewed as having the foremost pivotal role in overall programme efficacy (Leafe, 2015; Sochting, 2014). For instance, client motivation is an indicator of quality facilitation (Leafe 2015). Although motivation has previously thought to be a personality trait, research has proved otherwise. Those facilitators who are able to show empathy, built rapport and believe that change is possible for the client are said to improve client motivation. Motivation is particularly important because it directly leads to programme efficacy (Leafe, 2015). This applies even for those groups under treatment by coercion in accordance with court order. I need to add here that facilitator responsibilities are wide reaching. These are explored in other areas of best practice.

Cultural Competence

Culture is especially important in psychology because of its influence on behaviour (Ebbett & Clarke, 2010). However, mental health and addiction

practice has in the past, sat within a mono-cultural approach (Lee and Khawaja, 2013). This narrow lens failed to understand clients' needs therefore practitioners' ability to appropriately address client needs in a safe and respectful manner.

As developmental Psychology grew, discourse began to argue that practitioner cultural awareness is needed to identify the history, needs and strengths of those they are working with (Sternberg, 2014). Cultural competence ensures practitioners in any one field, have the skills to work with diverse cultures. For instance, The New Zealand Psychologists Board standards for Psychologists Registered under the Health Practitioners Competence Assurance Act (2003) ensures professionals practice in a culturally safe manner while also meeting obligations as outlined in Te Tiriti o Waitangi³. The Board explains:

Cultural competence is defined as a having the awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds. Competence is focused on the understanding of self as a culture bearer; the historical, social and political influences on health, in particular psychological health and wellbeing whether pertaining to individuals, peoples, organizations or communities and the development of relationships that engender trust and respect. Cultural competence includes an informed appreciation of the cultural basis of psychological theories, models and practices and a

³ Refer Te Tiriti o Waitangi in the Māori Health Deficit section of the literature review.

commitment to modify practice accordingly (The New Zealand Psychologist Board, 2011, p. 4).

The Nursing council of New Zealand, The New Zealand Association of Counsellors and the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) also reference the need for responsive cultural practice that upholds cultural *mana* and identity of clients. This includes the use of culturally safe frameworks of health and practice. Its relevance to impaired driving therapy is therefore apparent. Those administering Government contracts will need to ensure they are registered and practicing in alignment with an appropriate registration body whose ethics and competencies ensure cultural competence and ability to practice in a manner cognisant of New Zealand's diverse society and importantly, the Treaty of Waitangi.

Addressing the Coercion Issue

Impaired driving treatments are often court mandated. This is considered coerced therapy participation. Given participant drop-out of interventions is a major issue for all facets of therapy (Love, 1999), coercion can have a large role to play in ensuring recidivists seek help and participate in a full-course of intervention (Gustafsson, Nyberg, Hrelja, Samhälle, 2016). It does however have its downsides.

Coercion has been critiqued in reference to ethics and whether it affects programme efficacy (Leafe, 2015). For instance, In the USA, a Driving Under the Influence (DUI) Intensive supervision programme was created to address impaired driving recidivism (Lapham, et al., 2006). These therapies consist of “close supervision of offenders, extended judicial monitoring and

involvement, emphasis on treatment, and the requirement of sobriety” (Lapham et al., 2006, p. 163). A trial was undertaken to assess what components worked best in addressing recidivism for those who undertook the programme. The results showed that enrolling in the programme rather than attending per court mandate reduced re-arrest statistics by 48 percent. The issue here is that most Impaired Driving participants do not have the luxury of choice.

The experiences of court mandated community treatment orders of both Māori and non-Māori in Māori mental health services was explored by Newton-Howes, Lacey, & Banks (2014). They concluded that Māori experiences were no different to non-Māori however it may prove beneficial in allowing Māori to “self-select between mainstream and specialist Māori mental health services” (Newton-Howes, Lacey, & Banks, 2014, p. 267) in reducing negative aspects of treatment by court order for Māori. It also suggested treating people on an individual needs basis rather than by ethnicity basis.

Some practitioners are reluctant to work with those mandated to treatment because coerced individuals tend to be annoyed and angry for having to attend and therefore cause significant challenges affecting programme efficacy (Matua Raki, 2012). This is important to consider because facilitators are the critical factor in addressing the relationship between participant coercion and programme efficacy. For instance, internalisation of issues is a major process towards behaviour change in therapeutic programmes. For those undertaking a treatment order, a key of successful programme outcomes is to encourage internalisation of motivation which is particularly difficult where coercion is concerned. If motivation is

externally driven say by court order, it is highly likely that the client will not continue with treatment if given a choice. If the facilitators can internalise motivation it is highly likely the client will continue attending the programme without force. Internalising motivation leads to reaching programme outcomes and increased programme efficacy (Leafe, 2015).

Impaired Driving Evaluation

Impaired Driving evaluations are often measured using recidivism rates to assess effectiveness of an intervention (Ferguson et al., 1999; Waters, 2012). Given intervention is only one of many factors contributing to recidivism, this as a measure may not reflect actual effectiveness. From a mainstream perspective, it is therefore suggested that a mixed method approach is used to mimic best practice in evaluation of a mainstream impaired driving programme (Walters, 2012). This is because, from a mainstream perspective, previous impaired driving evaluations are characterised by methodological issues raised from a lack of control groups and ethical considerations (Ferguson et al., 1999; Waters, 2012). This is further supported by Walsh, Verstraete, Huestis & Morland, who state (2008, p.1258)

A major problem in assessing the true public health impact of drug-use on driving and overall traffic safety is that the variables being measured across studies vary significantly. In studies reported in a growing global literature, basic parameters assessed, analytical techniques and drugs tested are simply not comparable due to lack of standardization in the field. These shortcomings severely limit the value of this research to add knowledge to the field.

This was evident in the evaluation of the Impaired Drivers programme delivered through the Welsh and English probation services (Palmer, Hatcher, McGuire, Bilby & Hollin, 2012). The evaluation highlighted that reconviction rates were determined by programme completion. However, their evaluation model showed limitations in that pre-treatment differences and randomization of participants were not controlled. Such shortcomings are said to be a result of budget, time issues and limitations which are set by ethics and hospital committees (Walsh et al., 2008). Walsh et al., 2008 proposed an international guideline of impaired driving based on the work from the International Council on Alcohol, Drugs and Traffic Safety's (ICADTS) working group on illegal drugs and driving. Here, a total of 136 recommendations as how to approach the epidemiology, behaviour and toxicology aspects of impaired driving were made. These recommendations were reviewed for purpose of this evaluation.

The Programme

The Impaired Driver Treatment Programme

Several impaired driving specific interventions are available throughout *Aotearoa*. According to Waters (2012) these include but are not limited to:

- the Ashburton Driving While Impaired Programme;
- the Drink Drive Programme;
- the Drive Soba Programme;
- the Driving Forward / On the Road programme;
- the One for the Road programme;
- the Stopping Drinking and Driving Programme;
- the Repeat Drink Driving Interventions Programme; and

- the Right Track programme.

The ‘specific intervention’ focussed in this paper is the Impaired Driver Treatment programme. The Impaired Driver Treatment programme is an initiative established by the Ministry of Health to address the needs of repeat offenders convicted of driving while impaired by alcohol and other drugs (Matua Raki, 2012). Participation in the Impaired Driving programme is compulsory for those who aim at having their licences reinstated due to becoming disqualified drivers in accordance with section 65 of the Land Transport Act 1998.

Section 65 of the Land Transport Act “relates to mandatory penalties for repeat offences involving the use of alcohol or other drugs” (Ministry of Health, 2006, p.1). Those sentenced under section 65 are court-ordered to attend an assessment centre and are disqualified from holding a licence for a minimum of one year and one day. The programme may also be mandatory as determined by court order for first time offenders who present excessive, such as twice the legal limits, of breath alcohol measures (Matua Raki, 2012).

The initiative is delivered by various organisations throughout New Zealand through the funder-contract system. The Ministry of Health offer two strands of programmes aimed at meeting the needs of impaired drivers. These are therapeutic and education programmes. Education programmes are used to introduce impaired driving therapies using motivational enhancement techniques (Matua Raki, 2012). These programmes seek to educate and challenge first time offenders to think critically about alcohol and drug use in the context of participant lives specifically pertaining to

driving behaviours. This is based on the idea, that some offenders lack the knowledge needed to make best driving decisions (Ferguson et al., 1999).

The second programme types are structured psycho-social interventions. These sessions also use motivational enhancement techniques with the incorporation of cognitive behavioural strategies and relapse prevention planning for purpose of addressing underlying causes of impaired driving behaviours (Ferguson et al., 1999; Matua Raki, 2012).

Therapeutic programmes are delivered for approximately four hours, once weekly over a period of ten weeks. Groups consist of 12 or less individuals (Matua Raki, 2012). Therapeutic group interventions are used to address the behaviours of those considered as serious first time and recidivist impaired driving offenders. This evaluation is aimed at studying a therapeutic programme which is referred here forth as the Impaired Driving programme.

The Impaired Driving initiative is designed around the Ministry of Health's (2013a) aim to "reduce the harm from alcohol and to address the drivers of crime" (p. 60). Possible outcomes are projected to:

- challenge justifications of driving while under the influence of drugs and alcohol;
- address some of the myths about driving while impaired;
- address antisocial attitudes;
- address weak problem solving skills;
- address low self-control;
- address impulse behaviours; and
- address substance abuse (Ministry of Health, 2013a, p. 60).

The overarching expected outcomes of the programme as outlined by the Ministry of Health are far more general to meet the variation between the programmes that are delivered throughout New Zealand. The Ministry of Health (2013a, p. 61) overarching aims for Impaired Driving programmes are to:

“Provide offenders with relevant intervention services, based on their specific needs” to:

- 1) Eliminate participant drinking driving behaviour.**
- 2) Reduce participant consumption of alcohol and other drugs.**
- 3) Encourage participants to lead active, productive and safe lives amongst their communities.**

Course content and structure is designed by the Impaired Driving programme contractor. Impaired driving programmes are expected to be flexible to meet the requirements of programme participants. Matua Raki (2012, p.23) recommend that “all interventions need to be responsive and paces to the needs of participants and their particular characteristics, taking in to account the severity of alcohol and substance use problems and any co-existing problems”. This means that comprehensive assessment ahead of accepting participants to the programme as well as designing course content specific to participants are of importance.

The Ministry of Health offer a treatment guideline designed by Matua Raki (2012) that can be used by contractors to create a unique programme whilst adhering to contract specifications. A proposed programme outline is submitted by potential contractors during the Request for Proposal (RFP) phase. The methods, content, structure, facilitator experience and wider

organisational policies and procedures are considered by the funder ahead of awarding the contract.

Ngai Tūhoe and the Crown

Each *iwi* has their own experiences of colonisation (Rochford, 2004). I chose not to go in to depth here for Ngai Tūhoe, for feeling as though I am the wrong person to be retelling the stories of Ngai Tūhoe due to my limited knowledge of *iwi* history. I do believe however, that it integral to briefly acknowledge the major events that characterised the oppression experienced during Ngai Tūhoe interactions with the Crown.

Ngai Tūhoe are an *iwi* situated in the Eastern Bay of Plenty. They were one of few *iwi* who did not sign the Treaty of Waitangi. Because of this, their involvement with the Crown occurred much later than other *iwi* during the colonisation period. However, the Crown's want for Tūhoe land later impacted the *iwi* drastically. Relations with the Crown have since been marked by injustice and oppression. For instance, following the battle of Ōrākau (a battle site in Waikato), 1864, Tūhoe land was confiscated after the *iwi* was wrongly accused of being in rebellion to the Crown when a missionary was killed in Ōpōtiki (Mc Garvey, 2005).

In 1916, armed forces raided Maungapohatu (the sacred mountain of Ngai Tūhoe) in seek of Rua Kenana (a famous Maori prophet) which saw a battle between Tūhoe and the Crown take place (Mc Garvey, 2005). The Crown used a scorched earth policy and sought to kill anyone who stood by Rua Kenana, perceived to be Tūhoe as a whole. *Kāinga*, cultivation, food stores and livestock were targeted and destroyed and consequently, further Tūhoe land was taken by the Crown.

More recently, in 2007, anti-terror raids were executed throughout New Zealand. An estimated 300 police and members of the armed forces were involved in the raids. Police claimed Tūhoe activist Tame Iti was running a military-style training camp in the Te Urewera Ranges in an attempt to establish an independent Tūhoe state. Homes and school buses of Taneatua and Ruatoki residents were raided at gun point (Ministry of culture and Heritage, 2016).

Despite apologies and compensation from the Crown, these events have had a lasting and traumatic collective effect on Ngai Tūhoe. Ngai Tūhoe have however shown resilience and are on their way to seeking some justice. In 2012 an agreement was made between the Crown and Ngai Tūhoe, promising that the *iwi* could reclaim Te Urewera national park, and be given one of three largest Waitangi Tribunal settlement claims by any one *iwi* in *Aotearoa*. This has enabled the *iwi* to construct an approach to *iwi* development specific to the needs and aspirations of Tūhoe people; ascertaining *Mana Motuhake o Tūhoe*. While I was working with Tūhoe Hauora the Tūhoe *iwi* authority were amid constructing Te Kura Whare (the Tūhoe Iwi Authority building) in Taneatua. The building is the hub of Tūhoe development where the work of those striving for *Mana Motuhake* takes place.

Tūhoe Hauora

Rākeiwhenua Trust, trading as Tūhoe Hauora, is a *kaupapa* Māori addictions, mental healthcare and advocacy provider situated in the small rural town of Taneatua, Eastern Bay of Plenty. Although not *iwi* driven, Tūhoe Hauora represent various *hapu* of Tūhoe. Most Tūhoe Hauora

services are delivered in client homes or other community settings such as *marae* and other places important to Tūhoe *iwi*.

Tūhoe Hauora is funded by various government bodies and offer services using a referral process. At the time of my research, the majority of Tūhoe Hauora contracts were held with the Bay of Plenty District Health Board (BOPDHB) and the Ministry of Health (MOH). However, contracts with other Government departments also shaped the services which were delivered. The services which were offered by Tūhoe Hauora at the time of research, through these funders included:

- Whānau, Consumer, Alcohol and Drug Advocacy and Support.
- Alcohol, Drug and Co-Existing Disorder Counselling.
- Early Intervention Services.
- Mental Health Adult Planned Respite.
- Social Workers in Schools.
- Incredible Years Parenting Programmes.
- *Tane* and *Wāhine Tikanga* Programmes.
- Impaired Driver Treatment Programmes.

The organisational mission of Tūhoe Hauora is to improve the holistic⁴ well-being of Tūhoe *iwi* and those residing within *Te rohe potae o Tūhoe* (Tūhoe Hauora, 2013, p.3). The organisation is underpinned by the principles of *whakapapa*, *mana*, *māuri*, *tikanga*, *tapu* and *wairua*. The overall vision of Tūhoe Hauora is *Tihei Mauri Ora* (Tūhoe Hauora, 2013).

⁴ Refer to Chapter 2, Definition of Health, for the definition of holistic well-being.

Organisational practice is heavily influenced by the *kaupapa* of the organisation, with *karakia*, *inoi*, *manaakitanga* and *whānaugatanga* framing daily practice (Tūhoe Hauora, 2013). The organisational philosophies place service users as equal with health practitioners, where health improvement is viewed as determined by a wider social collective. In this context *whanau*, *hapu* and *iwi*, friends, co-workers and other health service groups are considered contributors of well-being. Service-users are encouraged to define unique personal views of well-being and are supported to reach this goal alongside this social collective. Furthermore, majority of the 20 staff who were employed by the organisation at the time of evaluation were of Tūhoe decent and *Te reo Māori*-first-language speakers whose individual beliefs and backgrounds reflected the principles that underpin the organisation.

The Tūhoe Hauora Impaired Driving Programme

Tūhoe Hauora were awarded a two-year contract to provide the Impaired Driving programme for residents of the Eastern Bay of Plenty in March of 2013, after a tender submitted in response to a RFP was accepted by the Ministry of Health. The Impaired Driving programme was proposed to be facilitated by the current General Manager, ‘Pare⁵’ and previous Clinical Team Leader, ‘Tama’. Both facilitators held extensive professional backgrounds in the fields of management, programme facilitation, social work and counselling. They also had worked for the Hauora for many years, were DAPAANZ accredited and had become well-known and respected amongst professionals and people residing within the Tūhoe Hauora service area.

⁵ Pseudonyms are used to protect anonymity of programme facilitators.

The Impaired Driving programme design that was proposed to be delivered by Tūhoe Hauora was an adaptation of the mainstream Impaired Driver treatment programme guide. The Tūhoe Hauora course structure was developed by the previous General Manager during the RFP phase.

According to the facilitators, as courses progressed, programme design was evolved to adapt to the requirements of course attendees. This meant Tūhoe specific elements of the programme changed over courses. Of importance to note, was the implementation of a full-day first aid course which provided attendees with a first aid certificate, Waka ama/canoeing (which was sometimes omitted with a confidence course programme), lunch and refreshments, *karakia* and implementation of programme *tikanga* determined by participants. Table 1 outlines the draft proposed course structure used to form the organisation's first cycle of the programme.

Table 1: Tūhoe Hauora Course Structure

WEEK	THEME
1	<ul style="list-style-type: none"> • <i>Whakawhanaungatanga</i> – Getting to Know One Another • Developing a Working Culture, Developing <i>Tikanga</i> & expectations • Programme outline, structure & timetable • Consents
2	The change process, barriers to change and supports to change
3	Waka Ama/Canoeing (subject to change)
4	NZ Police, Facts and Affects, <i>Te Whare Tapa Whā</i>
5	First Aid Course (all day provided by external agency at a location yet to be determined)
6	Thinking styles, ABCDE, understanding thoughts, urges and cravings, breathing exercise
7	Mood regulation, problem solving, SOLVE
8	Communication, resolving conflict, conflict style
9	Planning for safe driving, relapse prevention, What if? Where am I now?
10	<i>Poroaki, kai</i> , presentations & certificates

The implication here is that Tūhoe Hauora were considered the expert in addressing stakeholder health for their region thus course content incorporated the unique philosophical principles that underpinned Tūhoe Hauora practice. Facilitators however, were not involved in developing a measurement tool to assess the effectiveness of their unique programme for the Ministry of Health Impaired Driving evaluation (personal communication) which was rolled out over providers administering the programme between 2014 and 2015.

The programme design had no documented programme logic. For facilitators, success was informally assessed in participants' ability to share

korero during class about the effects that drugs and alcohol can have on a person when driving. Facilitators also considered it successful if the learnings and experiences from the programme impacted participant overall well-being in alignment with the mission of Tūhoe Hauora. Although facilitators had witnessed all participants contribute to session *korero*, documentation of this lacked. Furthermore, facilitators were not able to assess if participant knowledge and experiences gained from the programme impacted participant well-being in the context of their day-to-day lives post-programme.

The Hauora deliver two courses per year, a total of four courses per two-year contract. This evaluation focuses on their fourth delivered programme. The programme evaluated was predominantly held mid-week at the Department of Corrections, Whakatane. Transport to and from the venue was available to those who lived rurally using a Tūhoe Hauora van. Facilitators were responsible for the pick-up and drop off programme participants.

The Tūhoe Hauora Impaired Driving programme participants were referred by the Department of Corrections. Those referred underwent a comprehensive drug and alcohol assessment with the Clinical Team leader, Tama, ahead of registration to ensure eligibility and suitability of participants to the uniquely designed Tuhoe Hauora programme. Given majority of participants were also undergoing home detention and community service sentences, facilitators were also responsible for closely liaising with the Department of Corrections when the programme impeded on home detention or other court ordered restrictions.

Evaluation questionnaires were offered to participants following each course in alignment with Tūhoe Hauora quality improvement policies and Ministry of Health contract requirements. Previous survey results indicated general participant satisfaction and an intent for participants to improve driving, drug and alcohol related behaviour. The general assumption was that Tūhoe Hauora were achieving to some extent, the core expected outcomes which were set by the Ministry of Health. The feedback gained from this method of data collection was however limited in its ability to provide programme facilitators with in depth information in a way that captures, organises and evaluates the programmes ability to influence healthy change, using methods that respected the lived experiences of participants and acknowledges the practice of Tūhoe Hauora.

Evaluation Rationale

A core value influencing staff practice is the re-establishing of *Mana Motuhake o Tūhoe* (personal communication, 2013). *Mana Motuhake* drives how Tūhoe approach their well-being. It is exercised in the way staff empower their people towards a healthier lifestyle and the way in which Rākeiwhenua board determine the direction and future of Tūhoe Hauora.

Mana Motuhake o Tūhoe was closely examined by Williams (2010, p.27) who explains “For Tūhoe, *Mana Motuhake* has connotations of unique power and authority, freedom, liberty, nationhood, self-determination and independence that are inseparable from *Tūhoetanga*”. Not to be mistaken for *tinorangatanga* which holds connotations of self-determination from a *pakeha* perspective, Williams (2010) research defines *Mana*

Motuhake as taking responsibility for one's own freedom and liberty, understanding the costs and accepting those costs in seek of prosperity and in mitigation of poverty, ignorance and powerlessness. Thus, although Tūhoe Hauora contracts determine the services delivered, the way in which staff approach their work is shaped by their drive for *Mana Motuhake*. Herein lies the issue. *Mana Motuhake o Tūhoe* and the contract system which fund the organisation are based on conflicting conceptual frameworks.

Mana Motuhake is a by Tūhoe for Tūhoe approach which is difficult for the organisation to attain when it is dependent on government funding. Contracts offer promises of partnership in alignment with *Te Tiriti o Waitangi*. However, Masters-Awatere (p.38) states “where the government, as one party, has the ability to withhold resources (such as funding) and dictate the terms of the relationship then it is not an equal partnership”. The nature of health and health practice is therefore navigated by the management and governance of Tūhoe Hauora whereby the objective money focused needs of funders are juggled with unique Māori health needs and aspirations of Tūhoe. For example, Tūhoe Hauora are subject to a strong accountability culture perpetuated through reporting procedures, external audit and review driven by New Zealand's health funding system. The organisation is audited every three years against its contractual requirements and is subject to regular reporting requirements. Most commonly, audit is undertaken through Healthshare who assess the organisation against MOH contractual obligations and New Zealand Health Standards which are predominantly conceptualised from western health

frameworks. For the purpose of credentialing and competition for funding, the organisation is also accredited with the Designated Audit Agency (DAA) group who assess against Equip standards where they “address the essential elements of quality care across the organisational functions integral in supporting the provision of care” (DAA group, 2013). Both audit types work on a system that does not fully reflect organisational practice or a Māori world view, let alone reflect practice by those who nurture *Mana Motuhake*. This is an issue that Tūhoe Hauora management face daily. Systemically, they have little opportunity to have their practice analysed in a way which best captures, documents and disseminates the voice of those using and administering Tūhoe Hauora services.

This evaluation aims to bridge this gap by providing culture and context appropriate evaluation services of Tūhoe Hauora practice for Tuhoe Hauora. The rationale behind this project mimics the objectives of indigenous psychology as described by Nikora (2007, p.85) which is to evaluate Tūhoe Hauora using methods that are “culturally relevant and sensitive to indigenous peoples”. In this case, I am aware that a united Māori identity is one which has arose out of need (Durie, 1998) therefore meaning I need refine who the indigenous in my project are.

A good example of this lay in the quote by Tūhoe leader John Rangihau presented by Durie (1998b). Rangihau found it difficult to identify with a united Māori cultural identity. He believed that this was an attempt to unite Māori “by the *Pakeha* to bring the tribes together. Because if you cannot divide and rule, then for tribal people all you can do is unite and rule”. In reference to a united Māori culture he further states “Although these

feelings are Māori, for me they are *Tūhoetanga* rather than my *Māoritanga*” (in Durie, 1998, p. 55). I have therefore chosen to evaluate Tūhoe Hauora using methods culturally and *iwi* sensitive to Ngai Tūhoe. This means, Tūhoe Hauora management, programme facilitators and programme participants steer the direction, terms and framework of this evaluation.

Evaluation Purpose

This evaluation is formative in nature. Its purpose is to explore the lived experiences of programme participants in the context of a Tūhoe Hauora Impaired Driving course. This information is used with aim to acknowledge the health contributions the programme had made to those participant’s lives, to highlight areas in need of improvement and provide suggestions for improvement so that the organisation can meet both the mission of Tūhoe Hauora and the Ministry of Health Impaired Driving contractual requirements.

Evaluation Objectives and Measures

1) Identify key health outcomes for programme participants

This evaluation draws on both the overarching aims of Tūhoe Hauora and the Ministry of Health expected outcomes as per contract requirements.

Health will therefore be analysed by reviewing if:

- a. Participant drinking and driving behaviour is eliminated (Ministry of Health)

- Measured by reported recidivism during and post-programme to time of interview. Zero accounts of drinking and driving behaviour during this time is considered a good result.
- b. Participant consumption of alcohol and other drugs is reduced (Ministry of Health)
 - Measured by reported consumption during and post programme up to time of interview compared with reported consumption pre-programme. A good result here is undefined as measures are case specific.
- c. Participants are encouraged to lead active, productive and safe lives amongst their communities (Ministry of Health)
 - Measured by reported increase of social participation during and post-programme up to time of interview. A good result here is undefined as measures are case specific.
- d. Holistic well-being is improved (Tūhoe Hauora organisational mission)
 - Measured by reported increase/decreased in mental, spiritual, physical and social well-being during and post-programme up to time of interview. A good result here is undefined as measures are case specific.

2) Determine programme factors contributing to participant health outcomes

The following questions are considered in analysing this objective:

Ministry of Health programme purpose:

- Were offenders provided appropriate intervention services?
- Was the programme based on their specific needs?

Tuhoe Hauora specific:

- What role did the values of Tūhoe Hauora play in health outcomes?
- What Tūhoe Hauora methods and techniques attributed to health outcomes?

3) Identify key areas of the programme in need of improvement

In this section, I consider the following questions:

- What were the shortfalls in the participant needs being met?
- What were the shortfalls in contract requirements being met?
- What were the shortfalls in the participant's holistic needs being addressed?
- What could be improved for further positive programme experiences?

4) Provide practical suggestions towards areas in need of improvement

Chapter 4: Methodology

Introduction

The first draft proposal created for this evaluation was presented to programme facilitators late 2014. The proposal was based on the assumption that the Impaired Driving contract would renew in to its third year. This would allow for a process evaluation to take place using in-course participant observation and casual conversation methods supplement to *kanohi-ki-te-kanohi* interviews and survey forms. Data collection was proposed to begin during the first 2015 Impaired Driving session.

Upon presenting the proposal, I was informed by programme facilitators that the programme was not being renewed. Thus, the evaluation was quickly re-framed to research the programme in retrospect which is when ethics approval was sought through Waikato University.

At the time, the Ministry of Health were amid an Impaired Driving evaluation across treatment providers within New Zealand. I wanted to ensure my research did not emulate that by the Ministry of Health. I chose to focus within a critical community paradigm of psychology evaluating health outcomes using research methods which worked against generalisability and towards exploring information within a specified context.

My positions at the Hauora gave me unique access to many informal hui with both the General Manager and Clinical Team Leader that allowed us to plan the evaluation framework using a fully committed partnership approach. When I resigned from these positions later in 2014, I was invited to continue using computers, printers and interview rooms in support of the

research. This allowed me to continue gauging the support and input from programme facilitators throughout the data collection process on an as needed and informal basis.

Despite the organisation's preparation to cancel the Impaired Driving programme, mid-way through 2015 Tūhoe Hauora were notified that the Impaired Driving contract would be renewed through to its second cycle. At the time, the Hauora were amalgamating with another Eastern Bay of Plenty Māori health service provider. This resulted in an increased workload for previous facilitators. Previous facilitators stepped down from their roles allowing other staff to take on the facilitation of the renewed programme. At the time of writing, Tūhoe Hauora were continuing with their renewed contract for those residing in the Eastern Bay of Plenty.

Phase 1: Planning and Review

Approach

Dominant social science research methods are clear in their criteria for producing robust research frameworks. Research methods must meet the criteria of reliability, replication and validity (Bryman, 2004). Given my value laden position and considering the above criteria, researchers who favour positivism or objectivity may find my evaluation design contentious. I therefore believe it integral to discuss my approach to the evaluation.

I draw from the discipline of community psychology for this evaluation. Community psychology practices with the goal to “construct knowledge that challenges the societal status quo and is useful for the liberation of oppressed groups and the promotion of well-being for all” (Nelson & Prilleltensky, 2005, p.236). In consideration of Māori health deficit and

transformative change, I believe community psychology values best to analyse a Tūhoe driven, kaupapa Māori impaired driving programme.

Community psychology attunes to issues of power and oppression using an ecological perspective (Nelson & Prilleltensky, 2005). The ontological position of this project therefore meant that I approached evaluation with the idea that an external reality exists that is constructed of power structures that has caused oppression and health deficit. Health deficit, historical and socio-political factors are therefore considered in discussing the overreaching outcomes of the Impaired Driving programme. Furthermore, this meant I saw it as my role of evaluator to “question what is the fundamental nature of current practices and question whose interests these practices serve” (Bishop, Dzidic, & Breen 2013, p.2). This was achieved through “authentic collaboration with local people and the places they inhabit . . .co-construct knowledge and . . . bringing indigenous knowledge at the centre” (Watkins & Ciofalo, 2011, p.11). I attempted this using context and culturally appropriate methods of inquiry. I have therefore favoured social constructivism (Nelson & Prilleltensky, 2005) thereby validating stakeholder voice and opinion which is the underlying approach framing my methods of inquiry and evaluation framework.

Critical community psychology is value driven and begins with a value position (Nelson & Prilleltensky, 2005). For instance, Sheldon & Wolfe (2015, p.89) state “when a community psychologist conducts an evaluation, they are not value neutral in that the evaluator actually advocates on behalf of program beneficiaries for the sake of social justice”. For this project, I found it integral to acknowledge that firstly my want for the liberation, empowerment and better health for all stakeholders was the driving force

behind my undertaking this project. Furthermore, I held the position that some, if not all, programme participants occupied lower socio-economic groups and therefore had experienced oppression and inequality to some degree and were continuing to experience that oppression entering the Impaired Driving programme. Also, given Tūhoe Hauora are a *kaupapa* Māori organisation my assumption was that the organisation was also experiencing oppression to some degree, and that facilitators own experiences of oppression may have impacted the facilitation and design of the Impaired Driver programme. In saying that, I also approached the evaluation with the idea that given their experiences with the Crown, Tūhoe as a group including the staff of the Hauora, were experiencing a form of collective and historical trauma. Alternatively, from this perspective, I also saw it the role of Tūhoe Hauora as a health organisation to use the Impaired Driver therapy to address this oppression through consciousness raising of their programme participants. I also saw it my role as researcher to identify and communicate any issues of power and privilege.

My value position is influenced by my own experiences of oppression and adversity as a Māori woman who has experienced varying forms of racism, oppression, adversity and historical trauma. This is particularly evident in my inability to fluently speak *te-reo* Māori; particularly evident through my lack of confidence in saying my *pepeha* fully in *te reo* Māori for fear of faux pas. Here, I emphasised the need for self-awareness and reflexivity in my practice (Nelson & Prilleltensky, 2005). I was also prepared to mitigate any confirmation bias (Ilahverdyan & Galstyan, 2014) by consulting with my supervisor throughout the process.

My epistemological stance meant that the evaluation participants and I, and the staff of Tūhoe Hauora were interrelated. I saw it as my role as researcher to act as an agent towards transformative change for both the organisation and programme participants who I encountered at personal, relational and institutional levels through consciousness raising and empowerment (Nelson & Prilleltensky, 2005). As a student of community psychology my ability to achieve these goals was limited. But my want for the liberation and well-being for the Tūhoe Hauora organisation and service users was present none-the less. Given this social constructivist approach, I feel the need to further validate my use of subjective forms of inquiry specifically within the realms of programme evaluation.

Subjectivity in this Evaluation

Subjectivity in social research is somewhat controversial. Davidson (2005) explains that those who criticise subjective based research “assert that all (such) evaluative claims are based on personal values and preferences” (p.92). Davidson (2005) dismisses this idea explaining three categories of subjectivity exist.

The first is of a highly personal nature named ‘personal or cultural’ bias (Davidson, 2005). This form of bias is said to exist in every form of analysis where acting as a neutral observer highlights the researcher’s inability to acknowledge that their decisions are influenced by their values which means their research capabilities are flawed. This however can be mitigated by acknowledging bias (Midgley, et.al., 2007). In my research, I mitigate personal bias by stating my approach, drawing from literature and

supervisor expertise and working within ethical guidelines which is discussed later in my thesis.

The second category is considered subjective for the simple reason research analysis is reliant on a person whose judgement is always skewed by values. This is named 'informed judgement'. Literature relating to this field of subjectivity argue that given most research is somewhat bias (assessment dependant on a person) it is the reader's responsibility to critique the work (Smith, 1996). I therefore leave the readers of my research to do this for me.

Although the aforementioned are relevant to this project, I believe the third category of subjectivity important to address because firstly, the other forms of subjectivity can be either mitigated or controlled in this project using the aforementioned strategies further supplemented by triangulation and persistent observation (Nelson & Prilleltensky, 2005); and second, I have intentionally designed my evaluation framework in use of the third category of subjectivity. Here, the researcher reports on "peoples' inner lives or experiences" (Davison, 2005, p.91) also known as 'about my life' subjectivity.

'About my life' subjectivity is very much accepted in evaluation practice for two reasons. First, it is accepted for evaluating health issues which require the reporting of what Davison (2005) refers to as "internal states" (p.91). These are self-reports of "confidence, stress, anxiety, and sense of cultural identity" (Davison, 2005, p.91). The second reason is for reporting of "inter-subjective experiences of a community or group . . . These are aspects of group, community or organisational life that cannot exist independently

of peoples shared perceptions and intersubjective sense making” (Davidson, 2005, p.91). Both points resonate to the objectives of this specific evaluation; evaluating self-reported experiences of health as an individual and as a member of the Impaired Driving group.

Ethics

This evaluation is subject to the regulations, ethical requirements and procedures of the University of Waikato (2008) Ethical Conduct in Human Research. In keeping with these regulations, a research proposal was submitted to the Waikato University School of Psychology’s ethics committee for review in alignment with the School’s regulations. Ethics approval was awarded before data collection began.

I, as researcher and with guidance from my supervisor, also committed to working in accordance with the Code of Ethics for Psychologists Working in New Zealand (New Zealand Psychological Society, 2003). This was undertaken by reviewing the code of ethics before research commencement and by continually referring to the code of ethics throughout the evaluation when ethical dilemma or queries arose.

Open Participant Observation

One does not simply knock on the door of the Tūhoe Hauora General Manager and ask for opportunity towards evaluation-research experience. You would raise an eyebrow at the least. And this is with due understanding. Tūhoe Hauora are aware of outsider presence. Recent media coverage pertaining to Tame Iti and the 2007 Tūhoe raids were in most part negative. Any contractors who were required to undertake work for the

Hauora held deeply trusted professional working relationships with Management or governance.

My access to Tūhoe Hauora played a vital role here (Bryman, 2004). I entered the organisation in January of 2013 as *whanau* to the General Manager as her Personal Assistant. After expressing interest in the position, I was also given trial as Quality Management Coordinator. With a newly assigned Manager my role as Quality Coordinator was formalised and I was responsible for preparing us for several external audits and up-keep of internal quality management systems. When I resigned from that position I took on contract work for the organisation.

My position at Tūhoe Hauora was unique. I had the opportunity to build trusted working and personal relationships with staff at all levels. This not only allowed me the opportunity to carry out an evaluation, but also the ability to research 'As Tūhoe, by Tūhoe'. Although not of Tūhoe *whakapapa* myself, my son and partner are Tūhoe: therefore, I was considered *whanau*. Because of this I feel very accountable on many levels to the organisation; to the evaluated and future service users of Tūhoe Hauora. In many aspects, the accountability I feel as researcher equivalent to my time as a full-time Tūhoe Hauora employee. In saying this, during my time as researcher I also held responsibilities that would not otherwise be experienced by those who held limited relationships with the organisation. For instance, I often found myself taking on contract work for the organisation during data collection and helped around the office during documentation visits. As *whanau*, taking on these tasks was part of my responsibility in giving back to the Hauora for all they have helped me with.

My knowledge of working with Tūhoe Hauora has impacted my knowledge about the Impaired Driving programme and the way in which I approach the evaluation. As I utilise this information, I consider my time gaining this knowledge as working within the role as participant observer (Bryman, 2004; Dahlberg & McCaig, 2010). Most commonly used by action researchers (Dahlberg & McCaig, 2010), this method of data collection allowed me to draw on my experiences with Tūhoe Hauora to contextualise the interviews which are discussed later in thesis, and to frame my analysis of that information. Here, notes, letters and documents which I constructed and reviewed during my time as an employee of the organisation were analysed so as to not rely solely on memory. In consideration of this, I gained informed consent from Tūhoe Hauora management in retrospect.

I believed this relaxed relationship would not always work in a research context. I deeply trusted the management of Tūhoe Hauora to the point of feeling protected, and saw the General Manager as a mentor and expert in the fields of Māori health development. This trust worked well both ways for this project; for me as a student researcher in a learning environment and for Tūhoe Hauora who steered the terms and framework of this evaluation knowing I wanted what is best for them and their service users.

Evaluation Visits

Given the informalities of my visits and discussions relative to the evaluation following my resignation, I made it integral to organise one formal hui for purpose of formal evaluation practice. This was held with programme facilitators at Tūhoe Hauora with aim to discuss reframing the evaluation following presentation of the first draft. It was agreed interviews would be used as main method of data collection to appropriately reflect the

kaupapa of the organisation. This would also allow for mimicking the predominantly one-on-one services delivered by the Trust that most ex-programme participants were involved.

During this hui, the risks associated with interviewing participants who have gang affiliations and violent criminal histories and the complexity of tracking participants post-programme were also explored. It was proposed by facilitators that the group who participated in the final course of 2014 would be the focus of this evaluation. Although this would limit the scope of the evaluation, this group were considered articulate, friendly, and presented less risk to me as a student researcher.

I visited Tūhoe Hauora several times for purpose of informal briefing ahead of interviews. I was informed of any risks to my safety and was also provided feedback as to how the facilitators perceived the participant responded to the programme. Notes were taken during each briefing and reviewed ahead of interview.

Documentation Review

Evaluation visits were used to collect supporting documents that would help contextualise the evaluation. Documentation that were reviewed included:

- Previous Tūhoe Hauora Impaired Driver evaluation reports
- The MOH Impaired Driving treatment guidelines
- The MOH Impaired Driving Contract
- Programme attendance sheets
- Programme descriptions
- Programme structures and system documents
- Course booklets and session plans

- Client files

Appropriate security and confidentiality measures were taken during documentation review as per Tūhoe Hauora policies and procedures. Where I held issue with accessing client files or organisational documents, Tūhoe Hauora Management or my research supervisor were consulted.

Participant Questionnaires

Although there are limitations in what conclusions can be drawn from Survey feedback, it is apparent why Tūhoe Hauora rely on stakeholder survey to steer operational improvements. Questionnaires are the most commonly used research tool within the social sciences for its simplicity and cost effectiveness (Breakwell et al., 2004).

As requested by programme facilitators, the data collected from stakeholder questionnaires that were administered to programme participants during the final session of 2014, were used to supplement this research. Refer to *appendix E*. The questionnaire used in this evaluation is the generic survey used to gain a baseline of information from all Tūhoe Hauora programmes as per quality improvement policy and procedures. I found this information particularly beneficial for triangulation alongside interviews and participant observation (Dahlberg & McCaig, 2010)

Phase 2: Recruitment and Interviews

Hui

A hui with programme participants was planned to take place at Tūhoe Hauora early February of 2015. This hui sought to recruit interview participants, allocate interview dates and times and build trust between myself and participants through *whakawhanaungatanga* and *manaakitanga*.

It was also intended that the purpose of the evaluation and *korero* around the interview and associated ethical processes take place. At the most part, it would allow myself to build a rapport with participants over a provided *kai* ahead of interviews to mitigate trust or confidentiality issues.

Tūhoe Hauora attempted to contact programme participants requesting their attendance via phone call. The hui was cancelled due to a low response.

The Hauora were also experiencing a busy phase therefore chose to cancel as oppose to reschedule. As a substitute, introduction letters were sent to programme participants (see *appendix B*). I was invited back to Tūhoe Hauora after sending introduction letters so that I could phone programme participants to organise interview dates and times.

Kanohi-ki-te Kanohi interviews:

All programme participants were sought to take part in a semi-structured *kanohi-ki-te-kanohi* interview as main method of data collection. Interviews took place several months following programme completion. The overreaching purpose here was to gain in depth information relative to how the Impaired Driving programme influenced participant health outcomes in the context of their day-to-day living (Breakwell et al., 2004).

The approach to interviews are summarised by Watkins & Ciofalo, (2011):

Each participant evolves a sense of meaningful voice; a way of making sense of the world that is both valued and provisional within the larger context of multicultural community listening and discernment. The psychologically-minded relinquish their role as authorities and experts who have the final word, and develop instead

new capacities for listening, questioning, and facilitation of collaborative group processes (p.13).

For these reasons, I took the stance of researcher as 'learner' and the evaluation participants were approached as the 'experts'. In-depth unstructured interviews proved crucial here as it provided participants opportunity to steer conversations and share knowledge on their terms.

Discussions with facilitators early in the planning phase of the evaluation allowed them time to inform the 2014 programme participants about the evaluation. At the time, we were not sure what the evaluation would look like but facilitators thought it best to give potential evaluation participants time to think about their involvement in the programme. Following introduction letters, each were telephoned several times in attempt to seek their participation in the programme.

Most participants were very difficult to contact due to not having a stable residence. Seven of the twelve programme participants responded to phone calls however only five agreed to interview. Although I had planned to interview participants at the Hauora in special interview rooms, all respondents asked that I interview in their homes due to either driving restrictions, an inability to find other ways of travel to the Hauora or because they felt comfortable in their own homes which is where other Tūhoe Hauora support usually took place. I agreed to in home-interviews after talking with programme facilitators ensuring they were happy with this practice.

During each phone call, I introduced myself and asked if they had received the introduction letters. All those who responded had received and read the

letters and were willing to engage through a short phone call. During the phone call, I further talked of the aim of the evaluation and we discussed their possible participation and where and when they would like it to take place. Each, except one which is explained in the case study, were given a minimum of a one week notice to ensure they could think about the interview, had time to withdraw after our phone call and to organise a private and quiet space in their homes for purpose of interview. All respondents were asked their preference between gas or grocery voucher as a way of me reciprocating their generosity in taking part in my research.

Due to the difficulties in contacting each participant, interviews took place over half a year beginning January, 2015. Interview times were subject to change to 'fit' with participant lifestyles which meant most interviews were rescheduled several times. Interviews took no longer than an hour and were conducted in private rooms.

Consent forms (*Appendix C*) were signed after a thorough informed consent process took place. A copy of the introduction letter and signed informed consent form was left with each participant. Each participant was also given opportunity to request a copy of their interview transcript and interview recording.

Interviews concentrated on reflections and encouraged *korero* around positive and negative health impacts that may have occurred in the context of participant lives as a perceived result of attending the programme. To encourage *korero*, direct questioning was used. This approach was augmented using enabling techniques such as storytelling and idealisations (Wengraf, 2001). Topics that were probed are outlined in *Appendix D* –

The Interview Guide. Although an interview guide was used, I intentionally allowed the conversation to flow to mimic casual conversation methods thus, the aforementioned interview techniques were only used when participant input needed encouragement or I needed to mitigate semantic accent (Breakwell, et al., 2004).

A \$40 grocery voucher was gifted to participants upon completion of each interview. The purpose of this *koha* was to encourage participation, contribute to the cost of time associated with taking part in the interview and most importantly was a sign of appreciation for sharing personal stories for purpose of the evaluation (Jones, Crengle & McCreanor, 2006).

Method of Data Analysis

Grounded theory framed the process of data analysis for this evaluation. Grounded Theory is described as a process where “data collection and analysis proceed in tandem, repeatedly referring back to each other” (Bryman, 2004, p.401).

Transcription of Interviews

Kanohi-ki-te-kanohi interviews were recorded using android phone and uploaded to an online file secured by passwords. Each interview was transcribed with time-stamps for ease of referencing. In consideration of evaluation timeframes, key points were summarised and where information related directly to the research aims, direct quotes were transcribed verbatim (Dahlberg & Mc Caig, 2010).

Coding

At its simplest, coding is the starting point of any qualitative analysis. Its purpose is to identify and categorise data ready for analysis. (Bryman, 2004;

Dahlberg & Mc Caig, 2010). In this project, transcripts were coded against evaluation aims and again, to the pillars of health associated with *te whare tapa wha*. This was undertaken to align with the point made by Durie (2003) who suggested framing indicators around Māori frameworks of health when measuring Māori health outcomes.

Case Studies

A fair amount of literature exists outlining the benefits of a case study approach to research, especially where community psychology and evaluation is concerned. Hodgetts & Stolte (2012) explain that case studies are a way to provide context-specific detailed investigation for purpose of highlighting unique features of a case. In this project, a case study approach was viewed as beneficial for an in-depth exploration of the participants lived experiences relative to their involvement in the Impaired Driving programme. Given the evaluation concentrates on one of four courses administered by Tūhoe Hauora, and participant involvement was scarce, the method seemed fitting.

Hodgetts & Stolte (2012) further explain that case based research is particularly beneficial when an ecological lens is used for analysis as it allows the researcher to identify the functions of social groups, settings and processes within that context. When cases are used for analysis, naturalistic generalisation can be used by other researchers to extend the findings to add to the knowledge of wider social issues (Hodgetts & Stolte, 2012).

The case studies were themed chronologically to appropriately present the participants lived-journey on the programme. The themes used to organise the case studies included an introduction to contextualise the case, a

background of alcohol and drug use, an outline of events which led to conviction, programme experiences, participant reflections and a conclusion which references the case studies against the evaluation objectives.

Thematic analysis

According to Braun & Clarke (2006, p. 79) “Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data”. It is a prominent tool used by qualitative researchers and was seen particularly useful for this project. Thematic analysis was used across case studies to frame the prominent themes arising from each case. This was undertaken to summarise the information found in the case studies in reference to evaluation aims and wider community psychology issues. This was used specifically for the discussion section of the evaluation.

Quantitative Analysis

Quantitative data collected from questionnaires were averaged and analysed for frequencies. As sample size was small, key findings were summarised. This information was used for highlighting the outstanding aspects of the programme as well as the areas in need of improvement and assisted in triangulation in formulating evaluation recommendations.

Method for Reporting

A summary of preliminary findings was forwarded to programme facilitators via email. Facilitators were given an opportunity to provide feedback of these findings ahead of the draft report so that feedback could be co-constructed for reporting purposes.

A final report will be presented to facilitators via hui, at a time and place determined by Tūhoe Hauora. This hui will allow me to outline the key

outcomes of the programme and discuss recommendations. It will also allow the facilitators to provide me with practical feedback that will allow me to develop skills and outlook regarding the evaluation process from the perspective of a *kaupapa* Māori organisation.

Chapter 5: Case Studies

Pseudonyms have been used in each case study to ensure the anonymity of programme participants are protected. Place names, and names of relatives or associates that may identify participants are also changed where needed.

Case Study 1: Joy

Introduction

Joy is a middle-aged woman who identifies as both Māori and New Zealand *Pakeha*. She is of Tūhoe *whakapapa*. During the comprehensive assessment, Joy was described by the Clinical Team Leader as motivated to undertake the course. She is one of three participants who attended every session. Her interview took place 4 months after the completion of the programme.

At the time of interview, Joy was on the final four weeks of an eight-month home detention and community service sentence received because of the drinking and driving charge which led to her participation in the programme. Joy specifically asked that I interview in her home due to home detention and driving restrictions. Joy has many grown children but currently cares only for her youngest child who attends primary school. At the time of interview, Joy was flatting with another programme participant who she invited to stay with her upon hearing he needed a place to reside.

Joy was raised between foster families from birth. When Joy turned 13, her biological mother was given parental care of her for the first time. Joy became homeless a year later, after she was abandoned by her mother while

visiting Auckland. This abandonment had a traumatic and lasting effect on Joys life. She talks of her life as “rough” and her story includes a history of minor criminal charges, domestic violence, prostitution, depression and drug and alcohol addiction.

Relationship with Alcohol and Drugs

Joy identifies as an alcoholic. She has self-medicated with substances since her teens to mask early-life trauma experienced during her time as a foster child and homeless teenager:

I was a drug addict before I became an alcoholic. You know you stop one and you go to another sort of thing. I was a drug addict at 14. I was on my own at 14. Brought myself up at 14. Ah got off the hard drugs, that was the intravenous drugs when I was 19, and got in to alcohol when I was 21. So, I stayed clean for 2 years, then I got in to the alcohol and straight away I was addicted again you know. Ah, it was taking away the pain I was going through, because, you know, I've had a horrific life.

Joy had previously used prostitution to fund her drug habit. She recalled having “to do the odd job of course to survive”. Although she stopped using drugs at the age of 19, alcohol continued to feature greatly in her life thereafter as a way of coping with day-to-day living. For instance, “I’ve always had alcohol. Cos, um, you know, you gotta, just to block out things, I did it to put me to sleep, just to get through the day confidence wise”.

Despite her clear dependency, Joy detested the taste of alcohol which reflected the extent of her addiction:

I hated the taste of alcohol (said slowly). Seriously. I couldn't stand any – I wanted the effect of it. Any alcohol. I didn't even like the smell of it. At first I had to go like that (blocks her nose while imitating drinking a bottle). The only thing I wanted was the effect.

Joy is considered clinically comorbid, suffering from both alcoholism and depression which is common for alcohol sufferers (Davidson and Ritson, 1993). And although the relationship between alcohol and depression are widely explored in health literature, Joy's comorbidity posed possible challenges for programme facilitators. Kelly & Young (2000, p. 1538) explain very little is known as to how depression "impedes alcohol related gains in response to short term alcohol focussed interventions". It was therefore unclear how Joy would respond to the methods used through this group intervention upon accepting her to the programme. However, Joy's *Whakapapa* to Tūhoe and lack of connectedness with *whanau* had potential to aide in forming a positive cultural identity and building of social well-being for her (Ebbett & Clarke, 2010).

Joy held a particularly interesting perception of alcohol. She saw alcohol as her life saver. She explained it gave her confidence to participate in daily activities and importantly, it had helped her in a specific time of need:

It might sound really weird to you and it might be, and I'm not excusing it, but the, the alcohol saved my life. You know it wasn't, it, yeah. It saved my life. Cos I was very suicidal. Uhm, the alcohol blocked away the pain that was making me suicidal so, it was kind of, well, my life line like a lot of people say. And it did save my life in the end, cos I didn't have the coping skills to know how to cope with pain.

Addiction studies have found attitudes that resonate with Joy's life-saving perception of alcohol. In their research of Alcoholics Anonymous (AA) members, Strobbe and Kurtz (2012, p.45) found that those studied often denied that "alcohol had become the problem, rather than the solution". This period of denial presents itself during alcoholic regression; the period of alcoholism before 'hitting rock-bottom'. The study goes on to find that

this idea of alcohol is commonly portrayed by alcoholics after a period of sobriety in which they have had time to reflect on “what we used to be like” (Strobe & Kurtz, 2012, p.45). This seemed to be the case for Joy.

During the interview, Joy explained that she was seven months sober. She viewed being free from alcohol for this length of time as a great personal achievement and was optimistic that she could remain sober once her sentence was completed. She often spoke of herself as a person experiencing transformation and referred to her former self as a willing alcoholic and her new self as a ‘stronger’ alcoholic who is seeking change.

An example of this follows:

Yeah I'm in an awesome place at the moment. It's scary though – cos I think; aww I hope I'm strong enough for the little bumps along the way. It's been going quite smooth for the moment. But I am getting stronger. So I reckon if there are little bumps coming up – I'll be ready. Cos I've gotten a bit stronger. I'm getting stronger as I go.

Her dialogue does suggest however that the success of her stronger self be dependent on the continuity of varied, quality and easily accessible support services.

Road to the Impaired Driver Course

Central to Joy’s health journey are the experiences as a mother and victim of domestic violence. Although Joy did not talk in depth of the relationship with the father of her children, she openly expressed her continuing fear of him although they were separated for many years. This fear set the scene for her latest drinking and driving incident.

Joy's latest drinking and driving incident was referred by her as a "bad mistake". She was drinking at her then 19-year old daughters home when her ex-partner unexpectedly arrived:

I wasn't intending on leaving the house I was at, and ah, yeah, there was a violent situation. He ah walked in to the house, it was an ex of mine, and I had no idea that he was going to turn up, and it was ah, either get a beating, or get me and my 6-year-old out.

Joy's reaction resonated with the flight or fight response (Shelton, 1998).

She felt stressed and her immediate reaction was to flee the presence of her ex-partner. According to Joy, it was either leave or receive a beating:

And ah he turned up, got a bit mouthy, I could feel it was gonna get violent, um, the first opportunity I got, well in my mind, was I gotta get out of here because he will beat me. So bad. Saw the keys in the car, jumped in, went down the road and parked up- and they must have rung the cops from the house, and ah, the cops saw the car parked, I wasn't even in the car. I tried to explain to them what happened and um, but they said still, you still got in that car even though your instinct was to run.

Although the police were empathetic, Joy was charged for driving with excess breath alcohol. This was Joy's third impaired driving conviction.

Joy was "surprised" at the severity of her sentencing. She viewed herself as "actually doing really well before I came, ah, got DIC this time, I was doing pretty well". This had potential implications for programme facilitators as Joy rationalised her driving behaviour rather than discuss the incident in the context of a recurring problem. This is not uncommon. It is often difficult for recidivists to identify that a problem exists. Matua Raki (2012) explain that behaviour change is therefore motivated by avoiding future convictions as opposed to making healthy lifestyle changes. For Joy, home detention conditions as opposed to addressing recidivism was the key motivator for her sobriety.

Course Experiences

Joy's initial attitude to the programme was negative. This was for varying reasons. First, her participation was court mandated. Second, Joy didn't understand the purpose or implications of her participation in the programme. She recalls "Impaired Drive – Impaired driving course? Doesn't that mean your blind and stuff". She recalls being told to attend by her probation officer without an explanation about the programme. Third, this was the seventh alcohol and drug related programme Joy had attended. She assumed it would be like the others she had attended which she felt had not worked. Joy giggled when sharing her initial thought "yeah here comes the bullshit. I gotta sit here and listen to all the crap". Lastly, Joy was experiencing the longest period of sobriety in her adult-life. And to heighten the negativity, her sobriety was by force of court-order. On the outset, programme success for Joy seemed a difficult task. However, Joy's attitude shifted after only the first session.

Joy describes utilising the first session "sussing everyone out, it was very welcoming, nice feeling". She admitted she looked forward to attending the second session, and every session thereafter. When asked to reflect on the programme in general, Joy explained "It was an excellent programme I must admit. It was". It took some probing to encourage Joy to pinpoint what she felt made the programme excellent. She identified several factors.

In accordance with the discourse, Joy found that the skill and relatability of programme facilitators were central to her change of attitude (Sochting, 2014). Joy first engaged with Tama during the assessment process and found him "very sweet". Joy's first impressions of Pare differed, however this soon changed when sessions progressed:

As soon as I saw Pare – I was like whoa, she looks like a hard lady. (both laugh). A bit intimidated at first. Just looking at her – she looks like a tough lady you know. And she was, but in a nice way.

The facilitators were viewed as particularly skilled in creating a welcoming atmosphere. She explained, “the atmosphere. They were coming. Cos I’m usually a – don’t ask me no questions, go away -sort of person, but I actually opened up”.

Joy also identified belonging to a community of practice (Wenger, 2016) where she could continue session learnings through to lunch breaks and discuss topics freely with other participants. This was encouraged through relaxed breaks over provided kai and cup of tea:

Cos in the lunch times, oh well in our little breaks – it was neat how we continued talking about what we had been learning. You know, we didn’t go out and straight out start talking about the outside world, it was like, we kept talking about it.

Although Joy was quick to compliment the course she did express one downfall. She felt that one programme participant behaved in a disrespectful manner:

The ones that didn’t want to be there kind of. Made a joke out of it – well there was one particular person, she was always joking, and you need to be serious sometimes, and you could tell she didn’t want to be there. Kind of, like, trying like concentrate and be serious, and next minute she’s cracking up laughing, it’s like – have a bit of respect. You know, that sort of annoyed me.

I believe this is a sign of programme efficacy in that this ‘negative’ person was unable to encourage Joy to participate in the negative behaviour which sometimes occurs in court mandated therapies (Handwerk et al., 2001). Joy was motivated enough to steer clear of any deviant behaviours.

Perceived Health Outcomes

To put Joy's health journey in to perspective it is important to consider the following. Brady and Back (2012, p.408) explain,

Children exposed to severe adversity early in life are at increased risk of subsequently developing mental health problems, including alcohol dependence. In general, the onset of trauma precedes the onset of alcohol dependence. Although it is impossible to establish a direct causal relationship, this temporal relationship suggests a robust and positive relationship between exposure to early-life trauma and alcohol-related problems later in life.

Joy's health journey was a difficult one. Childhood trauma had framed a life-long journey which resulted in varying adverse experiences for her. The programme had a difficult task in challenging the oppression and trauma which began in Joy's childhood.

Joy was forced in to sobriety but she soon became a willing participant towards a process of change. It took Joy only one session to become self-motivated to attend the programme. This was a good start as several intervention studies have shown that a higher state of readiness to change is a precursor for better programme outcomes (Brown et al., 2012). The motivation for change can be viewed as Joys start to a positive health journey.

Experiencing life sober allowed Joy to approach the Impaired Driver programme differently to other interventions she had taken part in.

Following the first session, Joy was able to process the information given to her in a positive frame of mind:

So the impaired driving course just helped me, (pause) to like uhm, (pause), be focussed I guess, now that I've got the strength to actually stay sober its ah, it's there-you know what I mean, it's clear. It's more clear than hazed . . . My mind is more open. You know, for personal reasons I want to let it go. And, it (the programme) does take me back. Because I go oh, I remember one counsellor saying that and I remember someone saying that, so it's all, it's all coming in. You know I did all that counselling from a young age, and a couple of years ago, I would go – none of that worked. You know. Sort of. But uhm, yeah, just like the programme, its triggered me memories of rehabs – and I put it all together. So I got more knowledge in there – I took in more. More than I thought.

Joy realised how much knowledge she had retained over the years of counselling. Her confidence grew as she applied this knowledge to the Impaired Driving programme. She began a process of building a positive identity of herself in the context of that group setting (Strobe and Kurtz, 2012). This experience for Joy resembles the literature in that developing a sense of belonging is described as a known benefit of group cognitive behavioural therapy (Sochting 2014). This is particularly beneficial for those who have experienced multi-levelled oppression like Joy, as it addresses feelings of stigmatization and marginalisation (Sochting, 2014).

Joy most certainly gained a sense of belonging at the Impaired Driving programme. She learnt to trust and build healthy relationships with her Impaired Driving peers. An example of this is through Joy's new confidence:

Well like, part of my strengths now is talking to people. I couldn't even talk to you like this, about a year ago. (?) too shy, wouldn't look you in the eye, I'd be like (looks at ground) this and stuff, so like talking to people now is what I have gained through this, confidence. And, yeah I had fear of judgement, fear of trust, I didn't trust nobody. I still find it hard now, but, um, I feel trust and that is

better. I look back and think I have come a long way in such a short time.

One participant in particular had a significant influence on Joy. This individual helped Joy feel like an equal. He led the way in terms of sharing stories and opinions during class *korero*:

There was one particular boy that was there, young fella, that was very open you know. And he really, he really made the group open up. You know sort of thing, and you know I praised him quite a bit – you know saying you’re a good speaker and stuff. Yeah I found that interesting.

Joy actively began to heal by building trusting relationships. Her new-found trust in this group of people is illustrated in her current living situation where she flats with her Impaired Driving peer, Paul. Joy offered Paul an opportunity to flat with her upon hearing he needed a home. Her only condition was that he “behave” himself. They have been flatting since the Impaired Driving programme finished.

It would be interesting to reassess if and how, Paul and Joy’s dynamic has shifted given the completion of Joy’s home detention conditions. Both have a strong history of alcoholism and soon they will be free to make their own choices around alcohol use in their shared home, in which they could possibly encourage each other to participate in deviant behaviours (Handwerk et al., 2001; Powell et al., 2015). Despite concerns, Joy seems optimistic that they both can influence each other in a positive way:

Oh I think I’ll do fine. I think I’ll do fine. I know I’ll do fine, uhm, cos I haven’t felt this (short pause), so happy. You know, and I have figured out that you can be happy without alcohol. You know, and you’re more aware and, about alcohol.

When Joy was asked to consider how her experiences through the Impaired Driving programme may have attributed to *whanau* health, she gave the following story:

My 19-year-old, (points to the picture). She lives in Perth. She's – she hates alcohol, she hates drugs. She can't stand them because of what she's seen. And I have sat down and talked to her, cos you know, when I don't have any alcohol, I don't like the way – please darling don't be like this. She's always said I don't want to be like that – like you. But she meant it in that – in the nicest way. And I've always explained to her – I don't mean to hurt you – you know things like that. I'm not justifying my drinking but I've always said to her I don't like what I'm doing and I can't explain the reasons why I'm doing it. But one day I will, and uhm, yeah, when I became sober – well soberer, oh actually when I got on this (points to ankle), she was staying with me. And she sat down and she goes – so how you feeling? I said, I'm fine. And she'd ask me every day – how are you feeling? See mum you don't need the alcohol! You don't need it! – I haven't had a drink since I ah, since I got picked up.

Joy often smiled when looking at her children's photos which covered most of the walls in the room where our interview took place. It seems Joy has a very supportive network in her children and is using them as further motivation to stay alcohol free. Joy was aware that her drinking impacts them negatively and understood the necessity in maintaining her sobriety for the well-being of her children and grandchildren.

Long term, Joy has made some very clear goals. She wants to help others towards a positive health journey:

The thing is, I'm using the past as part of my journey. I want to be a youth and upwards counsellor. Cos you know, I've been there. Been there, and I understand a lot. Especially with teenagers. And I feel, I have this gift where I can feel peoples pain, and yeah, I can feel it.

Joy referred to the experiences of Tama and Pare and believed real life experiences helped both facilitators relate to those in the Impaired Driving

group. She believes her own traumatic experiences can be used to bring about positive outcomes for troubled youth.

In Joy's eyes, the programme played a supportive role towards better health. She expressed a strong sense of health awareness following the programme and attributed this to the programme's ability to "show me that I was in the right space of mind". A good illustration of improved holistic well-being follows:

I've come a very long way in quite a short time. Uhm, cos I've never felt this way before. . . And I ah, love it. Love it love it love it. So yeah. The cycle there has been broken already. . . I wish I was this strong years ago and I never would have, that this, that I could actually feel this way – years ago. Cos I don't think I've ever been this happy. You know, years and years and years, I've always had alcohol.

Despite the obvious challenges with this case Joy showed a willingness and want to continue a sober and healthy lifestyle. Small positive changes, such as no longer having a need to take the anti-depressants which she had been using since the age of 9, were affirmations to Joy that she has done well and can continue to do well post programme.

Participant Reflections

Joy struggled to pinpoint any downfalls about the programme. When discussion was encouraged however, I was able to identify small gaps for improvement. For instance, at the time of the programme Joy resided on the outskirts of the Whakatane township. Although transport was organised for rural programme participants it was not offered to her. She explained her walk to the course as "about 50 minutes to an hour, fifty minutes if I'm walking briskly".

Joy had three personal recommendations for the programme. She believed the Tūhoe Hauora Impaired Driving programme needs to be accessible more often and to more people. Furthermore, she wished that “it carried on”. She would have liked to continue meeting with her group and learning in that environment which is not uncommon for those attending group therapies as per the findings of Meltzman (2008). Joy was also aware that the Ministry of Health were concluding any further funding for the programme and was hoping that Tūhoe Hauora would have opportunity to continue providing the programme to others. In terms of course content, Joy thought “courses need to use a bit more scare tactics. In groups. Freak people out and just scare tactics, yeah, visual stuff, stuff like that”. Joy thought scare tactics worked particularly well for her and thought it valuable that Tūhoe Hauora incorporate more of this in future programmes.

Conclusion

Identify key health outcomes for programme participants.

Joy was a particularly vulnerable programme participant who illustrated strength in sharing her intimate health history for purpose of evaluation. At first glance, the programme was successful for Joy in terms of the Ministry of Health Impaired Driving goals. She reported that she neither consumed alcohol nor drove during or following the programme to date of interview.

Joy reported making good friends through the course and mentioned a want to increase social participation through further meet-up sessions with her peers. Her want to become a social worker is a good indicator of her intention of becoming a productive and safe member of her community.

In terms of her holistic health, Joy has developed a healthy level of self-awareness and is beginning to build confidence and positive self-identity. She understands the impact she has on her *whanau* when she is drinking and has a healthy understanding of the consequences of alcoholism and impaired driving recidivism.

Determine programme factors contributing to participant health outcomes.

Facilitator skill and their ability to relate to Joy were of particular importance in encouraging her to become an active and motivated member of the programme. It was through social participation which led Joy to self-report an increase in psychological well-being by being able to build a positive self-identity within this group.

Key areas in need of improvement.

A clear gap existed in the process leading up to Joy's participation in the programme. And that is with the referral process. Joy was unclear what impaired driving meant and was told to attend. This uninformed process added to Joy's initial negative attitude and lack of motivation to attend the programme. Furthermore, Joy walked to each session whereas others were provided commute to and from the programme.

Case Study 2: Whare

Introduction

Whare is a middle-aged Māori male who is of Tūhoe and Ngati Awa decent. Whare lives on his own in a tidy rental flat in the Whakatane township. His adult children live outside the Whakatane region. He divorced from his wife over 20 years ago.

Whare attended 9 of the 10 Impaired Driving sessions and specifically asked that I interview at his home as he had strained *whanau* supports to help with travel to interview. His interview took place 3 months following programme completion.

Whare was involved in his community as a previous rugby league player and now, a keen league supporter. He has spent most of his life working long hours as a labourer in the Bay of Plenty. However, Whare took redundancy over seven years ago and has since remained unemployed. He reported very little involvement with his community, *iwi* or *hapu* following his redundancy.

Whare had a pleasant and welcoming disposition. He had organised a table for us to interview and placed his impaired driving notes in a tidy pile in front of us which were organised by session date. Whare specifically asked that I inform facilitators that he had kept programme notes and resources. Pinned to the wall above the table was a large calendar that outlined a range of social service, Work and Income (WINZ), counselling and community probation appointments that he often referred during our conversation.

Whare clearly wanted me to see him as the 'star' student and provide what he considered correct answers. I initially attributed this to observer effect (Monahan & Fisher, 2010). As the interview progressed Whare became agitated particularly when the interview explored his health and behaviour in depth. His speech often slurred and it was difficult to understand him at some points.

In light of observer effect, I chose to use the perspective of Monahan & Fisher (2010) in analysing this case study. They propose that staged

performances are beneficial to qualitative data because it shows profound truths of the person being observed:

Staged performances are important because they are deeply revealing of how individuals perceive themselves and would like to be perceived. . . Rather than invalidate or cautiously tolerate data derived from staged performances, we embrace such data – not as a representation of any singular Truth, necessarily, but as rich symbolic texts that lend them-selves to multiple interpretations and provide critical insights into the cultures being studied (Monahan & Fisher, 2010, p.363)

Whare's want to protect some of his journey was of no surprise. As outlined later in this case study, Whare has experienced oppression at many levels (Nelson and Prilleltensky, 2005) and I was a stranger asking for information that could potentially place him at risk of further conviction. I therefore chose not to probe areas he seemed uncomfortable with. My challenge as researcher lay in seeking understanding of behaviour beyond our discussion.

Relationship with Alcohol and Drugs

Alcohol has long been part of every-day living for Whare. He began socially drinking alcohol in his early teens after rugby games. After years of alcohol abuse, his drinking developed in to alcohol dependency (Kring, Davidson, Neale & Johnson, 2007). I could not find evidence of comorbidity on Whare's client file however, Ebbett and Clarke (2010) explain that for Māori, alcohol dependency commonly begins in adolescence and correlates with other mental health disorders. I thought it

important to consider an undiagnosed mental health condition upon analysing Whare as this could influence therapy efficacy.

I found it interesting that Whare slurred his speech. I considered the possibility of his being under the influence during our interview and actively sought to note evidence of this (such as empty beer bottles in the house and the smell of alcohol on Whare). When I realised this was not the case, I considered his slurred speech possibly associating to the lasting physiological effects of his alcohol tolerance and withdrawal (Kring et al., 2007), unwillingness to provide me with a clear answer or considered it a sign of lack of understanding of the questions. I soon realised the latter suggestion may have been the case.

Whare reported on average, he would consume 2-4 bottles of beer per day. Whare said he was “having beers for the sake of it like, after the super 15 rugby and that . . . if I’ve finished mowing my lawns and that, I would have a beer”. Whare reported he was alcohol free for four months following the programme, with exception of having a beer during his brothers *Tangi*. He explained his alcohol consumption lessened once the programme started. “Last weekend and that, I had four small bottles. It’s only because I lost a brother. I didn’t want to take it out on the alcohol. But all up in the three months, that’s the only beer I had”. It is important to note use of language here. Whare refers an average sized bottle of beer as ‘small’ and one session of drinking as ‘a beer’.

Whare was open about the amount of addiction and social support he received but this seemed to outweigh reported amounts of drinking.

Aquilino (1994) studied the willingness of men to reveal sensitive or

socially undesirable information during differing modes of interview. He found that face to face interviews alone were less likely to attain responses reflecting actual use of substances than other methods; this was particularly present in ethnic minorities and mistrustful individuals. I felt this applied to Whare. He had reported feeling ‘scared’ of facing future conviction thus under-reported his alcohol consumption. It was at this point I realised further measures were needed to ascertain a trusting relationship with him.

In retrospect, I should have spent at least two sessions with Whare. First for purpose of relationship building, and once a mutual understanding reached, for purpose of interview so that any of his concerns over confidentiality and implications for sharing his journey could be put to ease. This is not to say I believe Whare was fully mistrustful. I believe Whare was both wary of interview outcomes and needed further time to understand the meaning of confidentiality and ethical protections in respect to his learning difficulties which are explained later in this case study.

Road to the Impaired Driver Course

For the reasons stated above, Whare was hesitant to openly talk of the sequence of events which led to his conviction. He described his latest drinking and driving incident as “Wasn’t very nice”. To mitigate response bias (Couper, Singer and Tourangeau, 2003) and contextualise his korero I referred to his client records.

According to record, Whare was found drink driving on his way home from the local league club at police check point. This incident led to a nine-month community probation sentence which included compulsory attendance of

the Impaired Driving programme. He also had his licence suspended for 18 months. This was his fifth drink-driving conviction.

Whare was told to attend the programme by his community probation officer. He explained, “all they would say, is just turn up here – yeah. But all they worry about is as long as I do programmes like that. It will help cover me up and that”. When asked what he meant by ‘cover up’, Whare explained he was preparing himself for future conviction. This statement suggests he did not consider his life free-of impaired driving leading in to the programme. I therefore considered this a point of reference in terms of analysing his outcomes.

Whare’s talk of preparing for future conviction diminished when I encouraged him to talk of the health gains associated with programme participation. He stated:

If it wasn't for that (points to his impaired driving notes), I would have been back, as soon as my times up, oh, well now, I would have been on the bloody behind the wheel. I'm going for a bloody party or things like that. 7 months now – my court case was I think. And it's just about half way Nicole. Why should I bloody abuse it.

At the time of interview, Whare was determined that he would no longer drink and drive and actively attributed this to the programme.

Course Experiences

Whare enjoyed the programme stating “I looked forward to getting there”. He made special mention of the *kai* during the breaks. Whare’s *korero* focussed mostly around course learnings. For instance, a big difficulty for Whare in terms of gaining from the programme was with his ability to comprehend course content. His first hurdle in terms of the programme was

to understand what impaired driving meant, and how it attributed to the context of his sentence:

It took me two classes to realise what it really was. Well they explained it alright they, you know, Pare and Tama told me, us right from the word go what it really is all about but I wanted to think myself. I said, oh yeah, but I wanted to find out for myself about what it was all about, you know?

Learning difficulties impacted how Whare responded to the programme.

However, compared to other courses, he found the Impaired Driving programme flexible to his needs:

Well ill tell you straight. We've got nothing to hide and that. To compare her (another provider) one and that – it was too high – but when I went on to that one – the Tūhoe one – it was good. That's what I said, it was good understandable for my level.

The utilisation of group activities was particularly beneficial for Whare's learning. He explained:

Yeah it was good. It was good. Especially like uhm you go in to groups. We would go in to groups of 3 or 4 or that. Imagine what people, people come up with some answers and that. And those bloody people, you know, one person won't know the answer, and the other person, they will get together and work together and that, you know little things like that – it was bloody great. . . Yeah, yeah. And then you know, like my spellings not the best. And the fulla like would go 'there' (re-enacts pointing at paper). Oh yeah by getting in a group like that.

Whare could contribute to the course through peer support in group-based session activities. Sochting (2014) explains cognitive group therapy particularly beneficial in terms of participant learning as peers tend to help and encourage one another. Bishop (1999, p.4) extends on this stating that in *kaupapa* Māori practice “individuals have responsibilities to care for and to nurture other members of the group . . . The group will operate to avoid

singling out particular individuals for comment and attention, and to avoid embarrassing individuals who are not yet succeeding within the group”.

This seemed to be occurring for Whare. He had built a *whanau* through *whakawhanaungatanga* and they were helping him to achieve in this course.

The facilitators’ ability to tailor the programme to participants needs also helped with *Whare*’s learning difficulties:

Pare and Tama would say, “make it just near enough”. Not like all clear, “as long as we know how to understand” and that, they says oh yeah. They always explain everything right before you go in . . . Pare and Tama and them were speaking out so clear and it was good understanding. Everything was good understandable. You know how they explained everything.

I believe this is a good example of facilitator approach whereby they existed as part of the *whanau*-group as opposed to existing separate of the group as ‘knowers’.

Whare explained that the programme challenged him to think continuously about impaired driving. “it was good challenging. . . Pare or Tama and that, they will set up another thing to get you thinking”. This learning was of great impact to Whare. He began to actively think about his actions and consequences in the context of his life:

Now I know what the consequences are all about. But the thing is, when I apply for a, well that will be in January and that, I gotta apply for a non-alcohol licence and that. And that’ll (alcohol) nock me right back. And now the readings for drinking and driving – well its gone down. Ya know – you just can’t afford it now! But it had to take me the fifth one and yeah . . . Well it scares me now. It’s really frightening. It’s scaring me now. . . You know probably scary and that, jail. Or indefinite. Or lose your licence. It’s scary. But you know, this programme made me think twice now.

It is of no surprise that facilitator skill enabled Whare to gain from the programme. According to Sochting (2014), facilitator ability in terms of delivery and utilisation of group dynamic are the foremost critical factors in effective therapy.

Unfortunately for Whare, frustration grew from the disruptive behaviour of two peers. He was particularly keen to share a dislike of these participants:

There was just two people every time. It was annoying me. No, It was uhm, like they had a lot to say while we are in class. You know. And I. And it really annoys me. And I like to think. And focus. (Gasps). . . And they would just start yacking away there and I would give them a dirty look because I wanted to get in to it. I get really annoyed with that.

Whare clearly needed time to process his new learnings however the continual interruption of other programme participants made this difficult for him. Whare reported addressing this disruptive behaviour by giving his disruptive peers “the look”. The fact that Whare was not encouraged to participate in the disruptive behaviour but rather address it, is a good illustration of his motivation to meet course objectives (Leafe, 2015).

Perceived Health Outcomes

Although Whare seemed an eager interviewee it was extremely difficult finding ways to encourage him talk on an emotional level about his health. On one level, he reported meeting the expected Ministry of Health outcomes. He reported he had reduced his drinking stating “my drinking and that has slowed down after all these (sessions)”. As per court sentence, he also reported that he no longer drove sober or while under the influence of alcohol. In fact, he was planning to sell the one vehicle he owned

because it was of no use to him. In terms of social participation however the results were mixed.

At an inter-personal level, his connection with those in his group enabled him to contribute to class learnings which showed that the programme had good impact for him in-session. Yet, Whare showed a widening social disconnect with those out of group context. This rings particularly true for his *whakapapa whanau* and drinking friends. When I first asked about his *whanau* he stated “I don’t wanna go there”.

I believe Whare’s alcohol and health journey is one which lies in the explanation put by Ebbett & Clarke (2010, p.244) in their review of cultural identity and alcohol use. The researchers explain that through loss of cultural identity “most Māori drank for companionship; the local drinking establishments might have functioned as substitute *Marae* for Māori whose traditional values had been lost”. As outlined earlier, Whare began drinking after his league games as an adolescent. This is important as this affected his ability to build relationships outside of his alcohol use.

Whare explained that *whanau* and friends would turn up specifically to drink and looked confused when he offered them a cup of tea instead of a bottle of beer during a brief period of sobriety. It seems for Whare, that his social circle approached his sobriety with scepticism rather than support:

Oh Now yeah! yeah. I had a few of the whanau around here Nicole. And I showed them this (flips through notes). And they reckon ao! And they asked me how did you get on there (the programme)? I just joked to them. Lose your licence. (both giggle). No but ah, I didn’t know how to go about it. It wasn’t until I finished this programme and that, cos ah, I woulda told Pare. But now ah, now they, my whanau and friends that are coming over and that, because ah when I had the Tangi for my younger brother, there was two there and they saw me and that – he was looking to go there (to the programme) – so whenever I get a chance I will give him a ring, or

tell him to ring – because his alcohol is bad. Yeah, cos now, now I know to let them know now. Cos they are getting some, a little bit of feedback about me. Cos when they saw me and that you know – bloody focussed and mobile and that, I know that two of them need it badly. And I know for a fact that he’s an alcoholic. And he wants to cut back – really cut back on it. I said its back there (point to direction of Hauora) – and that’s what they do.

Whare believed his *whanau* and friends negative attitude towards his sobriety was because they were struggling with severe addiction issues themselves:

We’re bloody professional abusers. But after getting some horrible comments from the whanau Nicole – it’s time to change that attitude. It’s time to change their life. Cos that’s all they do. It’s just alcohol and drugs.

Like Joy, Whare viewed himself as a recovering alcoholic and distanced himself from the identity of a current alcoholic which made further tension between him and his *whanau* who were continuing to drink without him.

For Whare, the health gains resulting from the programme manifested predominantly through a physical aspect of well-being. Whare reported:

I can focus. I am more mobile and that. . . like the next day I can do me housework. My housekeeping and all that. And I can, ah, really think. You know when I look back and that, oh, bloody hell, with the hangover and that, I ah, I think agh! I don’t want to pay any bills! (laugh). You know that sort of things.

His new experience of sobriety helped him with motivation to lead every-day activities. When Whare remained sober his gout pain eased which led to an increase in quality of life; small jobs around home became manageable.

Whare’s reported experience with severe Gout pain is of particular importance here. Severe physical pain is described as a leading cause of group therapy drop out (Sochting, 2014). I therefore see Whare’s

attendance as an extremely good achievement given his continuing battle with gout.

Pare's involvement helped Whare retain his place in the programme. When Whare expressed the amount of pain he was in due to gout, Pare referred him to a Tūhoe Hauora social service worker who specialised in *rongoa Māori*. He explained, "Well quite a while back, Pare told me I will send someone over to check you out. . . Cos I was in pain". As Whare further thought about the relationship between the programme and his drinking, he concluded that the underlying reason he felt better was the *rongoa*; "Ever since I been on that (programme) and also the *rongoa* (points to his bottles of Māori medicine)".

When Whare was encouraged to think about alcohol he realised that his efforts thus far were his main motivators leading to his sobriety.

Pania saw me cos I was suffering I think . . . So Pare got Zoe to come around on the 1st of December last year, I was on it for about a month. And because I thought, it (alcohol) clashed with that (rongoa) – I didn't want to have any alcohol. (He proceeds to show me all of his bottles of rongoa) . . . I didn't want to have alcohol. And mix it up with that (rongoa). What's the use of taking that (rongoa)– and getting it abused? So I thought I'm going to try this without alcohol. . . I've had a lot of changes in me . . . right from the word go – Zoe was always trying to find out all these things and that – especially this (points to his Māori medicine).

The programme indirectly benefitted Whare. The motivation for his continuation of sobriety were in due respect his Māori medicine and to the effort both he and Zoe had put towards his healing.

Participant Reflections

Whare would have liked the programme to continue. He "didn't want it to finish. Because I was just starting to get in to it . . .Cos to me we were just

starting to get a rhythm, with the times and that”. This reflects the literature in that therapy attendees tend to want to continue socialising with their new-found friends (Meltzman, 2008). Also, Whare’s learning difficulties affected how quickly he could process the information provided to him and spoke of wanting the programme to continue for learning purposes.

Whare found comfort in the *kaupapa* Māori aspect of the programme.

Whare believed his *whanau* and friends would resonate with this; “they (his *whanau*) don’t want the *Pakeha* way. They feel better with Māori. Māori to Māori. They feel comfortable with Māori”. Whare was therefore particularly keen to refer his *whanau* to Tūhoe Hauora in addressing their alcohol and drug issues.

A gap of importance in Whare’s case is with service overlap. Whare was engaged with two local *kaupapa* Māori health and social services at the time of interview. One of these services focussed primarily on addressing his alcohol addiction. Tūhoe Hauora focussed specifically on his impaired driving and offered other social supports post-programme. He also was expected to attend community probation meetings alongside his unemployment benefit meetings through WINZ. He often found that appointment times and dates clashed:

Last year I took on a lot of responsibility like my PD, home detention and reports and counselling and all that – it was just piling up and that, and now it’s starting to slow down – I thought ill see what happens in April and I will take it from there. That’s why I want to keep some of these notes and all these contact numbers and that. If I ah, if I need some more help and that – well I know where they are.

The demand from each of these services was overwhelming for Whare. He had raised concerns over missing the first Impaired Driving session to attend

counselling offered through a neighbouring service provider. He found Tūhoe Hauora flexible and accommodating here. However, where other organisations were involved, Whare was very concerned over what appointment he might miss. To add to this, given his lack of support, driving restrictions and gout issues; arriving to each appointment was not simply a matter of walk or travel by car. It in fact, consisted of a lot of planning and support.

Conclusion

Identify key health outcomes for programme participants.

Whare's drinking and driving to date of interview was successfully eliminated. He contributed this to course learnings and fear of future convictions. He reported lowering his alcohol consumption post-programme although I did raise queries as to whether he under-reported his alcohol intake. In terms of social participation, Whare signalled a want to encourage his wider *whanau* to address their own alcohol and drug addictions. Through his decreased alcohol intake, Whare found relationships with his *whanau* and friends strained but had gained a supportive *whanau* system within the Impaired Driving group. Physical health was vastly improved following the programme. As his gout pain eased, Whare could manage daily tasks such as cleaning the house.

Determine programme factors contributing to participant health outcomes.

Whare believed the programme was very suited to his learning needs as facilitator expectations and group tasks accommodated his learning difficulties. The *kaupapa* Māori aspect of the programme contributed to positive health outcomes for Whare; especially through helping with course

content and offering of *rongoa* Māori and ongoing social support post-programme.

Key areas in need of improvement.

Several gaps have been found in Whare's case. Whare explained that his visits with Zoe, his social support worker providing *rongoa* Māori, had ceased at the time of interview. This is clearly something he enjoyed.

Whare asked that these visits continue. Also, Whare was clearly overwhelmed organising his times between two *kaupapa* Māori providers, who were providing the same services to him. Another point of concern is that it took Whare half the course before he understood what role the programme played in relation to his sentence and life in general. Lastly, alcohol has been the 'glue' in terms of Whare building relationships with others and his positive social supports stopped the moment the Impaired Driving stopped.

Case Study 3: Paul

Introduction

Paul is a middle-aged male who identifies as *Pakeha*. Originally from the South Island, Paul was the only evaluation participant with no *Whakapapa* connections to Tūhoe or to those who identify as Māori. He attended 9 out of the 10 Impaired Driving sessions missing only the first class.

Paul's interview took place three months following programme completion. At the time of interview, Paul had already completed a four-month home detention sentence. He was the flat-mate to Joy who is discussed in the first case study. At the time of interview Paul had begun drinking again and went to the pub immediately following our interview.

Paul was a particularly insightful interviewee. He chose to stand during our interview while I sat and often used hand gestures to emphasise his talk. Paul also offered feedback about how well he thought others had done through the programme.

Before our interview took place, Paul insisted he quiz me on my knowledge of Impaired Driving as he was wary of my age and abilities. I was asked to define Impaired Driving and discuss the issue in the context of Community Psychology. After approximately five minutes of discussion Paul let me know he was ready to interview.

I was interested to analyse Paul's health outcomes in the context of a *kaupapa* Māori designed programme. I was aware his expression of and experiences with oppression and health may vary from other participants and therefore there was potential that Paul reacted to Māori health provision in ways that differed to his peers.

Relationship with Alcohol and Drugs

Paul was exposed to alcohol abuse early in life. His father and three of his ten siblings were reported to have suffered severe alcoholism and depression. Paul expressed relationship strain between he and his father due to his father's alcohol abuse stating, "there is alcohol in the blood".

Paul made sure to note that he personally did not attribute his alcohol use to his family explaining, "I'm not a believer that just because the whole family drinks alcohol, that I'm going to become one. I don't believe in that. I believe that, just, ya know if I drink I'll drink". Paul is a very aware individual who makes point of making himself accountable for his actions.

Unlike other participants Paul's journey with alcohol started late in life. He had his first drink at the age of 20 and seldom drank thereafter:

I never used to drink. I used to uhm (pause) well I could have a drink in my garage and it would get dust on it. And then when I would go on a motorbike rally I would have a weekend away, you know what I mean. Then it might be a month. Maybe two months before I go to a Rally, and that's about the only time I'd drink.

His journey with alcohol corresponds to experiences with depression and bipolar following two heart-attacks at the age of 45. He explains:

I got very depressed. There wasn't enough blood and oxygen going to my brain. The serotonin. And I got all fucked up. So I now have bipolar so I used to go in to highs and lows and, yeah. And uhm (pause). So I started drinking pretty heavily.

Central to Paul's journey with alcohol is the relationship with his ex-wife.

He met his wife at the age of 16, married her at the age of 20 and they parted when Paul turned 54. They have no children and his marriage ended many years ago. Paul attributes this to his alcohol abuse. Despite the marriage breakdown Paul spoke of his ex-wife in a positive light. However, Paul expressed that the experience of divorce worsened his alcohol abuse:

The last five years of our marriage. She couldn't take, ya know, take anymore. She tried. Uhm, so she took, ah, the only way to deal with it, was take a restraining order out. So, I haven't been able to talk to her in the last ten years which was sad. If we actually split up and I could still say hi to her ya know, that would be ok. But, ah, so my drinking got worse.

Paul clearly understood his drinking was an issue. He described once attempting to address his drinking habits by moving to Australia but despite the change in environment soon realised the problem "just follows ya". He also reported attending two rehabilitation programmes. The first was for a

twelve-week period and the second for four months. These were viewed by Paul as ineffective, and he continued to drink.

Paul's brother who is an ex-alcoholic offered advice which he referred, "He said to me, and I think he's quite right, he said to me – look. You can go to all the rehabs in the world – but you won't stop drinking if you don't want to. That's it". Paul was accepting of this idea. Paul believed that he was accountable for implementing the tools gained from therapies and rehabilitation in addressing his alcohol dependency.

Paul explained the issue with his alcohol problem does not lay in his inability to stop drinking. He believes this is easily done given his forced four-month period of sobriety during his home detention period. He believes his alcohol issue is the lack of self-control, "I am an alcoholic; you know I have been to AA meetings – I am an alcoholic. But generally, if I sit down and drink I can't stop at 3 glasses. I keep going." In reference to his home detention period, Paul continues:

You're not allowed to drink! Cos if I thought oh ill have a fucken drink. The cops will turn up and throw me in jail. That's fucken handy. That's what they do you see. Well they never ever come. But I had a party and an Irish jig out in the street when they took it (ankle monitor bracelet) off. And I'm thinking to myself, how come – how come, I can stop for four months, and when it's available to me – I just go and get it? I want someone to give me a little pill that will stop that. See like sometimes here I would be with Joy and um, all week and then ill nip down to the pub and have a drink. So, I don't, I don't need to get up in the morning and have a (uses hand motion to suggest he is drinking).

I thought this was a good illustration of self-reflection on Paul's part. He could identify that his underlying alcohol issue is because of low self-control. Self-control develops in childhood and those children who are disciplined are more likely to acquire the skills of self-control. Lack of self-

control has wide reaching negative implications in adulthood; on the most part, it affects how good individuals achieve in schooling, employment and relationships because these all require high levels of self-control. It also has direct causal relationships in terms of negative drinking behaviours and when alcohol is involved, clear associations with relationship breakdown. These findings all seemed to resonate with Paul's life experiences (Crane, Testa, Derrick and Leonard, 2014; Costello, Anderson & Stein, 2014). This implies that unless self-control was addressed during the Impaired Driving programme, it is unlikely that the programme would result in decreasing Paul's drink-driving behaviours.

I would also like to note Paul's adverse experiences with counselling as this had potential to impact programme efficacy. In talking of previous counselling experiences, Paul explained:

I would go in, and how are you today, and ask me questions, write stuff down, and then, send me on my way. What a lot of shit. Its fucken – I only went because I had to by the courts. The guy I went to in Ashburton, he would sit down there and how ya going Pete. How's the drinking. How's this. How's that. Ask, talk about my personal life. Then he'd talk about his. And we were having such a good conversation that (looks at his wrist), oh I'm sorry Pete, times up. The woman I had round at the hospital, wasn't even worth going in cos she done absolutely nothing. Absolutely fucking nothing. I didn't put a complaint in but, uhm, she done absolutely fucking nothing. She sat down there on here (pause) and just wrote something down and she was supposed to see me for the last time and she uhm, put an apology in, she was sick, and I never heard from her after that. . . if I wanted a counsellor to talk to, I'd have to sit down and interview them. Cos, I would never put up with that again.

Paul was clearly weary of health practitioners. As far as he was concerned, they had wasted his time. This was evident in his wanting to interview me ahead of our *korero*. Considering this, I believe facilitators had a particularly difficult task in breaking the perception Paul had developed

about health professionals to effectively motivate him to reach positive health outcomes (Leafe, 2015).

Road to the Impaired Driver Course

Paul was transparent about his drinking and driving recidivism. He explained his latest and drinking and driving incident was the latest of five. He was put on a four-month home-detention period as result of this. His offence occurred in the South Island but due to not having a stable residence in his hometown, was forced to relocate to his brother in the Eastern Bay of Plenty to carry out his home detention sentence. Upon the completion of his sentence, Paul decided to move from his brother. He met Joy while on the Impaired Driving course who offered him a room. He now lives with her in a tidy flat in the Whakatane township.

Course Experiences

In summary, Paul's attitude about the Impaired Driving course was very positive. Comments such a "I thought it was fantastic" and "Well, if you're a newbie – if you hadn't been through any ah, rehab programmes, I think it'd be fucken excellent" are indicative of his response to the programme.

An interesting point he made, was that despite being through rehab, he did not find the course repetitive due to its concentration of driving issues rather than the broader context of substance use. He summarises:

The impaired driving has a little bit of rehab in it which is good. Even though I knew it, the start it was like refresher course, um, the uhm (long pause) yeah but the programme itself taught me a lot of different stuff. . . the course gave me good insight into what can happen when you drink. What can happen if you're invited to party. So, I got quite a lot out of it which you don't get in rehab. . . In rehab, they teach ya about ya brain. They teach ya about ah – yeah they teach you a lot of stuff. There is nothing in a rehab they tell ya about driving.

Much of Paul's discussion focussed on facilitator skill. Throughout our conversation Paul related to Pare's ability. He stated "I like her because she wasn't boring – and she'd move around and use her eyes. And for somebody to concentrate while they move – I'd call her, I'd call her a good facilitator". He further explained "when someone speaks to me – and I follow them around, they are a good facilitator. I actually liked her". Paul's comments were not explicitly about Pare. In reference to Tama, Paul explained "He told us his background. And it makes a difference. I'm quite proud of people like that ya know". Paul believed both facilitators done their job well and were key factors in positive programme outcomes (Sochting, 2014):

Well I think the facilitators have gotta be good. There is no use having the wrong facilitators – the facilitators were good . . . if they're no good they don't get my attention. It's as simple as that. If they're fucking boring – I'd mislead shut my eyes and go to sleep. . . As soon as she's ready to start (Pare) righto – here we go. And I'd wake up. And one of the things, I don't know if she's been taught it or learnt it – the facilitators gotta move up and down. Not just stand in one spot.

Paul was particularly fond of course structure. He liked the fact that facilitators gauged the input of participants. He explained:

Now the first day I went in there, the first thing they do, is say how has your week been? What's the good and bad things? And we would all go around. And at the end ya know, they would go around and ask what'd you think of the session.

Paul's view of facilitator approach very much resonates with the reports in Whare's case, in that facilitators were a part of the group as *whanau*, opposed to adapting the role of facilitator as the 'knower' (Smith, 1999).

Paul could refer to several tasks in the programme that positively impacted him. One task in particular challenged him to think about preparing to drink which he thought was very beneficial. He liked that facilitators were not placing boundaries on him being able to drink, rather provided tools to deal with the issue of driving while under the influence:

The only rule, and we made our own rules, and some were made by the facilitator was - you don't turn up drunk or drugged on the day. Right? And through our course, the facilitators would say we're not telling ya to stop drinking. We're not telling ya to stop smoking. I mean stop taking drugs. We are just trying to train, ah ah. Tell you ah what happens . . . That's probably the biggest thing that stood out for me. I haven't actually forgotten that. . . I learnt a bit from that you know. To organise how much drink you take. Organise how you getting home. Organise how you getting there. Check out if it's the people you really wanna be with. So, a lot went on board.

Lastly, Paul found excitement assessing how well he thought others had achieved during the course. Given his experiences of rehabilitation Paul considered himself already knowledgeable about alcohol and drug therapies therefore seemed to utilise his time analysing others:

There was this one woman there, and her eyes were sort of like this (imitates squinting eyes, smirk on face, dropped shoulders, he imitates mumble sounds). Attitude at its highest level. Right? Can see the difference in that woman – the last day. Was just amazing. . . About the fourth or fifth session she was laughing, she was chatting, it ah, just turned her around I thought . . . The change I saw in her was just amazing.

I thought that comments like this illustrated Paul's inquisitive and caring nature in that he found enjoyment in seeing others gain from the programme.

Like other participants, Paul made special mention of two Tūhoe specific aspects of the programme. Paul mentioned the first aide course explaining he liked the idea that he "now has the skills to save somebody's life". He

also made mention of the provided kai “We got morning tea. Subway. So, that was nice. Didn’t have to. And ah, the day we finished we had a bloody big smorgas-board at the Chinese restaurant”. Overall, he seemed pleased with the course, particularly impressed by facilitator skill, the changes he found in his peers and his new-found tools in addressing his impaired driving issues.

Perceived Health Outcomes

Paul self-reported suffering from both depression and bi-polar disorder. He attributed alcohol use as a result of the depression explaining he began drinking only after he became depressed following his heart attacks. However, Paul’s overall well-being seemed to be improving post programme. This actualised through social aspects of the programme.

A lot of Paul’s narrative reflected a great sense of regret over his alcohol abuse because he felt this had caused he and his wife to split. As Paul explained she was “The only woman I’ve ever been with. Very nice woman. Still is. Uhm (long pause)”. His train of thought often drifted when speaking of her.

Paul had expressed regret particularly in terms of his behaviour towards his ex-wife. He explained previously consuming so much alcohol that he would wake in the morning to his distraught wife, not remembering what he had done or said to her the night before. In reference to his drinking, Paul explained:

I go silly. I think what caused my wife to let me go – and I didn’t know this because I was drunk and in the morning, I would say sorry and say blah blah blah ya know – be real apologetic. When I got drunk, I didn’t know this at the time but I used to verbally abuse her. Never ever hit her. One day she took off me glasses rolled up a newspaper and went ‘whack’. Then she says now fucking hit me.

And I never of course. And I thought what's that all about? And um, it was only when I was in um rehab. I was walking along with a couple of women and I was telling them the same story and they said I know exactly what you are talking about – what she was trying to do. I say what? She said, sick of you doing this (uses hand motion to imitate talking). She wanted you to hit her so you would stop verbally abusing her.

Losing the companionship of his ex-wife had a significant impact on Paul.

Paul had socialised with very few people other than his wife in their long time as a couple. When they split, he found himself socially isolated.

However, through the Impaired Driving course, Paul found friends; “the saddest part that come from most of us was um, that we weren’t going to be together anymore. Because it was such a good group”. This very much reflects the points earlier made by Maltzman (2008) that group therapy can lead to positive social outcomes for some participants’.

Paul made special mention of how his living situation with Joy has had impact on his overall well-being. This friendship grew through session *korero*. One day they realised each were spending Christmas alone so Joy invited him over for Christmas day. As Paul puts it, “Joy was having Christmas day on her own and I was having it on me own and I came around here and the rest is history”. He further explains:

I've been aye ah loner all my life. It was Laura and I. And since I've been alone. And that was part of my drinking, I drink a lot cause I'm alone, since they ah, now, my drinking is way way way way way way down. Because I um, um living in a house with somebody, and I've got someone to talk to, and they talk to me, and we have laughs, and she cooks ah most nights a week, and ah yeah so it's having someone around I think, has made a big difference. You're not as alone. Alone. I can't handle loneliness. Ya know with my mum, I left her and then I went to Laura until I was 54, and next thing ya know bang, you're on ya own.

“Isolation is said to reduce one’s sense of power and one’s sense of belonging” (Penehira et al., 2008, p.6). Social isolation can be viewed as an oppressive experience (Sochting, 2004). This resonated with Paul’s reports of loneliness. Through Joy’s friendship however, Paul’s drinking decreased. She also introduced him to many local people. Paul explained there are always people visiting Joy so it helps him overcome isolation he would otherwise experience without her companionship. As mentioned in Joy’s case study, I would be curious to see long term impacts of this friendship once both are given freedom to drink once Joy’s sentence is completed.

Paul was viewed as the joker of the class and he was content with that identity within the group (Strobe and Kurtz, 2012). He had a large smile on his face when explaining that “I was a bit of a joker. . .one of the facilitators said to me that the group likes ya Paul, you make them laugh. . .Joy used to come in and say I only come here cos Paul’s here”. Paul didn’t talk much of other participants but liked the idea that he had positive impact on them.

In terms of drinking and driving, Paul felt that he had finally learnt his lesson. When asked if he will drink and drive again, his response was “No. It’s taken five times – a lot of problems, basically I have stuffed up, stuffed up my life really”. He was aware that the goal of the course was not to stop him from drinking, rather address his impaired driving. And the course seemed to have been successful for him here:

If I had the um, thought of walking in there and thinking that this thing is going to stop me drinking – ah – no. What it does is gives me guidelines. Ya see, my problem is, and it’ll shock ya, and it sometimes shocks me too, sometimes if I was going from point a to point b I would have a can before I go. And have a can on the way. Like it was natural to feed my engine like it was natural to feed the

engine on the car. It's just ridiculous. And ah, some of my friends would say, Pete, ya have just got your licence back!

Paul could reflect how severe his drinking was and declare he will no longer drink and drive. This was a great indicator as to how far his attitude had developed during the course. In fact, he went as far to say he would not sober drive drunk people anymore as he saw it as putting himself in a vulnerable situation which could lead him to drink and drive.

Lastly, I thought that Paul discussing his future without my need to probe, was a good indicator of change. He was planning on making a new life in the Whakatane region. Paul was planning to re-gain his licence so he could get to and from work. He was aware he is fast approaching retirement age but ascertained his want to work beyond that age to keep himself busy.

Participant Reflections

Penehira et al. (2008) explain that from a psychological perspective, a researcher's attitude and beliefs are pivotal in evaluation. They state "If we as interventionists view the family as being 'in need' and operate from a 'needs based' position, then we immediately dis-empower families with that view. If on the other hand, we operate from a 'strengths based' position, then we immediately place power with the families that may be equal or greater than our own perceived position" (p.6). I realised upon analysing this case, that I fundamentally made a major mistake in my role as researcher who is supposed to be practicing self-awareness in seek of power and privilege structures. Because Paul is *Pakeha* I did not view him as needy and assumed he was less oppressed than others. In doing this, I automatically disempowered all other evaluation participants by assuming they were needier in comparison to Paul and while doing so, undermined

any form of oppression experienced by Paul. It was not intentional but second nature. I therefore, at this point, stopped my work and felt a need to review his and my first two cases. Some amendments were made to the case studies. In retrospect, I was grateful for this case in that it forced me to practice reflexivity.

I believe I fell in to this thinking not only because Paul identifies as *Pakeha* but because he was an extremely confident and articulate individual one-on-one. He could reflect on past experiences and interpret in a practical way, how to avoid those situations again. He was also able to derive suggestions for the programme. For instance, he said he would recommend the course to others. Given he was aware that this was potentially the last course being offered by Tūhoe Hauora, he also stated “the programme should keep going. I didn’t like the programme being shut down”. This attitude resonated with other participants who were also aware that, at the time, the programme would not continue in to its third year.

In terms of course content, Paul asked to “see a bit of audio”. He continued, “Videos of smashes. Videos of people sober and then drunk just to see how you are. I often used to say to my wife when I was drunk why don’t you video me? And if I looked back and can see that – I’d go hell! So I’d like to see more audio and more um, that audio what I mean is sort of movie. Movies. So, movies and stuff”. It seems for Paul, the underlying messages of the course would have more impact if he could see and hear through video, the impact of impaired driving.

Also, a gap apparent in this case is that like other participants. Paul experienced a lack of clarity in terms of the process leading up to the

Impaired Driving programme. For instance, when asked who referred him to the programme Paul responded “Well somebody did. I know by the order of the court that I had to do this and something else. But that’s it. But ah, yeah I think that came up when I got up here.”. He also had no idea what impaired driving meant as the purpose and implication of attending the course was not discussed to him prior to his attendance, “I thought you went there jumped in a car and went around in ah, around fucken cones”.

Conclusion

Identify key health outcomes for programme participants.

In general, Paul’s well-being improved through new found friendships. Paul also reported no repeat of impaired driving during and following the course. He also insisted he had no intention of drinking and driving in the future. He was aware of what situations would encourage him to ‘fall off the wagon’ therefore discussed an intent to stay away from potentially risky situations. Paul was also very adamant that an Impaired Driving course was for just that, and was very open that he continues to drink. He did report drinking less, however, due to his new friendship with Joy. Her companionship meant he felt less need to drink. Paul is keen to develop social relationships with others and likes that Joy has visitors he can interact with. He wants to re-gain his licence so that he can go back to work which illustrates a want to be a contributing member of his community.

Determine programme factors contributing to participant health outcomes.

It is difficult to determine whether Paul was provided with appropriate intervention services. Given the impact towards his drinking and driving, I would state that yes. This programme worked extremely well for Paul given

its social application, particularly in providing opportunity for him to build friendships with others. Although the programme did not directly have an explicit impact towards Paul's self-control behaviours, through his new-found companionship he no longer chose to drink the amounts of alcohol previously consumed. Paul contributed his new attitude to impaired driving to facilitator skill and course content which included offering of kai, asking for participant contribution during discussion and providing impact thinking exercises which stuck with Paul after the programme.

Key areas in need of improvement.

Paul was in the same situation as the first two participants heading in to the programme. Put simply, he was told to attend. He had no idea what the course was and the wider implication for his attendance in relation to his life and sentence. Furthermore, although Paul thought the course was great, he offered some advice for more audio-visual content that would help solidify the underlying impact and messages of the programme.

Case Study 4: Lynn

Introduction

Lynn is in her late twenties and a mother of two. She attended all available sessions of the Impaired Driving programme. Lynn identifies as Māori and is originally from the Gisborne area. Her interview took place 13 months after programme completion in her rental property where she lived with her partner. During our interview Lynn was busy tending to her children which created a challenging interview environment; yet she could articulate herself well. It is integral to note, as I believe this is evident in the lack of in-depth information in this case, that Lynn was the only participant who was not

given a one-week interview notice. In fact, she had only half an hour to prepare for interview. This was due to an interview cancellation I had while in the Whakatane region. Thus, I called Lynn on the off-chance she could take up my free interview space. She happily agreed on the grounds the interview take place in her home. Within half an hour of our phone call, our interview had commenced.

Relationship with Alcohol and Drugs

Lynn has taken part in previous drug and alcohol courses. This includes self-referred rehabilitation in 2011 to address issues with alcohol, marijuana and methamphetamine. However, she did not talk of herself as an alcoholic, or as someone who has ever experienced alcohol dependency.

Pre-programme, Lynn described prioritising buying alcohol on pay day above caring for her then-only-child and buying groceries. At the time of the Impaired Driving programme, Lynn had not consumed drugs for three years and had stopped drinking due to her pregnancy. She recognises now that her alcohol use was unhealthy. The main theme arising through Lynn's narrative is that she believes her alcohol use has been the result of selfishness but has since learnt to put her own and *whanau* well-being first.

Road to the Impaired Driver Course

To Lynn, the process to her participation on the Impaired Driving course was simple. She drunk, drove, was caught and convicted and court mandated to attend the course. When asked if this was her first time convicted of drink driving, she replied "nah, it was my fourth". Given it was her fourth conviction she was "wrapped" that she was given a chance at rehabilitation through the course. Especially so given the blood-alcohol

reading which led to her latest conviction was, per client file, nearly twice over the legal limit.

Lynn received 11 months' home detention for her latest offence which took place in 2014. She attended the programme during her home detention sentence. Given Lynn was also heavily pregnant at the time, she experienced feelings of shame when initially entering the programme with a monitor bracelet. However, this eased upon realising 8 of the 12 participants of her course were also required to wear a monitor bracelet.

Lynn had not heard about the course ahead of being told by her probation officer to attend. They had informed her it was for "improvement or something". She described probations attitude to the programme as "It was sort of, like it was unplanned, like last minute sort of thing. Like they had never heard of it before". Essentially, the only knowledge she had about how the course, was received through Tama during her assessment interview.

Lynn attributed Tama's mellow disposition to making her feel comfortable about attending the course. She stated "I was wondering what the heck it was but it was good because he was so mellow when he is interviewing. So, you know, reassured me that, you know, the course is going to be alright", even though initially she had presumed the course was going to be "bullshit".

Course Experiences

Like other participants, Lynn showed signs of motivational issues on the first session due to the coercive nature of the programme. But this soon changed; "the first day we were all looking at each other like what the hell

are we doing here, and then, um, the next time I went, it was cool as”. In fact, she went as far to say “like you wanted to be there. Last day was gutting coz we had finished. We were all gutted”.

When asked if she would take part in the programme again, Lynn replied “Shit yeah. I’ definitely do it again”. She continued:

I don't remember any sort of bad day, the only day that was really, really boring was the first day. Yeah, of course, everyone was like agh, this sucks (giggle), but I don't regret that we did that because now I've got it. And that was a big highlight too, getting that (course certificate) But that (first day) was the only day that was really boring.

When I probed Lynn to pinpoint what she liked about the course, she replied that she particularly liked all the new learnings and the constant laughter between her peers and the facilitators. Lynn also made special mention of “the feeds, every Tuesday. That was me!”. Furthermore, Lynn mentioned that the graduation ceremony “was cool. You get a beautiful big feed”.

Perceived Health Outcomes

In terms of health outcomes, it is obvious that Lynn has made a drastic improvement post-programme. She stopped drinking altogether and has learnt to prioritise self-and *whanau* well-being over alcohol. She also made special mention of feeling less tired and being able to get out of bed. Lynn stated, “I think generally my health has definitely changed. I think I was quite run down when I was drinking back then. . .I’m not so tired... not as tired as what I used to be. I mean, they’ll be days (back then) when I hang out and spend the whole day in bed”.

Mostly though, changes have been psychological. She states “I’m not cured of anything but I’ve just got a different mindset”. This mindset is one which

places her and her children's well-being first. A great example of this follows:

Oh, yeah, well, they've (family) just been amazed. We were at a Tangi and they were on the skulls aye and I was like the only one that wasn't drinking and my dad was surprised. It was different. I was all about the kids. . . I felt like the retard that looks, like oh hang on I just gotta go sort the baby. I'm the sober straight one that's sharp.

This was a big change for Lynn and she seemed proud to be the one making change in her larger family group for the benefit of her children. Lynn contributed her new-found health outcomes to two programme factors. First, in alignment with the argument posed by Walker (2014), was a result of continuity of care through counselling sessions and second, in accordance with the narrative of Sochting (2014), facilitator skill. Lynn explains “you know, were a fuckin bunch of crims, but it was the way they treated us, you know. They wanted to talk to us and just didn't um, didn't judge us for what we have done”. She further explains:

I could have a one on one talk to them. I was going through a lot of stuff at that point in time in my life as well. It wasn't just you know being on the course, I had a lot of other things going on and they gave me good advice and tried to help me out with a lot of other things. Mostly Pare but yeah, Tama was good too. They're awesome facilitators. . .Its coz the way they taught it. . . You know they're not like, you need to give up drinking, you need to go to jail . . .they're not down your throat. We were all there; we were all there with convictions. But they looked at us as normal people.

Lynn believed facilitator approach allowed the course to be “quite a confidence booster”. She used a specific example of how programme facilitators approached in a non-judgemental way:

You know, like you say, there's no right or wrong answer. And I think that's what boosted everyone's confidence up coz there was a guy there, can't remember his name, he was like, in a shell, he

wouldn't crack, he wouldn't say anything or...we'll go around a circle and say our name and he will be just like (shrugs shoulders) ... And then towards like half of the course, he would start saying his name, and then, speaking out and when they would ask group questions and that.

Lynn also realised she began to speak up too, “I don't really like speaking in groups either. I sort of clam up too (Laughs) . . .in the end I did”. The facilitator approach enabled a change in motivation for Lynn which led to her to become an active member of the group. The approach Lynn describes very much reflects *kaupapa* Māori practice that is illustrated earlier in my thesis by Moewaka Barnes (2009). It seems Pare and Tama facilitated with respect, nurturing participant *Mana*, while also being humble in their approach (Moewaka-Barnes, 2009).

Lynn's ongoing counselling through the Hauora also had a significant impact on her well-being. Her counselling began with Patty, a social worker, and she was later transferred to Johnny who specialises in Alcohol and Drug Counselling:

Having Patty here sort of had that one person that didn't know me that I could release all, all my stuff to...So yeah, the after counselling was good. Coz we were kind of shocked when we finished the course like oh no what do we do now. And then when I saw Patty coming once a week or once every 2 weeks or whatever...counselling was amazing. It was cool.

Patty helped address Lynn's anger issues that she had held on to for a long time. Johnny later took over counselling of Lynn. His approach differed to Patty. Johnny often took Lynn to differing places of importance to Tūhoe *iwi*. Lynn recalls that he took her to be treated with *rongoa Māori* including a traditional massage which she felt had calmed and helped heal her. At the time of interview her counselling had completed and she showed

contentment with the amount of sessions she received post-programme.

Lynn thinks she now has the tools to tackle life without those supports:

It has opened my eyes too, you know. . . I think it's just how they, they're so fun orientated, like how they are and well the whole business is aye I think it just opened up my eyes from another world really.

Lynn also experienced social rewards through the programme. The group got along well-together and she remembers laughing a lot which made her feel at ease with the group. In alignment with the discourse which highlights some participants tend to keep in touch with one another post group-programme (Maltzman, 2008), Lynn has kept in touch with programme peers via Facebook. However, Lynn would have liked to continue meeting with those people in face-to-face group situations.

In terms of community participation, Lynn would like to get out and about now that she no longer is on home detention. She is studying the road code in preparation for regaining her licence. She feels confident that she will not reoffend in the future.

I believe Lynn is doing particularly well given she has a partner who has alcohol issues himself. She mentioned how difficult it is for her to remain sober given his behaviour but ascertained that now, her priorities lay with her children. This is because her collective experiences with Tūhoe Hauora “opened” her eyes. Her attitude to alcohol has changed, where she now “hates what it does to people the alcohol oh Well, and drugs”. This, and her children, are her motivators to continue making healthy lifestyle choices.

Participant Reflections

Lynn was the first of the participants to critique the length of the programme. She provided the following advice “I kind of already had an understanding of the *whare tapa wha* and all of that . . . But I think if I didn't know anything about it. It probably would have been harder to learn all of it because it was such a short course. . .it would have been better if it was longer”. Despite this, she seemed very happy overall with the programme. Lynn did however express reservations about the change in facilitators for future programmes because of how effective Pare and Tama had proved in meeting her own needs.

Conclusion

Identify key health outcomes for programme participants.

Lynn's health story post-programme is a very positive one. Up to time of interview, Lynn's drinking and driving behaviour was eliminated and she had no intention of repeating this behaviour in the future. Her consumption of alcohol had also become non-existence. The cause of this varies. First, Lynn had just given birth to a baby boy therefore chose not to drink while carrying or post-birth due to the risks of drinking while breast feeding. Lynn also contributed facilitator skill during the Impaired Driving programme and ongoing counselling post-programme, as main influences towards her lifestyle change. Through the programme and counselling, Lynn learnt to make healthy choices for herself and *whanau*. In terms of becoming a healthy member of society, Lynn has an intent to regain her licence so that she can get-out-and-about in the community with her children more often.

Determine programme factors contributing to participant health outcomes.

The intervention services provided for Lynn were very much appropriate for her. Supplement to course learnings, facilitators also provided Lynn one-on-one counsel during course. Thus, her drink driving recidivism was addressed through group and course work, and personal issues addressed through individualised korero during programme and later through ongoing alcohol and drug counselling.

The *kaupapa* Māori aspects of the programme worked particularly well for Lynn. This was especially evident through facilitator approach to praxis which aligned with *kaupapa* Māori practice, and through her counselling sessions where she received traditional massage and *rongoa* Māori.

Key areas in need of improvement.

One gap that was highlighted in this case was again, the un-informed process which Lynn experienced during her referral from the Department of Corrections to the Impaired Driving programme. This un-informed process did not help with Lynn's initial motivation issues. Credit goes to Tūhoe Hauora however, given it took only one session for Lynn to internalise motivation and find a want to attend class.

Case Study 5: Sonny

Introduction

Sonny is in his early forties and identifies as both Māori and New Zealand *Pakeha*. He has two small children and resides in the Whakatane township with his long-term partner, Alicia, who also identifies as *Māori*. They recently relocated to Whakatane from Whangarei to live near *whanau*. At the time of interview, the family relied on the unemployment benefit for

income although Sonny was actively looking for full-time employment and taking up precarious opportunities when they arose.

Sonny participated in 7 of the 10 Impaired Driving sessions. His interview took place 10 months after programme completion in his rental property. Sonny's interview was the most challenging for me as an inexperienced interviewer. He had his own children at home with him as well as his nieces and nephews. This included his new born baby.

During the interview, I carried and settled Sonny's baby for him as he tended to other children's needs. I felt comfortable doing this as a mother to a toddler myself. And although this multitasking proved challenging while interviewing, this was by far the most enjoyable interview for two reasons. First, because it proved how effective and necessary cultural values are in building trust and rapport with evaluation stakeholders. As I cuddled the baby, both Sonny and I relaxed because it enabled me to connect with my interviewee and his *whanau*. When Alicia arrived home, and saw me with her baby, she immediately engaged with me and we were able to have a korero around Sonny's health and their want to make healthy lifestyle changes as a unit. This has however been omitted from the evaluation due to lack of consent. Secondly, Sonny's position was unique. Unlike other participants, he illustrated a great level of accountability for the wide-reaching impact his past actions have had on his family. He also felt a strong sense of responsibility to provide for his family as soon as possible. This responsibility is the main theme emerging from Sonny's narrative.

Relationship with Alcohol and Drugs

Sonny has a history of alcohol, marijuana and heroin use. He has previously attended rehabilitation while living in Sydney which enabled him to stop using heroin. He has not used heroin for the last 12 years. He was also a heavy binge-drinker but due to a medical condition is no longer able to consume large quantities of alcohol. Of all the participants, Shannon is the heaviest smoker, consuming approximately 20 rolls per day. Sonny was engaged with a Tūhoe Hauora drug and alcohol counsellor ahead of participating in the programme and had participated in further drug and alcohol based courses while in jail.

Road to the Impaired Driver Course

Sonny's latest drink-driving charge was the result of his choosing to drive a friend home after they had been drinking. Unlike others, Sonny told me his attendance on the programme was a choice explaining "I didn't have to do it". According to Sonny, his probation officer informed him about the course and how it may help him and his *whanau*. He explained "I agreed to do it. I needed to do something anyway coz of the family". This contradicts his client records. According to records, this was Sonny's fifth drink-driving conviction which led him to nine-months imprisonment and nine-months home-supervision. Thus, Sonny was required to participate in the course so he can re-apply for a zero-tolerance licence upon completion of his sentence. Despite his referral circumstances, the notable factor is that Sonny believed participation was a choice. Therefore, the want to change drink-driving behaviours was to a degree, self-motivated. This aspect of Sonny's participation needs to be considered when analysing the information he shared as it had possibility of affecting programme outcome

and measuring efficacy (Leafe, 2015). It could also cause difficulties inferring causation (Davidson, 2005) given Sonny may have already started a process of change leading in to the programme.

Course Experiences

Sonny described the course as “quite good”. He continues “there was stuff that I hadn't thought of for years and ... refreshed my memory and stuff. . . I think it's a good program helps people. Yeah.... definitely. And there's people out there, that need stuff like that”. Initially, Sonny was “wary” about contributing to group discussion “because um...well it's sort of hard talking in groups and stuff like that but it was... they did it quite well”. Sonny ended up sharing with his Impaired Driving group, even though it was “personal stuff too”. Sonny attributed his group contribution to facilitator skill:

Pare she was good yeah and so was umm Tama Yeah, they run it quite well and made it easy to um talk and stuff... they made you feel relaxed and...yeah. . . I think everyone felt pretty relaxed and got to know each other and stuff. You know, like when the first couple of times everyone's sort of looking at each other sideways and wondering what it's all about ... yeah. They did do a good job at that, making you Just yeah.... More comfortable. Which is important. I think.

Sonny also further talked of the social benefits of group therapy (Maltzman, 2008) where “we all got to know each other quite well and stuff. . . I found it was quite...you meet people in the same situation and support them, you know”. This very much reflects the experiences of other participants where peer encouragement helped with learnings through a community of practice (Wegner, 2000). For instance, he explained “Meeting other people in the same situation and stuff like that. And um...you know, talk about our own, you know, our own experiences”. Sonny also mentioned that given his

impression of the programme, he had “already told a lot of people about it. Well I’ve spoken about it to people, yeah”. This was a complement to the programme given Sonny had participated in many rehabilitation courses without such enthusiasm.

Perceived Health Outcomes

Post programme, Sonny and his family have made significant changes for the betterment of their well-being at individual and relational levels. Sonny reported that he has not driven sober or while impaired since the programme up to date of interview and has no intention of driving until he regains his licence. He explains “for the future I’ll be thinking before I actually go. . . before I start drinking is what I’ll be doing. Just thinking about all that (learnings) first coz I... there’s no way I’m leaving my license and going back to jail and stuff like that again. Just been too much of a mission”.

Sonny’s attitude to improving his holistic health is also very positive. He stated his motivation to change was “for kids and that. I want to be around”.

The programme role in this was to “put things into perspective”.

During my visit, there were clear signs of Sonny and his partner making positive lifestyle changes. Sonny’s partner, Alicia, has also previously taken part in a similar drink-driving course in Whangarei. She resonated with his experience. Following every course, Sonny and Alicia had a *korero* about his experiences. That process has allowed them to communicate better as a couple, and make plans to get healthy together. Sonny explained, “she’s doing stuff now, coz it’s sort of you know like... we talk and stuff and she’s um... started doing um... Mum’s Fit program and stuff like that, you know, cross training and stuff and... yeah we both looking at our health and stuff, yeah. I guess. And it probably did help

because I would come back and we would then talk, and stuff like that”.

Studies have found that the intervention of significant others during impaired driving rehabilitation are very useful in addressing male recidivist drink-driving behaviours (Kennedy, Isaac, Nelson, & Graham, 1997). This seemed to be happening for Sonny. His learnings and want for change was reinforced by his partner and it seemed to be having a huge impact on their relationship and well-being of the family as a unit.

For Sonny, the greatest negative health impact presented following the completion of home detention. It was here he realised that living in town, unemployed, was not healthy for his family. The biggest goal for him, was to regain a sense of normality in their lives by finding full time employment and a rural home. Sonny and whanau had previously lived rurally and earned an income through farming and fencing. He explained that the move “was a big thing, coz we were actually up North and they had like um. . .14 acres...sort of, well just leasing it. And building up like 8 cows of our own. We had to sell them, you know, shoot our pigs”. A big goal for Sonny was to regain his licence so he and his *whanau* could relocate to a rural area again. He explains “towns not really good, for me. Yeah... a lot of my mates and that just the same old thing you’re doing twenty years ago, sort of... you know? but it was good like...move back down here, like all the family is down here...yeah, but still you know it was like...it felt like we were getting ahead and it was like a step backwards really. . . I like having a veggie garden, you can’t have one here, you know, I’m used to having a bit of a veggie garden and stuff and so it’s ...yeah”. Town life was simply not for Sonny, and he had the goal of doing everything possible to ensure he and his family could move back to the country. In the country, he would not

only be able to earn a living, but also avoid potentially risky situations.

Exploring ways to mitigate potentially risky situations was learned through course and he was applying this to his life:

They were talking about people, places and things that trigger and stuff, like that and just um. that to me ... you know...I want to...like seeing as I'm getting my truck back and my license, sort of basically looking at moving back rurally, you know? I sort of think like it's out for my mates to come and visit me, anyway. You know? But they can't drive out to visit me and stuff, they can't just turn up on my doorstep. You know what I mean?

To Sonny a new environment meant he and his *whanau* could successfully take control over the well-being of their own lives and avoid individuals who may negatively influence their goal of change.

At the time of interview, Sonny was in the process of re-applying for his licence so that he could find and maintain full-time employment. Although, he made point of how expensive this process is. This was particularly difficult for Sonny given he and his family relied on the unemployment benefit for survival. When I asked if WINZ would help with those costs his reply was “Well, yeah not really. Because they sort of look at it as well...you know you put yourself in that situation, sort of thing”. From my perspective, I found this perplexing. Sonny clearly understood his past mistakes yet reportedly the beneficiary system was not assisting him to access the financial support needed to become a contributing member of the community. During the interview, I encouraged Sonny to again check with WINZ with view of gaining financial help to regain his licence.

Sonny admitted he was ready for change heading in to the programme which meant that although his attitude to drugs and alcohol had developed post-programme, the programme was one of several factors contributing to

his change. He seemed adamant that the programme helped him re-think his drug and alcohol use. In terms of mental health, he highlighted that potentially his choice to drink and drive was more than a bad mistake; “my partner reckons that I was uh.... sort of depressed or something, you know”. This was not easy for Sonny to share. He continues, “I thought um... I always thought that was a bit of a cop-out, really. Depression and stuff. You know? I think everyone’s different. You know I do think some people do use it as a copout. But, I still think that it’s some people develop, yeah... you know?” In retrospect, Sonny believed there was some truth to his partner’s idea that he was depressed, which led him to the incident causing his conviction. This is important to note as depression tends to present itself in recidivist drunk drivers due to co-existing dependency problems (Freeman et al., 2011). There are signs now however, that Sonny is motivated and actualising goals for him and his *whanau*.

Participant Reflections

Sonny is a very practical individual. His reflections illustrated this. It was clear that attending the Impaired Driving programme and other government-agency appointments had a significant impact on Sonny because it took up time that could have been used to find and undertake employment. He explained:

At the time, I had a lot of...I was doing a lot of stuff with probation and things like that. Just doing a bit here and there... I had turned off fencing work and stuff like that (to attend appointments). And I did think oh, this would be good when this is all over. . .Yeah, coz it was, coz I was sort of looking for work and stuff as well, you know? Yeah, and I was thinking, Jesus I could do them then. Like I could do a night one. Yeah. . . especially when, I mean, especially when you’re looking for work and then you find a job and then, “oh, but I can’t come on Monday, because I’ve got a drink, driving....”

Sonny was busy trying to rebuild his life, and the continual commitment required of him by government agencies and the Impaired Driving course halted his ability to do this. He shared a useful idea to mitigate this for future participants. He suggested that the programme be offered at night. According to Sonny, if this option were available to him, he would not have had to put off potential work and inform potential employers about his involvement in an Impaired Driving programme, which could have deterred their want to employ him.

Another very insightful suggestion Sonny explored, referred to continuity of care. Sonny explained:

Like they said it (further help) was there, you know to ring, but people don't tend to do that. It's sort of the last thing that you do is ring someone the people you should, but yeah. It's different if they rang you, you know? It's sort of.... or they follow you up. You know what I mean?

The suggestion he put forward was that Tūhoe Hauora actively engage with programme participants following the Impaired Driving programme. From Sonny's perspective, those who need help most, are less likely to seek further intervention from the Hauora. However, he also offered another approach:

Even if they had something like they ... where we all got together again and all.... You know, something like that. coz then it refreshes it all too. Even if we all got together once. You know what I mean? Like a year afterwards or something like that.

Given the group cohesion, Sonny thought follow up hui would act as a course refresher and help with his personal motivation issues to remain sober.

Conclusion

Identify key health outcomes for programme participants.

At the time of the interview, Sonny's impaired driving behaviour was successfully eliminated. He also had a clear intention of ensuring he will not make the mistake of driving while impaired in the future. He had reported reducing his use of alcohol: however, this was on the most part, due to a medical condition. Sonny did show signs of wanting to change his environment to ensure that he was not encouraged to take part in risky behaviours. Sonny was also taking up precarious employment and attempting to find permanent full time employment so he could provide for his family. In saying this, he had certainly made healthy developments post programme: however, this can-not be solely attributed to his involvement in the programme given he was making lifestyle changes ahead of programme commencement.

Determine programme factors contributing to participant health outcomes.

The skill of the facilitators was a factor contributing to Sonny's continuing motivation to make healthy lifestyle changes for he and his *whanau*. He believed it was facilitator skill which enabled him to share personal talk with his peers. In saying this, I would say given the outcomes, the intervention was certainly appropriate for him.

Key areas in need of improvement.

Sonny's experience of the programme highlighted some gaps worthy of mention. First, Sonny was inadequately informed about the referral to the programme. That is, he was under the impression his participation was a choice. Second, Sonny's experiences in terms of government expectation

were similar to Whare, in that each both expressed issue with the demand on them from varying agencies. Except, in Sonny's instance, this was affecting his ability to participate as a contributing member of society. Sonny had turned down jobs to attend the Impaired Driving programme. He was also wary about telling potential employers about choosing to attend the Impaired Driving programme over work due, to being stigmatised for drinking and driving. Sonny suggested night classes to mitigate this issue for future participants. Furthermore, Sonny also suggested follow up group sessions to address motivational issues. He believed follow up sessions would refresh his memory about learnings, and socialising in a group context would make him happy. Lastly, continuity of care was also a point of comment. Sonny believed that for people like him, continuing with social or counselling support may be an option if Tūhoe Hauora initiated the process. But it was unlikely he would ever actively seek out further help himself without encouragement.

Chapter 6: Discussion

Summary of Findings

The following section summarises key findings in reference to the evaluation aims. Each section can be identified as:

- MOH: An expected funder outcome as per contract requirement.
- Tūhoe Hauora: An outcome relative to the Tūhoe Hauora mission.

Please refer to case studies for in-depth discussion about health outcomes, inferred causation leading to those outcomes and any negative aspects about the programme experienced at an individual level.

Before I discuss the evaluation findings, it is important to mention limitations of this study as this needs to be considered when interpreting the results. First, the study relies on self-reports. Self-reports in terms of deviant behaviours are somewhat risky to rely on given participants want to avoid negative consequences for bad or illegal behaviours (Aquilino, 1994). Second, the sample size is small and context specific. It is therefore difficult to project these findings beyond the studied context. These limitations are discussed earlier in the thesis and measures were taken to counteract the study limitations.

Identify key health outcomes for programme participants

1) participant drinking and driving behaviour is eliminated (MOH)

All participants self-reported eliminating impaired driving behaviours post-programme, at the time of the interview. All evaluation participants reported an intent to stop any future impaired driving behaviours and were exploring ways to mitigate situations or contexts

that could place them at risk of undertaking future impaired driving behaviours. However, it is important to remember that this information is self-reported and may reflect a self-serving bias on the part of the participants.

2) Participant consumption of alcohol and other drugs is reduced (MOH)

Three of the five participants interviewed, reported that they had ceased the consumption of alcohol and drugs at the time of the interview. The two participants who continued to drink had drastically decreased their consumption of alcohol and drugs post-programme. Again, it is important to remember that this information is self-reported and may reflect a self-serving bias on the part of the participants. Also, the decrease in participant drinking/drug behaviour cannot be attributed solely to the programme given that all of them were, or had, carried out court-sentences that required sobriety. The programme was however, one of several contributing factors that motivated participants to reduce or eliminate alcohol and drugs from their lives post-programme.

3) Holistic well-being is improved (Tūhoe Hauora)

All participants self-reported an increase in holistic well-being during and following the Impaired Driving programme. This was illustrated predominantly through social and psychological facets of health although physiologically, participants had reported also feeling healthier. I have summarised the key health findings based on the *whare tapa wha model below*.

Taha Wairua & Taha Hinengaro

This project supported the findings discussed by Ebbett and Clarke (2010) in reference to alcohol use and loss of cultural identity. Leading in to the programme, all interview participants had experienced some degree of social disconnect between their *whanau* or culture while also presenting with alcohol problems. The programme did address some of these issues. For instance, Joy experienced building a positive self-identity in the group context. Her confidence grew to the point she could look others in the eye and hold an open conversation with a stranger. Lynn experienced confidence building ascertaining her role and identity foremost as a mother. And Sonny's identity as a father and provider strengthened during rehabilitation. Whare reinstated a connection with the Māori world using *rongoa* Māori and Paul illustrated interest in his peer's development and could reflect on his past relationship through his experiences in the programme.

Taha Tinana

Better physical health was experienced indirectly by all participants. On the most part, this was the physiological effects of a forced-period of sobriety. However, Whare was a strong illustration of how continuity of care using culturally embedded methods can achieve excellent health outcomes. After treatment using *rongoa* Māori, Whare reported feeling physically healthy. His gout pain eased and he could tend to daily activities and errands around his home without pain. This motivated him to remain sober. Lynn reported, through her sobriety, that she no longer slept during the day. Lynn's outcomes were augmented through the continued support of Tūhoe Hauora using culturally embedded

practice. Sonny's partner, Alicia, was motivated to take up a local fitness programme as part of their *whanau* goal towards better health. These goals were created through *korero* about the Impaired Driving course.

Taha Whanau

The social outcomes because of this programme were outstanding. All participants illustrated some form of enhanced social health during and following the programme. For instance, Paul found companionship with Joy through the programme which helped him overcome years of social isolation. Joy's psychological well-being was addressed by belonging to and contributing to the group. Whare was accepted as a respected member of the group and his learning was supported by his peers during group activities. Lynn did not want the course to stop because of the social benefits and laughter experienced at each session, and Sonny found himself contributing to class discussion despite his initial reservations to share his personal stories.

4) Participants are encouraged to lead active, productive and safe lives amongst their communities (MOH)

During the interviews, all participants reported that they were undertaking safe and healthy behaviours in their community. All participants also held a goal that they were working towards which would encourage them to become a contributing member of their community. For Joy, this was to remain sober and use her experiences to become a social worker to help troubled youth. Whare wanted to help his *whanau* address alcohol abuse issues by referring them to Tūhoe

Hauora. Peter wanted to regain his licence, find employment and remain working beyond his retirement age. Lynn was focussing on being the best mother she could for her children and was studying to regain her licence so that her *whanau* could gain a sense of normality in their daily lives. Sonny was planning a full lifestyle change for he and his *whanau*. He not only wanted to find full-time employment but also aimed to find a lifestyle block and earn an income through this lifestyle.

Determine programme factors contributing to participant health

outcomes

In summary, the following underlying programme features contributed to the health gains experienced by participants:

- Facilitator skill and approach
- Kaupapa Māori methods of practice

1) Was the programme based on the participants' specific needs?

(MOH)

In summary, yes; the programme was based on specific participant impaired driving and wider health needs. This was made possible through a screening and assessment process undertaken by Tama, the Clinical Team leader, in accordance with Matua Raki's (2012) recommendations.

Assessments considered the impaired driving history of each participant, *whanau*, alcohol and drug background of participants. It was through this process suitability to the programme was assessed. Potential course members were grouped based on similarities and therefore the programme

planned accordingly. Course outcomes are evident of the programme meeting individual needs.

2) Were offenders provided appropriate intervention services?

(MOH)

In summary, yes, each of the participants were provided appropriate intervention services. The focus of the Impaired Driving programme was, foremost, to address impaired driving recidivism. This was achieved, at least according to the participants' self-reports. This was so, even for those whose impaired driving sentences were completed. This study therefore very much supports the discourse highlighting the use of cognitive behavioural techniques in addressing impaired driving issues (Matua Raki, 2012; Quinn & Quinn, 2015). As per feedback, this was achieved through the utilisation of facilitator approach and skill, course content and group activities that addressed foremost, impaired driving behaviours.

Tūhoe Hauora also offered ongoing support to some participants. This ensured that where health provision was limited during the programme, Tūhoe Hauora could continue to address participants' health needs.

Therefore, not only did Tūhoe Hauora offer appropriate intervention services during programme but post-programme as well. Those who took part in post-programme services experienced significant health gains from those interactions. This very much supports the notion put forward by Walker (2014) who suggests continuation of care leads to increased health outcomes of participants.

3) What role did the values of Tūhoe Hauora play in health outcomes? (Tūhoe Hauora)

From some perspectives, the appropriateness of *kaupapa* Māori practice could be questioned here given that a) not all participants identified as Māori and b) those who identified as Māori held limited cultural identity/*whanau* connectedness. Nevertheless, the utilisation of *kaupapa* Māori methods actualised great social rewards for all participants, Māori and non- Māori. My findings therefore support the discourse presented earlier in my thesis arguing for the use of *kaupapa* Māori values and methods in addressing health deficit (Bishop, 1999; Smith 2003).

Tūhoe Hauora organisational values proved pivotal in encouraging health outcomes for participants. The processes of *tikanga*, *manaakitanga* and *whānaugatanga* were identified by interviewees as encouraging positive health change during the programme. For instance, participants formalised their own group *tikanaga*. This was the first step in empowering individuals to determine the direction of the programme and expectations of each other. This led to feedback which highlighted that participants felt respected. This was indeed a new experience post-conviction given the coercive nature of programme attendance. The process of participants' setting their own *tikanaga* created a relaxed and welcoming environment which aided in motivational issues.

Manaakitanga was exercised by facilitators through providing a welcoming, open and accepting atmosphere through a non-judgemental approach, providing *kai* during breaks and providing transport to and from the building where the programme took place.

whanaungatanga was also exercised by the group where for instance, in Whare's case, the group treated him as a family member and helped him with course learnings without shaming him. *whanaungatanga* encouraged participants to experience a community of practice, further allowing participants to internalise motivation and become active and engaged members of the group. Even for those who initially were reluctant to contribute to class discussion. It was through these *kaupapa* Māori processes that wider holistic health outcomes described in each case study, were achieved.

4) What Tūhoe Hauora methods and techniques attributed to health outcomes? (Tūhoe Hauora)

The skills of the facilitators were the standout feature in this course. This very much supports the discourse that highlights that programme efficacy is dependent on programme facilitation (Sochting, 2014). Programme facilitators were responsible for actualising processes of *whanaungatanga*, *manaakitanga* and *tikanaga* by using the practice methods outlined by Moewaka Barnes (2009) earlier in this thesis⁶. These skills and approaches directly improved programme efficacy.

The skilled approach of the facilitators was crucial in helping participants become internally motivated. This is important; participation in the programme is court mandated and therefore coercive. Such coercion can lead to motivational problems. Lack of motivation leads to course drop out and lack of desire to internalise course learnings and content (Leafy 2015). The implication for Impaired Driving administrators here is that lack of

⁶ Refer to page 31.

motivation leads to decreased programme efficacy and difficulties in encouraging positive participant health outcomes (Leafe, 2015). A sound indicator of programme efficacy lay in the facilitators' ability to help participants develop and internalise motivation to change. This occurred for all participants after the first session, except for Whare, who presented learning difficulties.

Areas in need of improvement and suggestions for improvement

The main theme presenting through my recommendations is that I have found the evaluation participants at the powerless end of institutional oppression (Nelson & Prilleltensky, 2005). My recommendations address this oppression to ensure participants receive a fair chance at rehabilitation.

In formulating these recommendations, I need to be clear that for those analysed:

- Tūhoe Hauora have met and exceeded the MOH contract requirements.
- Tūhoe Hauora have actualised the mission of Tūhoe Hauora.

Recommendations therefore do not focus solely on operational matters but rather are framed to address wider health issues which could potentially enhance health outcomes for future Tūhoe Hauora programme participants.

Referral to the Impaired Driving course

At the time of evaluation, all Tūhoe Hauora Impaired Driving participants were referred by the Department of Corrections. One of the major issues highlighted throughout this study is the dislocation between the referral agency and Tūhoe Hauora. The findings showed that the referral process is

very much an uninformed one. One participant was under the assumption his attendance was a choice and all participants were unclear of the referral process which led to their participation in the programme. When we consider that participation is coercive, the lack of information pertaining to the programme is clearly adding to motivational issues leading in to the programme. Walker's (2014) segment in the New Zealand Corrections journal specified a need for collaboration given the interdependency between agencies and sectors in improving offending outcomes. I believe there is room for improvement in the referral process used by the Department of Corrections. Every participant has the right to be informed about the programme they are mandated to participate in. Based on the feedback I have received; the referral agency should be able to provide potential programme participants information pertaining to the following questions:

- What is the Impaired Driving programme?
- What does Impaired mean?
- Why am I attending?
- How will my attendance affect my sentence?
- How long is the programme (what days, time, how many weeks)?
- What will happen if I choose not to attend?
- What does the course content include?
- What have others gained from this programme?
- Who can help me if the course impedes other government agency requirements?

If a probation officer is referring an individual to attend a programme, the probation officer should clearly understand how that programme is

contributing to the offender's overall rehabilitation and recidivism. It will be the responsibility of Tūhoe Hauora to provide that information to Corrections.

From a community psychology perspective, I consider this current referral process used by Corrections oppressive (Nelson & Prilleltensky, 2005). I believe Tūhoe Hauora can use an empowerment approach by supporting and advocating the participant voice (Nelson & Prilleltensky, 2005). Here I recommend Tūhoe Hauora communicate to Corrections, the need for an informed process to take place for every potential programme participant. This may help to address initial motivation issues and programme efficacy, but importantly, address any form of institutional oppression. My recommendation is therefore:

- Review the Impaired Driving referral process.
- Advocate the need for an informed referral process to take place.

Collaboration with other Agencies

Government and health agencies have clearly expected significant amount of time and commitment from those interviewed. This was particularly evident in the cases of Whare and Sonny. These commitments included attending Probation, WINZ, the Impaired Driving and subsequent counselling and social service appointments. This demand overwhelmed Whare to the point he cancelled health appointments so he could tend to government agency expectations. This priority reflected the fact that government agencies controlled his unemployment income and his sentencing conditions. Whare was also confused about the names of his counsellors because his health issues were addressed from two differing

health organisations. Similarly, Sonny felt that the commitments he was expected to keep undermined his ability to find full-time employment. I believe this is an area Tūhoe Hauora could address through open communication and collaboration with fellow non-government and government agencies. I therefore recommend that:

- Tūhoe Hauora explore the overlap of health provision offered to Impaired Driving participants. This may mean an enhanced collaboration with neighbouring health providers is established to mitigate future counselling or social support overlap for any one programme participant during or post programme.
- Tūhoe Hauora explore how government agency expectation impedes programme efficacy and participant health outcomes. This may mean Tūhoe Hauora advocate to government agencies, on behalf of participants, the adversities which are experienced by each individual when demands to attend appointments supersede healthy lifestyle choices.

Introduction Session

Matua Raki (2012, p.23) state:

Where people have been mandated to attend treatment with a significant history of impaired driving but have had no or limited previous treatment it may be helpful for them to initially attend an educational group to introduce them to the content and to begin the process of engagement with the programme.

Although a partial induction was undertaken during the assessment process with Tama, participants continued to seem unaware of the programme

purpose. Whare, who experienced learning difficulties, said it took half the course before he understood how the programme applied to his life. Lynn also said that if she held little prior knowledge about *te whare tapa wha* she may have found it difficult to understand and keep up with course content. I believe that some programme participants may benefit from an introduction session ahead of the first Impaired Driving therapeutic session. This would allow facilitators to address motivational issues ahead of the therapeutic programme and introduce how the programme affects court-sentences and consequently contextualise the programme in participant lives. I therefore recommend that

- Tūhoe Hauora explore the option of offering an Educational Impaired Driving session to potential programme participants.

Blanket approach to transport provision

Two participants interviewed were not given the option of being picked up and dropped off from the programme. This was because they resided in the Whakatane township. However, it also took those participants a great deal of time to walk to and from the course. I would recommend that the organisation offer a blanket approach to transport provision to ensure all are given equal opportunity to get to and from the course safely and within an appropriate timeframe:

- A blanket approach to transport is considered if possible, to all participants regardless of location of residence.

Continuity of Care

Matua Raki (2010) insist that “after Impaired Drivers have attended an intervention the ongoing monitoring of their behaviour and attitudes by corrections workers will help to identify any need to access further treatment if necessary”. Rather, I would suggest access of further treatment is initiated by Tūhoe Hauora. A helpful point, as suggested by Sonny, is that not all those who want or need help, seek help. I would recommend that facilitators refer programme participants to other social or counselling support and provide those people with an opportunity to decline the help. I recommend this for varying reasons. First, the feedback of those who received ongoing services from Tūhoe Hauora demonstrated greater enthusiasm for maintaining a healthy lifestyle and illustrated positive health change post-programme in comparison to those whose support ceased upon completion of the Impaired Driving programme. Second, Tūhoe Hauora provide an oppression free space that continues the use of *kaupapa* Māori methods. All participants in this study seemed to respond to those methods very well. I therefore recommend that,

- Tūhoe Hauora initiate referral of programme participants to other available social support and counselling services upon the completion of the Impaired Driving programme.

Discussion from a Community Psychology Perspective

Individual (Micro)

Personal Empowerment

From a community psychology perspective, I was cognisant that each participant interviewed had experienced and were continuing to experience

multiple levels of oppression as they belonged to varying minority, marginalised and powerless groups. I was interested to see if any had experienced a personal empowerment processes because of their participation in the Impaired Driving programme. I referred to Nelson & Prilleltensky's (2005, p.272) table illustrating the process of personal empowerment to determine if each participant had overcome internalised oppression. And, I have concluded that all participants post-programme, and through the methods of *whanaungatanga*, *manaakitanga* and facilitator approach, have reached at the least, the levels of 'awareness', 'learning of new roles' and 'participating towards' their own conscientisation (Freire, 1998). However, for each to reach a point of 'contribution' in the process of personal empowerment, further measures need to be taken. Sadly, with the exception of Sonny, none of the participants had active kinship or family ties. As per the literature, internalised oppression can be addressed through identity building. I therefore believe that each participant can further overcome internal oppression by addressing cultural and *whanau* dislocation. Aho & Liu (2010, p.126) state "kinship is a strength and deterrent to mental illness because it renders individual pain a collective concern rather than treating it as a personal issue". Here, I believe that Tūhoe Hauora can act as an agent of change and encourage building of kinship through the provision of further culturally embedded practice. This would-be *iwi* specific, by Tūhoe for Tūhoe.

I would like to mention that I as the evaluator, experienced a level of conscientisation myself. Through this project I was constantly forced to be mindful of how my assumptions affected my research. I was forced to be reflexive in my practice. As time passed, I could recognise my conditioning

and think beyond that conditioning. Put simply, at an individual level, I reached a ‘light bulb moment’ through this project and feel I have reached a new level of awareness about myself and the systems around me.

Relational (Meso)
Kaupapa Māori Practice

Through this experience I have found oppression ever-present through our collective rehabilitation system (Corrections, the health system and the Justice system using punitive measures). All participants interviewed came from lower-socio-economic backgrounds and were exposed to environments that led to mental health and/or addiction problems. The information gained from interviews illustrated that the referral process and the coercive nature of programme referral were, again, exposing participants to another layer of oppression (Nelson & Prilleltensky, 2005). Tūhoe Hauora, as mentioned, provided a welcoming space for the five participants to heal and learn. I therefore believe this evaluation very much supports the necessity for *kaupapa* Māori practice to become normalised in health praxis (Moewaka-Barnes, 2009).

It was the forming of a judgement free space, created through a *kaupapa* Māori practice by Tūhoe Hauora which led to positive health outcomes (Smith, 2003). The space was free of power-privilege structures which participants were exposed in the outside world. Thus, I believe, facilitators worked within a transformative paradigm. I view Tūhoe Hauora as an organisation and programme facilitators as individuals, as agents of change (Watkins & Shulman, 2008). Here in lies an implication for this study. While reviewing the literature, it was clear that very little evidence exists

suggesting that *kaupapa* maori embedded practice leads to positive outcomes in relation to impaired driving. Nor could I find any literature relating to impaired driving in the context of Tūhoe or any *iwi* in the Eastern Bay of Plenty. I believe this study fills that gap (Thompson & Barnett, 2007). However, due to the limitations in my study I believe further *iwi* and context-specific investigation is needed to determine how culturally embedded practice can aide impaired driving and wider substance dependency issues in *Aotearoa*. Alternatively, I believe that further focus on *iwi* specific evaluation is needed so that every *iwi* is acknowledged for their own histories, dynamic and collective goals. As it is made clear. Every *iwi* is unique, and evaluators need to acknowledge that.

Collective (Macro)

Mana Motuhake o Tūhoe and the Funder Provider System

My want to empower and liberalise Tūhoe Hauora staff and stakeholders was at heart throughout this project. I therefore ensured that Tūhoe Hauora management/programme facilitators were involved in as much aspects of the evaluation possible. The approached used, allowed the organisation to voice their view and shape decisions. I further attempted to empower Tūhoe Hauora stakeholders by acknowledging their unique violent and traumatic history with the Crown and lastly, by taking a social constructivist approach in validating the voices of the often-unheard stakeholder. Although I cannot measure how this evaluation attributed to empowerment of the organisation (or stakeholders), my want to validate the voice of stakeholders in movement towards *Mana motuhake* was present none the less. I believe that for me, an inexperienced evaluator, this open collaboration aided my learnings about evaluation by feeling supported. Collaboration also allowed

both parties to honour the organisation's drive towards *Mana motuhake*. However, one of the underlying issues evident throughout this process, which I believe disabled Tūhoe Hauora to move towards *Mana motuhake o Tūhoe*, was the unequal power systems existing in our funder-provider health system.

This project is a very strong example of Masters-Awatere (2015) argument that there is no equality where threat of losing funding exists. As mentioned, my evaluation proposal was reframed to the new knowledge that the MOH were no longer renewing the Tūhoe Hauora Impaired Driving programme through to its second cycle. Evaluation participants were also aware that no further programmes were taking place and they were upset over the community's lost opportunity to be involved in the Impaired Driving programme. Furthermore, as Tūhoe Hauora were under the belief that no further programmes were taking place, internal organisational shifts took place. Once the second contract was renewed however, new facilitators were appointed to the programme to cover the organisational changes. The threat of losing funding, then again, having that funding renewed had multi-levelled implications for the organisation, for the Impaired Driving participants and for me as researcher. And although I could support the underlying *kaupapa* of the organisation through appropriate evaluation methods, a greater power continued to show its influence throughout the study. That was the power of the funder. Tūhoe Hauora was able to provide an oppressive free space for Impaired Driving programme participants yet were experiencing oppression through that contract themselves. I argue that if impaired driving and wider health equity are to be addressed, Māori based NGOs should be supported to achieve in a

system which nurtures good practice rather than perpetuates power systems. This study therefore supports the narrative put forward by scholars that argue for socio-political change to occur especially where our health system and policy is concerned (Durie, 2003). I believe what this study has illustrated, is that further investigation is needed to determine how NGO's can immobilize this oppression to provide proven best practice for vulnerable and oppressed individuals currently experiencing health deficit.

Chapter 7: Conclusion

All participants in this study had an underlying alcohol or other drug problem which caused them to engage in risky behaviours throughout their lives. In this study, the participants' impaired driving behaviours were of concern. For all participants, traditional western approaches to addressing impaired driving had been ineffective in that all continued to repeat the behaviour despite the known outcomes. Participants were therefore mandated to attend the Tūhoe Hauora Impaired Driving course, because they were recidivists. All participants had stopped drink driving at the date of interview and all presented intent to no longer drink and drive in the future. All participants also benefited physically, socially or psychologically as a direct result of their participation in the programme. The findings support the use of *kaupapa* Māori methods of practice in Impaired Driving programmes in *Aotearoa*. It also highlights the importance of facilitator skill in programme efficacy, especially for groups who are reluctant or hard to treat. However, the study also highlights a need for collaboration in referral processes between government agencies and Māori NGOs. The lack of equity existing in our funder-provider health system was also made apparent in this study. I conclude that further *iwi* and context specific research should be undertaken to address impaired driving and wider health issues in *Aotearoa* so that the Māori health deficit can be better addressed.

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Appendix A: Glossary of Māori Words and Terms⁷

<i>Aotearoa</i>	New Zealand
<i>Hapu</i>	Kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society. It consisted of a number of <i>whānau</i> sharing descent from a common ancestor, usually being named after the ancestor, but sometimes from an important event in the group's history. A number of related <i>hapū</i> usually shared adjacent territories forming a looser tribal federation.
<i>Hui</i>	Gathering, meeting, assembly, seminar, conference.
<i>Hui Te Ara Whakamura</i>	Name of the meeting which took place.
<i>Inoi</i>	Prayer.
<i>Iwi</i>	Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory.
<i>Kai</i>	Food, meal.
<i>Kainga</i>	Home, address, residence, village, settlement, habitation, habitat, dwelling.

⁷ Unless otherwise stated, translations are sought from the online Māori dictionary: <http://Māoridictionary.co.nz/>

<i>Kanohi kitea</i>	To have a physical presence, be seen, represent. A term to express the importance of meeting people face to face, and to also be a face that is known to and seen within a community and at important gatherings, such as <i>Tangihanga</i> .
<i>Kanohi-ki-te-kanohi</i>	Face to face, in person, in the flesh.
<i>Karakia</i>	To recite ritual chants, say grace, pray, recite a prayer, chant.
<i>Kaupapa</i>	Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative.
<i>Kawanatanga</i>	Government, dominion, rule, authority, governorship, province.
<i>Koha</i>	Gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity.
<i>Kohanga reo</i>	Māori language preschool.
<i>Korero</i>	To tell, say, speak, read, talk, address.
<i>Mana</i>	Prestige, authority, control, power, influence, status, spiritual power, charisma - <i>Mana</i> is a supernatural force in a person, place or object
<i>Manaakitanga</i>	Hospitality, kindness, generosity, support - the process of showing respect, generosity and care for others.

<i>Maoritanga</i>	Māori culture, Māori practices and beliefs, Māoriness, Māori way of life.
<i>Marae</i>	Courtyard - the open area in front of the <i>Wharenui</i> , where formal greetings and discussions take place. Often also used to include the complex of buildings around the <i>Marae</i> .
<i>Matauranga Māori</i>	Māori knowledge - the body of knowledge originating from Māori ancestors, including the Māori world view and perspectives, Māori creativity and cultural practices.
<i>Māuri</i>	Life principle, vital essence, special nature, a material symbol of a life principle, source of emotions - the essential quality and vitality of a being or entity.
<i>Mokopuna</i>	Grandchild - child or grandchild of a son, daughter, nephew, niece etc.
<i>Pakeha</i>	English, foreign, European, exotic - introduced from or originating in a foreign country. New Zealander of European descent
<i>Pepeha</i>	Tribal saying, tribal motto, proverb (especially about a tribe), set form of words, formulaic expression, saying of the ancestors.
<i>Poroaki</i>	Farewell.
<i>Rongoa Māori</i>	Natural remedy, traditional treatment, Māori medicine.

<i>Tane</i>	Husband, male, man.
<i>Tangata Whenua</i>	local people, hosts, indigenous people - people born of the whenua, i.e. of the placenta and of the land where the people's ancestors have lived and where their placenta are buried.
<i>Tangi</i>	Funeral - shortened form of <i>Tangihanga</i> .
<i>Tapu</i>	Sacred, prohibited, restricted, set apart, forbidden
<i>Te Puni Kokiri</i>	Ministry of Maori Development
<i>Te reo Māori</i>	The Māori language
<i>Te rohe potae o Tūhoe</i>	The Tūhoe area
<i>Tihei Mauri Ora</i>	Sneeze of life, call to claim the right to speak.
<i>Tikanga</i>	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context.
<i>Tino Rangatiratanga</i>	Self-determination, sovereignty, autonomy, self-government.
<i>Tohunga</i>	Skilled person, chosen expert, priest, healer - a person chosen by the agent of an <i>atua</i> and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation

<i>Tuhoetanga</i>	Unique Tuhoe practices and beliefs, Tuhoe way of life.
<i>Wāhine</i>	Women, females, ladies, wives.
<i>Waiata</i>	Song, chant, psalm.
<i>Wairua</i>	Spirit, soul - spirit of a person which exists beyond death. It is the non-physical spirit, distinct from the body and the <i>mauri</i> .
<i>Whakapapa</i>	Genealogy, genealogical table, lineage, descent
<i>Whakawhānaugatanga</i>	Process of establishing relationships, relating well to others.
<i>Whanau</i>	Extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members.
<i>Whaikorero</i>	Oratory, oration, formal speech-making, address, speech - formal speech
<i>Whānaugatanga</i>	Relationship, kinship, sense of family connection - a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group. It also extends to others to

whom one develops a close familial, friendship or reciprocal relationship.

Whare House, building, residence, dwelling, shed, hut. This is also used in thesis as a name of one of the programme participants.

Wharenui Meeting house, large house - main building of a *Marae* where guests are accommodated. Traditionally the *Wharenui* belonged to a *hapū* or *whānau* but some modern meeting houses, especially in large urban areas, have been built for non-tribal groups, including schools and tertiary institutions. Many are decorated with carvings, rafter paintings and *tukutuku* panels.

Appendix B: Introduction Letter

January, 2015

Tena koe

My name is Nicole Waru. I am a student at Waikato University. I am researching the Impaired Driver Treatment Programme you were part of last year. I would like to talk to you about the programme.

Your feedback will help me understand the good and not so good points about the programme. If you choose to have this korero with me, you will receive a \$40 voucher (you can choose between a grocery or gas voucher).

The interview will take no longer than an hour.

Purpose of the Interview

I want to sit and korero with you and ask how you think the programme has had an impact on your or your whānau well-being. This is not a test, and there is no right or wrong answer. I just want to know if the programme has helped you in any way and what changes you think need to be made to the programme.

The Interview will be informal but I will need to record our korero, so that I can analyse the information.

Privacy

The interview will be held at Tūhoe Hauora in a private room. Everything you say will be confidential. The research has been approved by the Ethics Committee of Waikato University School of Psychology which means that I

have taken the measures to ensure the research will not harm you in any way.

If for some reason however you can't make it, I would be happy to give you a phone call on a home line and interview you that way - I will send you the voucher through the post once we finish our phone call.

interviews will take place:

- Friday February 13th
- Tuesday February 17th
- Wednesday February 18th
- Phone call interviews can take place at any time suitable to you.

Participation is voluntary. You do not have to take part in an interview, nor will you be disadvantaged in any way regarding your ability to retain your licence if you don't want to have an interview.

Who am I?

I have links to Tapuika and Ngati Pikiiao through my mother, and Ngati Ranginui through my Fathers mother. My father is also a Waru from Whangape but unfortunately I do not know my Whakapapa to this side. I have links to Tūhoe through my Partner who is of Kahungunu and Tūhoe decent.

I have previously worked at Tūhoe Hauora as Pania's Personal Assistant and as the Quality coordinator. I left early 2014 so I could look after my baby boy who is now 15 months old.

I thank you for taking the time to read the letter. If you do not understand any part of this letter, or have any questions please do not hesitate to ask me.

If you feel more comfortable, you can also ask Te Rangimaria or Pania.

You are also welcome to have a support person contact me to answer any of your questions.

If you are happy to take part, please let me know on any of the below numbers so that we can allocate a day and time for your interview. Or feel free to leave a message for me at Tūhoe Hauora (07 3129874).

Again, I thank you for your time and I look forward to hearing from you.

Naku noa na,

Nicole Waru

You can contact Nicole by:

Email: **waruwhaanga@hotmail.co.nz**

Phone: **07 5737792 or 0212616804**

Appendix C: Consent Form



Background Information

Kia ora. My name is Nicole Waru. I am a student at Waikato University. I am researching the Impaired Driver Treatment Programme you were part of last year.

I would like to interview you so I can find out how the programme has impacted your well-being. If you choose to have this korero with me, you will receive a \$40 voucher (you can choose between a grocery or gas voucher). The interview will take no longer than an hour.

Purpose of the Interview

I want to sit and korero with you and ask how you think the programme has had an impact on you or your whānau well-being. This is not a test, and there is no right or wrong answer. I just want to know if the programme has helped you in any way.

The Interview will be informal but I will record our talk so that I can later refer to our discussion and write the helpful discussion points down.

Ethics

Please note: This project will be undertaken with the ethical and methodological supervision of Neville Robertson from Waikato University's department of Psychology and has the approval of Waikato University's school of Psychology Ethics Committee.

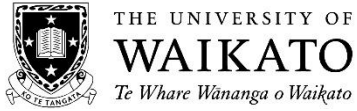
Please take the time to read the following and sign once you have clarified any areas you may not understand.

- I. Nicole acknowledges her limitation of knowledge in relation to evaluation research and the issues concerning Impaired driving. To mitigate this, Nicole will closely liaise with her supervisor to ensure any limitation of her knowledge does not harm you or cause ethical error in any way.
- II. The interview will be audio-recorded so that I can obtain an accurate representation of your experience and views. Once recorded I will transcribe the interview. You may choose to have a copy of the recording and transcript.
- III. You are not obligated to undertake this interview. You will not be affected in any way if you choose not to take part in the interview.
- IV. You have the right to withdraw from the interview at any time.
- V. You do not have to answer every question.
- VI. Everything shared in this interview will be confidential. Nicole and her supervisor will be the only individuals with access to the raw-data.
- VII. All evaluation information stored on computers will be protected by passwords accessible only to Nicole.

- VIII. Once the evaluation is complete, all data will be kept in a secure cabinet in the psychology department of Waikato University for 7 years. Up until analysis of data is complete, the information will be kept in a secure office at the personal home of Nicole, accessible only to Nicole.
- IX. Your name will not be identified in the evaluation report. However, you do need to know that there is some risk that those that know you who have access to the final report, could still ‘guess’ what information you provided for the evaluation. I will do everything in my ability to mitigate this risk.
- X. An evaluation report will be forwarded to Pania Hetet, the General *Manager* of Tūhoe Hauora so that she may be informed of the results of the Impaired Driving evaluation.
- XI. The evaluation report will be used to form a thesis for Nicole to submit to Waikato University as research towards a Master degree in Applied Psychology. Thesis will be complete in 2016. You are welcome to contact Nicole if you wish to read the thesis once completed.
- XII. You are welcome to contact research supervisor Neville Robertson at any point, for further clarification around any issue related with the evaluation.

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
1. I have read the Background Information and Introduction Letter (or it has been read to me) and I understand it.		
2. I have been given sufficient time to consider whether to participate in this study		
3. I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet		
4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without penalty		
5. I have the right to decline to participate in any part of the research activity		
6. I know who to contact if I have any questions about the study in general.		
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.		
I wish to receive a copy of my recorded Interview		
I wish to view my interview transcript		

CONSENT FORM



A completed copy of this form should be retained by both the researcher and the participant.

Research Project: An Evaluation of the Impaired Driving Treatment

Programme for Tūhoe Hauora

the convenor of the Psychology Research and Ethics Committee (Associate Professor John Perrone, Tel: 07 838 4466 ext 8292, email: jpnz@waikato.ac.nz)

Participant's name (Please print):

Signature:

Date:

Declaration by researcher:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact

Researcher's name (Please print):

Signature:

Date:

Researcher Contact Details:

Nicole Waru (*Researcher*)

waruwhaanga@hotmail.co.nz,

Neville Robertson

(*Supervisor*)

scorpio@waikato.ac.nz,

Appendix D: Interview Guide

Rough Interview Guide.

FORMALITIES

- a. Welcome and thanks, offer hot drink or refreshments (create natural, relaxed environment)
- b. Re-cap research purpose and topic.
- c. Determine that their story is important to me as a researcher from a CP point of view (Encourage conversational Competence)
- d. Informed Consent. Read through letter aloud with interviewee.
Make time for any clarification needed. Ask to sign. Check over to ensure date, name and signature is on the form. Give a copy for the interviewee to keep.
- e. Remember to let the conversation flow. Let them tell their stories.
- f. Ask them for verbal consent: please say yes or no to the following.
 1. *Do you give me consent to interview you about the impaired driver treatment programme?*
 2. *Have I read through the informed consent information with you and do you understand it?*
 3. *Do you have any further questions?*

OPENING KORERO

Kia ora. Thank you again for coming to the interview/allowing me to interview you. We shouldn't be more than an hour however If you need a break let me know.

Before we start, just a reminder that there is no right or wrong answer and I appreciate and respect your input and anything you choose to share with me. I'm going to start recording now. So to start off, I was wondering if you . . .

SECTION ONE – GENERAL FEEDBACK (20 MIN)

- 1) Could you tell me a little bit about yourself?
- 2) Can you share with me how you came to be on this course?
- 3) What were your expectations about the programme?
 - a. Were your expectations met?
- 4) What were your initial thoughts about the programme?
 - a. Did these change? If so, how? Probe:
 - Timeframes
 - Resources used
 - Facilitators
 - Venue
 - Health
- 5) What aspects of the programme do you think were particularly good?
- 6) What about the programme was useful to you in every-day life?

Probe:

 - Learnings
 - Korero

- Tasks
 - *Tikanga Māori/Kaupapa* Māori practices
- 7) What about the programme do you think weren't so good?
- Least favourite aspects?
 - Why?
 - What needed to change to make these better?
- 8) What would a good programme look like to you? Or if you were to attend the programme again what would you change?
- 9) Do you have any further reflections you want to share with me?

Outline/summarise main points of section.

SECTION 2 - PROGRAMME OUTCOMES (40 MINS MAX)

This part of the interview will focus on if and how the programme impacted on your life and well-being. So, to start off, I was wondering

1. What aspect of the programme do you think had the biggest impact on you?
 - a. Why?
 - b. Could you give me an example how it has impacted on you?
2. Tell me about what you learnt.
 - a. How have you used this in your day-to-day life?
3. Tell me, what are your feelings about Alcohol and Drugs?
 - a. How do you think the programme changed your ideas about A&D?
 - b. What about the programme do you think caused this change?
 - c. Why do you think this is?
 - d. What does the future look like for you in terms of A&D use?

4. So, when I talk about health, I consider the physical, mental, emotional and spiritual aspects of our well-being. . Like you learnt during the course (may need to refer to te *whare* tapa for recall)
 - a. How do you think the programme has impacted on these aspects of your life?
 - b. How has your health changed? Improved or worsened?
 - c. Probe Why?
 - d. Probe How?
 - e. What aspects of the programme influenced this change?
 - f. What aspects of the programme would you need to change for you to get better health outcomes?
5. How has the programme affected your thinking about driving while impaired?
 - a. Probe examples
6. Tell me how you think attending the programme has Impact on your whānau health?
 - a. Can you give me an example?
 - b. Would you recommend this course to your whānau?
Why/Why not?
 - c. What would have made the programme better for you, you and your whānau health?
7. Tell me, have you found yourself in a predicament where you were deciding whether to drive while under the influence since the programme?
 - a. If so, could you tell me about that experience?

- b. What influence has the programme had on you re-offending (or not reoffending)?
 - c. Tell me, do you think you will re-offend in the future? (probe why)
8. I'm going to set you a challenge. Say you get to design the programme. So, I would like you to describe to me what you would have in the programme (If the goal was to influence healthy choices around A&D, this includes driving while impaired).
9. Do you have any recommendations for Tūhoe Hauora so they may improve the programme?
10. So, that's about it. My last question for you would be to ask if you have any further comments?

Thank you for choosing to take part in the interview. We are finished now. Your feedback will be very useful for the research. Make sure to Contact me if you have any queries.

*Give grocery/petrol voucher. COULD YOU PLEASE CONFIRM THAT I HAVE GIVEN YOU YOUR VOUCHER (Yes/No)?

*Make sure they take their form and Turn off voice recorder

Appendix E : Tūhoe Hauora Programme Evaluation Survey

PROGRAMME EVALUATION

To ensure that we are maintaining high standards of programme delivery we seek your honest feedback on the programme you have just completed.

Please read each question carefully and write your response in the place provided.

FACILITATOR(S)	
NAME(S)	
DATE	

A rating system of 1-5 is used in this evaluation (1=poor, 2=needs improvement, 3=good, 4=very good, 5=excellent)

How would you rate the programme overall?	1	2	3	4	5
What would you tell your friends or family about this programme?					
How would you rate the faciliator(s) overall?	1	2	3	4	5

What would you tell your friends or family about the facilitators skills in delivering the programme?			
Did you enjoy the programme?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you understand the subjects discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What if anything did you like the MOST about the programme?			
What if anything did you like the LEAST about the programme?			

Were you given opportunities and encouraged to ask questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you think participating in this programme will help you and your whānau?	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Please describe your experience of the role-plays and other activities used during the programme and what you learnt.										
Would your learning influence your behaviour in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Korero / Comments								
How would you rate the resources used in the programme? E.g handouts, workbooks, videos, posters etc.	<table border="1" style="width: 100%; text-align: center;"> <tr> <td data-bbox="824 995 976 1233">1</td> <td data-bbox="976 995 1128 1233">2</td> <td data-bbox="1128 995 1281 1233">3</td> <td data-bbox="1281 995 1433 1233">4</td> <td data-bbox="1433 995 1581 1233">5</td> </tr> </table>					1	2	3	4	5
1	2	3	4	5						

COMMENTS

Thank you for taking the time to complete this evaluation. Your feedback will be considered along with others for the ongoing development and maintenance of this programme.

Appendix F: Survey Results

November 2014- course 2 Tūhoe Hauora Impaired Driver Survey Results

Overview:

- 11 out of 12 of the participants completed and handed a survey form back to the facilitators.
- Surveys were completed at the final (graduation) Impaired Driver session.
- It was not compulsory to complete a survey
- Participant responses numbered 1-11. Participant feedback referenced P1, P2 and so on.
- The survey used, is the generic Tūhoe Hauora Programme evaluation survey form used for quality improvement purposes.
- Quotes verbatim

Rate Scales

1=poor, 2=needs improvement, 3=good, 4=very good, 5=excellent

Averages are rounded to the nearest whole number to indicate what “rate” each question was scored.

Left-Right = participants no.1-11

1. How would you rate the overall programme?

5	4	5	5	5	5
5	5	5	5	5	
AVERAGE = 4.9					
Result = Excellent					

2. How would you rate facilitators overall?

5	4	5	5	3	5
5	5	5	5	5	
AVERAGE = 4.7					
Result = Excellent					

3. How would you rate the resources used in the programme?

5	3	4	5	4	4
5	5	5	5	5	
AVERAGE = 4.5					
Result =Excellent					

Closed Yes/No Questions

1. Did you enjoy the programme?

100% = YES

2. Did you understand the subjects discussed?

100% = YES

3. Were you given opportunities and encouraged to ask questions?

100% = YES

4. Do you think participating in this programme will help you and your *whanau*?

100% = YES

5. Would your learning influence your behaviour in the future?

100%=YES

Open-ended questions (qualitative)

1. What would you tell your friends or family about this programme?

- 1) It's worth going too
- 2) I talk about the journey and how it affects my family etc.
- 3) Unsure
- 4) Yes I would
- 5) It is worth going
- 6) It was primo. Mean Kai
- 7) That this is a good programme
- 8) -
- 9) It's all good
- 10) Its life changing
- 11) -

2. What would you tell your friends or family about the facilitators' skills in delivering the programme?

- 1) From my experience I found the facilitators awesome at what they do
- 2) That they were human, easy to talk to and got us to open up
- 3) Certainly no what they are talking about and can back it up
- 4) That it is enjoyable learnt heaps
- 5) Good
- 6) They are good facilitators. Non judging. Make you feel normal haha
- 7) That they would get a lot out of it
- 8) Bloody awesome. Good understanding.
- 9) Very helpful
- 10) -
- 11) -

3. What, if anything, did you like MOST about the programme?

- 1) Other peoples input and the facilitators teachings
- 2) I liked the way that we all could get our point of view across
- 3) Meeting people with different issues in their lives
- 4) First aid course. Meeting new people. Didn't like it at first but now I love it.
- 5) The hole thing
- 6) The food, the facilitators, the group.
- 7) Everything
- 8) Well spoken. Clear. Good understanding.
- 9) The hole thing was good
- 10) Generally everything but first aid was a bonus
- 11) Meeting people from different lifestyles and walks of life some with the same or different circumstances or situations

4. What, if anything, did you like the LEAST about the programme?

- 1) Nil
- 2) Nil
- 3) Being forced by the courts to attend course
- 4) Nothing
- 5) Nothing
- 6) Should be longer than 10 weeks
- 7) There was nothing that I didn't like
- 8) By being here listening to teacher
- 9) Going home
- 10) Its over already
- 11) Nil

5. Please describe your experiences of the role-plays and other activities used during the programmes and what you learnt?

- 1) The dangers with drink and driving and what I lose from it

- 2) It just helped me remember coping skills and how to use them in day-to-day
- 3) Every person in the programme participated each week in the topics for the day
- 4) To be yourself. Open up.
- 5) Good
- 6) Felt like I'm not an outsider (before?)*
- 7) That every person in the programme participate
- 8) -
- 9) Loss the shy ness
- 10) It was awesome I learnt too much to write about
- 11) -

6. Extra comments

- 1) Really good programme really enjoyed and learnt a lot
- 2) It's been real and I will put some of the tools I learnt in to practice

- 3) Completed the 10 weeks of the programme and as a bonus passed the first aid course. Good morning tea nice coffee and fresh milk
- 4) I've enjoyed everything about this course. Met a lot of people. Really good friends/associates.
- 5) Good program. Good to meet likeminded people. I have made some good friends.
- 6) Enjoyed the programme would recommend to anyone.
- 7) That this programme is a good programme is good for everyone
- 8) It's getting to me. Don't drink and drive. Your legend.
- 9) -
- 10) Thank you guys
- 11) -

