

**Critical Success Factors in Kaupapa  
Māori AOD Residential Treatment:  
Māori Youth Perspectives**

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# ABSTRACT

There is a significant gap in the research literature regarding issues related to Māori rangatahi (Māori indigenous youth) alcohol and other drug (AOD) residential treatment. Historically, the majority of residential AOD treatment services for adolescents have been modelled on adult residential AOD treatment services which paid little, if any attention, to the developmental and cultural needs of indigenous youth. The lack of services available to address a young person's developmental and cultural needs has often left indigenous youth with no alternative but to attend mainstream services, to which they may already feel alienated and have experienced a sense of diminished self worth and identity. One important way to ensure that developmentally and culturally appropriate treatment services are developed in the future is to understand what these services might look like from a youth perspective.

**Aim:** This thesis aimed to explore the perspectives of Māori rangatahi, who had previously accessed a kaupapa Māori (Māori ideology) youth residential AOD treatment service, on the critical success factors in their treatment.

**Method and Procedure:** Qualitative semi-structured individual interviews were conducted with ten Māori rangatahi, employing a kaupapa Māori framework. In order to ensure a diverse range of participants were interviewed, participants were randomly selected from the 65 youth who attended RA in 2009. Participants were asked a number of open-ended questions about their experiences of AOD residential treatment and what they thought worked and did not work for them while they were in residential AOD treatment. The data were transcribed and analysed utilising a general inductive approach. The data analysis was then refined through an applied thematic analysis to more effectively organise and identify key themes and subthemes.

**Findings:** Māori rangatahi viewed kaupapa Māori AOD residential treatment as vital to their recovery and well-being. Success factors included multifaceted AOD programme interventions that reflected a positive youth development approach. The strength of incorporating Māori health concepts and Māori tikanga in lived practice in AOD treatment for

rangatahi was conjointly supported. Kaupapa Māori treatment, that ‘lived’ Māori practice and values facilitated a sense of belonging among participants and served to help secure who they were as Māori youth.

The findings from this study emphasised the critical importance of cultural interventions that are holistic, work with the young person ‘where they are at’, and encompass a broad range of areas to help support rangatahi in their recovery. There was unanimous agreement from the rangatahi in this study that there is a need for culturally appropriate, multifaceted, residential AOD youth treatment services which offer multiple interventions/components delivered through a holistic way of healing for Māori by Māori. The importance of including youth voices in the development, design and implementation of AOD services, especially in assisting to improve access and retention in treatment for Māori rangatahi, was also highlighted.

**Implications for Practice and Policy:** Policies that incorporate easier access for young people and support their continuing care into or back into residential treatment are crucial in order to be more responsive to Māori rangatahi. It is vital that greater flexibility and diversity is offered in terms of treatment options and that interventions are relevant to the particular young person’s needs and support positive Māori youth development. Overall, a comprehensive review of current practice, policy and funding levels to honor Te Tiriti o Waitangi is essential in order to address and implement the appropriate AOD treatment service needs of Māori rangatahi.

# PREFACE

Improving the well-being of indigenous peoples has been my passion and my life's work. As an indigenous woman (Native Hawaiian), I have a personal understanding of the daily life experiences of the impacts on indigenous health in a Western society framed by colonial oppression. Due to my own perspectives and values as an indigenous clinical therapist and as an emerging health researcher, I am all too familiar with the systemic racism, both as a barrier and a contributor to the poor health among indigenous peoples.

For the past 15 years I have been working in the area of addictions as a clinical practitioner. My work with adolescents began in a mainstream residential alcohol and other drugs (AOD) treatment facility and it was there that I have grown to have a passion for working with adolescents.

During my time in mainstream treatment, I noticed the different treatment needs of indigenous clients and the absence of appropriate cultural input or aspects of cultural treatment in the service design, service development and service interventions. Hence, I perceived that treatment services were not supporting the engagement and retention of many indigenous clients. I became aware of the number of early discharges, whether self or service initiated of indigenous clients, due to a number of reasons, but mostly, I felt because of the lack of the service to engage indigenous clients through appropriate cultural interventions. With this in my mind, and with life events changing, I found myself in Aotearoa/New Zealand and was asked to participate in work on indigenous initiatives.

This led to my joining Te Rūnanga o Kirikiriroa Trust, the Urban Māori Authority health provider based in Kirikiriroa (Hamilton), Aotearoa (New Zealand). Through their guidance, I had the honour of developing the first kaupapa Māori youth AOD residential treatment service in New Zealand, called Rongo Ātea (RA). The time spent developing RA allowed me to bring together my professional experience, along with my experience of working alongside other indigenous communities in and around the US and the Pacific. In addition to my experience of working with Māori youth, I have spent most of the last 15 years in Aotearoa working solely with Māori and supporting the political and health development of Māori.

Regarding my last statement, my experience tells me that any health improvement of any indigenous peoples is, by virtue of having to challenge colonial systems of care, political in and of itself.

In the development stages and day-to-day running of RA, I learned more about indigenous young people from the youth themselves than any human development class could ever have taught me. Our early beginning was in a suburban residential home. This was a temporary arrangement as we were awaiting for the new premises to be built. With a core group of indigenous women and no instruction book at hand, we began to explore models of residential treatment to address the substance abuse problems, while simultaneously addressing other co-existing problems and behavioural issues that the young people may bring with them. Additionally, we explored Māori models of health that were being used at that time. In the end, a Minnesota model of youth residential treatment (of course *Māorised*<sup>1</sup>) won out because of how it was embraced and accepted by other indigenous peoples with a similar colonial legacy as a preferred model of AOD treatment. The Māori health model that was overarching in application was Mason Durie's Te Whare Tapa Wha Durie, (1994) which could be easily understandable to the rangatahi.

During the first few months of operations we did a great deal of exploring contingency management techniques. A token reward system was then put into place to support not only the learning of economic management, but which in turn further supported engagement. I must say that overall, Māori tikanga and kawa was the contingency management 'lived', and became the core interventions/components within the programme. Kaimahi were then further skilled to better support, advocate and understand the young person, not by their diagnosis, but for the circumstances (historical and personal) that led them into residential AOD treatment in the first place.

During the first few months of service delivery, the youth in treatment were the key in guiding our thinking, and gave valuable input into the day to day interventions/components and treatment regimes. Sometimes the rangatahi did this assertively/verbally and sometimes by virtue of continual resistance to interventions/components that were not working for them.

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<sup>1</sup> A word I use meaning to apply a Māori philosophy of delivery, or Māori styled.

By the time the service was moved into the purpose built centre next to the marae, we considered the programme was pretty much complete and that all areas were covered. However, what we learned very quickly was that working with 12 to 16 rangatahi and being attentive to the group, attending to their individual needs, their specific gender needs and age developmental issues warranted a greater number of qualified staff. This understood, the staff numbers increased; however, shortly after, due to budget cuts in funding that placed RA in a position of uncertainty, the availability of staff waxed and waned.

The funding arrangement was not conducive for 16 youth and to secure sufficient numbers of staff. Even so, in 2006, RA was recognised for the most innovative service by the Midlands Mental Health and Addictions forum. My interpretation of this acknowledgment was affirmation that kaupapa Māori youth AOD residential treatment was not only delivering what was expected by the funders of an AOD youth residential treatment, but, perhaps delivering even more than what was expected.

Today, RA continues to struggle with low funding levels to support appropriate staff numbers in order to more effectively support the complex and diverse needs and numbers of the rangatahi who reside there. However, RA has persevered, as many kaupapa Māori services do sometimes, with meagre resources in order to serve the people.

Although I have not had a developmental role with RA for the past ten years, my hope is that this research study will bring the marginalised and often unheard voices of indigenous youth in need of treatment for substance abuse disorders to the forefront to be heard. Although I am no longer employed by RA, my hope is to provide the information necessary so that adequate resources and further research can be offered towards the development of RA and other youth services' development to ensure the provision of high quality services are available for rangatahi and their whānau, inclusive of their cultural needs.

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There are a number of people who have contributed to this study at different stages and whom without their support I could not have accomplished this thesis. Hence, I would like to acknowledge and thank the following:

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# CHAPTER ONE: INTRODUCTION

In New Zealand, *Māori* are the First Nation people or *tangata whenua* (people of the land) and a priority population requiring appropriate health interventions. The government funded health sector in New Zealand recognises the special relationship obligations that the Crown have with Māori and the need to reduce disparities in order to improve Māori health and wellbeing.

This chapter provides a historical overview of the impacts that have contributed to the health related disparities Māori presently experience, and explains the unique treaty relationship between the Crown with Māori. This chapter also outlines the Māori response to the health disparities, including Māori models of health and kaupapa Māori responses and solutions. This, in turn, provides the context for the development of the alcohol and other drugs (AOD) youth residential service, which is the focus for this study.

Understanding that the ill health of Māori did not happen in a vacuum, is critical in addressing the health disparities that Māori face today. The position in society in which Māori find themselves today can be attributed to the accumulation of 160 years of colonial rule. The historical implications and disadvantages that Māori have experienced are closely linked to ill health and are important factors to acknowledge in order to begin to address solutions; only then can health related responses be applied in a competent and appropriately cultural way from which Māori can benefit (Durie, 1997a; 1997b; 1998).

The aim of the current study was to explore Māori youth perspectives on the critical success factors in *kaupapa Māori* (Māori ideology) AOD residential treatment. For the purpose of this thesis ‘critical success factors’ are defined as what Māori rangatahi identified worked for them and others while in residential AOD treatment. The experiences and viewpoints of ten *Māori rangatahi* (Māori youth) who have accessed the RA kaupapa Māori residential AOD treatment service were gathered to address this issue. Providing a cultural platform for Māori rangatahi voices to be heard and their perspectives shared was a key motivating factor in this study.

Adolescent substance abuse and poor mental health are concerning and serious problems (Plant & Panzarella, 2009; Sellman & Deering, 2002; White, Dennis, & Tims, 2002). Statistics in New Zealand show that Māori under the age of 23 years make up 17% of the total general population with Māori under the age of 15 years making up about 33% of the Māori population (Statistics New Zealand (SNZ), 2013). Given the youthfulness of the Māori population, meeting the mental health and AOD needs of Māori rangatahi is a priority, and although they have been identified as a priority population within Aotearoa/New Zealand, there has yet to be adequate attention paid to address the limited AOD and mental health treatment options available for this group (Schroder, Sellman, & Frampton, 2008).

There have been a number of New Zealand national health policy documents published that commit to addressing the limited availability of kaupapa Māori mental health and addiction services, and to involve rangatahi in the design, implementation and evaluation of appropriate addiction and mental health services for rangatahi (Ministry of Health (MOH), 2005; MOH, 2008a; 2008b; Ministry of Youth Development (MYD), 2008). Despite this commitment, there is still much to be achieved to realise this goal. Involvement of rangatahi in the development of health services is presumed to play a vital role in addressing issues of access, engagement and retention in youth AOD services, and as a result, contribute to improved health outcomes for rangatahi and their whānau. This presumption is supported by existing research literature that suggests that youth involvement in the development of AOD youth services is the key to understanding what the success factors are for youth attending AOD treatment services (Bell, 2006; Birkin, Kent, & Ashton, 2004; Checkoway, 2011; Finn & Checkoway, 1998; Māori Youth Council, 2011; MYD, 2008).

## **HISTORICAL CONTEXT OF TODAY'S HEALTH AND SOCIAL INEQUALITIES EXPERIENCED BY MĀORI**

In order to provide a comprehensive understanding of the distinct circumstances that Māori, as the indigenous peoples of Aotearoa/New Zealand, face today, it is vital to understand the historical context. Similar to many colonised indigenous peoples around the world, Māori have experienced the suppression of their native language, loss of land, dramatic collapse of population, suppression of traditional cultural ways of life, and oppression and marginalisation

to name a few, all of which have impacted directly on Māori mental health (Durie, 1994; 2001; Walker, 1990). These are now discussed within the next sections of this chapter.

## COLONISATION AND URBANISATION

Long before the arrival of Europeans to New Zealand, Māori lived within their unique tribal structures. The basic social units comprised of *whānau* (extended family), *hapū* (subtribe) and *iwi* (tribe). Important social stratification roles included *ariki* (chief), *rangatira* (noble), *pakeke* (adult), *tuakana* (elder sibling), and *teina* (younger sibling) (Durie, 1998).

The imposition of Western culture through the British colonisation of Aotearoa beginning in the mid-1800s resulted in Māori being displaced from their original tribal lands, causing disruption to their traditional social structures, loss of language, deities, cultural practices, and loss of economic base. As has been well recorded, the effects of colonisation on Māori have been disastrous and have been attributed to the cultural erosion that took place as a result of European settlement (Alderete, 1999; Durie, 1998; Kingi, 2006; Orange, 2011; Walker, 1990).

The results of this cultural erosion (Kingi, 2006) have been comparable to those of many other indigenous cultures. Māori have experienced and are still recovering from colonisation and the forced assimilation by Western societies and the suppression of their cultural and spiritual ways. These historical and ongoing traumas and stressors related to poor health and social development amongst indigenous peoples, such as Māori, are linked to increased mental and emotional problems, self-destructive behaviours, including violence, and substance abuse (Brave Heart, 2003; Durie, 1998; Paradies, Harris, & Anderson, 2008; Walker, 1990).

Māori society, in which Māori identity is intrinsically intertwined, further broke down due to the changing economic climate and the implementation of urban social structures (Alderete, 1999; Durie, 1998; Walker, 1990). Reports show that by 2006, 84.4% of Māori lived in urban centres, compared to 1956 when the majority or two-thirds of Māori lived in rural areas (SNZ, 2006). The reasons for moving into urban areas were not only loss of tribal lands, but included purposes such as seeking education, employment and better housing conditions.

This change saw migratory shifts en masse of many Māori to the cities to take up better employment and living opportunities. However, due to having lower levels of education (white institutional education), Māori workers were the dominant population of the low skilled workforce, earning a low wage (Ministry of Māori Development (MMD), 2012).

Prior to the changes that came about through colonisation and urbanisation, Māori traditional structures were well established. Māori protocols and practices promoted and acknowledged Māori as being connected to the environment, to the spiritual realm and to the cosmos, and acknowledged a holistic approach to all things, which valued their interconnectedness to physical features of the land. Often, Māori will identify who they are and who they descend from in relation to their ancestral mountains and rivers. This is encapsulated within *te reo Māori* (Māori language), and the connection through *wairuatanga* (recognition of the spiritual dimension) is said to be central to *whakapapa* (genealogy) and the wellbeing of Māori (Durie, 2001; Henare, 1988; McLachlan, Hungerford, Schroder, & Adamson, 2012).

The disconnection of traditional ways through the colonial process has been related to Māori socioeconomic deprivation, along with poorer health and other negative social aspects. The disconnection from cultural opportunities such as language, knowledge, *whānau*, land, cultural practices and native foods etc, has been well documented as being directly linked to poorer health among indigenous peoples (Durie, 1998; Huriwai, 2002; World Health Organisation (WHO), 1999).

As a result of this colonial history, Māori as *tangata whenua o Aotearoa* (people of the land of New Zealand) are now viewed as a priority population, requiring appropriate health interventions in order to improve the health and social conditions among Māori that have been so detrimentally affected by the injustices imposed on Māori through Western colonisation (Alderete, 1999; Durie, 1998).

## **INTRODUCTION OF ALCOHOL AND OTHER DRUGS**

Historically, Māori were a people who had very little psychoactive substance use prior to Western contact (Huriwai, 2002). There is, however, evidence that Māori had access to substances that were chewed, such as gum from certain trees. Even so, these were not widely

used and it was usually reserved for the pleasure of chiefs. Prior to European contact, Māori usually drank water and it was the arrival of James Cook which saw the introduction and increasing use of alcohol and other psychoactive drugs by Māori (Hutt, 1999).

The effects of alcohol and other psychoactive substances on Māori served to further undermine traditional societal structures, and negatively impacted on the ability of Māori men and women to fulfil their roles and responsibilities according to their tikanga, kawa, traditional values and beliefs (Hutt, 1999). The early undermining of traditional practices that supported individual and collective well-being can now be seen in the inter-generational transmission of unhealthy alcohol and drug related behaviours (Hutt, 1999). It is therefore crucial to identify methods for addressing these misconceptions of alcohol as a ‘traditional’ part of Māori rituals and practices within the process of treatment delivery, and ensuring that this information is delivered in a way that is meaningful and connects to the historical accounts of alcohol and indigenous peoples (Brady, 1995; Durie, 1998; Hutt, 1999).

## **TE TIRITI O WAITANGI (THE TREATY OF WAITANGI)**

In 1840, Te Tiriti o Waitangi (the Treaty of Waitangi) was signed, and is recognised as the founding document of Aotearoa/New Zealand. At its core, it describes a partnership entered into between the British Crown and Māori, in which Māori interests would be protected.

In 1975, The Treaty of Waitangi Act was incorporated into legislation and highlighted the importance of Te Tiriti o Waitangi (The Treaty of Waitangi) as the founding document of New Zealand and made legislative provision for health and social and economic inequalities between Māori and non-Māori to be addressed. The Act led to the establishment of the Waitangi Tribunal. The work of the Tribunal was to address historical grievances and more broadly, to protect Māori interests (Oh, 2005; Ward, 1995). Māori not only placed historical grievances of land on the table of the Tribunal, but moreover used this platform to promote health development for Māori based on three key principles: partnership, participation and protection (Kingi, 2006). These principles underpin the government’s commitment to working with iwi, hapū and other Māori communities, to develop strategies to improve Māori health, involving Māori at all levels of planning, decision making, and development and service delivery, and to ensure that Māori can access the same level of health as non-Māori

with cultural appropriateness (MOH, 2002a). These principles are evidenced in many ministerial documents supporting Māori development, particularly within the health sector (MOH, 2005; 2008b).

## **MODELS OF MĀORI HEALTH WITHIN THE HEALTH SECTOR**

In attempting to address these disparities, and within government frameworks, Māori have made a stand to hold health professionals who are working with Māori accountable to kaupapa Māori core frameworks/structures. Furthermore, for health professionals to have an understanding of Māori culture in their practice in order to ensure health providers are culturally safe to engage with Māori (Durie, 1994; Papps & Ramsden, 1996).

Māori health workers have further advocated that when working with Māori, a holistic approach is essential to Māori wellness. This is in comparison to many Western processes that do not acknowledge the importance and the connectedness of all things; for instance, the physical, spiritual, emotional, whānau, heavens and earth (Alderete, 1999; Durie, 1994). In regard to healthcare provision, Durie (2001, p. 35) asserts that “Māori have a right to be comfortable in their own Māoriness and health service provisions should encapsulate things that affirm Māori identity and culture.” According to Pōmare and Durie (1999), health needs to take into account the quality of the interaction between people and the environment that surrounds them. They identify six key components of health:

1. *Mauri ora* which is derived from a secure cultural identity and that although there are many facets to good health among indigenous peoples all over the world, cultural identity is a precondition;
2. *Waiora* which brings together people with their environment;
3. *Toiora* is affected by healthy personal behaviours through specific interventions and positive development;
4. *Te Oranga* which directly correlates health to socioeconomic conditions. Good health will not be achieved if policies that lead to the lack of access to education and employment remain unchanged;
5. *Nga Manukura* which is concerned with good health promotion leadership and communication between iwi and community and the number of alliances between these groups;

6. *Te Mana Whakahaera* which speaks to the need for autonomy and is demonstrated in the involvement and control that people have in their own health promotion.

What this model (Te Pae Mahutonga) illustrates is that in viewing health from an indigenous world view, the physical health and mental health of a person is intertwined and interrelated. The Ministry of Health's report *Te Puāwaiwhero 2008–2015* (MOH, 2008b), illustrates this view and acknowledges socioeconomic disparities as a determinate of health for Māori and attempts to address this within the Māori mental health and addiction national strategic framework. The *Te Puāwaiwhero* document's assertion is supported by the earlier World Health Organisation's (WHO, 1947) statement which articulates that health was greatly influenced by not only social factors but was inclusive of cultural factors, with both international and national studies advocating that access to health care services by indigenous peoples is greatly improved if services are based on indigenous worldviews and that services are culturally appropriate (Alderete, 1999; Cram, Smith, & Johnstone, 2003; Gurung & Mehta, 2001; Huriwai, Sellman, Sullivan, & Potiki, 2000; Maramba & Hall, 2002; Snowden, Masland, Ma, & Clemens, 2006).

In a practical sense, Māori models of health recognise that interventions likely to aid Māori health and well-being need to ensure they support the facilitation of the reconnection of Māori to Māori processes, by Māori for Māori (Smith, 1992; Smith, 1999). This is further encapsulated in the following quote by Durie (1997) that “the healing process for Māori requires validation of our reality, finding who we are on all levels — spiritual, emotional, physical and mental and coming into our own power both individually and as a people” (p. 72).

Of significance is that Māori models of health do not align themselves with Western philosophical models or Western medical models that focus on illness rather than on holistic ways of healing. In contrast to Māori health models like the *Te Whare Tapa Wha* model (Durie, 1998), which is accepted widely among Māori mental health and addiction service providers, and forms the philosophical basis of kaupapa Māori service delivery. *Te Whare Tapa Wha* views health as a four-walled house or the four cornerstones. The four walls comprise of *taha wairua* (spirit), *taha hinengaro* (thoughts and feelings), *taha tinana* (physical side), and *taha whānau* (family). Māori assert that integration of all of these elements is necessary for good health. For Māori, the *taha wairua* is the most essential for good health and well-being. The fourth dimension of *taha whānau* is the cornerstone of

kaupapa Māori health services. In understanding Te Whare Tapa Wha, one can assert that should any of these four walls become unbalanced, the person would become unwell. This model of Māori health aligns well with many other indigenous people's beliefs that view health as strongly related to the unspoken and unseen power or force that Māori call *wairua*. Wairua is often overlooked and even missed in mainstream health models as a possible contributing factor to a person's illness.

## **KAUPAPA MĀORI AND MĀORI HEALTH SERVICE DEVELOPMENT**

An important concept underlying this study, both in terms of the methodology and the underlying philosophy of the treatment service involved in this study, is the concept of kaupapa Māori. Whilst a more indepth description of kaupapa Māori research will be given in the methodology chapter, it is important at this point to define what is meant more generically by the concept kaupapa Māori. However, in reviewing the importance of indigenous ways of being and doing, we are reminded that kaupapa Māori is not a new practice (Mahuika, 2008), nor is it Māori philosophies wrapped around Western theories. Kaupapa Māori is an entity of knowledge that Nepe (1991) illustrates as embodying a distinctive epistemology and metaphysical grounding, which dates back since time immemorial. Māori health, then, is the interrelativeness of relationships between the individual and the environment.

For many years, Māori organisations and groups expressed their belief that existing mainstream mental health and addiction services did not adequately meet the needs of Māori (Durie, 1994). Māori then articulated the view that services run by Māori, which were inclusive of Māori cultural beliefs, values and practices, as well as contemporary Western treatments, could achieve better health outcomes if they were given the opportunity (Cram et al., 2003; Crengle, 2000).

In 1984, the first Māori mental health cultural treatment unit, '*Whaiora*' was established at Tokanui Hospital (Durie, 1994). This initiative was developed and run in part by Māori mental health nurses, and was designed to give Māori tangata whaiora (person seeking wellness) an alternative experience of mental health care. The Whaiora unit recognised the contribution of cultural awareness when working with tangata whaiora well-being and mental health. This approach involved consideration of Māori cultural beliefs, values and practices,

whilst maintaining the use of Western treatments. This concept and approach that Whaiora embodied, largely influenced the development of modern kaupapa Māori mental health services that are operating today (Durie, 1994).

In summary, it has been widely recognised that colonisation and urbanisation have played a significant role in the ill health of Māori (Cram et al., 2003; Durie, 1997a; 1997b; Huriwai, 2002; Huriwai et al., 2001). Durie (1994; 1997) and many others have consistently advocated that the good health and well-being of Māori is directly connected to cultural security and cultural identity, and so the need to accommodate culturally appropriate treatment services for Māori is crucial. Kaupapa Māori services fulfil a vital health need that cannot be filled by mainstream services, as Māori wellbeing is derived by the principles of the Te Tiriti o Waitangi and the government's commitment to supporting Māori developments, particularly in the health sector. These developments lead to the establishment of kaupapa Māori services to address alcohol and drug issues, such as RA, located in Kirikiriroa (Hamilton) under the auspices of Te Rūnanga o Kirikiriroa Trust Inc.

## **RONGO ATEA YOUTH ALCOHOL AND OTHER DRUG RESIDENTIAL TREATMENT SERVICE PROGRAMME BACKGROUND**

In 1998, a marae-based AOD residential treatment service for the Midlands Health region was proposed, which targeted 16 beds, eight for adults and eight for youth. In 2000, the contract was renegotiated with the arrival of a new CEO for Te Rūnanga o Kirikiriroa Trust Inc, who had experience in the mental health field. The CEO argued that placing adults and young people with substance use and co-existing problems in the same residence would compromise the safety of all, particularly the vulnerable young people. The Health Funding Authority agreed and the first kaupapa Māori youth residential AOD service was developed.

RA is a purpose built, 16 bed residential centre located next to Kirikiriroa Marae that is a 24 hour, seven day a week, ten-week abstinence based treatment service for youth between the ages of 13 and 18 years of age. All of the programmes' interventions/components are focused on the goal of learning and experiencing living drug free, and the tools are in the form of 'lived' cultural practices, such as *tikanga* (cultural customs and procedures), *noho marae* (a marae stay), *powhiri* (traditional welcome), *whakawhānaungatanga* (relationships), and

education through experiential learning, individual and group therapy, as well as other concrete strategies for achieving positive behavioural change.

## THESIS OVERVIEW

The focus of this thesis is to explore indigenous youths' perspectives of AOD residential treatment. There is a great deal of evidence that the misuse of alcohol and other drugs (AOD) can create complex problems and contribute to poor mental health (Alcohol Advisory Council of New Zealand (ALAC), 2009; Alderete, 1999; Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Fergusson & Horwood, 2001; Schroder, Sellman, & Deering, 2007; Vega et al., 2002; WHO, 1999). These problems are not only associated with the individual user, but extend to wider social problems that negatively impact on many other people and systems who are in contact with the person affected (Vega et al., 2002).

In New Zealand, mental health and addictions became a priority in the Ministry of Health's (MOH) New Zealand Health strategy in 2000 (MOH, 2000; 2005). This baseline report led to the Government's *'Te Tāhuhu Action Plan 2006-2015'*, which implemented a blueprint to improve mental health and addiction services. More recently, the MOH's *'Rising to the Challenge'* service development plan was designed to ensure that every person in New Zealand affected by mental illness and addictions, particularly those with high needs, would be able to access specialist services (MOH, 2012).

In improving mental health and reducing harm from AOD misuse or abuse, youth aged 15–24 years of age were recognised as a priority group that particularly targeted Māori rangatahi, who make up approximately 1/3 of the total Māori population, and 17% of the total general population (MMD, 2012). Making youth services a priority was a direct result of the high risk rates recorded for the total youth population (both Māori and non-Māori). The need for youth-focused services was evident through the findings from two longitudinal cohort studies and comprehensive studies of school attendees conducted in New Zealand (Adolescent Health Research Group (AHRG), 2004; Fergusson, Poulton, Horwood, Miln, & Swain-Campbell, 2003; Habgood, Casswell, Pledger, & Bhatta, 2001; Horwood & Fergusson, 1998; MOH, 2002; Staton, 1996). *'Te Raukura'* (MOH, 2007), a government strategy to improve the mental health and well-being for children and youth, identified priorities from the mental

health and addiction sectors. These included broadening the choices of services offered for young people who are severely affected by mental health and/or addiction issues. Included in this strategy was reducing inequalities, which included access to services, especially for Māori and Pacific peoples. The recent government service development plan, '*Rising to the Challenge*' (2012) places Māori as one of its priority populations.

Many government documents in New Zealand have identified youth and in particular Māori youth as a priority population urgently in need of health attention. Some of the areas that have been identified as a starting point are strategies that look at better ways to gain access to services and service choice as a way to reduce inequalities. Against this background, as services have developed there is still a need to further develop services by hearing youth perspectives so that questions that remain unanswered can begin to be addressed, such as: What are appropriate treatment interventions for Māori youth? What are the success factors of Māori youth AOD treatment? What are Māori youth saying is important to them in AOD treatment?

For this reason, the current research aims to answer the question "What are the critical success factors in kaupapa Māori AOD youth residential treatment" from the perspectives of Māori youth who have accessed a kaupapa Māori AOD residential treatment service. Gaining an understanding into these perspectives will assist to better inform the future practice, design, and implementation of AOD residential treatment services for Māori rangatahi. Furthermore, the research findings will provide information to help guide the development of government policy, action and commitment to improve Māori health services.

## **Terminology**

Throughout this thesis, a range of terms are used to describe groups of people, treatment, different levels of substance use, and the research approaches utilised. Throughout the study, Māori language is in italics and translated in the first occurrence. In addition to this, a glossary is provided to enable the reader to understand the meaning of the Māori language used throughout this study. A full glossary of translations can be found in Appendix 1.

## ***Adolescence***

Adolescence is commonly described as a transitional and developmental stage of life, and yet definitions of this stage vary from context to context. The World Health Organisation (WHO), for example, describes three diverse developmental phases that occur between the ages of 10 and 19 years of age (WHO, 2002). WHO defines the first phase as ‘early adolescence’ (10–13 years of age), as this is when young people begin to think abstractly, experience a surge in physical growth and begin to develop sexually. The second phase is ‘mid-adolescence’ (14–15 years of age), when young people develop a strong sense of identity, relate strongly to their peers and their thinking becomes more reflective. The last phase is ‘late adolescence’ (16–19 years of age), when young people develop individual identities, establish their own independent opinions, and physical development into adulthood are deemed to be complete. More recently, however, emerging literature on brain development has challenged this claim and development is seen to continue into the early to mid 20s (Cauuffman & Steinberg, 2000).

Although this breakdown in age is useful in illustrating the varying risks associated with the different adolescent developmental phases (MOH, 2002b) for example, when considering AOD treatment, what may be an appropriate intervention for young people aged 12–13 years of age, may not be appropriate for those aged 16–18 years of age, or those aged 19 years and older (MOH, 2002b). It is important to note that definitions vary and many terms are used to describe this age group. These include youth, young people, adolescents, teenagers, teens and rangatahi. In this thesis, these terms are used interchangeably, and do not always distinguish the developmental differences that may be present among people in this age range.

## **Māori Rangatahi**

The term Māori rangatahi or rangatahi has been used throughout this study to firstly refer directly to the participants of this research project and secondly, to generally describe young people of Māori descent and who are indigenous to Aotearoa/New Zealand.

The term rangatahi gained popularity when Sir Apirana Ngata referred to a group of young Māori leaders as “rangatahi”, even though the group he referred to were in their thirties, as encapsulated by his following proverb: “*Ka pu te ruha, ka hao te rangatahi*” (*the old net lies in a heap while a new net goes fishing*). This proverb speaks to the succession and leadership

of a younger person upon the retirement of an elder. The term rangatahi further gained acceptance in the middle of the 1900s when Māori educationalist Hoani Waititi published two principal Māori language texts entitled *Rangatahi 1* and *Rangatahi 2* (Waititi, 1971).

The term rangatahi has since become a term used to refer to young people, regardless of whether they are male or female, Māori or non-Māori, and has particularly featured in government documents, such as the Māori Youth Council (2011) report. More recently, the 2013 New Zealand census defined rangatahi Māori as being Māori aged 12–25 years (SNZ, 2013). Māori under the age of 15 and as mentioned earlier, constituted 33% of the total Māori population according to the 2013 census data, and is further predicted to increase to 820,000 by the year 2026, which translates to an increase of approximately 1% per year (SNZ, 2013). It is important to make this distinction between Māori and non-Māori youth in terms of the definitions utilised to describe them, given that this population is defined by two sets of definitions; one being the western definition of a young person, the other being the definition of a young person as understood from a Māori world viewpoint; namely a First Nations young person of New Zealand.

The term *taiohi* when referring to Māori youth, is a contemporary term that is generally accepted when referring to Māori youth between the ages of 12 and 25 years. My study, however, privileges the term rangatahi and specifically refers to those between the ages of 13 and 18 years as a term preferred by my Māori Advisor to this thesis. Throughout this thesis, the terms Māori rangatahi, indigenous youth, youth, young person/s and young people, are used interchangeably to refer to Māori youth between the ages of 13 and 18 years, reflecting the common usage of these terms in the New Zealand health funding context, within which AOD services for youth encompass those aged between 13 and 18 years (MOH, 2002b).

### ***Substance Use/Abuse & Dependence***

Substance use, abuse and dependence are three terms that are not always clearly defined. On a continuum, substance use refers to the use of both legal and illegal psychoactive substances, such as alcohol, nicotine, prescribed drugs (legal substances), and illegal substances, such as cannabis and other illicit street drugs. It is important to recognise that the term substance use is not a diagnostic term (American Psychological Association (APA), 2000), but rather, provides a behavioural context in which diagnoses can be made. Substance use (licit and

illicit) usually begins during the teen years, as does the onset of substance abuse and dependence, referred to collectively as substance use disorders (SUDs) (Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV-TR), 2000). According to the fourth edition of the DSM-IV-TR (2000), substance abuse (harmful use) and substance dependence (addiction) are clinical diagnoses that are used when a person begins to experience significant problems (interpersonal, social, psychological and/or physical), as a result of their substance use. Experiencing these kinds of problems while using substances does not always translate to having a SUD, and could be categorised as problematic substance use or substance misuse, rather than an SUD. The full DSM-IV-TR criteria for substance abuse and dependence can be found in Appendix 2.

Throughout this thesis, the term abuse may be used singularly or cumulatively and refers to substance misuse or problematic use. The rangatahi involved in this study all had a diagnosis of either substance abuse or substance dependence that met the criteria of the DSM-IV-TR (APA, 2000). In this respect, problematic use and abuse are used as terms that refer to substance abuse and dependence.

## **CHAPTER OUTLINE**

Chapter Two provides a literature review to draw a broader picture of the many environmental factors that led to this study being formulated. The literature explored information already available in the area of youth and alcohol and other drug use and treatment, longitudinal studies and the prevalence of substance use. The literature presents prevalence data of substance use and misuse in New Zealand, substance use/misuse among Māori youth, and examines youth AOD treatment in New Zealand. The literature review addresses the effectiveness of youth AOD treatment along with treatment retention, accessing treatment and improving youth AOD treatment. In addition, literature regarding cultural interventions and positive youth development were reviewed. Due to the vast area of literature to cover and the time constraints of a master's thesis, it was not possible for the review to be exhaustive. Instead, I focused on key areas, with particular relevance to Māori rangatahi and AOD residential treatment.

The literature chapter is then followed by the methodology and methods chapter, which provides an overview of the methodology and methods used in this study.

Next, I present Chapter Four, the results chapter. In this chapter I present a summary of findings from the ten interviews with Māori rangatahi. The findings are presented through three key themes. Highlighted throughout the themes were the success factors of kaupapa Māori AOD residential treatment from the viewpoints of the participants.

Chapter Five, the discussion and conclusion chapter, discusses the results from this study in relation to the existing literature. This chapter pulls the threads of the previous chapters together to provide a critical interpretation of the meaning of the results and the relevance of the information obtained. Finally, this chapter addresses clinical implications that arise, offers some recommendations and identifies areas for future research.

# **CHAPTER TWO:**

## **LITERATURE REVIEW**

### **INTRODUCTION**

This chapter provides an overview of the literature that has informed the development of this study and the interpretation of its results. It begins by providing an overview of the prevalence of substance use/misuse among New Zealand youth. The section on AOD treatment provides an overview of youth AOD treatment services in New Zealand, the effectiveness of youth AOD treatment and improving youth treatment, including indigenous models and positive youth development.

### **Search Strategy**

The literature discussed in this chapter was identified through a range of sources, which included searching the University of Otago online library databases: PsychInfo, Medline (OvidSP), Cochrane Library (Wiley) and Google Scholar.

The search terms that were used included: Māori, youth, alcohol, drug, treatment, Māori health, kaupapa Māori and youth development.

In addition, the reference lists from source documents identified were reviewed for relevance, as were references recommended by academic supervisors and cultural advisors. Included were key government documents pertaining to youth, Māori youth, Māori AOD treatment, mainstream AOD treatment, as well as youth focused prevalence studies and literature. It is important to note that the researcher was unable to locate any empirical information regarding residential AOD treatment and Māori youth.

## **PREVALENCE OF SUBSTANCE USE AND MENTAL HEALTH ISSUES AMONG NEW ZEALAND YOUTH**

A salient issue for many adolescents in New Zealand is poor mental health and substance use issues (Fleming et al., 2013). There have been a variety of studies in New Zealand that have examined the prevalence of substance use and misuse amongst New Zealand youth. These studies have utilised a range of data collection methods, including longitudinal surveys, national telephone surveys and examination of government statistics, in order to collect vital data on the prevalence of substance use among adolescents. The most notable of these studies include the Christchurch Health and Development Study (CHDS), and the Dunedin Multidisciplinary Health and Development Study (DMHDS). Although youth-related data from these two cohort studies were collected during the 1980s and 1990s, both longitudinal studies looked at lifetime rates of substance use and misuse of more than 1,000 adolescents per study that were recruited from the general population.

The CHDS longitudinal birth study continues to follow a general urban population cohort of 1,265 participants who were born in the mid 1970s. The DMHDS investigated the health and development of more than 1,000 babies born in Dunedin during 1972–1973. Both the CHDS and DMHDS studies have provided important information regarding the development of substance abuse and mental health disorders among adolescents over time and the impacts on their lives. Of particular use from these longitudinal studies has been the prevalence of SUDs within a New Zealand population. Not surprisingly, the study found that misuse of alcohol and particularly cannabis led to repeated difficulties in these young peoples' lives.

In the CHDS a diagnosis for any SUD was about 18% in the 16–18 year age group (Horwood & Fergusson, 1998). By 18 years of age 24% of participants were found to meet the diagnostic criteria for alcohol and cannabis dependence; 40% of young people between the ages of 15 and 18 years were also found to meet criteria for other psychiatric disorders, with Māori youth having higher rates of psychiatric and SUDs than non-Māori. Horwood and Fergusson (1998) found that Māori females were more likely to be diagnosed with multiple disorders (mood and SUDs) than non-Māori females, and that Māori males had the higher prevalence of multiple disorders compared with non-Māori males.

Other studies, such as *Te Rau Hinengaro*, the New Zealand Mental Health Survey (Baxter et al., 2006), a nationwide survey conducted in 2003 and 2004 targeting people aged 16 years and over, support the findings of the CHDS and the DMHDS. *Te Rau Hinengaro* examined the prevalence of mental health disorders in New Zealand and looked at lifetime rates of mental illness among the New Zealand population. Approximately 39% of people in this study met the criteria for experiencing a mental health disorder at some time in their lives, with 50% of those having experienced their first episode of mental illness early in their lives. Twelve percent of the participants were found to have experienced a SUD by the age of 18 years. It is important to mention that this survey only included those who were 16 years of age and older. The proportion of young people in this survey aged 16–24 years of age comprised just 15% of the study (Wells et al., 2006). Noted, is that these studies are not a representative sample of the New Zealand general public; however, they provide an important snapshot of the prevalence of mental health and SUDs in New Zealand.

Another national survey, *The New Zealand Alcohol and Drug Use Survey 2007–2008* (MOH, 2010a) measured the self-reported AOD use behaviours of over 6,700 New Zealanders aged 16–64 years. Although only a small portion of the total sample were youth, the findings revealed important information on drug related harm by gender, ethnic group and neighbourhood socioeconomic deprivation. This study looked at the substance use of participants over the past year of the survey being taken. Results found that by gender and ethnicity, European and Māori males had a higher rate of drug use. Forty-nine percent of the total participants had used drugs in their lifetime, such as alcohol, tobacco or party pills. Eighteen percent of the participants had experienced harmful effects from their drug use in the past year. According to the evidence presented in this survey, New Zealanders have higher rates of drug use per population compared with other populations across the developed world (MOH, 2010a).

## **Substance Use**

The three most commonly used drugs among youth in New Zealand are alcohol, cannabis and nicotine (MOH, 2010a). The patterns of use of these ‘top three’ substances are now discussed alongside a brief mention of the role of other drug use.

## **Alcohol Use**

Alcohol continues to be the most common and most frequently used drug among adults and youth in New Zealand. In general, the average age of onset of regular alcohol use in New Zealand is 15 years of age (MOH, 2013; Wilkins & Sweetsur, 2008), with 52% of young people between the ages of 12 and 17 years reporting drinking to ‘some extent’. A further 24% of New Zealand youth fit the category of ‘binge drinkers’, which is defined as consuming more than five or more standard drinks in one sitting (Fryer & Kalafatelis, 2007). These findings are supported by data from the CHDS that showed 7% of young people drank alcohol at least once a week by the age of 15 years of age, with a further 40% reporting this pattern of drinking by the time they were 18 years of age (Fergusson & Horwood, 2001; Fergusson et al., 2003).

In 2007–2008, as part of the youth drinking monitor survey conducted by the Alcohol Advisory Council (ALAC, 2009), 913 youth between the ages of 12 and 17 years were interviewed about their alcohol use over the previous two weeks. The sample was divided into Māori, Pacific, and non-Māori groups. Of the 913 youth interviewed, 82% of Māori, 87% of European/other ethnic youth, and 58% of Pacific youth had reported drinking alcohol in the previous two weeks. Relevant to this current thesis is that of the Māori participants, 69% reported being regular drinkers, 48% reported having more than five standard drinks of alcohol during their last drinking session, with a further 10% drinking ten standard drinks or more (ALAC, 2006; 2009). In a random sample of 9,000 mainstream secondary school students in New Zealand the study found that 17.6% of the young people reported drinking 10 or more standard drinks in one session with half of the sample reporting binge drinking at least once in the past four weeks (Ameratunga et al., 2011).

## **Nicotine Use**

The *New Zealand Tobacco Use Survey* (MOH, 2010b) reports that the mean age of the onset of nicotine use in New Zealand is 13 years of age, with about 20% of cigarette smokers being between 15 and 19 years of age (MOH, 2010b). Although cigarette smoking amongst youth is reported to have declined in the past 30 years, smoking remains by far a leading preventable cause of disease (MOH, 2008b; Nielsen, 2006;). The 2012/2013 *Youth Health Survey* (MOH, 2013) data shows that there is a reduction in smoking in young people. In regards to ethnicity, Māori continue to have higher smoking rates than non-Māori (45% and 19%

respectively). Among 15–19 year olds, significantly more Māori females smoked tobacco than non-Māori females (47% and 13% respectively). In the same age group, 29% of young Māori males reported smoking, compared with only 14% of non-Māori males (MOH, 2007; 2011).

## **Cannabis Use**

The third most recreationally used drug in New Zealand is cannabis, with youth representing a high risk group for cannabis use (MOH, 2013). Approximately half of the New Zealand population aged 16–64 years, reported using cannabis in their lifetime (MOH, 2010; 2013), with the onset of use commonly occurring between 15 and 17 years of age. Among Māori, the age of having first tried cannabis was slightly younger than the general population, with the onset occurring at around the age of 14 years or younger. The onset of cannabis use before the age of 16 years has been correlated with problems such as criminal offending, poor mental health, school dropout and other drug use later in life (Fergusson, Horwood, & Swain-Campbell, 2002). In addition, young people from disadvantaged backgrounds were more likely to be cannabis users, putting Māori at greater risk of cannabis use and dependence. Furthermore, Māori were more likely to report experiencing more harmful effects due to cannabis use than non-Māori (Marie, Fergusson, & Boden, 2008). The *New Zealand Alcohol and Drug Use Survey* (MOH, 2010a) found that in general, past-year drug use was higher amongst the younger age groups (16–17 years, 18–24 years and 25–34 years) than in older age groups. For instance, among those who had used cannabis in their lifetime, Māori and non-Māori had similar rates of first starting cannabis when aged 15–17 years, but Māori were significantly more likely than non-Māori to have been aged 14 years or younger when they first tried cannabis.

## **Other Drug Use**

Other drugs used in New Zealand, such as benzylpiperazine (BZP), ecstasy, amphetamines, other depressants, hallucinogenics, inhalants and opioids, are reportedly minimal in terms of lifetime use, compared to alcohol, nicotine and cannabis (MOH, 2013). It is therefore important to be mindful that although many youth may experiment with illicit drugs, less than 10% will continue to use any of these drugs in their lifetime (Sellman & Deering, 2002).

## **Substance Misuse**

Although many people now consider AOD use during early adolescence to be the norm, particularly in Western societies, there is clear evidence that early onset of substance use is associated with poorer, longer term outcomes, including the onset of SUDs (Fergusson et al., 2002; Stanton, 1996). In New Zealand, young people have higher rates of AOD use and abuse than any other age groups (Buckley et al., 2013). The Ministry of Health 2008 New Zealand Health Survey reported that young people aged 15 - 24 had the most hazardous drinking patterns of all New Zealanders surveyed, with young males in this age group being the heaviest drinkers (Buckley et al., 2013).

The increase of substance use amongst youth in New Zealand generally, combined with the increase in substance use among younger aged youth, places many young people in New Zealand at risk of experiencing future problems associated with their substance use and the potential development of SUDs (Habgood, Casswell, Pledger, & Bhatta, 2001; MOH, 2002b). Not surprisingly, Habgood et al. (2001) and the MOH (2002c) found that misuse of alcohol led to repeated difficulties in these young peoples' lives. Adolescent SUD is complex, and is commonly influenced by multiple factors that include both environmental factors and genetic vulnerability. Included in the complexity are familial and social dynamics, along with the developmental age of the user (Sellman & Deering, 2002).

At 18 years of age, 24% of participants in the CHDS were found to meet DSM IV criteria for alcohol and cannabis dependence (Horwood & Fergusson, 1998). Similar rates of SUD were also found in the DMHDS. Before 18 years of age, 10% of participants in the Dunedin cohort met criteria for alcohol dependence and 5% met criteria for cannabis dependence (Feehan, McGee, Raja, & Williams, 1994). At 18 years of age, similar to the Christchurch cohort, 24% of the Dunedin cohorts were found to meet criteria for alcohol or cannabis dependence (Horwood & Fergusson, 1998).

More recently, the *New Zealand Alcohol and Drug Use Survey 2012/2013* (MOH, 2013) measured the self-reported AOD use behaviours of over 6,700 New Zealanders aged 16–64 years of age. Although only a small portion of the total sample were youth, the findings revealed important information on drug related harm by gender, ethnic group and neighbourhood socioeconomic deprivation. According to the evidence presented in this

survey, New Zealanders have higher rates of drug use per population compared with other populations across the developed world.

### ***Substance Use/Misuse Among Māori Youth***

In the last decade, there has been increasing concern regarding the prevalence of addictions and associated problems, particularly for young Māori (Baxter et al., 2006). Over 27% of Māori experience SUDs (mainly from alcohol and cannabis) during their lifetime, and SUDs have been identified as a primary cause of hospital admissions for Māori (Durie, 2001).

As reported above, nicotine is one of the most common and most frequently used drugs by Māori youth, with those aged 15–19 years having significantly higher smoking rates than non-Māori of this age group. In addition, 38% of Māori youth report being current smokers, compared with 14% of non-Māori youth. Onset of nicotine use for Māori youth has been found to occur at an average age of 11.5 years, compared to non-Māori youth at 12.7 years (MOH, 2011). According to a secondary school student study of over 1,700 Māori students, 18.5% reported being current smokers with a higher rate of 16 year olds smoking at least once a week. In addition, more than ten percent of Māori students who lived in areas of higher deprivation were smoking weekly compared to 7.9% from medium deprivation areas (Crengle et al., 2013).

In the top three of the most used drugs, alcohol use is the most common, with 66% of Māori youth aged 12–17 years, identifying themselves as ‘drinkers’ in an alcohol survey (ALAC, 2009b). The Adolescent Health Research Group (AHRG) found that 71% of the 1,701 Māori students that were interviewed had tried drinking alcohol with one third reporting a binge drinking episode in the previous four weeks. This study of secondary school students found that the percentage that were binge drinkers increased with age (Crengle et al., 2013). Moreover, 43.5% of Māori students thought it was acceptable for people in their age group to drink regularly (Clark et al., 2013).

In a further report twenty-five percent of Māori aged between 15 and 17 years reported that when they planned to drink, it was to get drunk. Further, they believed that it was acceptable to do so. This belief puts Māori youth at a higher risk of developing future problems associated with their drinking behaviours (“Kua Warea Te”, 2010). Even though the misuse

of alcohol affects everyone in New Zealand, identified as two of the three populations that are affected the most are young people and Māori (“Kua Warea Te”, 2010).

As mentioned earlier, Māori youth were more likely to have tried cannabis at the age of 14 years or younger (Mason, Hewitt, & Stefanogiannis, 2010). Moreover, Māori youth have been identified as a higher risk group regarding cannabis related harms (Baxter et al., 2006). The Māori secondary school student study ‘Te Ara Whakapiki Taitamariki’ reported that Māori students in their study (10.0%) that came from high deprivation areas reported using cannabis weekly with a higher prevalence for males than for females (Crengle et al., 2013).

Although using substances can be seen as a normal rite of passage for adolescents with only a small percentage of youth going on to acquire a SUD (Sellman & Deering, 2002; Schroder et al., 2007), the cause for concern relates to the detrimental long term effects that substance misuse can have on young people (MOH, 2012). Some of these include disruption to learning, brain development, and achieving developmental tasks and skills, including effective coping strategies and other social skills (Sellman & Deering, 2002).

It is clearly suggested by the information provided that the percentages of young people who use drugs and go on to acquire a SUD is small. However, the profound harm that having a SUD can cause is far reaching and affects not only the individual but everyone in the community of the person afflicted. Particularly vulnerable are young people from lower social economic backgrounds and young Māori who are less likely to even access services or be able to choose a culturally appropriate service to address their needs (Adolescent Research Group (ARG), 2004).

## **Youth AOD Treatment Services in New Zealand**

In New Zealand, child and adolescent mental health and AOD services are provided by the countries publically funded District Health Boards (DHBs). The DHB entities include funding for youth AOD services delivered by non-governmental organisations (NGOs) (Buckley et al., 2013; Ramage, Towns, Vaque, Cargo, & Nuimata-Faleafa, 2005). Schroder et al. (2007) identified only 11 services in New Zealand that at the time of their study met the criteria of being youth specific AOD services. Included in their study were day programmes, residential and out-patient treatment, and encompasses mainstream, Pacific and kaupapa

Māori services. The authors made seven recommendations that need to be considered when treating youth in AOD services. These include the need to: 1) understand and respond to the complex treatment needs of youth, 2) provide adequate resources of services to allow continuity and the continuum of care, 3) improve the understanding of youth attending AOD treatment with conduct disorders, 4) standard procedures to include comprehensive assessments, 5) focus on programme factors and dynamic client characteristics, 6) adequately fund youth AOD services, and 7) establish ongoing research in the area of youth AOD treatment.

The findings from this New Zealand study are in accordance with overseas studies that suggest that the majority of services, while set up specifically to serve youth, are mainly based on modified adult models of addiction treatment (Friedman, Glickman, & Morrissey, 1986; Hser et al., 2001; Spooner, Mattick, & Noffs, 2000; Winters, 1999a, 1999b). Modified adult treatment models do not always recognise and cater to the unique developmental needs of youth, and have therefore been questioned in terms of their effectiveness with youth (Bell, 2006; Schroder, Sellman, Frampton, & Deering, 2009). This highlights the call for more responsive and appropriate services that address the requirements of youth, and within New Zealand particularly Māori youth, who were less likely to access services (AHRG, 2004; Schroder et al., 2007).

## **Effectiveness of Youth AOD Treatment**

In New Zealand, studies on the effectiveness of youth AOD treatment have been extremely limited. To date, there have been no New Zealand studies found that have examined the effectiveness of the different treatment modalities (internal programme characteristics) or treatment types (out-patient, residential, adventure therapy) available to young people. However, there are two New Zealand outcome studies that will be presented in this section.

However, due to the limited studies in New Zealand international research provides a better picture of the outcomes associated with youth AOD treatment, including the effectiveness of different treatment modalities (Vaughn & Howard, 2009). Overseas studies concentrated mainly on treatment modalities rather than on types of treatment. It appears that there has been an absence of literature that has investigated treatment types (Williams & Chang, 2000).

In one overseas outcome review on residential youth treatment, the researcher investigated what factors increased positive change by examining seven studies that measured outcomes once the young person had completed treatment and 11 studies in which the progress of the young person was assessed at different intervals after discharge (Hair, 2005). This study asserted that young people who experienced emotional and behavioural problems benefitted greatly if they were attending residential treatment that offered multi-modalities and that were holistic and ecological in approach. This outcome study illuminated that family involvement post discharge along with community support and aftercare services is crucial for positive post discharge changes. Hair's (2005) study affirmed that residential treatment is a valuable intervention as part of a system of care for young people.

Another systematic review (Minozzi, Amato, Vecchi, & Davoli, 2011) examined 74 treatment programmes that included 43 out-patient and 31 residential treatment programmes on the effectiveness of the different psychosocial interventions and compared them with other psychosocial interventions regarding retention in treatment, pharmacology interventions and no intervention. Two of the most significant results found by these authors were: 1) that programme characteristics accounted for a reduction in drug use, and 2) providing 'special services' such as recreational activities, schooling, vocational and birth control services were effective. These, the authors asserted, had better treatment outcomes than gestalt therapy, music/art, or group confrontation (Minozzi et al., 2011).

In reviewing the New Zealand literature on the effectiveness of youth AOD treatment only two New Zealand studies were identified that were specific to youth. These were the Christchurch Odyssey House Therapeutic Community study (Schroder, Sellman, & Frampton, 2012), and the Queen Mary Hospital study (Faisandier, Bunn, & Brandam-Adams, 1998). Both of these studies provided an overview of some of the characteristics of youth who had attended their programmes. The Queen Mary Hospital study included 54 youth under the age of 18 years, who took part in the Queen Mary Hospital adult residential programme (Faisandier et al., 1998). The study provided a snapshot of the types of young people that presented to this particular service in the late 1990s. Outcomes showed that post treatment, clients had more stable living environments, use of government agencies had decreased, their self-esteem had improved as had their mean incomes, and they were more likely to be in employment or in some type of training.

In a more recent study, Schroder et al. (2012) examined the 12-month outcomes of 80 youth, aged between 14 and 18 years, who had attended the youth day and residential programmes at Odyssey House Therapeutic Community in Christchurch. The findings from this study indicated significant improvements on a range of measures, including substance use, behavioural difficulties, criminal activities, physical and psychological well-being, and family relationships.

Similar to other international studies, the findings of these studies were limited by a number of methodological issues, such as differing client criteria, small sample sizes and the lack of a control groups (Kaminer, 2001); however, the findings from these New Zealand based outcome studies tend to support conclusions drawn from the international literature and methodologically; stronger studies that found that the majority of adolescents who have received treatment (regardless of the treatment type), have shown a significant reduction in their substance use and associated problems in the 12 months following treatment (William & Chang, 2000; Winters, 1999a, 1999b).

## **Accessing Treatment**

A major barrier to achieving good treatment outcomes for youth with substance use issues is their ability to access treatment in the first instance. For example, in New Zealand *Te Rau Hinengaro* found that of Māori who had serious mental health and SUD problems, only 58% had presented to a health service with a mental health concern (Oakley-Browne, Wells, & Scott, 2006). What is of great concern is that Māori are less likely to even make contact with mental health and addiction services (Oakley-Browne, et al, 2006; Ramage et al., 2010). It has been found that Māori youth with SUDs were also less likely to access care despite the high prevalence rates (MOH, 2008b; Oakley-Browne, Wells, & Scott, 2006). A range of barriers for Māori youth accessing mental health and addiction services were identified in a report commissioned by the Werry Centre (Ramage et al., 2010). These included cultural barriers, such as the way that services are delivered, the impact of colonisation, and the lack of cultural consideration in services, processes and practices (Durie, 2001; Dyal, 1997; Ramage et al., 2010). It appears that addressing barriers to access is an important consideration when reviewing AOD treatment with the aim of improving treatment outcomes.

## **Treatment Retention**

A variable that has consistently been shown to be associated with positive treatment outcomes is treatment retention. For this reason, considerable attention has been paid to examining factors associated with treatment retention and improving treatment retention among youth in AOD treatment settings.

In general, international retention studies suggest that longer treatment stays (at least three months in residential) lead to improved outcomes (Brady, 1995; Gossop, Marsden, Stewart, & Kidd, 2003). Findings of both adult and youth research studies have found those who attended long term residential treatment had improved behavioural functioning outcomes post-treatment, such as decreased post-treatment drug use, decreased criminal activity, and improved social and employment functioning (Edelen et al, 2007; Orlando, Chan, & Morral, 2003; Simpson & Brown, 1997).

Some of the key features that have been found to be associated with retention are staff to client ratios, positive staff attitudes, positive rapport with staff, an individual's therapeutic involvement, and family inclusiveness throughout the duration of treatment. These retention factor studies have shown to have been attributed to youth achieving completion of a programme and overall satisfaction with the programme (Brannigan, Schackman, Falco, & Millman, 2004; Hawke, Hennen, & Gallione, 2005; Pagey, Deering, & Sellman, 2010; Schroder et al., 2007).

A New Zealand youth AOD treatment specific study conducted by Schroder et al. (2007) examined a range of variables, including fixed dynamic client characteristics, and found that these characteristics did not necessarily predict early dropout rates of youth attending AOD treatment. Rather, the study found that dynamic client characteristics, such as motivation for treatment, outcome expectations, along with characteristics of the programme that included establishing rapport with staff and involvement in the treatment process, were more highly associated with treatment retention. These data supported findings from international studies suggesting that dynamic client and programme characteristics, which include a client's perceptions of the treatment programme and a client's admission experiences, can influence treatment retention (De Leon, Melnick, & Kressel, 1997; Hser et al., 2001; Pagey et al., 2010; Schroder et al., 2007). Understanding factors that support client retention is important because studies have correlated youth retention in treatment with positive treatment outcomes

(Catalano, Hawkins, & Wells, 1990–1991; Muck et al., 2001). Even though retention factors have not been fully understood in the past, what studies do link is that longer stays (better retention) in treatment result in positive treatment outcomes (Catalano et al., 1990–1991; Williams & Chang, 2000). It is important to note that well-resourced treatment programmes that had a larger number of staff have been shown to have more successful treatment outcomes and greater treatment retention rates (Schroder et al., 2007). This finding points to the vital importance of sufficient funding levels. An additional suggestion for improving treatment services is to engage youth input into the design and development of AOD treatment services for youth in order to gain a deeper understanding of youths' needs and what engages youth to want to participate while in treatment (Bell, 2006; Jansen, Bruce, Campbell, Pawson, Harrington, & Major, 2010; Ministry of Youth Affairs (MYA), 2002).

With most research agreeing that overall, adolescents are particularly hard to engage and retain in AOD treatment, there is agreement about the urgency for more research in the area of adolescent programme effectiveness and ways to increase engagement and retention (Brannigan et al., 2009; Hawke et al., 2005; Schroder et al., 2007; Vaughn & Howard, 2004).

### **Improving Youth AOD Treatment (Including Indigenous Models)**

As mentioned previously, in New Zealand there is an absence of research regarding youth AOD treatment, and insufficient research regarding the effectiveness of varying treatment modalities (New Zealand Health Technology Assessment (NZHTA), 1998) with most studies being conducted in the United States. Despite research showing that attending youth AOD treatment programmes assists youth in a variety of domains, evidence on the low numbers of youth accessing treatment and the low retention rate among youth when they do enter treatment, indicates that there is still much to be done to improve AOD treatment services for youth (Williams & Chang, 2000; Winters, 1999a; 1999b; Schroder et al., 2012). This is especially true for Māori youth (MOH, 2007). Based on adult and youth literature regarding AOD treatment services in New Zealand, there is a significant need for kaupapa Māori services (Huriwai, 2002; Huriwai, et al., 2000). In addition, there is just as an important need for youth friendly services that promote positive youth development (PYD) (Catalano et al., 2004; Jansen et al., 2010; Lerner, 2005; MOH, 2002b; MYD, 2008). In order to improve youth AOD treatment, it appears that more extensive research is needed urgently, and further,

that treatment services take into account the principles that ensure positive Māori development for indigenous youth (Durie, 2001).

## **Promoting Optimal Development**

Positive youth development (PYD), while not traditionally focused on AOD treatment, is useful in outlining components of youth friendly services for enhancing optimal development for youth, and can be usefully translated to assist in designing and developing youth AOD treatment services. The strength based principles underpinning the PYD framework have been recognised as important features of youth friendly treatment services and can offer important insight into helping to develop resilience factors while youth reside in treatment programmes (Schroder et al., 2007).

PYD is a strengths-based theory that has been derived from two decades of youth development research based on a “developmental systems theory” (Lerner, 2002). This theory demystifies old beliefs that viewed adolescents as ‘problems’ to be ‘solved’ or ‘fixed’ that emerged from earlier deficit models of adolescent development theories (Hall, 1904; Roth, Brook-Gunn, Murray, & Foster, 1998). Currently, a renewed attitude toward adolescent development recognises that this is an age when support and guidance is most needed in order for the young person to thrive (Catalano et al., 2004).

PYD views adolescence with a positive outlook, examining a young person’s assets and acknowledging their diversities, strengths and their resilience (Lerner et al., 2005). PYD programmes seek to accomplish one or more of a range of objectives that include support and bonding with others, encouraging resilience, advancing youth in areas such as social, emotional, cognitive, behavioural and moral competencies. Other objectives include cultivating spirituality, positive identity, self-determination and hope. The remaining three objectives are about creating spaces and opportunities for youth to experience pro-social involvement, relationships and norms, whilst acknowledging the positive behaviours in the young person (Catalano et al., 2004).

PYD is withal recognised as an appropriate framework for use in New Zealand as it endeavours to ‘weave’ the social environment of the young person, by linking and connecting them back to their whānau, their culture, their communities and their peers (Jansen et al.,

2010). In doing so, organisations can support young people to build community competence, which will result in interdependence rather than creating dependence on one particular service or organisation.

A similar view is again expressed in *Te Kōtahitanga*, a broad educational research study conducted in New Zealand which found six areas that teachers needed to incorporate into their work with students in order to promote positive learning and developmental outcomes. These included: *manaakitanga* (to care for), *mana motuhake* (control over one's destiny), *nga turango takitahi me nga mana whakahaere* (to create a secure learning environment), *wananga* (meet, discuss, engage, share knowledge), *ako* (to learn as well as teach), and *kotahitanga* (to promote unity). This research effort has brought forth the importance of developing quality relationships between teachers and students, in order to improve student achievements (Bishop, Berryman, Tiakiwai, & Richardson, 2003). These areas align well with national and international literature regarding PYD (Catalano et al., 2004; Lerner et al., 2009; Lerner & Galambos, 1998; MYA, 2002), such as building positive relationships that support and encourage the development of a young person's attributes. PYD theorists have suggested that aligning individual strengths with environmental assets will enhance variables that youth need to thrive in life. These are known as the Seven Cs: competence, confidence, connection, character, caring/compassion, contribution and co-operation (as cited in Lerner, Boyd, & Du, 1998). One of the key outcomes of PYD is the development of the whole person, and this 'holistic' concept is encapsulated as a matter of course within the Māori model of health *Te Whapa Tapa Wha* (Durie, 1994).

Adding to positive youth development in New Zealand was a project in 2001 conducted by the Ministry of Youth Development (MYD) aimed at devising a Māori youth development package. This youth package gave rise to a theoretical framework specifically for Māori youth development entitled, "E tipu e rea: An indigenous theoretical framework for youth development" (Keelan, 2001). Keelan (2001) understood that in order for true Māori youth development to occur the origins of the framework must come from their indigenous culture: Māori. The foundation stones of this indigenous youth development framework incorporates indigenous values/ways of being that began with *whakapapa* (genealogy or biological origin), *whanaungatanga* (relationships), *hoa- haere* (companions), *awhi* (foster), *manaaki* (respect) and *tiaki* (guard). These indigenous values and ways of being when interpreted and expanded upon in their meaning "promotes a healthy respect for and participation in the culture of the

ancestors” (Keelan, 2001, p. 63; Ware & Walsh-Tapiata, 2010) which is essential in order for Māori youth to develop not only culturally, but also in youth specific capacities. Other indigenous researchers agree as well that Māori youth initiatives need to include Māori values and ways of being otherwise known as tikanga. Tikanga provides a crucial component in the wellbeing and development of Māori (Ware & Walsh-Tapiata, 2010). These authors suggest that a more in-depth ‘consideration of culture’ must be incorporated in PYD in order for Māori youth to reach their full potential (Ware & Walsh-Tapiata, 2010). Ware and Walsh-Tapiata (2010) go on to suggest that in order to enhance youth development policy and practice in New Zealand, it must incorporate a Māori youth development approach that involves an ‘in-depth consideration of culture” (p. 18).

## **Indigenous Models**

Research indicates that when working with indigenous populations, indigenous models of treatment are found to be most effective (Brady, 1995; Cram et al., 2003; Durie, 2001; McClintock, Tauroa, & Mellsop, 2013; Withy, Lee, & Renger, 2007). Indigenous interventions and youth friendly services are promoted by The World Health Organisation (1999a; 1999b; 2002) and supported by government policy documents in New Zealand’s *Youth Development Strategy Aotearoa* (MYA, 2002), including the *He Korowai Oranga* (MOH, 2002a).

Similarly, other studies in New Zealand have emphasised that success factors in AOD treatment for Māori sit within dedicated Māori services that can provide a treatment approach that aligns with, and recognises cultural values and processes alongside treatment (Huriwai, 2002; Huriwai, et al, 2000; Sellman, Huriwai, Ram, & Deering, 1997). More specifically, researchers have highlighted the important role of Māori services based on Māori practices, and Māori values and Māori beliefs in promoting treatment accessibility for Māori. These factors are congruent with the argument that indigenous approaches enhance access for indigenous people, hence, improving their health and wellbeing (McClintock, Mellsop, Moeke-Maxwell, & Merry, 2012).

Further, findings from other indigenous AOD treatment researchers have emphasised the importance of cultural connections in order to facilitate taking pride in being indigenous and re-establishing clients’ connections with their culture (Brady, 1995; Withy et al., 2007).

There is evidence that culturally based treatment resulted in longer retention of clients utilising the service and demonstrated benefits to its participants (Fisher, Lankford, & Galea, 1996). In addition, New Zealand research has shown that culturally congruent or dedicated Māori services bring positive health outcomes for Māori (Huriwai, Sellman, Sullivan, & Potiki 1998; Huriwai et al., 2001). Huriwai et al. (1998) argued that it is cultural connectedness that contributes to improved treatment retention for Māori, which translates to positive outcomes. A study by Withy et al. (2007) indicated similar findings for working with indigenous youth.

In examining retention factors in relation to more positive outcomes for indigenous Hawaiian youth in AOD treatment, Withy et al. (2007) espoused not only that cultural factors were vital in treatment for indigenous youth but that treatment for youth required being ‘multifactorial’ as well as individualised in order to fit the young person’s specific needs. These authors advocate ‘cultural tailoring’ of treatment as a success factor, and further advocate that indigenous youth treatment programme variables, alongside individual cultural needs, should be inclusive of practical skills, such as life skills, emotional regulation and behaviour modification skills in order to help the young person with planning their future. Moreover they emphasise the need for psychosocial interventions and to take into consideration developmental delays, and include addressing developmental issues that may have occurred during the youth’s substance use, along with vocational programmes being provided (United Nations, 2003).

Findings from overseas research suggest that young people benefit from AOD treatment that utilises multi-modalities, and that utilise a holistic approach that ensures that programme delivery is facilitated in a manner that is ‘culturally and linguistically competent’ for the young person (Hair, 2005; Withy et al., 2007). In addition, research has shown that treatment must take into account and address the multiple and complex problems that young people bring with them (Hair, 2005; Schroder et al., 2007; Withy et al., 2007).

In summary, in order to improve indigenous youth AOD treatment, it appears necessary to combine what we already know about positive youth development with the insight gained from the youth, retention and treatment outcome literature and indigenous health models in order to maximise the chances of meeting the needs of indigenous youth in AOD treatment. Of particular note is the importance that kaupapa Māori and PYD models place on the value

of having youth voices, inform treatment and service development. To date, these voices are missing from the AOD treatment literature providing the impetus for the current research project.

## CONCLUSIONS

The range of literature reviewed in this chapter regarding mental health and SUDs among Māori youth highlights the increasing level of concern about Māori mental health over recent decades. Although much of the prevalent data from New Zealand literature regarding mental disorders and addictions have focused on the adult Māori population, the same concerns are applicable to Māori rangatahi aged between 15–24 years, amongst whom high rates of mental health and SUDs are found.

Treating adolescents with SUDs is not a simple task. Many aspects of the young person in treatment must be addressed simultaneously, along with SUDs and frequently coexisting mental health issues. The literature reviewed in this chapter has revealed that there is very limited research on the various factors that influence effective residential AOD treatment for youth, and an even wider gap in the literature regarding culturally responsive residential AOD treatment programmes for indigenous youth that incorporate a positive youth development approach.

Although New Zealand and international studies suggest that culturally tailored approaches to AOD treatment show initial success, culturally congruent AOD treatment has yet to be accepted as best practice alongside mainstream practice models (Brady, 1995; Carvajal & Young, 2009; Gurung & Mehta 2001; Huriwai et al., 2000; 2001; 2002; Robertson et al., 2001; Sellman et al., 1997; Withy et al., 2007).

Compared to the general population, Māori and Māori youth are at greater risk of mental health and SUD issues, and yet to date, there has been little investigation that addresses the most appropriate AOD treatment interventions for this significant and vulnerable population, particularly from the experiences and perspectives of the rangatahi themselves. Given this absence, it is important that the current study makes a positive contribution to the unexplored area of success factors in culturally based strategies for Māori rangatahi in AOD treatment.

# CHAPTER THREE:

## METHODOLOGY AND METHOD

### INTRODUCTION

This chapter provides an overview of the methodology that underpins this study and a description of the method used to gather the stories of ten Māori rangatahi who had been participants at a kaupapa Māori residential AOD programme.

The study was designed to gather the perspectives of these Māori rangatahi in order to identify their views of what worked for them while in a kaupapa Māori youth residential alcohol and other drugs (AOD) Service.

### METHODOLOGY

#### **Indigenous/Kaupapa Māori Theoretical Framework**

As described in the prologue to this thesis, as an indigenous Hawaiian, I recognised the importance of employing an indigenous research framework to examine the needs of indigenous groups of people. Given that my study explores alcohol and other drugs residential treatment for Māori youth, an indigenous/kaupapa Māori theoretical framework, rooted in Māori protocol and processes and one that advocates *mana Māori* (Māori integrity) and *mana motuhake* (autonomy/self-determination), was deemed as appropriate for this study.

An important assumption underpinning this framework is that the research must take for granted the validity and legitimacy of Māori world views, the importance of language and culture, recognise the ongoing struggle for Māori autonomy and Māori cultural wellbeing, and indigenous protocols, practices and processes based entirely on native perspectives (Kahakalau, 2004; Smith, G., H., 1997; Smith, L., T., 1999). An indigenous theoretical framework gives validity to indigenous health models whereby “health is intimately linked to indigenous world views and indigenous development” (Durie, 2004, p. 9). Hence this

research study not only endeavours to promote better health outcomes for Māori rangatahi, but more importantly acknowledges Māori rangatahi voices and experiences as valid, and looks to them as their own experts. This gives regard to protective mechanisms regarding cultural and intellectual property of participants (Kawakami, Aton, Cram, Lai, & Porima, 2007; Patton, 2002).

In a recent mental health research article regarding Māori is a discussion about the value of indigenous processes, practices and protocols as being the acceptable way to engage Māori and increase Māori probability to participate in mental health research (McClintock et al., 2012; McClintock et al., 2013). The authors specify four traditional elements of the Māori process of *pōwhiri* (invitation ritual), of which components include *karanga* (to call), *mihimihi* (speech to pay tribute), *whaikōrero* (oration), and *koha* (offering). The pōwhiri process of engagement upholds the values and beliefs of Māori that preserve the importance of the role of kaupapa Māori. The authors assert that these protocols are the essence of respect and help to nurture relationships. They go on to say that in order to engage Māori and to gather full and accurate data in researching Māori, the powhiri protocols are a basic element of shaping positive relationships and respect (Bishop, 1996; Bishop & Glynn, 1999; McClintock et. al, 2012; Te Awekotuku, 1991).

In acknowledgement of this, the approach used in the current study included *Māori kawa* (protocol) around pōwhiri (invitation ritual), *whakawhānaungatanga* (relationship building), *kanohi ki te kanohi* (face to face), *kai* (food), *karakia* (prayer), *koha* (process of reciprocity), and promotion of te reo Māori (Māori language) whenever possible (Kahakalau, 2004; Rigney, 1999; Smith, 1999). These protocols are based on the premise of mutual respect and relationships between *tangata whenua* (First Nation's people of Aotearoa, and for the purposes of this study Māori rangatahi) and *manuwhiri* (visitor/researcher). Bishop's (1996) model of whakawhānaungatanga was applied. This model describes three interrelated and essential elements of research with Māori: i) establishing and preserving relationships; ii) addressing issues of power and control by establishing relationships within a Māori context; and iii) that the researcher be involved not simply as a 'researcher', but at the same time spiritually, ethically, morally and physically.

This approach was applied to this study. Aligned and guided by the ethical research principles of Te Tiriti o Waitangi (that of partnership, participation, and protection), this

research study was designed to greatly respect the rights of the indigenous peoples' involved (Hudson & Russell, 2008).

## **Qualitative Research Method**

Qualitative research attempts to interpret social and cultural phenomenon through a system of inquiry that is holistic and narrative usually takes place in naturalistic settings (Patton, 2002). Qualitative research allows for data to be collected through a wide range of collection and analysis methods, such as in-depth interviews, focus groups, covert and overt observations, as well as the collection, collation and analysis of existing documentation, including written and recorded material from a number of national and international sources. Often, the stopping point of data collecting is when the data reaches a particular saturation point (i.e., that what emerges from the data becomes the same and all options have been exhausted to the point where clear patterns of significant similarities and/or differences can be clearly identified). In this way, qualitative methods are time consuming, and require the researcher to utilise a range of interactive and communicative skills to engage successfully with potential participants. Once the raw data is collected, it can then be transcribed, edited and collated, after which it can be analysed (Marshall & Rossman, 2010).

There are a wide variety of methods of analysing data through qualitative research. For example, exploratory analysis utilises coding, whereby themes that are generated by the data are not predetermined. Confirmatory analysis on the other hand utilises codes or themes generated from a hypothesis or hypotheses that are predetermined. The analysis of choice would be dependent upon the initial approach that has been taken. In this particular study, a 'content driven' or 'exploratory approach' was employed through a thematic analysis (Guest, MacQueen, & Namey, 2012). Codes were identified to represent reoccurring themes or categories gathered from the raw data in order to "locate the meaning in the data" (Guest et al., 2012, p. 49). This inductive process brings meaning to the data through the researcher's interpretation of the data, which then becomes the research 'findings' (Marshall & Rossman, 2010). This procedure is primarily an inductive process of organising data into themes that can identify relationships between categories (McMillian & Schumacher, 1993).

The qualitative research method utilised in this study was one that investigated social settings, and how individuals make sense of these settings. The method used advocated that a

subject's or participant's reality is socially constructed by the participant's "own perspectives or subject experiences of their worlds" (Fossey, Harvey, McDermott, & Davidson, 2002, p. 730). This research method aimed to explore the subject's social processes, their understanding and belief systems (Barbour, 2008).

Fossey et al. (2002) emphasise the importance of the study reflecting an accurate account of the perspectives of the subjects that the study asserts to represent; although, it is understood that meanings are subject to interpretations and the understandings that people bring to them (Kvale, 1996). The advantages of utilising a qualitative method was that it gave the participants in this study the ability to voice their views freely; it gave the researcher the ability to clarify information if it was not understood, and further allowed the researcher to probe for additional information. Understanding that findings are often ambiguous and open to interpretation, qualitative researchers attempt to interpret phenomena from this vantage point (Finlay, 2006).

The value of qualitative research is that it prioritises human experiences and views these experiences as valid, and in this case, the perceptions of minority groups, such as Māori rangatahi. In addition, a qualitative methodology encourages the use of natural settings and gives validity to Māori rangatahi through their own unique experiences. Ultimately, a qualitative method evidenced the validity of Māori rangatahi perceptions and their personal life experiences (Kawakami et. al., 2007). Investigation of the quality of the human experience is a type of inquiry which can be explored circumspectly by the researcher in justifying social phenomena (Marshall & Rossman, 2011; Silverman, 2011).

Indigenous ways of knowing how indigenous people make sense of their world and what is significant to them can only be better understood from their world view (Kawakami et. al, 2007; Patton, 2002). The qualitative approach used in this study allowed that interconnectedness through the Māori research strategy of the three elements of whakawhānaungatanga (relating to others) (Bishop, 1996).

## **General Inductive Approach**

A qualitative research method utilising a general inductive approach was chosen as the most complementary method in researching indigenous groups, and the most fitting for this

research topic as it allowed the researcher to report the viewpoints from the participants' perspectives (Kawakami et al., 2007; Smith, 1999).

Further, a general inductive approach provided a more straightforward approach to data analysis than other traditional qualitative approaches (Marshall & Rossman, 2010; Patton, 2000; Thomas, 2003). As a first time researcher, general inductive theory gave me a set of procedures that I could follow, devoid of the technical language associated with various traditional approaches.

Mays and Pope (2000) propose that the fundamental principles of the general inductive approach are in fact similar to other qualitative analysis approaches. At times, the outcome of a general inductive approach can be indistinguishable from a grounded theory approach in that both approaches rely on the observation of raw data which is then concluded in a brief summary (Marshall & Rossman, 2010; Thomas, 2003;). The summary then sets up a direct link between the objectives and summary of the data in the research study (Silverman, 2011).

## **METHOD**

### **Developing an Indigenous/Kaupapa Māori Study**

Several authors have described the process of Western research and practices as 'social pathologising' theory and practice, positioning Western culture and knowledge as superior, and Māori knowledge, culture and traditions as unable to cope with human problems (Bishop, 1999; Smith, 1999). Western deficit models have not served Māori well, and in fact, add to further ostracisation and marginalisation of Māori. In contrast, a strengths based approach gives 'privilege' to the self-efficacy of Māori rangatahi and how they think about themselves, which contributes to the legitimisation of their world view and experiences (Hollis, Deane, Moore, & Harre, 2011).

My approach in this study was in the utilisation of the first element of Bishop's (1996) whakawhānaungatanga approach, which was to establish and maintain relationships. Working collaboratively, and in particular, in partnership with Māori, was a crucial component from the outset of this study. This has been a reciprocal process between Te Rūnanga o Kirikiriroa Trust Inc, my cultural advisor Dr Kahu McClintock, academic

supervisors Dr Ria Schroder and Dr Daryle Deering, and myself as the lead researcher, regarding how this study would be developed and progressed.

In addition, prior to the proposed study, consultation and the 'idea' of the study was discussed with Te Rūnanga o Kirikiriroa Trust Inc's Chief Executive Officer, Mere Balzer, and the 2009 Manager of RA Youth Residential Alcohol and Drug Treatment Service. This occurred by way of *kanohi ki te kanohi* through numerous hui, which began in late 2008. Consultation was undertaken with the Māori Clinical Staff member at RA, and through in-depth discussions and ongoing dialogue with Pou Tuia Rangahau, Te Rūnanga o Kirikiriroa Trust Inc's research and development team. Further to this, thorough consultation was carried out with Ngareta Turunui, the quality assurance person for the Rūnanga, to discuss any in-house policies that may impact on access to any potential participants. A formal letter of the intent of this research study was then sent to the Chief Executive Officer in 2010. The letter of intent sought permission and endorsement of this research study, which was accepted (Appendix 3).

Bishop's second element of *whānaungatanga* was the need to establish relationships within a Māori context that addressed issues of power and control in research, and lends support to research practices that are participatory. *Kanohi ki te kanohi* (face to face) was a preferred process through interviews that nurtured and valued rapport and respect between the researcher and participant alike. This allowed for openness in communication in regards to establishing meeting times and places that were culturally appropriate and safe for all involved, and a nurturing of trust by the participant in the research process. Face to face meetings, the sharing of *kai* (food) and ensuring that participants were well informed and comfortable to participate, gave more meaning to our interactions than just simply researching the subject. Furthermore, this method of interaction has been given validation by experienced academic indigenous researchers as their preferred method of engagement in research (Cram, 2001; Kahakalau, 2004). I wanted to explore the expressions and perspectives of indigenous young people from their experiences in having accessed an AOD kaupapa Māori residential service. It was vitally important that the participants' views and experiences were presented in a way that allowed for the kind of detail and depth to their stories that a questionnaire on its own, simply would not do justice (Kawakami et al., 2007; Marshall & Rossman 2011).

Additionally, I was concerned to ensure that the research process was respectful and reciprocal for each participant. Such a process is likely to generate a better flow of conversation among the researcher and participant, thus allowing more in-depth data to be collected (Denzin & Lincoln, 2006; Taylor & Bogdan 1998;). Such data is crucial in order to inform a wider audience, which in turn, would support programme development aimed at what rangatahi Māori say works for them. This was honoured by actively working by the principles of Te Tiriti o Waitangi.

## **TE TIRITI O WAITANGI IN PRACTICE**

### **Article 1 – The Principle of Partnership**

The principle of partnership is about working collaboratively with any potential participant in any research study through ensuring their involvement in the research process, and providing them with all relevant information that is clear and transparent throughout. This was a crucial component that took place from the outset, and as previously mentioned, was a reciprocal process between Te Rūnanga o Kirikiriroa, my academic supervisors (Dr Ria Schroder and Dr Daryle Deering), my cultural advisor (Dr Kahu McClintock), and myself as the lead researcher, regarding how this study was to be developed and progressed.

### **Article 2 – The Principle of Protection**

All participants who agreed to take part in this study were assured of their anonymity and that they would not in any way be able to be identified in the results of this study. All participants were fully informed and were given information sheets and consent forms to read through and to sign prior to participating in this study. The participants were given the option of receiving a copy of their interview transcript to keep, and to provide any further feedback to ensure that they were happy that their transcript was a fair reflection of what was discussed during the interview process. Participants were offered the opportunity to withdraw from their interview at any time without having to give any reasons for doing so, and were assured that their refusal to answer all or any of the questions would in no way adversely affect any future opportunities for receiving further support from the lead organisation (in this case, RA) in the future, if so required. These assurances are vitally important, particularly when as a researcher, the focus is on ensuring consent and trust by participants in the research process.

### **Article 3 – The Principle of Participation**

Consultation and collaboration between RA and the academic and cultural advisors involved in the current study had already occurred and was ongoing throughout this process. This was accomplished through having regular meetings to provide updates on progress, to seek further clarification and advice on all components of the project wherever necessary, and to assist in the overall completion of the study. This highlights the importance of establishing an external advisory team that has the ability to advise, support and further inform the development and implementation of the study, and ensures that the overall aims and objectives remain true to its original potential.

### **Tino Rangatiratanga**

Tino Rangatiratanga acknowledges the rights of Māori to organise and maintain control over their resources as their own. Hence, all considerations regarding protection of intellectual property and knowledge were vigilantly respected throughout this study.

Lastly, addressing Bishop's third element is the researcher's understanding that they are involved spiritually, physically, ethically and morally, and "not just as a researcher concerned with methodology" (Bishop & Glynn, 1999). As a Kanaka Māoli (Indigenous Hawaiian) I have experienced a very similar colonial history to Māori and understand a similar traditional and current colonised world view. Along with Māori, I share a transposal genealogical whakapapa (genealogy) to ka pae aina o Hawaii nei (the Hawaiian archipelago). Although I remain tauwi to Aotearoa, my relationship to the tangata whenua has always been motivated by contributing positively and participating fully in Māori communities with the greatest respect.

### **Participant Selection**

With an indigenous philosophy guiding this study, data was collected from a randomised selection of rangatahi Māori who had previously accessed RA, a kaupapa Māori youth AOD residential treatment service, within the past twelve months, and who were between 15 and 19 years of age. A list of a total of 65 young people who accessed RA in the year 2009 was collated. To reduce selection bias, a computerised randomisation process of the 65 young people came up with a sample of ten young people as potential participants. An equal number

of five *wahine* (women) and five *tane* (men) were then sought to provide a gender balanced perspective. It was predicted at the start of this study that ten participants will be sufficient to achieve data saturation, and that ten participants would provide sufficient data for completion of a Master's thesis.

## **The Recruitment Process**

The recruitment process was led and carried out by the staff of Te Rūnanga o Kirikiriroa Trust Inc, utilising their vast and well established networks. This ensured that issues around privacy, confidentiality and anonymity that where required was adhered to at all times to guarantee participant safety. The potential ten participants (five *wahine* and five *tane*) were then approached by staff of Te Rūnanga o Kirikiriroa Trust Inc, who informed them of the study and sought their verbal consent in the first instance, to be involved. Once participants consented verbally to be involved, their contact details were then passed to the lead researcher for further follow up.

This allowed me to then make contact with each participant to negotiate an appropriate date and venue in which to hold the interview. The recruitment process was based on the process of *whakawhānaungatanga*, utilising social networks that were already established, to bring together participants who were already connected, such as the *rangatahi*, Te Rūnanga o Kirikiriroa staff, and the study researcher (Bishop and Glynn, 1999).

## **Information Sheet for Youth Participants**

The 'Information Sheet for Youth Participants' was given to each participant in advance, and then again at the time of the interview to allow them adequate time and space to be able to ask and clarify any questions they had in terms of their participation in the research study (Appendix 4). The information sheet provided a detailed explanation of the study and its purpose, including a detailed description of participant involvement. The information sheet informed participants that ethical approval was sought and granted for the study to occur.

The *rangatahi* were informed that they could ask questions at anytime during and after the interview. A copy of the information sheet was then reviewed with the *rangatahi* at the time

of interview, to ensure that they were fully informed about the study and their rights as a participant.

### **Informed Consent (Karanga)**

Rangatahi were informed that their participation was voluntary, and should they decide not to participate, their future relationship with RA would not be affected in any way. Participants were informed that they could withdraw from the interview at any time, without having to provide any explanation for doing so, and that they had the right to decline to answer any particular question or questions during the interview process. Furthermore, participants were informed that they could withdraw any or all information they had provided to the study by notifying the study researcher within the first month after their interview had taken place (Appendix 5).

### **Confidentiality (Whakawhānaungatanga)**

Whakawhānaungatanga was utilised in order to make connections and form relationships with the rangatahi. Overall, whakawhānaungatanga helped to develop and strengthen reciprocal relationships. The guidelines to confidentiality were discussed fully; ensuring each participant that information that could personally identify them would not be used on any forms, reports or publications that may stem from the study. If they wished, rangatahi were given a choice of using a pseudonym as a way of further ensuring their identity was kept anonymous. They were assured that all information would be kept confidential unless they were at risk of harming themselves or others. In addition, participants were assured that all of their information would only be stored in a locked and secure filing cabinet, and that limited access to the information would be by the lead researcher and academic supervisors only.

## **DATA COLLECTION**

Semi-structured, individual interviews utilising open-ended questions were selected as the most appropriate and fitting way to adhere to the principles of a kaupapa Māori process, in that they were supportive of kanohi ki te kanohi (face to face) (Bishop, 1996; Jahnke & Taiapa, 2003). The questions were predetermined, which gave structure and focus to the

interviews. However, there was ample freedom to deviate from these during the interview in order to follow other issues that were raised by participants as important issues to them, but did not necessarily fall within the parameters of the overall study (Berg, 2007; Marshall & Mossman, 2011; Patton, 2002). I approached each interview as a naive enquirer, placing the rangatahi in the position of ‘the expert’. This position helped to actively engage the young people.

Open-ended questions were designed to elicit Māori rangatahi perspectives on ‘what worked for them’, while accessing and participating in a kaupapa Māori youth alcohol and drug residential treatment programme. The application of open-ended questions provided an opportunity for participants to openly express their feelings, thoughts and experiences. This allowed Māori rangatahi a ‘voice’ which has been rarely heard or solicited as valid input into youth addiction treatment design or programme content.

The broad areas covered in these semi-structured interviews/interview prompts included:

1. What worked/did not work for you while in a kaupapa Māori residential alcohol and drug treatment service?
2. What did you see/or not see as vital to your learning/growth?
3. What would your ideal residential AOD service include/or not include?
4. If you could talk to a person designing a kaupapa Māori residential alcohol and drug treatment programme and tell them what were the three most important aspects for Māori rangatahi recovering from alcohol and drug abuse/dependence/problems, what would that be? (Appendix 6)

The interviews did not include questions regarding past or present drug use that the young person may or may not have participated in, as the focus of the study was solely on their experiences while in the RA kaupapa Māori AOD youth residential programme.

As a part of the interview, a few socio demographic questions were asked in order to collect minimal information that included age, gender, tribal affiliation/s, how many treatments the young person had attended, current education and employment status, and whether the participant had graduated from the RA programme. Participants were then asked to rate their treatment outcome on a rating scale of 1 to 5; 1 being much better, through to 5 being much worse. This socio demographic information and participants’ ratings were gathered to provide

an overall description of the Māori rangatahi who participated in this research study, which helped to formulate a profile of the research participants (Appendix 7).

Each interview took place at negotiated locations that were deemed “suitable” and “safe” for the rangatahi who participated, and for the lead researcher. The venues chosen by each participant were places that were significant to them, and where they felt safe, at ease and were comfortable talking about their time in an alcohol and other drug residential treatment programme. Participants were given the option of bringing with them a support person/s if they so wished, who would be someone whom they felt they could trust, and whom they felt comfortable with in answering personal questions without any concern about potential adverse repercussions.

Six of the interviews took place in the homes of each the participants’ parent/caregiver, with the parent/caregiver either sitting in on the interview in one case, or waiting in an adjoining room. Two of the interviews took place at different community social service agencies familiar to the participant, and which they chose to attend alone. The final two interviews took place within the residential treatment service that the participants were attending at the time of this research study. Although staff were present in the residence they did not sit with the young person during the interview.

All participants were asked for their permission for the interview to be digitally recorded, and this was again specified in the information sheets provided. These recordings of the interviews were recorded and transcribed solely by the lead researcher. The recordings were then transcribed after each interview had concluded and all revealing details were removed so that each participant could not be personally identified. To ensure each participant’s privacy, the recordings, transcripts and other data were stored in secure facilities at the National Addiction Centre, University of Otago, Christchurch.

Participants were offered a copy of the transcript of their recorded interview to keep. They were given a choice to read or comment on their transcript. Although all ten participants declined the offer to comment on their written transcripts as an alternative, four of the rangatahi agreed to meet at a later date when they could be presented with, and participate in a discussion of the findings. Initial written findings of the research study were posted to all participants, unless they requested otherwise. Three participants opted not to receive the

findings of this study. Te Rūnanga o Kirikiriroa Trust Inc was also provided with a copy of the study findings.

At the start of each interview, all participants were asked if they wanted to begin the interview process by way of a *karakia* or prayer, and/or a waiata. *Kai* (food) was provided in recognition of the process of *manaaki* (care, support). Upon the completion of each interview, all participants received a *koha* (gift) to the value of a \$20.00 store voucher. This *koha* was given in recognition of their time, sharing of information and their overall contribution made to the study through their participation in the interview. *Koha* is given as an act of reciprocity that maintains indigenous processes of respect and acknowledgment (Bishop & Glynn, 1999), which was declared to, and supported by the Northern Y Ethics Committee as a benefit to the research participants. It is important to note that participants were not made aware of the *koha* until after their interview was completed. This ensured that participants were not coerced or provided with an incentive solely aimed at encouraging their participation, as participation in the study was voluntary and based solely on their willingness to participate.

## **DATA ANALYSIS**

A general inductive approach was utilised as the method of data analysis. This approach is often used in health and social sciences (Thomas, 2003). The data collection relied exclusively on the participants' experiences collected through the interviews. The transcribed data were organised into different themes and ideas that emerged after several readings of the transcripts. Raw data were read and re-read, then sorted into emerging themes which aided the lead researcher to become 'intimate' and 'familiar' with the responses of the participants (Marshall & Rossman, 2010). The analysis heavily relied on the meanings derived from the data gathered of the participants' collective and individual situations and experiences. References that appeared often from each interview enabled specific themes to be identified. Selected segments of the interviews were then placed under a designated theme found by reoccurring data of the participants.

In order to organise the data that arose from the analysis, NVivo 9, a qualitative data software programme, was utilised. In its simplest form, NVivo 9 is a programme that allows in-depth

analysis of qualitative responses that enables the researcher to create nodes (that may often be predetermined) that assist to identify, separate and code various themes or patterns that emerge from the data, whilst at the same time keeping the overall nature of the information within the context in which the response was provided. After the completion of all transcripts, all ten interviews were entered into NVivo 9 and coded, utilising various nodes. Selected passages from each interview were organised under prescribed nodes with specific reoccurring themes that emerged as a result of the combined data.

This process assisted in the ordering of the data through a thematic approach, and served as a database for the findings (Thomas, 2003). Multiple themes emerged which were then refined into subthemes, that eventually sat under three broad overarching themes. From the thematic analysis, it was my role as the lead researcher to organise the data thematically. However, as discussed in the literature review chapter, Māori concepts and ways of being are generally not separated into independent parts. Hence several of the korero (speech) used by the participants were able to be viewed across a range of themes. For example, when a participant talked about tikanga (customary procedure), for them, it represented and encompassed all things Māori, including the practices and process they perceived as part of the recovery programme. As the lead researcher, it was important that the themes identified were kept within the context of the information collected from each participant and presented in such a way that it provides the reader with a clear understanding of what the themes represent and how they are interconnected overall.

## **Issues of Rigour**

From the outset of this research study, I have been aware that my prior experiences and understanding of adolescent AOD treatment would have an influence on my interpretation of the data collected. This insight directed me to be even more diligent regarding the interpretation of the data in this study. Finlay and Ballinger (2006) describe this self-awareness as “reflexivity” and explain that, “this involves critical self-reflection, focusing on the ways a researcher’s social background, assumptions, positioning and behaviour affect the research process” (p. 21).

The first step to minimise researcher bias, and selective recording and recall of information, was to transcribe each interview verbatim, so that the actual words of the participants were

analysed, rather than the recall of those words by the researcher. This provides a means of quality control to keep the participants verbatim responses within the context of which it was shared during the interview process. Additional qualitative research techniques were undertaken, such as peer review, member checks, cultural research mentoring and university research supervision. These are described further below.

## **Researcher Bias**

As mentioned previously, I was acutely aware that my interpretations of the data might be influenced by my personal bias for a number of reasons: 1) because I identify as an indigenous person investigating indigenous people; 2) because I advocate for indigenous self-determination; 3) because by profession I am a clinical addictions therapist; and 4) because I was previously in a service development role and served as the clinical manager of the residential AOD youth residential service that this study is based upon, and of which the participants were former clients. As I had disengaged from employment from RA in 2006, and have not had any clinical or other involvement with the participants of this study, it is hoped that this did not directly impact the participants. The staff of Te Rūnanga o Kirikiriroa who helped to recruit the participants for this study, reassured me that the participants had no prior knowledge of my past involvement at RA; however, I must make mention that it was unknown if this was fact.

## **Member Checks**

Member checks with key informants were conducted. This involved presenting the findings to participants in order to check with them my interpretations of the data (Marshall & Rossman, 2010). Although participants did not want to review a copy of their personal transcripts, four of the participants agreed to meet to discuss the preliminary findings. During this meeting, all four participants indicated that the findings, as I had presented them, accurately reflected their experiences and perceptions. Comments such as, “that’s what we’ve been telling them all along, that works”, exemplifies the participants’ responses to this preliminary data analysis.

## **Peer Review**

Careful discussions through peer review were held with “disinterested peers” (Johnson, 1997) who were not involved directly with this research study. Discussions were held about my initial findings and themes. Peer feedback gave me more insight into my interpretations and challenged me to stay true to the data collected. The background of the peer reviewers who worked with me, which included an indigenous academic who held a position as head of department at a local university, and a clinical psychologist who specialises in working with adolescents.

## **Cultural Supervision**

Cultural supervision took place from the outset of this research study with ongoing discussions throughout. Consultation and guidance through integrated cultural and academic supervision was an important part of my research study process. It supported me to pay attention not only to academic protocol and priorities, but at the same time and equally important to the cultural aspects in the study design process and subsequent research processes. As an indigenous woman who has had the privilege to work with Māori, it was a fundamental priority to honour the cultural guidance of my supervision, in order to demonstrate cultural sensitivities and practice that are in line with kaupapa Māori practices.

## **University Research Supervision**

Supervision with academic research supervisors took place regularly throughout this study, particularly during the data collection and analysis phases of the overall study. Having discussions with peers familiar with my research topic was important in providing thought provoking discussions and challenges. Supervision raised important ideas concerning the data, coding and analysis that helped to challenge some of my interpretations, and provided an excellent debriefing forum. Supervision gave validation to the findings and confirmed that my interpretations were grounded in the data.

## **Ethical Considerations**

A rigorous ethical approval process was applied in the undertaking of this research study. Application for ethical approval was obtained through the New Zealand Health and Disability

Ethics Committee's Northern Y Region Ethics Committee (NTY/10/06/056), and this is appended (Appendix 8).

As the participants were based in the Waikato region, it was decided that approval from a Waikato based Māori consultation collective was necessary. As such, *Te Puna Oranga* (the Māori health service) of the Waikato District Health Board, and the Kaumatua Kaunihera research subcommittee were approached for research ethical approval (Appendix 9). As well as approving the direction of the intended research, this committee focused specifically on ensuring the integrity, ethics and cultural safety of the overall research processes and practices. Research proposals were provided to both groups, and an oral presentation on the proposed research provided for each committee. Research approval was granted by both of these groups.

It is important to reiterate that although I, as the lead researcher of this study, was previously the Director of RA, I am no longer employed at this service, and had no involvement with clinical or other matters affecting this service during the time of the research study.

## CONCLUSION

The purpose of this chapter was to outline the methodology and methods applied throughout this research study. An indigenous/kaupapa Māori theoretical framework was employed given that my topic explored AOD treatment for rangatahi Māori.

In conjunction with an indigenous/ kaupapa Māori framework, a qualitative research method which utilised a general inductive approach was used in order to gather and interpret social and cultural phenomenon through an inductive process of analysing data.

The data analysis was then refined through an applied thematic analysis method which helped to refine, organise and identify key themes and subthemes. Application of these methods were critical in order to answer the research aim of identifying what the critical success factors in kaupapa Māori AOD residential treatment from a Māori youth perspective are.

# **CHAPTER FOUR:**

## **RESULTS**

### **INTRODUCTION**

The aim of this study was to examine what Māori rangatahi, who had accessed a kaupapa Māori alcohol and other drug youth residential treatment service, perceived as the critical success factors in their treatment. Understanding these perspectives will assist to better inform the future design and implementation of AOD residential treatment services for Māori rangatahi.

The first segment of this chapter is a description of the characteristics and demographics of the ten rangatahi who participated in this study. The second segment presents the findings that emerged from the face to face interviews with the young people.

Each rangatahi was asked to answer a number of open ended questions regarding their experiences while in a kaupapa Māori residential AOD treatment service. What emerged from the interviews were captured under three key themes. Within these key themes are a number of subthemes. The three key themes that evolved were:

- Kaupapa (philosophy/agenda);
- Te Ao Māori (the Māori world); and
- He Tangata (the people).

These themes represent the three major areas that rangatahi had highlighted as success factors during their stay in residential AOD treatment.

### **Demographic Profiles**

The following demographic information of the Māori rangatahi that participated in this research study was obtained from a socio demographic questionnaire asked of each participant prior to their individual interview. Demographic data collected included age,

gender, tribal affiliation/s, how many treatments the participant attended, current education and employment status, and whether they had graduated from the RA programme. This information was important in that it provided further insight and a snapshot of the rangatahi involved in the study.

## **Age and Gender**

Of the ten rangatahi, five were female and five were male, as purposively selected through the randomised recruitment process. Rangatahi ranged in age from 15 years to 19 years, with a mean age of 16.8 years.

The rangatahi in this research study reported that their ancestral genealogy came from a range of different tribal areas throughout Te Ika a Maui (North Island of New Zealand). These were: Maniapoto, Tuhoe, Ngati Raukawa, Ngati Tamahaua, Te Whakatohea, Te Rawhiti, Ngati Porou, Ngati Paoa, Nga Puhi, Ngati Rangatihi, and Te Rarawa. None of the rangatahi identified whakapapa links to Te Waipounamu (South Island of New Zealand), and despite the RA service being a Midlands-based, District Health Board funded service, it is a service that has always been open to any rangatahi and their whānau, from anywhere across the country.

Of the ten participants, three young people reported speaking both Māori and English. Although the majority interviewed reported speaking English only, all of the rangatahi interviewed illustrated quite an extensive vocabulary of the Māori language, and a living understanding of the kawa and tikanga that was practised while they were in residence at RA.

Five of the ten participants reported they were currently in a relationship, while the remaining five reported they were single. None of the participants reported having any dependents. Nine rangatahi identified as being heterosexual, and one identified as bisexual. The question of sexual orientation was asked because of speculation that sexual orientation may play a part in the types of experiences that young people have when they are in AOD residential treatment. Sexual orientation may have some bearing on how young people perceive these services, and/or how residential treatment services could best meet their needs. In the current study, the young person who identified as bisexual did not mention feeling different or having special needs that were not met during their time in treatment.

Two rangatahi were part-time students not in paid employment. One young person was in part-time study and part-time employment. Three were in work experience but not in paid employment. Two were unemployed, and the remaining two were currently attending a residential alcohol and other drugs service.

Seven rangatahi reported being financially supported by their whānau. Two reported being on a benefit, and one reported their source of income as being from “other sources”; however, this young person did not specify where this income came from.

## **Treatment Experiences**

At the time of the interviews, seven participants rated themselves as being “much better” compared to how they were when they were admitted to RA. One reported being “a little better”, and two young people “a little worse”. The two young people who acknowledged becoming “a little worse” reported being discharged from treatment prior to completing the full ten weeks of the RA programme duration.

When asked about how much they thought that RA had helped them with their problems, four rangatahi answered “a lot”, three answered “very much”, one “moderately”, one answered “a little”, and one young person reported “not at all”.

The majority of the participants had been admitted to RA more than once for treatment. Four participants had only one admission, four had two admissions, one had three admissions and one had five admissions. Table 1 displays the average duration of time participants spent at RA during each admission.

<b>Table 1: Length of Stay in Treatment</b>	
<b>Admission Event</b>	<b>Total Mean Time in Treatment (weeks)</b>
One admission (n=4)	9.4 weeks
Two admissions (n=4)	6.9 weeks
Three admissions (n=1)	8 weeks
Five admissions (n=1)	7 weeks

Seven participants reported graduating from the programme, meaning not at the full term of ten weeks but having a pre-planned exit from the service. The remaining three participants were discharged from the programme prior to graduation. Reasons for discharge were not explored.

## **FINDINGS**

The results of this study emerged through a qualitative methodology, utilising a general inductive approach encompassed by an indigenous/kaupapa Māori theoretical framework, to gather the perspectives of Māori youth. Analysis of participant interviews generated three main themes of Kaupapa; Te Ao Māori, and He Tangata. These themes depicted participants' perspectives of both the strengths and limitations of their experiences in a kaupapa Māori AOD residential programme. Within the three key themes, a number of subthemes emerged, which highlight the way in which participants viewed and shared their experiences as Māori rangatahi within a residential AOD treatment setting. The rangatahi spoke of changes they would make to an AOD treatment programme and the reasons why they thought the changes would benefit other Māori rangatahi.

The process to categorise the results into different themes was challenging. It became obvious that indigenous ways of knowing and being could not be neatly placed in individual and separated components. As the themes and subthemes emerged it was apparent that they were all interconnected. This is not surprising, given the holistic and interconnected nature of Māori health. The resulting themes should therefore be seen as interrelated themes that cannot be considered in isolation from each other. Each of these themes and their associated subthemes are described in detail below.

### **Theme 1: Kaupapa (Philosophy of the Treatment Approach of RA)**

The theme of 'Kaupapa' represented the philosophy of RA, and how this philosophy is operationalised in interventions delivered. These included distinctive AOD treatment interventions/components that helped to guide the participants' behaviours and interactions with each other, by nurturing their *taha tinana* (physical health), *taha hinengaro* (mental health), *taha wairua* (spiritual health) and *taha whānau* (familial health).

When talking about ‘what worked’ in residential AOD treatment, participants most frequently mentioned the various interventions/components of the treatment programme. Participants identified a number of key elements that made these programme components helpful. These included providing valuable and relevant information, being fun, being interactive, providing opportunities to learn skills and strategies, and alternative ways of doing and being. By their own assertions, they felt the classes and activities promoted a sense of achievement.

The Kaupapa theme depicts the programme elements that were foundational or core, and that were focused on addressing issues of addiction, including life skills and general education. These programme elements strongly resembled activities not different from the core activities of what may be included in most youth AOD residential programmes. The nine subthemes that emerged from the key theme of Kaupapa provide a picture of the different types of programme interventions/components that participants participated in while in residential treatment, their experiences of them, and their perceptions of how and why they helped or hindered their recovery process. This theme includes insights into participants’ recommendations about improvements to AOD residential treatment services. The nine subthemes under Kaupapa that emerged were:

- alcohol and other drugs and relapse prevention strategy classes;
- quit smoking classes;
- music classes;
- Northern Health correspondence schooling;
- 12-step, self-help community meetings;
- length of stay in treatment;
- areas of specialist treatment and individualised programmes;
- rangatahi programme recommendations; and,
- downtime.

### ***Alcohol and Other Drugs Classes***

Alcohol and other drug classes at RA involve education on the effects that alcohol and other drugs have on a young person’s physical, mental, emotional, spiritual and whānau well-being. All participants reported that these classes were valuable, with some identifying that this was the most favoured intervention/component during their treatment. They understood the significance of the information being provided, and strongly felt that it was relevant and

important to them. As one young person recalled: *“That was my main class ... that’s where I got to learn ... how drugs affect your body ... alcohol ... cigarettes ... this class was important.”* (Participant 4, wahine)

Participants talked about how they enjoyed the classes and felt they were beneficial for their recovery. One participant spoke of the ‘strategies’ that the AOD class covered, and felt that this information helped her significantly by saying: *“It was the classes ... and ... the strategies they took us through ... that helped me heaps.”* (Participant 3, wahine)

Participants highlighted the importance of being able to have fun; role-playing allowed them to relate to the AOD classes, as one rangatahi Māori attested to: *“Everyone was enjoying it ... we had a lot of fun activities around drugs ... learning about them ... just acting activities ... everybody loved it.”* (Participant 6, tane)

One young person appreciated the benefits that the AOD class provided, saying: *“AOD was good information about what drugs you take and what they really are ... I got heaps out of that.”* (Participant 5, tane)

The above quotes illustrate how beneficial the rangatahi felt the AOD class information was for them, and provided a basic need during their stay in residential treatment. The young people clearly identified that this class offered them important information that was delivered in a fun and interactive way that they could relate to while learning.

### ***Quit Smoking Classes and Cigarette Smoking***

Although the young people were not asked a specific question regarding their thoughts about smoking while in residential treatment, they all raised the subject and shared their views on smoking in their interviews. It is important to note that in 2009, when the young people interviewed resided at RA, the service was beginning to transition into a smoke free programme and environment, offering the young people alternatives to nicotine.

Given that cigarette smoking in indigenous communities is unfortunately common, a smoke free environment was a real challenge to some of the young people, and sometimes presented a source of conflict. The views on smoking were contrasting; however, the majority of the

young people supported a smoke free environment with just a few giving reasons why they should be allowed to smoke. The reasons participants gave for and against a smoke free kaupapa provide useful information for future service planning around this contentious issue.

Rangatahi who supported the smoke free kaupapa acknowledged the problems it could cause and felt the benefits outweighed the negatives:

*“I’d have no smoking at all ... if I couldn’t have drugs and alcohol then I’d depend on cigarettes to get me through the day ... I played up quite a few times a day, but then ... I kept myself busy ... got more involved in the classes and activities ... going without smokes at that time ... actually does something.” (Participant 3, wahine)*

Another young person who was a non-smoker adamantly supported having a smoke free environment: *“I don’t smoke cigarettes ... and I suggest others don’t smoke.” (Participant 4, wahine)*

A further supporter of a smoke free environment mentioned her concern about the connection between cigarette smoking and other substance use as a reason why smoking should not be allowed: *“I wouldn’t let them smoke cigarettes ... when I think about it ... what’s the difference between having a cigarette and having a joint ... just get that sort a thinking again.” (Participant 9, tane)*

Rangatahi recognised, however, that a smoke free kaupapa could not be implemented without providing significant support for stopping smoking. One rangatahi thought that young people should be supported with more education to give up smoking while in treatment, even though he acknowledged that because of the high numbers of smokers, this would make things difficult:

*“More help ... quitting smoking ... we had a couple classes ... there were heaps of smokers ... I think they should take out smoking ... might cause more drama ... I think that’s how it ran smoothly ... because they were allowed to smoke ... I’d get rid of that.” (Participant 5, tane)*

Not all rangatahi supported a smoke free kaupapa. Some were undecided on the issue because of the potential negative consequences it could have:

*“Yes and ... no ... if you’re having a bad day you can have a smoke ... your attitude will change ... at the same time if you’re stressing for a smoke you’re going to go ‘angus’ over everyone asking for a smoke.” (Participant 7, tane)*

Others were clear that the risk of negative consequences meant that they did not support a smoke free kaupapa: *“Have smoking cos, they go crazy for a smoke, smashing stuff and everything for a smoke.” (Participant 8, tane)*

The power of nicotine addiction was mentioned as a reason by another rangatahi for not having a smoke free environment in residential treatment:

*“I needed my cigarettes ... I have one addiction and they expected me to give up another addiction ... that’s one thing that calmed me down ... I just couldn’t wait until I could get my hands on a cigarette.” (Participant 10, wahine)*

The rangatahi in this study provided strong views on whether or not to allow smoking in residential AOD treatment. The diversity of perspectives expressed by these young people reflects that most discussions supported a smoke free environment, regardless of whether they were a smoker or not.

By the end of 2009, RA had become a smoke free environment. RA provided support for rangatahi who wanted to become smoke free through a quit smoking class. Rangatahi from this study indicated that if a programme chooses to be smoke free, some kind of quit smoking programme must be available for participants.

For some participants, quitting cigarette smoking was a significant part of the programme. Participants indicated that the information provided in the quit smoking classes was good and said that it reflected well why cigarette smoking was unhealthy: *“The no smoking class ... was mean, learned heaps ... got put off for good.” (Participant 2, wahine)*

The same participant further acknowledged that the classes significantly reduced, and continued to prohibit her use of cigarettes:

*“The first time I went to RA ... she was trying to tell us ... what it does to your body ... and we listened ... I liked that class ... I was a heavy smoker ... and now I can go without ... which is different ... if I didn’t go into RA the second time when they had wiped out the smoking I would have just been the same ... I couldn’t go without a smoke ... but now I can go without a*

*smoke for a couple of days ... four days max ... I'm sweet without it.”*  
(Participant 2, wahine)

As this participant reflects on her multiple stays at RA, it appears that the key for her to significantly reduce her smoking was the requirement of abstinence from cigarette smoking in the treatment programme, rather than just reducing the number of cigarettes smoked, as she had experienced on a previous stay.

One participant identified that they would have liked even more support to quit smoking and would have welcomed being provided with additional ‘quit smoking classes’ by expressing that: *“More help with people quitting smoking ... we had a couple classes of that ... some more will do.”*(Participant 5, tane)

### ***Music Class***

Music was highlighted by the participants as one of the most favourable of classes. This was not surprising as music is an intrinsic part of many youths’ lives. This was described as a class they all really enjoyed: *“Yeah that was the main highlight of my being there ... music class ... that was just mean ... I just loved it.”* (Participant 3, wahine)

In particular, participants enjoyed the opportunity this class provided to write their own songs and express their feelings regarding what they were going through, which had a therapeutic effect for the young people, as one rangatahi elaborates:

*“We could write a song about anything ... so that got me thinking ... I ... wrote most of my life ... stuck that into a song and ... jumped on the piano ... started making up a couple of beats ... it ... was a relief for me that class ... I got more things off my chest that I wouldn't say to other people ... mean as ... said everything that was bugging me there in those classes.”*  
(Participant 3, wahine)

Through the medium of music the young people could freely express and process their feelings in a way that appeared to be acceptable to them.

### ***Northern Health School Class***

Classified as ‘special schools’, Northern Health Schools were established in 2000 following a review of the ‘Special Education 2000’ policy of the Ministry of Education in New Zealand (Ministry of Education (MOE), 1995). Through the Northern Health Schools a tutor is provided to RA to support the young people while in residential AOD treatment, via a correspondence school curriculum. Participants’ comments regarding schooling clearly expressed the benefits gained from this class.

One participant identified school as a significant area of their treatment programme when asked what worked for her. She found the normalcy of reading, writing and maths to be beneficial, and this particular participant further reflected that she would have preferred more than one teacher in the class to provide more one-on-one support:

*“I reckon it would’ve been class ... just normal things ... reading, writing, maths ... just normal things ... I think the time was all right ... but ... having more than one teacher would have been more helpful ... It’s kinda hard ... if people in the class need ... one on one help.” (Participant 2, wahine)*

This was further supported by other participants who felt that it was important to have more than one teacher supporting the daily classroom activities.

Another rangatahi highlighted schooling as significant because they had not been to school for ‘ages’: *“sport ... art ... school ... and fun things ... learning, reading, maths, arts, Māori, bilingual ... yeah all that sort of stuff.” (Participant 9, tane)*

This class allowed them to self-assess their aptitude in the aforementioned areas, as one young person acknowledged: *“I didn’t do ... school work in ages ... it was good to get back into it and it was good to know that I was still up there.” (Participant 5, tane)*

### ***12-Step Meetings***

The first 12- step program/meeting Alcoholics Anonymous was founded in 1935 and has resulted in additional 12- step groups being formed such as Narcotics Anonymous and others in order to address addiction problems. The 12- step programs are based on total abstinence, attending regular 12- step meetings along with applying the suggested 12 steps of the program in their daily lives. Since 1935 12- step programs/ meetings have become one of the most

widely 'disseminated' self- help treatment groups and considered an 'effective adjunct' to residential treatment (Sussman, 2010). The interrelatedness of relationships from an indigenous world view often have overlapping boundaries which are interwoven. Although the 12-step meetings were a programme activity, the responses from the rangatahi focused on the interpersonal relationships and how these occurred, and the passing on of knowledge through *tuakana* (elder sibling), *teina* (younger sibling) relationships. The 12-step programme served as the conduit for this exchange to occur.

When asked the two interview questions, "What worked for you while in residential AOD treatment?" and "What did you hear about RA that made you want to go to rehab?", the resounding answer given by all the rangatahi was that it was because of them regularly attending the 12-step community meetings as part of their recovery. They all mentioned and/or made reference to the 12-step, self-help community group meetings of Alcoholics (AA) and Narcotics Anonymous (NA). They were able to explain what the 12-step meetings were all about, what happened during the meetings, how they felt about them and what they got out of the meetings:

*"The NA meetings that we were going to ... and the Higher Ground people ... seeing ... the adults ... what they're going through with ... drugs ... and what it's doing to their life. Made ... us younger taiohi ... sit there and think ... should we be like them or should we go start a new life where we wanna be, like ... raise a family without that stuff [drugs] around." (Participant 3, wahine)*

The same rangatahi continued by saying how she felt accepted at these meetings: *"The NA meetings because how it's open and they don't judge you ... if you had relapsed they don't judge." (Participant 3, wahine)*

The 12-step meetings appeared to capture the rangatahis' thoughts through the sharing of personal stories, and it provided a place where they felt safe to say what was going on for them, as one rangatahi explained:

*"Everybody gets together ... and tell them about our life stories. Some place where you can let anything out and what's said in the room stays in the room ... you let out your problems, your past life problems ... what you were like when you were using ... just let it all out. That was a mean way to let out ... all of your stress. That's what worked for me ... lot of things that I wouldn't tell anyone, not even my mother." (Participant 10, wahine)*

Even though one of the rangatahi had forgotten the “steps”, they were still able to express their experiences and what they took away from the meetings: *“I’ve forgotten the steps ... but I still kind of know ... we went to meetings ... they were mean as ... we liked listening to all the ... elder people’s stories. I shared a couple of times.”* (Participant 2, wahine)

One rangatahi affirmed that the meetings were a huge help, indicating an acknowledgement of the long term benefits that can be gained through being able to carry on attending 12-step community meetings: *“The 12 steps those helped ... they’re a big help ... and NA meetings ... that’ll be choice if after RA they can still try and go ... cos, that’s a big help.”* (Participant 2, wahine)

Another rangatahi talked about the support they felt they received from the meetings:

*“I would probably say more NA meetings ... if that was on a weekly basis ... that would have been major help for everybody ... it’s really good to hear older people’s perspectives and what they’ve been through ... you realise ... where you don’t want to go ... It really makes you think.”* (Participant 4, wahine)

Rangatahi appeared to be attracted to the meetings because the people there were non-judgemental. The stories of the adults who were attending the 12-step meetings gave them food for thought about their own situations, and messages that recovery is possible.

Although most of the rangatahi shared enthusiastic accounts about their attending the 12-step meetings, two of the younger rangatahi (both 14 years of age at the time of treatment) were not as enthusiastic, and had a slightly different view: *“NA meetings I thought ... were boring. Sometimes interesting, go talk to the adults ... some interesting stories but, sometimes boring.”* (Participant 5, tane)

### ***Length of Treatment Stay***

During the interviews the rangatahi held strong views on the length of stay that residential AOD treatment should provide. They shared stories and experiences of personal growth during their stay and could identify when changes had begun to occur for them. One rangatahi reflected that: *“I do think that if the taiohi were committed to doing it [residential treatment] then I reckon two rounds would do them.”* (Participant 2, wahine)

This was followed by an explanation offered by another rangatahi as to why they felt that at least two treatment stays were necessary:

*“The first time ... it’s long, but when you start ... getting things right ... getting along with the programme ... then that’s when the weeks start going fast ... having to settle down in the place ... then you have to get along with everyone and get to know everyone ... get to know the staff ... get to know your classes, get to know your routine ... by the time you got that ... sorted and ... you’re sweet and ... you want to go for it then that’s practically when you got to leave. I think it should be ten weeks then one week break then ten weeks ... for me that worked.” (Participant 2, wahine)*

Another rangatahi shared his insights into the differences he found when comparing his time spent in AOD residential treatment to the time he spent in a youth offender’s residential programme:

*“Make the time period longer ... like months ... you know not just ten weeks, basically it [drugs] hasn’t left your system in ten weeks. It’s ... put you in there [residential AOD treatment] ... try to teach you this stuff quickly, then throw you out again ... all of a sudden you gotta make it work. In Te Hurihunga [the name of a youth offenders programme] ... I was there 11 months ... they gradually put me back in my home environment. I’d go there [home] for a weekend, then I’d go there [home] like on a Tuesday and the weekend, then, Thursday, Tuesday, and the weekend ... something like that and yeah.” (Participant 9, tane)*

One rangatahi, however, experienced wanting to make changes during the earlier stages of her stay:

*“It would have been the third week ... that’s when I started changing my ways ... going oh! I wanna change my life, I wanna do this (treatment), I don’t wanna go back out and do the same stuff I did all the time and get arrested again.” (Participant 1, wahine)*

There was a significant overlap in discussions about the importance of the length of stay in residential AOD treatment. The rangatahi highlighted the need for time to settle in, get to know each other, get to know the staff, and the programme. As one rangatahi had pointed out, just when you get started, the programme is about to end. Other rangatahi identified the benefits of having a second term in residential treatment in order to better focus on their needs and issues. They stressed the importance of transitioning back home, particularly the one person who had experienced treatment within an offender based residential programme.

## ***Areas of Identified Specialist Treatment and Individualised Programmes***

Rangatahi spoke about the importance of specialist treatment and individualised programmes that they could attend in addition to RA. An example of this was individual specialist counselling. In particular, one rangatahi talked about the success of supporting individualised programmes while in treatment: *“I use to go to counselling at HAIP [Hamilton Abuse Intervention Project] ... for when ... I was abused ... those things really helped me big time.”* (Participant 10, wahine)

Another benefit identified about having individualised programmes was that it conveyed good positive social messages for rangatahi: *“It’s for your anger ... that’s like no violence ... and they just teach you that violence isn’t good ... I like that all right.”* (Participant 7, tane)

Physical activity and sports, such as boxing, kung fu and weightlifting, were identified and highlighted by rangatahi as important parts of keeping active and healthy, as were non-physical activities, such as just watching television and listening to music.

Although activities and programmes were inclusive of all the rangatahi residing in treatment, RA identified the unique needs of each rangatahi, and tailored their treatment programme to most benefit them. One rangatahi who was supported to participate in a specialised sport exclaimed: *“I like kung fu it’s good!”* (Participant 9, tane)

Rangatahi spoke about some of the planned events they took part in, and especially appreciated events such as the trip to Rainbow's End, which was an activity that they would not normally experience that was dependent on funding. Other ‘day outings’ when they could ‘hang-out and have fun’, or *“Rainbow’s End ... just trips away for swimming like AC baths ... stuff that we wouldn’t normally go to.”* (Participant 1, wahine)

Rangatahi often spoke about activities they were involved in that they felt were beneficial and suited them, even though they were not necessarily a part of the normal programme: *“Gym ... yeah ... cause I know when I work out it calms me down and a boxing part, just a bag ... would be good.”* (Participant 10, wahine)

The rangatahi comments above reflect the uniqueness of each rangatahi in terms of their own needs as individuals. Of particular importance was the scope they had within RA to have their individual needs met.

### ***Downtime***

Despite clear support from rangatahi in engaging in the range of cultural and physical activities offered by the programme, there was evidence that rangatahi experienced boredom while in residential treatment, which can often be seen as a typical phase of adolescent development. Downtime highlights the value of having dynamic programmes in place, as well as the provision of individualised treatment planning.

The rangatahi involved in this study were residents at RA during different intervals of treatment throughout 2009. It is important to acknowledge that during that particular year, the service had suffered a lack of sufficient funding levels, which impacted negatively in terms of the range of programme interventions and activities that the service could offer, as well as a drop in overall staffing numbers that were needed to ensure that all of the interventions within the programme were monitored sufficiently as required.

A number of rangatahi commented on the times that there were no activities available and how they felt about it. One rangatahi stated that: *“You get bored ... I think the most things that makes you ‘use’ is boredom ... when you’re bored you wanna use.”* (Participant 7, tane)

Another rangatahi had some strong comments to make regarding the lack of activities:

*“It was just staying there during the day ... it’s so little [space] and you’ve got a lot of teenagers ... some of us fought ... that’s how much we want to be out of each other’s face ... that’s when it got hard for us, when if we had nothing to do, that’s when we’d be like ... we want to get out of here. That’s why I would say more outgoing stuff would be good. It’s hard staying in a small space with a lot of young people ... that’s hard.”* (Participant 4, wahine)

Downtime was summed up by one rangatahi, describing what happens to him when there is nothing to do:

*“You should do more cos, ... you can get bored ... the only thing that stirs me up is ... when I’m bored I get really mad ... cause I got nothing to do*

*and you're not allowed to go anywhere ... so basically I'm bored."*  
(Participant 7, tane)

Although residential treatment provided rangatahi with time to reflect on their days during downtime, they talked about the times when the lack of resources for activities negatively impacted on their own programme activities. Although time in their dorms gave them an opportunity to develop social group skills, two rangatahi expressed experiencing difficulties when they did not have set activities to keep their minds positive, to stay physically active, and to give them physical space from one another.

### Alleviating Boredom

Most of the rangatahi wanted to be and enjoyed being kept busy and active throughout the programme and they valued the life skills and experiences they learned during their time. However, there were some rangatahi who felt that they would have liked more downtime time as this was a way for them to be able to just be on their own 'chilling out'. Others found learning about cooking a valuable component of the programme. While there were suggestions that the rangatahi be involved in selecting the different food menus.

When sharing what rangatahi thought should be included in the programme, a number of activities were identified to help fill the gaps and alleviate boredom. These included:

- writing personal journals
- later bed times
- more time to watch television
- more downtime
- less downtime
- more offsite activities (swimming, beach, going out to eat)
- more music and dance
- more alcohol and other drugs classes
- more dedicated school hours

As one rangatahi summed up:

*"A lot more ... programmes ... outside activities ... going to beaches ... going out to eat ... having a say in the menu. I would like to see more sports and outside activities like rugby ... or ... bowling, stuff like that... we had*

*this thing called 'downtime', was for us just to relax in our dorms or where ever outside ... just listen to music and ... that was helpful. I think it should be daily ... more downtime would be very helpful." (Participant 4, wahine)*

## **Summary**

Throughout their involvement in their treatment programme, the rangatahi felt comfortable being able to express their opinions, views and ideas around what they thought a residential treatment programme should include as part of its curriculum. The ideas and views expressed were seen as their 'own recommendations', what they would want to see being put in place. There were similarities as well as differences found. For instance, there are downtimes during the day programme, and while some appreciated this time to themselves as very important, others associated this time with risks.

Being kept busy or stimulated during the day was important to all of the participants. The participants appeared to have participated in all given interventions mentioned; even though some of them voiced being bored at times they still were able to grasp the positive concept of why programmes were offered to them.

Rangatahi strongly felt that the Kaupapa theme and its nine associated subthemes that were identified were success factors that provided them with strategies and tools to become and remain abstinent from alcohol and other drugs. These strategies and tools were in the form of tikanga (Māori values), education, experiential learning, as well as concrete approaches for maintaining a clean and sober life. Being able to express themselves in different ways through the Kaupapa of the programme next door to the marae and through cultural aspects integrated into recovery activities were perceived clearly by rangatahi as success factors in their treatment.

Although opinions varied regarding what rangatahi felt should be recommended to include in the programme, the activities that were suggested indicated the potential of more involvement and input into their individual programmes, as rangatahi felt that they were sensible, pro-social and developmentally appropriate activities that would be more suited for rangatahi. It is important to note that these were based on the young people's own experiences of living within a residential treatment environment that they considered may assist future rangatahi in their treatment experience.

## Theme 2: Te Ao Māori

This theme reflects the important role of Māori tikanga; that is, those values, practices and protocols that have been a tradition and a way of life for Māori for thousands of years, and that have supported the well-being of Māori. The three subthemes that were revealed within this key theme were:

- kawa (protocol);
- noho marae (marae stay); and
- cultural connectedness.

This theme highlighted the importance of the role that *kaumātua* (elders) play, as conduits of *Māori tikanga* (customs) for rangatahi participating in the programme. Conveying health through cultural practice was identified to support a secure identity which promotes personal confidence. Māori processes, such as *pōwhiri* (a welcome), *tangi* (funeral ceremony) and *poroporoaki* (farewell), just to name a few, are healing processes within themselves and fulfil a spiritual component of *wairua* (spirit) from an indigenous viewpoint.

Equally important was having a kaupapa Māori service that was marae based, which provided a safe space for Māori, and the freedom to learn about being Māori within this space. All of the rangatahi interviewed identified the importance and place that cultural aspects have within the programme, such as *karakia* (prayer/chant), marae visits, *kapa haka* (performing arts), engaging with kaumatua, and the physical appearance of RA. As one rangatahi put it:

*“Kapa haka and ... Koro, he was the man ... he’d just come and talk to us about Māori stuff and just life ... it relates to the programme. He just pops in ... everyone’s happy to see him when he comes around. He talks about girls, life, just works to have someone like him there. He’s different than other old people, some of them are just up themselves ... but, he’s just laid back ... other ones they just wanna growl.” (Participant 5, tane)*

Another rangatahi talked about feeling connected as a Māori person, while another rangatahi shared about the confidence he felt through participating within a programme that engages with, and was facilitated within a cultural context: *“I just felt ... Māori ... basically ... Māori.” (Participant 3, wahine)*

For all of the rangatahi, cultural content was vitally important and a key factor that enhanced their engagement in the programme and gave them a sense of belonging. As one rangatahi

put it: *“More kapa haka ... because I wasn’t really into kapa haka ... but they gave me confidence.”* (Participant 5, tane)

Rangatahi illustrated through their sharing, the collective efforts that came about when on a marae. One rangatahi embraced the importance of having access to a traditional Māori elder to convey and pass on cultural and life knowledge within a marae setting. The reciprocity of relationships when working collectively in order to accomplish a task was a highlight that was deeply meaningful to this particular rangatahi.

*“We went to Taupo to Waihaha marae ... on the West side of Taupo lake ... we had a ‘mean’ weekend there ... we had to work as a group to get down to the marae cos you can’t drive down to the marae ... it’s a marae that’s in the bush.”* (Participant 6, tane)

One rangatahi felt secure in the environment setting of RA which in turn, helped them feel comfortable: *“It was nice and fresh ... I was out of my area ... it was beautiful ... all nice Māori designed ... it made me comfortable.”* (Participant 4, wahine)

While another young person reinforced the underlying message of culture and kawa as what worked for them: *“The cultural aspects, the tikanga behind it and everything ... we do.”* (Participant 1, wahine)

Throughout the interviews, all of the rangatahi agreed that the cultural components of the programme were a success factor. Not only in terms of various aspects of the programme itself, but included the design of the facility and the cultural artwork. Rangatahi were able to make connections to themselves, as well as their ancestral world, through varying cultural practices that they participated in. It was recognised that the programme in its holistic practices is intrinsically linked to indigenous health. The rangatahi embraced their learnings through the cultural application of the programme and strongly felt that having kaumatua involved was vitally important, in terms of the passing on of cultural knowledge from one generation to the next.

### ***Kawa (protocol)***

Kawa was a significant key theme discussed by rangatahi. The rangatahi felt that the kawa of RA was important, and understood how it supported the infrastructure of the overall recovery

aspects of treatment. The kawa provided the guidelines and rules for behaviours that were acceptable while in RA. One rangatahi identified that without kawa, treatment would not be successful because everyone would just do what they wanted to do. Some rangatahi shared that they liked the routine of RA, and were comfortable adhering to the schedules of the day as they knew what was going to happen each day. Other rangatahi shared that they found the routines different to what they were used to; however, they experienced the difference in routines as positive and helpful for them. One rangatahi had the following comment to make: *“The rules ... they’re important ... the kawa ... the children need space ... can’t always be in a group they’ll go crazy.” (Participant 10, wahine)*

Confirming the significance of kawa, another rangatahi shared that:

*“We had a schedule ... if we started in the middle of the intake we would start to do things automatically ... like chores ... what time to wake up ... I liked having a routine ... so you know what you’re doing in the day.” (Participant 2, wahine)*

In contrast, a further rangatahi spoke about kawa being different to what they were accustomed to before they attended residential AOD treatment:

*“The lifestyle there and the routine was very different for me ... a good change ... I just wasn’t use to it ... like getting up in the morning ... breakfast about 8am ... that’s like normal ... I use to get up at 1pm ... a schedule was very helpful ... you just gotta make it work for yourself ... it was very, very helpful.” (Participant 4, wahine)*

Furthermore, one other rangatahi stated: *“The rules were good ... helpful.” (Participant 5, tane)*

While another young person elaborated more on why he thought the kawa was useful: *“If there were no rules ... they’d (the young people) rule ... RA ... they’d take RA over ... the kaimahi (staff) ... would just get headaches ... and they’ll (kaimahi) probably kick them out.” (Participant 8, tane)*

The significance of the kawa of RA was that it provided rangatahi with certainty and consistency in their day to day programme. It allowed them to feel safe and added a sense of security during their stay in treatment, and supported the underlying recovery-focused feature of the programme, which all of the rangatahi understood well.

## *Noho Marae*

During their time at RA, rangatahi were able to participate in, and experience a *noho marae* (marae stay), alongside recovering adult clients from the Higher Ground residential AOD treatment service. This particular aspect of the RA programme was unique for a number of reasons. It integrated cultural practices, Māori tikanga alongside contemporary treatment. For example, the practice of powhiri and whakawhānaungatanga, while incorporating the facilitation of the 12-step recovery therapy. Rangatahi highlighted the noho marae as a positive experience, with one rangatahi commenting: “*National recovery hui [gathering] ... yeah that is pretty cool.*” (Participant 1, wahine) While another rangatahi described it as: “*It’s like a NA [Narcotics Anonymous] wananga.*” (Participant 1, wahine) The following quote speaks to the welcoming atmosphere of the noho marae activity:

*“Anyone from all over the Nation or anywhere can come ... if they’re recovering. They just stay there for a couple days ... just hang out ... share your thoughts your feelings ... share the food ... yeah.”* (Participant 1, wahine)

The chance to share and learn from older people in recovery from alcohol and other drugs was particularly valued by rangatahi, as was the sense of safety and open communication:

*“We went ... to the marae that was next door ... stayed on other marae (tribal meeting place) ... I think it’s useful for everyone ... we had a young group ... with the older ones staying ... we’d all go ... the tables are set up like a marae and when everyone’s there it’s ... safe ... there’s so many people to communicate with you don’t get bored ... your mind’s always distracted ... you talk more.”* (Participant 6, tane)

One rangatahi commented on the integration of recovery through NA and the cultural aspects of the noho marae and how it worked for him:

*“We go around in a circle and introduce each other, then we had dinner ... then we had a NA meeting. On my first intake I never really got into it, but, my second intake ... was pretty cool. After that we went to the pool that was cool ... we do a skit ... that was fun ... then we had a big sing ... I learned one song that was cool ... then a hangi (earth oven) ... then one day we just left.”* (Participant 5, tane)

Central to the theme of Te Ao Māori was that the participants expressed having had positive learning experiences that were relevant to them, and that they were presented in a way that was fun for them to participate in, and easily understood.

## *Cultural Connectedness*

Throughout the *korero* (talk) shared by rangatahi, they constantly referred to, or emphasised the importance of having a kaupapa Māori AOD treatment service as essential to their identity, their own health, and their own overall well-being. They identified the ongoing relationships they had established with others that they interacted with, and had encouraged some positive changes for themselves that were uplifting for their own wairua or spiritual well-being.

One rangatahi conveyed feelings of being within a whānau environment, while another expressed that being Māori and having people of the same culture and lifestyle was ‘huge’. Furthermore, another rangatahi shared that ‘what worked’ for her was being reflected as a Māori person: *“Being the same culture ... they’re [staff] Māori and I’m Māori ... it really made a difference ... just to have ... the same culture.”* (Participant 2, wahine)

However, rangatahi tended to be critical when asked about their view of mainstream services. Rangatahi had discussed their personal experiences of mainstream services not meeting their specific needs, and what they had experienced while in mainstream treatment. In light of past experiences of being excluded, rangatahi were inclusive and open in their desire to share their own experiences of living with a Kaupapa Māori AOD treatment service environment with rangatahi of other cultures:

*“Pakeha services ... ain’t as helpful as Māori ... for Māori it’ll be more helpful because they been there ... experienced what the taiohi (youth) are going through ... so they’ll be more helpful. I’m not saying that Māori are mainly the ones that are in this work, but ... most Māori got a big heart and they can step out of their comfort zones to help ... some Pakeha they can’t ... I’m not sounding racist or anything ... but, that’s how it is.”* (Participant 10, wahine)

In agreement, another rangatahi articulated the difference he felt with being around other Māori versus being around ‘white people’:

*“Just knowing they’re Māori ... white people they intimidate ... thinking they are richer or whatever, but, being around other Māori was all good like pretty much family ... felt comfortable and I could relate to them.”* (Participant 5, tane)

Indigenous relationships are complex and closely interrelated, and this was clearly indicated through comments made by one particular rangatahi, who felt alienated by mainstream services and practices, but felt strongly that a kaupapa Māori service and their practices were more inclusive and welcoming:

*“Because from my knowledge of the stats of ... Pacific Islanders and brown people, the drug use and drug rates and crime ... the majority of New Zealand is brown people ... you won’t see brown people going into a rehab ... called ... you know ... Pakeha name ... they’ll go into a rehab and ... not feel comfortable ... they’ll feel like they can’t fit in. If there’s like a Māori place ... you go to those kind of places they make you feel welcomed from your first step you take on to their property. You know you got a pōwhiri and after the pōwhiri they introduce and go around and hongi (press noses) ... and hariru (shake hands) everyone. It just makes you feel warm and welcomed. Where the white ... well, I don’t know how they do it but ... you just go in there and they are like ... okay there’s the rules, okay guys your room, and after this we’ll have dinner ... you know, you don’t feel welcomed especially for a brown person, yeah ... that’s how I see it.” (Participant 6, tane)*

One particular rangatahi shared the first thing that worked for him while in treatment: *“First ... it was a Māori kaupapa ... and I like my Māori te reo [Māori language] ... that’s one of the things and ... people were good to me ... yeah.” (Participant 7, tane)*

Another rangatahi spoke of the benefits in the sharing of cultural knowledge not only for Māori, but also non-Māori:

*“Like a lot of Māori stuff ... a lot of white people enjoy Māori things because it’s just a cultural thing. They (Māori) do it in a different way ... they use their marae ... our rehab had a marae next to it and so you know you’re still in that ... tribe thing ... still around Māori stuff ... it’s good ... learning about your own culture. Even if you’re not Māori you ... learning about New Zealand ... a bit of history ... going to marae and people learning things.” (Participant 6, tane)*

He shared a past experience he had with a non-Māori youth who attended RA, and over time, began to recognise a changed attitude about the youth’s racial prejudices, which can be attributed to his time spent at RA:

*“This one guy that went away learnt to ... meet different colour. There was this white boy and ... he was anti ... I had just got stood down and I come back into rehab and I just seen a look on his face ... soon as he seen me with this moko (Māori tattoo) ... he just gave me those eyes ... I was ... shout ... what’s up bro my name is (name) ... he just looked at me, then couple of*

*days ... he said ... I've never shaken a brown ... boy's hand ... you boys in here are one of the first that I've shaken hands with. He said ... brown people not as bad as what I thought ... he told us ... he's racist and he's always been racist because of his dad ... he was all good when he left ... shook our hands, gave us a bit of a man hug ... whatever their families tell them ... you know growing up in a skin head family ... putting words into his head, instead of for him getting out of it for himself.* (Participant 6, tane)

Māori cultural content was cited repeatedly as being one of the main grounding elements in successful treatment factors for the rangatahi. Comments such as: *"It just made me feel a part of my culture."* or: *"Learning Māori things every day."* (Participant 7, tane)

Other korero by rangatahi around the processes of pōwhiri and poroporoaki clearly indicated a 'knowing by doing', as well as they could: *"Learn more about your culture that you didn't know."* (Participant 7, tane)

This rangatahi went on talking about the cultural content of the programme and how it made him feel like he was an important part of the programme: *"Just makes it part of my culture ... if you're Māori and you're interested in your culture then it's important."* (Participant 7, tane) He further explained that: *"You learn more about your culture that you didn't know ... that's what's important to me ... I find out heaps of different things about Māori every day ... I learn ... new Māori things every day ... we do karakia every morning."* (Participant 7, tane)

One rangatahi spoke about how the cultural content of the programme helped him to find his whakapapa, by sharing: *"What does it mean? Means that they try to relay you back to where you come from ... they tried to find my whakapapa and ... they did."* (Participant 9, tane)

Rangatahi spoke about the need for more kaupapa Māori-run, residential AOD treatment services, so that Māori have more options of treatment to choose from: *"There needs to be more ... there's a lot of Māori out there ... that need these, there needs to be more options out there."* (Participant 10, wahine)

Another rangatahi talked about how it was 'good' learning about your own culture and having a marae next door to the rehab felt like a: *"...little tribe thing."* (Participant 6, tane) While another rangatahi shared about liking the daily use of te reo Māori and how people were 'good' to him.

## *Summary*

The views, opinions, ideas and attitudes that rangatahi have shared within this theme of Te Ao Māori were success factors that they identified for positive outcomes they had experienced. These success factors were in the form of *tikanga* (Māori customs/values), education, and experiential learning, as well as concrete strategies for maintaining a clean and sober life. Being able to express themselves in different ways through the kaupapa of the programme, on marae and through other cultural aspects integrated into recovery activities, was perceived clearly by the participants as high on the list of success factors in their treatment.

## **Theme 3: He Tangata**

This theme depicts *whakawhānaungatanga* (relationship building), *kotahitanga* (unity) and Māori protocols and practices based on rangatahi views and opinions about the importance of relationships with others, connectedness, and mutual respect. It is about the significance of establishing and preserving relationships. This particular theme encompasses four subthemes, which are: 1) staff, 2) dynamic programme activities, 3) whānau contact and 4) age and gender.

Overall, rangatahi talked about their experiences of learning to make new relationships with other people outside of their ‘normal’ lives. They spoke at length about the new-found relationships that were established with fellow rangatahi involved in the programme, as well as those relationships established through participation in the noho marae and the 12-step group meetings they regularly attended. The connections with others had positively impacted their treatment journey.

The value of interpersonal relationships with peers and with staff proved to be an extremely important theme for rangatahi. Relationships made a significant impression and difference to the approach that rangatahi took to their participation in the programme.

## *Staff*

During the interviews, all of the rangatahi shared their experiences regarding the positive support they received from the staff at RA. These included that staff was non-judgemental and always encouraged them. Of significance to rangatahi was the fact that some staff

members were open to sharing their stories and experiences that were very similar, and they could identify where the young people were coming from. In particular, one rangatahi commented that: *“They [staff] naturally understood where I was coming from ... they went through similar things”*, and that: *“There was ... the support and how they helped you ... they shared ... their stories.”* (Participant 10, wahine)

Furthermore, rangatahi felt that the staff believed in them, as illustrated through the following comments: *“Encouraging youth to do better in their life and carry on without doing drugs.”* (Participant 3, wahine) While another rangatahi added:

*“The staff here, they had so much ... support ... they tell every taiohi you have potential to do this ... you can do this ... it’s achievable, you can prove people wrong who have said ... you can’t do this sort of thing.”* (Participant 1, wahine)

Rangatahi shared how they felt safe physically and emotionally in terms of being able to express feelings of anger where they weren’t going to be retaliated upon or abused by the staff. Feeling physically safe and ‘loved’ in a residential AOD treatment environment was clearly important to them. Another rangatahi shared her enthusiasm by exclaiming: *“Safety, safety ... love ... and yeah just warmth.”* She went on to explain that: *“You’ll get angry, there’s no doubt about that ... but you don’t get like hurt from the adults or ... abused in a way where you don’t feel safe.”* (Participant 1, wahine)

As the following rangatahi put it, being listened to and heard was something to take comfort in:

*“She used to just come in sometimes and talk to me ... cos, I felt comfortable around her ... they was just something comforting about her ... she would listen ... she been through kind of the same things ... she listened which was helpful when I needed to get it out.”* (Participant 2, wahine)

Rangatahi often talked about feeling supported by staff, for example: *“The staff helped me pull through ... they’ll like support you and help you in any way they could.”* (Participant 10, wahine) And: *“Just that loving feeling from the staff, the support feeling and just ... being together and being able to talk and stuff.”* She added, *“What worked was the ... support they gave ... they just gave their all ... spent time and spent money on ... us to go to trips ... when they didn’t have to.”* (Participant 1, wahine)

The *awhi* (support) and *manaaki* (care) that rangatahi openly spoke about receiving from staff was in vast contrast to what some of them had experienced in their lifetime, as spoken about by one particular rangatahi: *“We come from backgrounds that ain’t very good ... violence and all that ... and then we go into a place where they just praise us ... and ... it feels good.”* (Participant 1, wahine)

Another rangatahi added that if she felt unsafe and spoke out, she felt confident that she would be able to count on being supported by the staff:

*“You can speak out if you don’t feel safe. You’ll be like, “I don’t feel safe” and they’ll remove you from the area ... and put you in a safe environment. If you’re at home and you feel unsafe and you say that, it’s just like not the same ... they’ll just say, “oh well ... go”, and then you just move into a different place which is pretty much more unsafe. And ... you just want to get into trouble.”* (Participant 1, wahine)

Another positive aspect identified by rangatahi was that they felt the staff “listened” to them and “heard” what they said. They spoke about how staff members would help them sort things out and work through the issues they were facing: *“They were awesome ... it was really hard for them aye, taking up to 16 teenagers you know ... both male and female ... but, at the end of the day they had things sorted.”* (Participant 4, wahine)

Supportive staff attitudes and attentiveness led to rangatahi making positive changes in their own attitudes and behaviours. Treating each other with respect was important for rangatahi, with one stating that: *“There was some choice staff ... their attitude, I liked it.”* (Participant 2, wahine)

As well as being treated fairly and equally, as commented on by one rangatahi:

*“The kaimahi ... they show interest in what you have to say no matter what it is ... and they’ll take your word ... they’re there to help ... they don’t got sides or anything, every one’s ... treated as the same ... that’s a rule in there. You know you gotta be fair, you can’t have more than the other one ... cause once they start having ... unfairness ... you get dramas ... the kaimahi ... treated every one as one ... fair.”* (Participant 6, wahine)

During the time spent in residential treatment by the rangatahi involved in this study (2009), government funding regimes had changed, which meant some significant reductions and changes in staffing numbers and staff availability. Some rangatahi were concerned about

what these changes meant in terms of their own feelings of safety, with one rangatahi in particular, stating:

*“The staff helped me pull through ... they’ll ... support you and help you in any way they could but ... sometimes there wasn’t enough. Like three or four staff on and ... 16 children and ... only four, five staff on the floor ... they needed more staff on to really support you especially in detox. They can’t run around and help everybody ... when the children are running around freely.” (Participant 10, wahine)*

One rangatahi linked personal safety to staffing numbers and their experience at another residential facility:

*“Young people should know that they’re safe ... you know keep them in your eye sight. If there’s a large group of kids have different kaimahi for ... each house. They should have a kaimahi in each whare (house). They should have one for each group as well ... or even two. Like two staff to four young people. That’s what they used to do in Te Hurihunga ... they had like five staff on to eight kids.” (Participant 9, tane)*

### ***Dynamic Programme Activities***

In addition to attending the noho marae and 12-step group meetings scheduled throughout the programme, RA provided other dynamic interventions and activities, though many of these were often dependent on external funding sources being sought. These interventions/activities allowed rangatahi to experience positive alcohol-free and drug-free fun through participating in a range of pro-social activities and events. Relationships were developed and nurtured through rangatahi taking part in the activities offered, and these were freely discussed by rangatahi throughout the interview process. Having relationships with tutors, recovery adults, and staff along with their peers were important to the rangatahi and added to their sense of belonging to a whānau.

Te Ahurei a Rangatahi is a Māori peer educator group service based in Hamilton who provide a series of graffiti and hip-hop classes for rangatahi at RA, and which all of the rangatahi found extremely enjoyable: *“Te Ahurei for rangatahi ... they’re cool. They talked about being young ... about hip hop and graffiti.” (Participant 5, tane)*

Rangatahi expressed the importance of their relationships while in residential treatment, whether it was with fellow rangatahi, staff, kaumatua on the marae, or other adults attending

the noho marae and 12-step group meetings. The practice of whakawhānaungatanga connected them to others, and impacted on them in a positive, pro-social way.

### ***Whānau Contact***

Throughout discussions with rangatahi about their experiences, their relationships and what they considered as success factors in treatment for themselves and possibly others, there were rangatahi who shared that contact with others but was not always of benefit to themselves and the other person. This was a significant topic as participants discussed the pros and cons of having whānau contact while in treatment. On one hand, rangatahi expressed that they would have liked more support from their whānau, but they were also aware that some of their own whānau members were themselves experiencing parallel difficulties at the time their rangatahi member resided in treatment. While some appreciated the whānau contact during their time in treatment, others considered that contact with their whānau was an obstacle to their treatment progress. Some felt it was all dependent on the relationship they had with their whānau prior to entering treatment and whether they would be supportive before, during and after. Although opinions varied regarding how rangatahi felt about having whānau contact, it is important to note that these were shared within the context of their own whānau situations and experiences. It is important to understand that in Māori terms, the meaning of whānau, or family, is not limited to ‘blood’ relatives, and can refer to those whom someone may identify and connects with, whom they consider to be ‘family’ to them.

In contrast, there were some rangatahi who did not support having contact with their whānau while they were in treatment and reasons for this varied. In particular, one rangatahi shared her particular experience:

*“No contact with the family would have been good ... I just couldn’t handle that. It would have helped me ... if I didn’t keep ringing them ... and all I can hear them saying is ‘oh we’re having a bong’.” (Participant 3, wahine)*

Another rangatahi thought that whānau contact should not happen but for different reasons again, and chose not to have contact with his parents and family until he knew he had completed the programme:

*“Wasn’t useful ... going back with your family for just a day or so, cause you’re only in there (rehab) for a couple months. It’s not as if ... you’re in there for two years. Because you’re only in there for ... three months I just*

*see no point in ... seeing your family. I'd do it just until you make a good change ... in three months when you make a difference in yourself, then you can see your family, then they can feel proud ... when it comes to the poroporoaki ... and the achievements that you have done ... I'd just save it for the last day ... then you have a lot to talk about ... so, I'd take that out.”* (Participant 6, tane)

However, one rangatahi commented: *“Let them go see their family ... just through the weekends, family comes into RA. You could just see everyone ... with their family and they looked brighter ... cos, they know that their family is there to support them.”* (Participant 8, tane)

Some of the rangatahi pointed out that the service itself should encourage parents to visit more: *“My mum came in only when she really, really could ... my dad didn't come once. The rehab should get the parents to come more often and different people to give talks ... like ... motivational speakers ... that helps.”* (Participant 9, tane)

### ***Age and Gender***

As has been discussed previously, relationships play a vital role in the well-being of rangatahi, and age can often play a determining role as to whether rangatahi are able to develop good, positive relationships with peers who may either be slightly older or younger than themselves due to different levels of maturity. Two particular concerns that were considered as potential barriers related to the different age groups of rangatahi, and the dynamics of intimate relationships.

Half of the rangatahi made specific references to the differences in age groups and developmental maturity of their peers during their time in residential AOD treatment. One of the older rangatahi described his experience with younger rangatahi in treatment:

*“Mixing us 17 year olds with 13 year olds ... is a big maturity gap between us ... they're just ... a bit immature and too smart. We mix in with people because we're all like 17. Young ones are real smart and they go on and go on. Seventeen is a big gap and I wouldn't mix them with 13 ... they should just have their own facility for ... the younger from 13 to ... 16, 15 ... but 17 they coming into more ... of an adult life ... there's no time for all that cheekiness ... that's the only thing I didn't like.”* (Participant 6, tane)

Some rangatahi identified an understanding of a particular need for gender specific treatment services, and discussed the reasons why this was important. Four of the rangatahi commented on the issue of gender, and one of the rangatahi specifically talked about the risks involved in developing ‘intimate’ relationships within a mixed gendered programme: *“Relationships don’t work in some places ... I know that it distracted me from treatment and what I needed to do.”* (Participant 5, tane)

A further rangatahi stated:

*“What didn’t help ... the boy and ... girl thing. If you get involved with someone ... they get easily distracted. It’s a big watch out for. It’s all right to have them together I guess but you ... just got to watch ... the young ones. The boys and the girls when they ... start getting too close ... that’s distracting ... when they looking at each other and ... spending heaps of time together something’s going to happen ... like relationships. That’s really distracting. I find that distracting.”* (Participant 2, wahine)

One rangatahi spoke in length about the reasons why they thought that residential AOD treatment should be gender specific:

*“I’d make it a girls’ programme. I would not make it a male and female. With male and female that’s where we get lost. We think about ... oh he’s nice ... and that’s when relationships started. We all got told ... that we’re all brothers and sisters ... but, come on. There was couples in there, I was one of them ... it was distracting. I would make it a ... girls’ programme and probably have another one just for boys and maybe we would get together when we go out. For males and females that was a distraction it was ... a major distraction. What the staff members had to deal with ... and because of that when they had relationships one would have to leave the programme. I was with this boy and he had to leave and that didn’t help him. I’d make it a girls’ programme.”* (Participant 4, wahine)

This view was supported by another rangatahi:

*“They (girls) were a distraction. If I had a rehab I’d have ... one facility in one area for the males and one facility in another area for the females ... like a rugby field or down more and have a fence between us ... a fence were you can’t see what they’re doing.”* (Participant 6, tane)

Important parts of the kawa of RA are the guidelines around forming intimate relationships with others in treatment. Although one rangatahi found this humorous at first, after a time, he was able to see the value and purpose to these:

*“You weren’t ... allowed to build relationships with the opposite sex. I did anyway. If you do you get ... a five foot or six foot ban first and if it carries on then you get ... a foot ban, it made me laugh. I can see why now you shouldn’t have relationships. Drugs was like a relationship ... it use to make you happy ...now take that away and you go sad. And, a lady comes in and oh yeah, makes you happy, then if you have a little bit of fight then it makes you sad, then it makes you want to use again. So yeah, I probably have that rule.” (Participant 9, tane)*

Although the majority of rangatahi expressed their support for establishing same-gender-services, there was one rangatahi who particularly argued for the usefulness in having a mixed-gender-service:

*“My mate ... I met him through rehab and now ... are good mates. He really didn’t know about respect ... he really learnt to respect by being with people. Some of the girls in there were annoying ... even though they’re annoying ... you just can’t ... like ... if it’s a guy you can just say ‘ah f--- up’. But ... you can’t talk to a girl like that ... and that’s what he learnt. Even though the girls in there were real smart it still doesn’t give you a reason to swear at a girl.” (Participant 6, tane)*

## **Summary**

The theme, He Tangata, highlighted the important role that relationships play in facilitating treatment for young people. It speaks to the challenges of maturity and intimate relationships that are challenges that rangatahi face every day. They are all presented within different situations and contexts, and may even be intensified within the confines of residential treatment. Despite this, the korero shared by rangatahi has provided some insights into how our rangatahi learn, develop, establish, and practice the skills gained during treatment, to cope with the range of issues that they will face throughout their day-to-day life after treatment.

## **Conclusions**

The responses given by rangatahi have emphasised the importance of, and the need to have a culturally congruent, residential, alcohol and other drug treatment service specific to the needs of Māori rangatahi. For all of the Māori rangatahi who took part in this study, cultural identity was foremost in their willingness to participate in the programme. Identifying with, and being well cared for by staff of the same cultural background was a vital aspect for the

rangatahi, particularly in the sense that they felt that their issues meant something to those around them.

Rangatahi voiced the importance of staff attributes that were caring, nonjudgmental and respectful. Rangatahi favoured staff whose lives reflected their own life experiences. They saw the need for higher staff numbers and the need to be listened to and heard, and for physical and emotional safety. Physical and emotional safety were significant factors in successful treatment. Knowing that the adults who are caring for them would not harm them physically or verbally gave them comfort in forming important key relationships with them. This highlighted the important relationship building skills of confirming appropriate behaviours.

Within a kaupapa Māori service the rangatahi felt that they were a part of the 'norm' rather than the 'other'; as opposed to feeling alienated within mainstream services. Being marae based and having the opportunity to participate and learn in an environment that was meaningful to them was a very important factor in successful treatment for these Māori rangatahi.

Having programmes that stimulated rangatahi and kept them active throughout the day was one of the aspects that they perceived as an important success factor in their treatment regime. Since boredom was linked to negative moods, ruminating over past negative experiences and substance using thoughts, rangatahi reported that staying active helped them to move forward and not dwell on their past. The suggestion to write in a journal was considered valuable as a healing tool.

One of the ways that activity worked well to support rangatahi in working through uncomfortable emotions and negative past experiences was the exploration of music and composition of songs/waiata. Rangatahi expressed that there are many ways and styles in which learning takes place; for example, in a classroom, through music, learning whakapapa, participating in kapa haka and waiata, through tikanga and kawa, and communicating (for instance, talking with kaumatua, reciprocal sharing of experiences, through physical activity, and experiential learning).

Although the rangatahi in this study came from varied geographical areas within the North Island (with some having more traditional unbringings and others brought up in less traditional and urban settings), they understood inherently that they were Māori and voiced the need to have kaupapa Māori services available to support their needs and wellbeing.

# **CHAPTER FIVE:**

## **DISCUSSION AND CONCLUSION**

### **INTRODUCTION**

The findings from this study have highlighted a number of factors that rangatathi Māori perceived helped them engage and maintain a healthy lifestyle while in a kaupapa Māori AOD youth residential treatment. This chapter will discuss the findings from the study, beginning with the benefits of a holistic treatment approach that takes into account a range of cultural aspects within the context of kaupapa Māori based treatment.

Findings are discussed in relation to how treatment engagement facilitated relationships and cultural connectedness. Discussed are the uniting benefits of cultural and contemporary treatment processes as a way of improving indigenous youth AOD treatment. The findings are discussed in relation to past literature, focusing on Māori health frameworks, indigenous models of health, effective youth treatment, Māori rangatahi, positive youth development and the practices of youth-friendly services, all of which utilise a range of strengths-based approaches that enhance the capabilities of youth.

Finally this chapter will conclude with a discussion of the clinical implications, recommendations and possible future implications of this study's findings.

### **Holistic Treatment and Kaupapa Māori Based Treatment**

Treatment, inclusive of cultural aspects, has been shown to be important in achieving good health and well-being for Māori and many other indigenous peoples (Anea, Barnes, McCreanor, & Watson, 2002; Durie, 1999, 2001; Huriwai, 1998; McClintock et al., 2012; WHO, 1999; Withy et al., 2007).

It is often stated that Māori health is positioned within the interrelatedness of relationships between the individual and the environment. In addition, Māori tikanga does not separate out dimensions of a person and their world. Hence, kaupapa Māori treatment is holistic and

encompasses interrelated factors such as *wairua* (spiritual), *hinengaro* (mental/emotional), *taiao* (environment), *taha tikanga* (cultural), *whānau* (family), *whakapapa* (genealogy) and *whenua* (land) (Anae et al., 2002; Durie, 1999; 2001).

Findings from the current study have reiterated the benefits of a holistic treatment approach that takes into account a range of cultural aspects that are important to achieving overall good health and well-being, within the context of a Māori world view. These findings are congruent with concepts of positive youth development, which advocate the need for youth-friendly services that utilise a range of strengths-based approaches and enhance the holistic development of youth (Lerner et al., 2005; Jansen et al., 2010).

The rangatahi in this study clearly indicated that being able to access a kaupapa Māori service that is marae-based is what first attracted them to engage in the RA residential programme. More importantly, they identified this as a critical success factor to their actually becoming more fully engaged in the treatment process, because it helped to facilitate their participation into the Māori world. This in turn allowed them to identify as being Māori, and to express their ‘Māori-ness’ within an environment that was nurturing and affirming for them. The marae based setting clearly defined a place and sense of belonging to the rangatahi.

It was important to the rangatahi that once they were engaged with the treatment programme, their levels of interest increased beyond just the physical aspects of the marae, and they took the opportunities to learn more about their own culture. They experienced first-hand what it was like living within a cultural environment, through participating as well as facilitating those cultural practices and processes that are fundamental to Māori, such as powhiri, mihi, tangi, poroporoaki, kawa, waiata, karakia and kapa haka, manaakitanga, whanaungatanga, aroha ki te tanga and rangatiratanga to name a few. Within this environment, rangatahi discussed how they were able to express themselves freely within these practices. They conveyed that it was this environment that helped them to feel comfortable and not judged which in turn increased their levels of confidence in themselves. These practices could be said to be healing processes within themselves, and fulfil the spiritual component of *wairua*, which is often missed in mainstream treatment, but critical for the wellbeing of Māori (Durie, 1994). These practices appeared to assist rangatahi to put the necessary steps in place to support their readiness to work towards their recovery.

This cultural self identification was supported and enhanced by having a kaupapa Māori marae-based service that was important in the role that it played in affirming the ‘Māori-ness’ of youth participants. This was described as occurring in a number of different ways. Not only was the environment conducive to identifying as being in a ‘Māori’ space, the cultural structures helped to facilitate a routine for them to live by and to guide them during their stay. Furthermore, affirming who they are as Māori was reflected through having Māori staff who role modelled being Māori through speaking te reo Māori, had knowledge of Māori values and who validated the use of karakia and spirituality. Being amongst other Māori rangatahi who are experiencing similar situations (peers) made them feel connected as a Māori person. This was perceived by participants as an important factor in their treatment success. Rangatahi expressed the importance for them of being within an environment that is nurturing, in this case a Māori space and place.

Rangatahi explained how the cultural setting facilitated their engagement into not only the Māori world, but just as importantly, for these rangatahi, into AOD treatment. These findings suggest that when providing successful residential AOD treatment for Māori rangatahi, consideration must be given to the environment of the service itself, in order to attract Māori youth at a place where they are at and in a manner in which they feel comfortable. The marae, as identified by rangatahi in this study as a kaupapa Māori health setting, provided a familiar environment to many, and an affirmation that this kind of setting is more welcoming for Māori, in contrast to many mainstream AOD services which often struggle to engage Māori youth.

The existing treatment literature typically mentions treatment settings as out-patient (community-based treatment), in-patient (residential treatment) services, and outdoor adventure therapy. The findings of this study highlight the importance of giving consideration to designating the cultural setting and design, as key factors for access regardless of the specific treatment modality. Furthermore, the findings of this study support the notion that settings such as marae, coupled with kaupapa Māori programmes as described in this study, may be better able to serve the AOD treatment needs of Māori rangatahi.

In addition, treatment services that offered flexibility in access to the service may better serve young people as many of the young people had the opportunity to have multiple entries into the service. Given “another chance” provided the young people time to process within

themselves and recognise that they did want and needed support. Another success factor for many of the young people was a longer duration of treatment stay.

## **Relationships and Cultural Connectedness**

The initial attraction to RA for the rangatahi in this study was having a Māori place to go to, and was identified as important for their engagement into AOD treatment. Being immersed within Te Ao Māori on a deeper level allowed the rangatahi to experience living within the culture and adhering to the cultural protocols and practices that were established in the service they attended. These protocols were perceived to keep them safe (physically and emotionally) which helped to establish feelings of security and gave them a sense of self control. This was demonstrated by participants' descriptions of their willingness to engage in treatment interventions because of feeling culturally connected to their surroundings and safe in their overall environment.

Although the rangatahi in this study had varying degrees of engagement in te ao Māori prior to entering treatment, they all actively engaged, incorporated and embraced kaupapa Māori practices within their treatment programme. Rangatahi viewed the inclusion of te ao Māori as a key point of cultural connection, whether it be through learning about their own culture, or culturally connecting to staff and other rangatahi, some of whom were of different ethnicities, and who were in RA. For example, even though the rangatahi could not specifically articulate what kaupapa Māori meant, they talked about feeling 'it', and described the cultural connectedness of being with other Māori, participating in rituals, the generosity of spirit the staff portrayed and staff's desire to help them progress in their treatment. This generosity of spirit can be described as whakawhānaungatanga which is underpinned by wairua through which kaupapa Māori relationships are created (McLachlan et al., 2012; Robertson et al., 2001). Rangatahi identified the practices of whakawhānaungatanga and whakapapa as a success factor, as these practices connected them to others who they considered their recovery whānau, and felt safe with. In one case it connected a young person back to his biological whanau. They described how these practices gave them a sense of contributing, as they were actively participating in lived culture. The findings support previous research that found the practice of whakawhānaungatanga had direct effects on the engagement and retention of Māori in AOD treatment (Huriwai et al., 2001). Further effects are that cultural background and spiritual dimensions are inextricably linked to the process of healing for Māori (Durie,

1999, 2001; Huriwai et al., 2001; Mead & Mead, 2003). Whakawhānaungatanga creates a whānau where all members strive to work towards a common end as a collective, adhering to similar processes. This sense of belonging to a wider collective not only reinforces a sense of belonging but ensures that there is an accountability to each other which is supportive yet insistent (Huriwai et al., 2001; Mead & Mead, 2003).

Another success factor revealed in the current study was the kinship that rangatahi felt toward the staff, often referring to them as whānau. They described this relationship as whānau who didn't judge them and listened to what they had to say. For example, rangatahi expressed the importance of the staff treating them fairly and equally, and providing a safe and non-abusive environment. Another example given was that rangatahi felt physically safe in knowing that the staff would not abuse them. According to the rangatahi, whānau were those who affirmed who they were as Māori youth, who positively encouraged them while in treatment, who had similar life experiences and who understood what they were going through. The words that rangatahi used to express staff attributes were 'awhi', 'manaaki', and 'choice'. The positive and supportive role modelling of staff supported rangatahi wanting to make changes to their own behaviours and attitudes. Positive relationships with tutors on their courses, other recovering adults that were present at their community meetings and the Māori peer health educators were identified as critical success factors for rangatahi in this study. These relationships served to extend their pro-social networks. The findings support the existing literature, which identifies that having supportive pro-social role models is of great importance to young people's well-being, and for making positive long term changes (Bishop et al., 2003; Schroder et al., 2009). These positive connections to significant adults have been acknowledged to facilitate positive development and enhance resilience (Lerner et al., 2005).

## CONTEMPORARY TREATMENT

Previous studies have emphasised the benefits of utilising a multi-faceted approach in AOD treatment interventions, particularly when working with adolescents (Bell, 2006; Hair, 2005; Withy et al., 2007). Rangatahi in this study identified that the highly structured, multifaceted interventions used in their treatment were beneficial and a key success factor in their treatment. They discussed a range of interventions that helped them to make positive changes. Interventions included individualised counselling, having an active role in the

development of their treatment plan, and being able to learn from kaumatua who frequented the treatment service and spent time sharing life stories. Rangatahi referred to the 'outings' off site as an important treatment component because they wanted external experiences to aid their learning and development and opportunities to relate to each other outside of the treatment facility. This need for utilising a broad range of interventions has been recognised as essential, particularly in AOD treatment for youth with co-existing disorders and complex problems (Bell, 2007; Kaminer, 2001; Plant et al., 2009).

The diversity of the life experiences of the rangatahi in this study highlighted that individualised treatment planning was necessary in order to address their varying needs. A key intervention was that the service gave them the opportunity to feel in control of their own individualised treatment plans, which over time increased their confidence and self-esteem. The ability to be able to contribute to a plan that would work for them was a vital success factor that rangatahi described, as it made them feel more connected to their programme. Feeling in control of their treatment plan helped to increase the young people's motivation to want to participate in their recovery (De Leon et al., 1997; Hser et al., 2001; Schroder et al., 2007).

The findings from this study support and extend those from previous studies that describe interventions that work for adolescents in residential AOD treatment. These include a variety of therapeutic, educational and activity based components that are important to engage and treat young people while in residential AOD treatment (Bell, 2006; Hair, 2005; Kaminer, 2001; Plant et al., 2009; Withy et al., 2007).

One success factor was the formal education classes that were provided in this culturally set environment. It provided structure and opportunity to re-engage with a system that they had previously not engaged with in a way that was meaningful. This opportunity gave the young people the ability to build their confidence. Other classes that were informative and relevant to their needs and that made learning fun were also deemed successes. For instance, the music class as a success factor that stood out due to the therapeutic effect the class had on many of the participants to express and make sense of their feelings and life experiences. It was an accepted process for the young people to 'work through' what they were feeling. Classes on smoking, though contentious with its pro and cons, gave evidence that abstinence can work, at least for those who were willing to enter into a smoke free programme. An

implication could be that it may impact the decision to attend that programme in the first instance.

Clearly, rangatahi like learning in general, and their korero throughout the study reflected this. Anecdotal evidence has often suggested that young people in general learn better from other young people. However, findings in this particular study strongly indicate the value these participants got from being with adults. All of the rangatahi in this study acknowledged how grateful they were to learn from other adults who were in recovery, and that the sharing of stories of experiences from kaumatua were of great value to them.

Despite acknowledging the importance of multifaceted treatment approaches and individualised treatment plans, participants in this study suggested that multi-faceted treatment interventions alone are not sufficient to meet their needs. Participants strongly perceived that these multifaceted interventions needed to be closely linked to their cultural values and beliefs in order for true healing to take place.

## **Integrating Culture and Contemporary Interventions**

Another key success factor described by many participants was the noho marae. This was a prime example of providing a 'true' cultural experience steeped in cultural protocols such as powhiri, whakawhānaungatanga, waiata, kotahitanga, hakari and poroporoaki. The significance of the noho marae was seen in the way in which contemporary forms of AOD treatment, such as the 12-step recovery meetings, were interlinked throughout the noho marae experience. Participants highlighted how the interconnectedness of different people's experiences with those of young people, through being together on the noho marae, aided to re-enforce their reconnection to Māori and Māori processes, again, through whakawhānaungatanga, which is significantly linked to Māori health improvement (Durie, 1997; McLachlan et al., 2012; Robertson et al., 2001).

Having a recovery forum (12-step meeting) within an environment like a noho marae appears to have allowed a space for rangatahi to feel comfortable and willing to become involved in their own therapeutic processes. It gave the rangatahi the opportunity to glimpse into the future by hearing older people's experiences so that they could make decisions accordingly by realising "where they don't want to go". This recovery forum provided a place for the young

people for stress relief by sharing what they've been through and at the same time feeling understood. Existing literature supports that such an environment can promote behavioural and social competence (Lerner, 2002; Lerner et al., 2005), and the findings of the current study indicates that being able to reflect on their personal experiences while learning from other's experiences about recovery from addictions and co-existing problems reflected a strengths based approach which empowered the rangatahi through respectful relationships. Adolescent treatment literature strongly asserts that young people's therapeutic involvement in their own treatment processes is one of the best predictors of retention (Hawke et al., 2005; Schroder et al., 2007). This recovery forum provided an ongoing source of support for the rangatahi. Literature asserts that 12- step approaches are successful for adolescents and can provide an on-going source of support for the young person (Plant & Panzarella, 2009).

Of vital significance to rangatahi in respect to engagement and retention in treatment interventions and overall health and well-being, was the concept of storytelling, the sharing of stories of experiences within a group setting, and how storytelling can convey messages of support and acceptance. Rangatahi strongly felt that transmitting learning and knowledge through stories was a huge success factor in their treatment.

The results of this study demonstrate that kaupapa Māori in practice embraces the concept of whānau and whakapapa relationships that are central to overall well-being (Durie, 1997a, 1997b; McLachlan et al., 2012; Robertson et al., 2001; Smith, 1992) Given how strongly rangatahi endorsed the benefits of attending a kaupapa Māori treatment programme steeped in Māori tikanga, it is possible that the cultural environment itself supports the facilitation of rangatahi to want to learn, and may be considered by some as an intervention in its own right that contributes to the success of AOD treatment for young people. In saying this, evidence in this study showed that it is more than just one intervention that compromises successful treatment for Māori rangatahi. This would indicate that alongside health initiatives, cultural security and cultural identity cannot be separated from indigenous learning, but cannot be separated from other youth culture and activities. The results of this study described the importance of conveying health through Maōri tikanga that promotes self identity and confidence for participants in who they are as Māori (Durie, 1999, 2001; Huriwai et al., 1998; Mead & Mead, 2003).

## SUMMARY

Rangatahi identified that the context of kaupapa Māori treatment supported them to be able to enact things Māori, such as participating in traditional ceremonies and living Māori practices which made them feel a part of their culture. Rangatahi expressed that ‘knowing by doing’ and making them ‘feel a part of my culture’ were seen as vitally important to their successes experienced in treatment. Providing the content of the programme through a Māori world view supported rangatahi to have a sense of community, and fostered the ability for positive behaviours and self efficacy. Finding familial connectedness (whakawhānaungatanga and whakapapa) through these cultural practices helped them to feel like they ‘belong’, and this appeared to have a very positive impact on their self-identity and self-security. This finding is a common protective factor for youth resilience (Catalano et al., 2004; Lerner et al., 1998; Lerner et al., 2005).

Rangatahi talked about the importance of having Māori elders to pass on cultural knowledge, and the reciprocity of relationships when working collectively in order to accomplish tasks on the marae, as success factors in the treatment programme. Working together helped with their self confidence and promoted kotahitanga, or unity with others, and helped to build a positive character as evidenced in the results of this study. Māori protocol and practices were identified factors recognised as being successful in their daily treatment, as it highlighted the importance of keeping everyone safe and secure.

Immersion in Māori values and practices was a success factor for rangatahi in this study, as they identified these as essential to their identity and strengthened who they are as Māori. This study emphasises literature on the importance of cultural connections in order for Māori to take pride in being Māori (Durie, 1994; Huriwai et al., 2000; Sellman et al., 1997). Fulfilling the cultural needs of indigenous youth while in treatment appears to be a critical factor to successful treatment. Strengthening cultural identity in conjunction with addressing SUDs are seen as necessary for significant and secure changes to take place for Māori rangatahi. As emphasised earlier, Māori rangatahi cannot be seen in the narrow context of a SUD, as the evidence is clear that it is essential that they be seen in a broader context of who they are as Māori youth.

## IMPLICATIONS

There are a number of implications that can be drawn from the findings of the study. Of importance is the value and benefits that were clearly identified by rangatahi, of incorporating western contemporary treatment models and interventions within a framework that sits within the context of a Māori world view underpinned by traditional values, beliefs, practices and processes. What this implies for service development is the inclusion of indigenous frameworks and services that are culturally congruent with indigenous values and practices that incorporate contemporary treatment.

Anecdotally, it has been acknowledged within the Māori health research area that if a solution to a problem works well for Māori, then it is highly likely that it will work well for non-Māori. In this study, this factor was pointed out by a Māori rangatahi who spoke of a non-Māori rangatahi who attended RA. The participant spoke of shared experiences, including feeling the connectedness, belonging, relationships, which was appreciated and that the youth found meaningful. This Māori rangatahi told of his experience of how the non-Māori youth learned to accept other cultures due to attending a Māori treatment service. Rangatahi indicated it was not only about 'treating the problem', but rather being able to immerse themselves into an environment that utilises approaches that are strengths-based and holistic and focused on achieving overall good health and well-being. Further, that an environment that was not only welcoming for Māori but was just as welcoming to non-Māori, where they could receive all the benefits of AOD treatment and not be judged. Therefore the environment of kinship relationships was embraced irrespective of ethnicity.

It is important to acknowledge the korero from rangatahi on issues of gender and age mix, particularly within a residential service that deals daily with those who present with a diversity of complex needs. This has led to the conclusion that it is vital that greater flexibility and diversity is offered in terms of treatment options and interventions, so that individuals are able to choose and engage in those interventions that are relevant to their individual needs.

However, it is important to note that a flexible approach is likely to place further demands on current funding and resources (time and staffing included) and will need to be planned effectively and robustly. Therefore managing change within existing resources will require innovative planning. It is further important to emphasise that inadequate resourcing for

AOD youth residential treatment is not likely to result in effective or high quality outcomes for indigenous youth and their whānau in a context of disproportionate high rates of AOD and co-existing health related problems. Without appropriate levels of resource changes to residential AOD treatment for young people will lack the capacity required to be more effective for young people, especially indigenous young people.

Linked to the diversity of treatment intervention options that are offered, rangatahi noted how important it was for them to be involved in determining their own individual treatment needs. Being involved in other programme interventions/components that were identified as important to them, such as the activity-based programmes that offer new skills to learn about ways of living healthier lifestyles and better ways of interacting and engaging with one another and other peers. As well as being more proactively involved in a wide range of activities that helps to manage levels of boredom that rangatahi may experience during their time in residential treatment.

The participants put forward their arguments for age and gender specific treatment facilities and more sensitivity of this matter to better serve their specific needs while in residential treatment. Implications of this finding proposes that consideration in service development and delivery address the specific needs of the age and gender of youth who access residential AOD treatment.

Translated into service delivery, these findings suggest that planned interventions or activities need to be an integral part of the daily treatment that serve not simply to alleviate boredom but that comprise an empowering and motivating factor for learning and engagement. Beyond this, there is a need to cater for individual treatment needs that involve the young person in the planning.

Rangatahi acknowledged the importance of a service being flexible in regards to admission, discharge and length of stay, as many of the rangatahi in this study had multiple admissions, discharges and re-entries into the RA service. This reflects a need for services to keep trying to provide the best they can for rangatahi by meeting them where they are at. For the young person this may represent a one off opportunity to enter treatment, which is perceived as facilitating good treatment outcomes. Services should envisage to maintain an open door policy in order that young people may enter when they are ready too. This response reflects

rangatahi views that even if it doesn't work for them the first time, at least they have an opportunity or a choice to go back and try again.

Highlighted in this study was that rangatahi themselves acknowledged that they knew they needed more support and that they felt free to re-enter into the service. The important point is that treatment is not a singular event but a process (Sellman & Deering, 2002). It is crucial that services incorporate policies that allow easier access to young people and support continuing care during the process into or back into residential treatment.

Another aspect of engagement with a responsive treatment service was that many of the rangatahi were able to re-engage with their education as they had been disengaged from their schooling through the mainstream education system. Because education was incorporated into the holistic programme and therefore provided within a different environment, rangatahi were more open and ready to re-engage, with positive results and more of a willingness to learn in an environment that was culturally supportive and promoted pro-social adult-youth relationships which is an important aspect of positive youth development. What this implies for service development is the inclusion of culturally supportive educational environments that foster positive relationships.

Of primary importance, the implications from the findings of this study emphasise that Māori youth service development needs to involve Māori youth experiences and voices in the implementation, design and development of AOD treatment specific to Māori youth. This would challenge current policy and funding levels to honour Te Tiriti o Waitangi and to provide a comprehensive review of the treatment needs of Māori youth in order to actively implement appropriate services and treatments. It is hoped that this research will be helpful to other professionals and services who work with Māori rangatahi in the addictions and mental health sectors to improve current treatment. This study may aid those engaging in research with or about Māori rangatahi.

In respect to further research, the findings of this study add to the small New Zealand AOD literature. More importantly this study provides important information on the success factors in working with Māori youth residential AOD treatment and provides the platform for future research.

## **Strengths and Limitations**

This was a small-scale qualitative study and only a small number of participants were interviewed. These findings therefore should not be interpreted to reflect the majority perceptions of Māori rangatahi that have accessed a kaupapa Māori AOD youth residential treatment in New Zealand.

Further, programme specifics did not take into account how much of the success of the programme may have been directly linked to other variables, such as participants' personal circumstances, level of motivation or other interventions, such as therapies, indigenous or otherwise, that may not have been mentioned. However, the findings are congruent with New Zealand and overseas literature on cultural congruence in treatment, retention factors and treatment outcome studies (Bell, 2006; Brady, 1995; Huriwai et al., 2000; Schroder et al., 2007; Withy et al., 2007).

Possible researcher bias as declared in the methodology chapter and preface of this thesis is that I was once employed at this kaupapa Māori youth residential and was instrumental in its development in 2006 (prior to the time of the participants that participated in this study). I am an indigenous person that advocates for indigenous developments and self-determination and have an indigenous world view that is by virtue pro indigenous. I am also an indigenous clinical therapist working the AOD sector who is steeped in my own indigenous culture. A limitation is that I am not Māori and could not fully carry out a kaupapa Māori research process taking into account the true concept of this type of research would be by Māori for Māori (Smith, 1999).

In the absence of prior research on this specific topic, the current study has laid a foundation to start to understand and examine the research question of what the critical success factors in kaupapa Māori youth residential AOD treatment are. An additional strength of this study is that it is the first study that places at the forefront the perceptions and voices of Māori rangatahi who have accessed a kaupapa Māori AOD residential treatment service.

It is hoped that having these perspectives will prove beneficial in future research and development of youth friendly and culturally appropriate treatment services for Māori rangatahi. It is hoped that this study will be able to be translated to other indigenous youths' AOD treatment development and services.

## **Future Research Direction**

As this study only begins to answer the important question of what the critical success factors in kaupapa Māori youth AOD residential treatment are, there remains a need for ongoing research in this area. Most importantly this research should focus on expanding knowledge about appropriate and acceptable practices in AOD treatment with Māori rangatahi. Future research could explore in more detail: i) the implications for mental health and addictions policy, planning, and providers, in addressing the holistic needs of indigenous youth and AOD treatment; ii) factors associated with treatment retention and completion for Māori rangatahi; iii) the role of traditional elders in AOD treatment for indigenous youth; iv) the alignment between current provisions of care for Māori rangatahi in AOD treatment and Te Tiriti o Waitangi; v) when do cultural interventions become clinical interventions' and, what are the indicators of a young person's wellness as an outcome measure in cultural interventions. Finally, ongoing research to give a more complete picture of the approaches necessary to successfully address the disproportionate numbers of Māori rangatahi that present with SUDs and to provide them with the most appropriate treatments is greatly needed. Regardless of the research questions, the current study reiterates that such research will be greatly enriched by the involvement of the experiences and perceptions of Māori rangatahi who have had treatment experiences.

## **Conclusion**

This research attempted to identify the critical success factors in kaupapa Māori AOD residential treatment from a Māori youth perspective. It is the first systematic investigation to examine the responses and experiences of Māori youth who have accessed a kaupapa Māori residential AOD treatment service.

The rangatahi in this study were able to identify the benefits they gained were not only for themselves, but for their peers in treatment, the wider whānau and communities from which they came. This study illustrated that kaupapa Māori residential treatment strengthened the values of whānaungatanga, manaakitanga, aroha ki te tangata, and rangatiratanga in its responsive care of young people, both as individuals and as a collective group.

The conjecture of this study is that traditional cultural ways, indigenous models of health, contemporary AOD treatment and positive youth development models combined are

necessary to ensure improved treatment services for Māori rangatahi. The findings from this study reinforced the premise that a culturally significant and holistic approach to AOD treatment worked for Māori rangatahi, but that alone was insufficient and what was needed in addition was a multifaceted treatment programme approach. Finally, this study spoke to the importance of having unhindered access to health services in order to begin to address the disparities in Māori health, particularly with Māori rangatahi. It is envisaged that the findings from this study will inform the future design, development and implementation of AOD treatment services for indigenous youth AOD treatment models. It is important that AOD treatment is considered within a public health context alongside those services that are already working towards meeting the needs of Māori youth in treatment. Just as importantly, it is hoped that this study will inform on how to better resource services to become more effective in the provision of residential AOD for indigenous youth populations.

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# APPENDICES

- Appendix 1: Glossary
- Appendix 2: Diagnostic and Statistical Manual of Mental Disorders (DSMIV-TR) Criteria for Substance Abuse for Dependency
- Appendix 3: Letter of Introduction to CEO of Te Runanga o Kirikiriroa Inc.
- Appendix 4: Information Sheet for Youth Participation
- Appendix 5: Consent Form for Youth Participation
- Appendix 6: Semi Structured Questions/Interview Prompts
- Appendix 7: Socio Demographic Questionnaire
- Appendix 8: Northern Y Ethical Approval
- Appendix 9: Te Puna Oranga Māori Health Ethical Approval

## APPENDIX 1:

### GLOSSARY

Ako .....	To learn as well as to teach
Aotearoa .....	New Zealand
Aroha ki te tangata .....	Goodwill to all people
Ariki .....	Spiritual chief, priest, leader
Awhi .....	To embrace, foster, cherish, support
Hangi .....	Earth oven
Hapu .....	Pregnant; section of a large tribe, a clan, or sub tribe
Hariru .....	To shake hands
He Tangata .....	Human being(s), people
Hoa- haere.....	Companions
Hongi .....	To press noses
Hui .....	Gathering
Iwi .....	Tribe. Tribal groups, e.g., Nga Puhi, Te Arawa, Ngati Pikiao, etc. are made up of Hapu, that are interrelated whānau
Iwitanga .....	Tribalism
Kai .....	Food, to eat
Kaimahi .....	Worker, employee, staff
Kanaka Māoli .....	Hawaiian person
Ka pae aina o Hawaii nei .....	The archipelago of the Hawaiian Islands
Kapa haka .....	Traditional Māori performing arts
Karakia .....	Prayer, chant, religious service
Karanga .....	To call, call out, summon, shout
Kaumatua .....	Adult, elder
Kaupapa .....	Philosophy, agenda, issue, reason, purpose
Kaupapa Māori .....	Cultural ideology
Kawa .....	Protocol
Kawanatanga .....	Government, dominion, rule, authority, governorship
Kanohi ki te kanohi .....	Face to face
Kiwa .....	Famous ancestor of Te Aitanga-a-Māhaki tribe, North Island
Koha .....	Gift, present, offering, donation, contribution

Korero .....	Speech, talk etc.
Koro .....	Elderly man, grandfather – term to address an elderly man
Kotahitanga .....	Unity
Manaaki .....	To support, take care of, give hospitality, protect, look out for
Mana Māori .....	Māori integrity
Mana Motuhake .....	Autonomy, through self-determination and control over one's own destiny
Manawatu .....	A province located in the North Island of Aotearoa/New Zealand
Maniapoto .....	The name of a sub-tribe of indigenous peoples of Aotearoa/New Zealand
Manurewa .....	A major suburb in South Auckland, New Zealand
Māori .....	The First Nations people of Aotearoa/ New Zealand
Marae .....	Tribal meeting grounds; village common
Mataatua .....	The province from Bowentown in the West to Whangaparāoa in the East Coast
Mauri .....	Life essence, life force, energy, life principle
Mauri ora .....	Life principle, knowing who we are
Mihimihi .....	Speech of greeting, pay tribute, thank
Moko .....	Māori design tattoo, grandchild
Nga Puhi .....	The largest iwi, Ngapuhi iwi boundaries cover the middle far North District from South Hokianga through to Mangakahia, across to the South-Western Whangarei district
Ngai Tamahaua .....	The name of a sub-tribe of indigenous peoples from the Bay of Plenty area of Aotearoa/New Zealand
Ngati Paoa .....	The Ngati Paoa iwi has maintained its presence along the Tikapa Moana coastline and inland to Tahuna, Waiti
Ngati Porou .....	The name of a Māori iwi traditionally located in the East Cape and Gisborne regions of the North Island
Ngati Rangatihi .....	The name of a Māori Iwi located in the Bay of Plenty. <i>Ngati Rangitihi</i> is the senior tribe of Te Arawa
Ngati Raukawa .....	The name of a sub-tribe of indigenous peoples from a particular area of Aotearoa/New Zealand
Noa .....	Be free from the extensions of <i>tapu</i> , ordinary, unrestricted.

Noho Marae .....	A marae stay
Pakeha .....	A New Zealander of European descent
Pakeke .....	Be grown up, adult, mature
Poroporoaki .....	Farewell, to take leave
Powhiri .....	A welcome, invitation ritual
Rangatahi .....	Younger generation, youth
Rangatira .....	Noble, esteemed, revered
Rangatiratanga .....	Leadership, independence
Rongoa .....	Remedy, medicine, drug, cure, treatment, tonic
Taha Hinengaro .....	Mental health as referred to by Professor Mason Durie
Taha Tinana .....	Physical health as referred to by Professor Mason Durie
Taha Wairua .....	Spiritual health as referred to by Professor Mason Durie
Taha Whānau .....	Family health as referred to by Professor Mason Durie
Taiaha .....	A long spear like weapon of hard wood with one end carved and often decorated with dogs' hair.
Tainui .....	Province in the Waikato region of the North Island
Taiohi .....	Be young, youthful, young person, youth
Tairawhiti .....	The Tairawhiti region has Gisborne metro at its heart and runs from north of Wairoa inland to Matawai and extends as far north up the east coast to Hicks Bay
Tai Tokerau .....	New Zealand's Northern-most region
Taketake .....	Native, indigenous
Tapu .....	Sacred, prohibited, restricted, set apart, forbidden
Tangata whaiora .....	A person who is seeking wellness, consumer of health services
Tangi .....	A Māori funeral ceremony
Tangata Whenua .....	People of the land or First Nations peoples of Aotearoa
Tauīwi .....	Foreigner
Taupo .....	A town in the centre of the North Island, New Zealand
Te Ahurei a Rangatahi .....	A youth health and well-being organisation
Te Ao Māori .....	The Māori world
Te Ao Turoa .....	Light of day, world, nature, earth
Te Hurihanga .....	Changing, circumstance of changing, turning
Te Ika a Maui .....	The traditional Māori name for the North Island of Aotearoa/ New Zealand

Teina .....	Younger sibling, junior in line
Te Mana Whakahaere .....	Governing body
Te Oranga .....	Survivor, food, livelihood, welfare, health, living
Te Rarawa .....	An iwi of Northland
Te Rawhiti .....	The name of an iwi from the South-western most point of the North Island
Te Reo .....	Language, dialect, tongue, speech
Te Ritenga .....	Likeness, custom, habit, practice, resemblance, implication
Te Rūnanga o Kirikiriroa .....	The Urban Māori authority in Hamilton, Aotearoa, New Zealand
Te Tiriti o Waitangi .....	The founding document of
Tiaki.....	Guard
Tikanga .....	Correct procedure, custom, habit, lore, method, manner, rule, way, code, practice, convention
Tino Rangatiratanga .....	Self- determination
Tokanui .....	The name of a psychiatric hospital that was located in the small town of Tokanui
Toiora .....	Survivor
Tuakana .....	Elder sibling
Tuhoe .....	The name of a sub-tribe of indigenous peoples from a particular area of Aotearoa/New Zealand
Waiata .....	To sing, song, chant, psalm
Waihaha .....	A place in the Waikato region of New Zealand's North Island
Waiora .....	Health, soundness
Wairua .....	Spirit, soul, quintessence – spirit of a person which exists beyond death
Wairuatanga .....	Recognition of the spiritual dimension
Waka .....	Canoe
Whaea .....	Mother, aunt
Whakapapa .....	Biological kinship system, genealogy
Whakamana .....	To give authority to, to give effect to, confirm, enable, legitimise
Whakamarama .....	To illuminate, explain, account, clarify
Whakapiri .....	To stick, fasten, remain close to, keep close, paste
Whakatohea .....	The name of a sub-tribe of indigenous peoples from a particular area of Aotearoa/New Zealand

Whakawhānaungatanga .....	Relating to others, relationship/s
Whaikorero .....	To make a formal speech, oratory, oration, formal speech making
Whaiora .....	In pursuit of wellness
Whanake .....	To grow, spring up, develop, to rise
Whānau .....	Family, traditionally extended kinship relations, contemporary form includes non-kin relations
Wananga .....	To meet and discuss, seminar, conference, forum, tertiary institution
Whānaungatanga .....	Establishing relationship in a Māori manner
Whare .....	House, home, habitation

**APPENDIX 2:**

**DIAGNOSTIC AND STATISTICAL MANUAL OF  
MENTAL DISORDERS (DSMIV-TR) CRITERIA FOR  
SUBSTANCE ABUSE FOR DEPENDENCY**

Table 1: DSMIV-TR Criteria for Substance Abuse for Dependency
<b>Criteria for Substance Abuse</b>
<p>A pattern of substance use leading to significant impairment or distress, as manifested by one or more of the following during in the past 12 month period:</p> <ol style="list-style-type: none"> <li>1. Failure to fulfill major role obligations at work, school, home such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household</li> <li>2. Frequent use of substances in situation in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)</li> <li>3. Frequent legal problems (e.g. arrests, disorderly conduct) for substance abuse</li> <li>4. Continued use despite having persistent or recurrent social or interpersonal problems (e.g., arguments with spouse about consequences of intoxication, physical fights)</li> </ol>
<b>Criteria for Substance Dependence</b>
<p>Dependence or significant impairment or distress, as manifested by 3 or more of the following during a 12 month period:</p> <ol style="list-style-type: none"> <li>1. Tolerance or markedly increased amounts of the substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of substance</li> <li>2. Withdrawal symptoms or the use of certain substances to avoid withdrawal symptoms</li> <li>3. Use of a substance in larger amounts or over a longer period than was intended</li> <li>4. persistent desire or unsuccessful efforts to cut down or control substance use</li> <li>5. Involvement in chronic behaviour to obtain the substance, use the substance, or recover from its effects</li> <li>6. Reduction or abandonment of social, occupational or recreational activities because of substance use</li> <li>7. Use of substances even though there is a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance</li> </ol>

Source: APA, 1994.

**APPENDIX 3:**  
**LETTER OF INTRODUCTION TO CEO OF**  
**TE RUNANGA O KIRIKIROA INC.**

26 May 2010

Mere Balzer, CEO  
Te Runanga o Kirikiriroa Trust  
59 Higgins Road  
Hamilton

Aloha mai e Mere,

My name is Mino'aka Kapuaahiwalani-Fitzsimmons and I am an extramural student with the University of Otago, Christchurch campus in the department of Psychological Medicine, National Addiction Centre. I am working on my Masters of Health Sciences (endorsed addiction and co-existing disorders) where a requirement is the completion of a research project for a thesis. The topic I have chosen is, *What do Rangatahi Māori who have accessed a kaupapa Māori alcohol and other drug (AOD) youth residential service perceive as the critical success factors in their treatment?*

The aims of the study are:

- To examine what Māori rangatahi who have accessed a Kaupapa Māori youth residential alcohol and other drugs (AOD) treatment service in the past 12 months perceive as the critical success factors in their treatment.
- To include their experiences into recommendations that may contribute in the future design and treatment management of AOD residential treatment services for rangatahi.
- To better inform government policy, action and commitment to improve Māori mental health and addiction services.
- To enhance and support the overall and sustainable well-being of rangatahi Māori and their whānau.

*Background to the study*

In 2000, I was employed by Te Rūnanga Ō Kirikiriroa Trust to develop and implement a residential treatment programme targeted to young, predominantly Polynesian (Māori and Pacific Island) youth suffering from addiction to alcohol, other drugs and co-existing

disorders. In saying this, the service is not exclusive to rangatahi Māori as youth of other ethnic backgrounds who meet the AOD criteria and are willing to participate in a Kaupapa Māori programme are also eligible to be in the programme. As you are aware, this service was the first of its kind in Aotearoa/New Zealand. Rongo Atea AOD youth residential treatment service has now been successfully in operation for the past 10 years. It is a premiere service of its kind and in 2006 was awarded the Midlands District Health Boards, Whānau Ora Award for innovative service.

During my time at Rongo Atea I experienced many challenges within this area of youth treatment. From the young people in treatment, I was introduced to the notion that if staff and services would incorporate factors in residential treatment that were important to the young people and appropriate to their needs, then there would be an increased chance of developing and practising those skills necessary for a healthier future. Hence, I believe providing the most robust treatment requires not only specific skills and clinical knowledge, but also insight gained from the youths' perspectives.

#### *My intentions*

This year, I would like to interview a number of young people in a kanohi ki te kanohi (face to face) approach. I will use a semi-structured questionnaire which will gather relevant information regarding what works for Rangatahi Māori who have accessed a Kaupapa Māori Youth AOD residential treatment service.

I am therefore seeking your permission to invite a representative group of young people who accessed Rongo Atea in 2009 to participate in this research study. I am aware of the many ethical issues that must be considered when conducting a study of this type, including cultural sensitivities which need to be discussed. My research requires that I apply for ethical approval which protects the confidentiality of the participants. I am therefore required to gain your permission for endorsement of my study. All information that will be obtained will be confidential. I can assure you that my research practice will not in any way compromise the cultural and professional integrity of your organisation. In addition it is important that you understand that your organisation itself is not under critique, rather I am just seeking to learn from rangatahi about what works for them in treatment. The aim of enhancing your and other youth residential AOD programmes in the future is for the benefit of our rangatahi.

Mahalo for taking the time to read over my request. Please find my contact details below.

Yours sincerely,

Mino'aka Kapuaahiwalani- Fitzsimmons

P O Box 21097

Flagstaff

Hamilton

027 5333 148 (mobile)

07 854 0938 (home)

07 834 2964 (work)

Email: [decolminoaka@paradise.net.nz](mailto:decolminoaka@paradise.net.nz)

# APPENDIX 4:

## INFORMATION SHEET FOR YOUTH PARTICIPATION



# National Addiction Centre

(Aotearoa New Zealand)

## INFORMATION SHEET FOR YOUTH PARTICIPANTS

### ***Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives***

#### **Introduction**

In 2009 you attended Rongo Atea Kaupapa Māori Youth AOD Residential Service. You are invited to take part in a study that I am currently undertaking with other youth from this treatment service. This study is being conducted to fulfil my requirements for a Masters in Health Sciences at the University of Otago's National Addiction Centre (NAC).

The main reason of this study is to find out what Rangatahi Māori who went to Rongo Atea Kaupapa Māori alcohol and other drug (AOD) youth residential service see as the most important parts in their treatment that helped them to succeed.

It is hoped that the results of this study may help health care professionals develop and put in place programmes that will better meet the needs of Rangatahi Māori in residential addiction treatment programmes.

#### **Aims of the Study**

- To examine what Rangatahi Māori who have accessed a Kaupapa Māori youth residential alcohol and other drugs (AOD) treatment service in the past 12 months perceive as the critical success factors in their treatment.
- To include their experiences into recommendations that may contribute to the future service design, programme content and delivery of AOD residential treatment for Rangatahi.
- To better inform government policy, action and commitment to improve Māori mental health and addiction services for Rangatahi.
- To enhance and support the overall and sustainable wellbeing of Rangatahi Māori and their whānau.

## Method

A 60-90minute individual interview will be conducted with 10 young people who accessed Rongo Atea AOD residential treatment service in 2009. These interviews will take place in a location of your choice. This place should be somewhere private where you feel safe and comfortable talking about your time in treatment. You may choose to bring a support person(s) with you to the interview. This person(s) should be someone who you can trust and feel comfortable answering personal questions in front of.

During the interview a variety of questions will be asked relating to your treatment experiences, family background and what worked or didn't work for you while in you were in treatment. If you agree, this interview will be digitally recorded. These recordings will be written up and all revealing details will be removed before the recordings are stored in a secure place that can only be accessed by the researchers in this study.

## Participation

Your participation in this study is voluntary (your choice).

If you decide not to participate in this study, your future relationship with Rongo Atea will not be affected in any way.

If you do agree to take part in this study you can withdraw your participation at any time without any need for explanation.

You will be asked a number of questions during the interview some of which are quite personal in nature. You only need to answer the questions you wish to. You can also stop the interview at any point if you decide that you do not want to continue.

If any issues arise as a result of participating in this study, support and help will be made available to you. Should you require such assistance you should contact **Mino'aka** immediately and she will organise the necessary support for you.

If you have any questions or concerns about your rights as a research participant you may wish to contact a **Health and Disability Consumer Advocate Service**, by telephoning 0800 555 050 (if you live in Auckland or north of Auckland), 0800 423 638 (if you live in the North Island south of Auckland), 0800 377 7766 (if you live in the South Island outside of Christchurch) and 377 7501 (if you live in Christchurch).

## Confidentiality

No information that could personally identify you will be used on any forms, reports or publications that come out of this study. If you wish you may choose a pseudonym (fake name) for yourself. You will be asked about this at the time of your interview.

Your name will not appear on any of the questionnaires. All information you give will be kept confidential unless you are at risk of harming yourself or others.

All the information you give us will be stored in a secure place where only the Principal Investigator and the Researchers will have access.

## Results

If you would like the chance to read and comment on the written notes of your interview we will send these to you at an address you supply.

If you would like a copy of the results we will send them to you at an address you supply. Remember it will take some time to complete this research study so there will be some delay (approximately 2 years) between when you are interviewed and when you receive a copy of the results of the research.

## Statement of Approval

This study has been reviewed by the:  
Northern Y Regional Ethics Committee  
and was granted ethical approval on \_\_\_\_\_(date).

## Principal Investigator

Ria Schroder  
National Addiction Centre (NAC)  
Department of Psychological Medicine  
Christchurch School of Medicine and Health Sciences  
University of Otago  
Christchurch  
Ph. (03) 364 0480 or 0800 Addiction (0800 233428)

## Researcher

Mino'aka Kapuaahiwalani- Fitzsimmons  
Masters Student  
Pai Ake Solutions Ltd  
21 Commerce Street  
Frankton  
Hamilton  
Ph. (07) 847 2351 or 027 5333 148

## Cultural Advisor

Kahu McClintock  
P O Box 5731  
Level 7, Agriculture House  
12 Johnston Street  
P:64 4 473 9591  
F: 64 04 473 9573

***IF YOU REQUIRE ANY FURTHER INFORMATION OR HAVE ANY QUESTIONS  
REGARDING THIS STUDY, PLEASE FEEL FREE TO CONTACT MINO'AKA, KAHU, OR RIA.***

**APPENDIX 5:**  
**CONSENT FORM FOR YOUTH PARTICIPATION**



**National Addiction Centre**  
(Aotearoa New Zealand)

**CONSENT FORM FOR YOUTH PARTICIPANTS**

***Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives***

I have read and understood the information sheet dated 01 June 2010 outlining a study designed to gather information about what Rangatahi Māori who have accessed Rongo Atea Kaupapa Māori alcohol and other drug (AOD) youth residential service perceive as the critical success factors in their treatment.

I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and I have not been influenced in any way to participate.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports or publications on this study.

I have had adequate time to consider whether to take part in this study.

I understand that I may withdraw from the study at any time and this will not affect my future health care or treatment options.

I know whom to contact if I feel any distress or have any concerns as a result of my participation in this study.

I wish to receive a summary of the results of this study.

YES/NO

Please provide the address to which you would like a copy of the results sent:

.....  
.....  
.....  
.....  
.....

I \_\_\_\_\_ (full name) hereby consent to take part in this study.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Project explained by: \_\_\_\_\_

Project Role: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Name and Contact Details of Principal Investigators:**

**Dr Ria Schroder**  
National Addiction Centre (NAC)  
Department of Psychological Medicine  
Christchurch School of Medicine and Health Sciences  
University of Otago  
Christchurch  
Ph. (03) 364 0480 or 0800 Addiction (0800 233428)

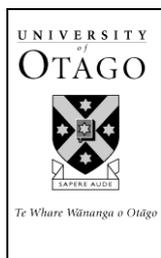
**Name and Contact Details of Interviewer:**

**Mino’aka Kapuaahiwalani- Fitzsimmons**  
Masters Student  
Pai Ake Solutions Ltd  
21 Commerce Street  
Frankton  
Hamilton  
Ph. (07) 847- 2351 or 027 533

**APPENDIX 6:**  
**SEMI STRUCTURED QUESTIONS/INTERVIEW PROMPTS**

1. What worked/did not work for you while in a Kaupapa Māori residential alcohol and drug treatment service?
2. What did you see/or not see as vital to your learning/growth?
3. What would your ideal residential AOD service include/ or not include?
4. If you could talk to a person designing a Kaupapa Māori residential alcohol and drug treatment programme, and tell them were the three most important aspects for Rangatahi Māori recovering from alcohol and drug dependence/problems, what would that be?

**APPENDIX 7:**  
**SOCIO DEMOGRAPHIC QUESTIONNAIRE**



**National Addiction Centre**  
(Aotearoa New Zealand)

**Socio Demographic Questionnaire**

The following descriptive data will be collected in order to describe the young people who participated in this study.

**Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives Socio Demographics Questionnaire**

<b>1. What is today's date?</b>	
<b>2. What is your birth date?</b>	
<b>3. How old are you?</b>	
<b>4. What is your Iwi/Hapu?</b>	
<b>5. What languages do you speak?</b>	
<b>6. Are you tane or a wahine?</b>	1 Tane 2 Wahine
<b>7. Do you have children?</b>	1 yes 2 no
<b>8. What do you identify as your sexual orientation? (circle one option only)</b>	<b>If yes, how many? _____</b> 1. straight/ heterosexual 2. gay 3. lesbian 4. transgender 5. bisexual

<b>9. What do you describe as your current relationship status?</b> (circle one option only)	1. married 2. single 3. have a partner
<b>10. Which of the following best describes your current educational/employment circumstances?</b> (circle one option only)	1. Part time student not in paid employment. 2. Part time student working part time (30 hours or less per week). 3. In work experience/training, not working in paid employment. 4. In work experience/training course, but also working in part time paid employment. 5. Working part time only (30 hours or less a week). 6. Working full time only 7. Unemployed (not in paid employment or enrolled in education or training). 8. Parent caring for dependent child. 9. Other (specify) _____
<b>11. Which of the following best describes you MAIN source of income or support over the past 6 months?</b>	1. Paid full time employment. 2. Paid part time employment 3. Supported by partner 4. Supported by whānau 5. Student loan/student allowance 6. Government benefit eg DPB. 7. Self employment. 8. Proceeds from crime. 9. Other (specify) _____
<b>12. Compared to how you were when you first were seen at Rongo Atea how are you now?</b>	1. Much better 2. A little better 3. About the same 4. A little worse 5. Much worse
<b>13. How much do you think that Rongo Atea has helped you with your problems?</b>	1. Not at all 2. A little 3. Moderately 4. A lot 5. Very much
<b>14. How many times did you attend Rongo Atea?</b>	
<b>15. How long were you at Rongo Atea each time you attended?</b>	Time 1) _____ Time 2) _____ Time 3) _____ Time 4) _____
<b>16. Did you graduate from the programme?</b>	1 yes 2 no

# APPENDIX 8:

## NORTHERN Y ETHICAL APPROVAL



Northern Y Regional Ethics Committee  
Ministry of Health  
3<sup>rd</sup> Floor, BNZ Building  
354 Victoria Street  
PO Box 1031  
Hamilton 3204  
Phone (07) 858 7021  
Fax (07) 858 7070  
Email: [northern\\_y\\_ethicscommittee@moh.govt.nz](mailto:northern_y_ethicscommittee@moh.govt.nz)

8 September 2010

Dr Ria Schroder  
National Addiction Centre  
3<sup>rd</sup> Floor Terrace House  
4 Oxford Terrace  
P O Box 4345  
Christchurch 8140

Dear Dr Schroder

**Ethics ref:** NTY/10/06/056 (please quote in all correspondence)  
**Study title:** Critical Success Factors in Kaupapa Maori AOD residential treatment: Maori Youth Perspectives.  
**Investigators:** Dr Ria Schroder, Dr Daryle Deering, Ms Mino'aka Kapuaahiwalani - Fitzsimmons

This study was given ethical approval by the Northern Y Regional Ethics Committee on 8 September 2010.

#### Approved Documents

- Information sheet and Consent form for youth participants version 1/01 June 2010
- Socio Demographic Questionnaire version 1/01 June 2010
- Semi Structured Questions

This approval is valid until 30 July 2013, provided that Annual Progress Reports are submitted (see below).

#### Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

#### Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 8 September 2011. The Annual Report Form that should be used is available at [www.ethicscommittees.health.govt.nz](http://www.ethicscommittees.health.govt.nz). Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at [www.ethicscommittees.health.govt.nz](http://www.ethicscommittees.health.govt.nz).

Requirements for the Reporting of Serious Adverse Events (SAEs)

For the purposes of the individual reporting of SAEs occurring in this study, the Committee is satisfied that the study's monitoring arrangements are appropriate.

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see [www.ethicscommittees.health.govt.nz](http://www.ethicscommittees.health.govt.nz) for more information on the reporting of SAEs, and to download the SAE Report Form.

We wish you all the best with your study.

Yours sincerely



Amrita Kuruvilla  
Administrator  
Northern Y Regional Ethics Committee  
Email: [amrita\\_kuruvilla@moh.govt.nz](mailto:amrita_kuruvilla@moh.govt.nz)

## APPENDIX 9:

# TE PUNA ORANGA MĀORI HEALTH ETHICAL APPROVAL



*Te Puna Oranga (Māori Health)*  
*Waikato District Health Board*  
*P.O.Box 934,*  
*HAMILTON 3240*  
*Phone: (07)834 3644*  
*Fax: (07) 834 3619*

Date: 10 August 10

Mino'aka Kapuaahiwalani-Fitzsimmons  
98 Discovery Dr,  
Flagstaff,  
Hamilton

Tena koe Mino'aka,

Re: **Critical success factors in kaupapa Māori AOD residential treatment:  
Māori Youth Perspectives**

On behalf of the Kaumatua Kaunihera Research Subcommittee thank you for submitting research material for comment. The subcommittee has considered your research proposal and is pleased to provide you with their support subject to:

1. The Kaumātua Kaunihera receiving a copy of the results being forwarded to the subcommittee at the completion of the study, and
2. A report is provided at the end of the study on the total amount of Māori participants vs total participants.

Thank you for submitting your research to the subcommittee and should you have any further queries please contact me.

Noho ora mai



Jonas Hapuku  
Manager - Te Puna Oranga  
On behalf of Kaumātua Kaunihera Research Sub-committee