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CLIENT EXPERIENCES OF THE WHANAU GROUP AT HIGHER GROUND, AN ALCOHOL AND DRUG TREATMENT PROGRAMME REHABILITATION TRUST

By

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[1] Waigth, S. (2012). Client experiences of the Maori focused components of an alcohol and drug rehabilitation programme at Higher Ground drug rehabilitation trust. (Unpublished honours dissertation). University of Auckland, New Zealand.

Abstract

The aim of this study was to identify client perspectives of the Whanau group at Higher Ground. This study is a part of a broader evaluation of the services currently offered at Higher Ground. Qualitative methods were employed within a Kaupapa Maori framework and data was obtained from interviews with 12 residents: 10 Maori and 2 non-Maori. Five key themes were identified. Participants indicated that: understanding addiction through Maori symbolism and activities was helpful to their recovery; the powhiri was an integral aspect of the rehabilitative process; they connected with Maori identity; the Whanau group enhanced progress through rehabillitation and as a result of being a part of the Whanau group, participants identified areas of personal change. These findings suggest that the Whanau group is valued amongst Maori residents for restoring connections to their Maori identity. These connections foster positive personal growth during their time in rehabilitation which then sets a foundation for recovery in the future once they have moved beyond Higher Ground. For non-Maori, the Whanau group assisted with personal growth which was valued as an integral part of the rehabilitative process. There were some limitations identified by participants, these include not having enough time to learn, and the processes being too repetitive. Overall, these findings provide good support for the Whanau group as a valid and integral aspect of the rehabilitation process for Maori and non-Maori residents at Higher Ground.

Glossary

Māori	**English**
Aotearoa	New Zealand
Haka	Traditional war dance
Iwi	Tribe
Kanohi ki te kanohi	Face to face
Karakia	Prayer
Karanga	Ceremonial call
Kaupapa Maori	Maori practice
Manaaki	Support
Manaakitanga	Support
Maunga	Mountain
Mihi	Speech
Pakeha	European/Caucasian
Patu	Paddle
Paua	Abelone
Pou	Carving
Powhiri	Traditional welcome
Pupuritaonga	Guardian of taonga
Teina	Younger sibling
Tuakana	Older sibling
Taonga	Gift/treasure
Taniwha	Mythical sea creature
Te Ao Maori	The Maori world
Te Whare Tapa Wha	The four sided house
Te Taha Hinengaro	The mind
Te Taha Tinana	The body

Maori	**English**
Te Taha Wairua	The spirit
Te Taha Whanau	The family

Te Wheke	The Octopus
Tikanga	Protocol
Tinorangatiratanga	Maori sovereingty
Tohatohatia	Sharing resources
Waka	Canoe
Waiata	Song/sing
Waipiro	‘Stinking water’/Alcohol
Whakamana	Enabling family
Whanau	Family
Whanaungatanga	Establishing connections
Whakamaumahara	Rememberance
Whakatakoto tikanga	Positive planning for the future

Introduction

Recent statistics relating to alcohol use reveal that alcohol is the most commonly used recreational drug in Aotearoa New Zealand. Over the year 2007-2008, figures indicated that 85.2% of the population consumed alcohol at least once a year and 61.6% reported heavy alcohol use at least once in the same year. Likewise a recent national drug and alcohol survey revealed that almost half (49%) of the population aged 16-64 have used recreational drugs in their lifetime. Of this population, 4.5% had received help from a drug and alcohol counsellor, family member/friend or general practitioner. Furthermore, 2.6% reported that they wanted to get help for their drug use but were unable to for various reasons (Ministry of Health, 2010).

The most recent census (2006) reported that the total population was 4,027,947 (Statistics New Zealand, 2012). Of this number, people identifying as European comprised the largest number at 67.6%, whereas Maori, the indigenous peoples of Aotearoa New Zealand, only comprise 14.6%. Although the proportion of Maori in the total population is relatively small, statistics for alcohol and drug use reveal that Maori are over-represented in most areas related to alcohol and drug use including patterns of use, age of first use, and outcomes related to alcohol and drug use. For example, in the year 2007-08, Maori were more likely to start drinking at age 14 or below than non-Maori. Maori were also more likely to drink heavily at least once a week. Finally, Maori, especially Maori women, were more likely to experience the harmful effects of alcohol either from their own or another's use (Ministry of Health, 2010). With regard to drug use in the year 2007-2008, Maori were significantly more likely than non-Maori to report having used 'P', 'ice' (both forms of methamphetamine), Cannabis and Benzylpiperazine (BZP). Maori were also more likely to have started using drugs at the age of 14 or younger than any other ethnicity (Ministry of Health, 2010).

Internationally, recent statistics produced for other indigenous cultures reveal a similar pattern of substance use. For example, the Native American Indian (NAI) population comprise less than 1% of the total population in the USA (Norris et al., 2012). However, data from the National Survey on Drug Use and Health reported that when compared with the rest of the population, the proportion of NAI that heavily use alcohol (12.0%) and 'binge' drink (29.0%) are higher than any other ethnicity in the United States (Chartier & Caetano, 2010). Furthermore, the proportion of adolescent

NAI that use Marijuana (13.8%) is higher than the general population (6.9%) (Substance Abuse and Mental Health Administration, 2011). In Australia, the aboriginal population comprise 2.3% of the total population (Australian Human Rights Commission, 2008). However, recent survey statistics reveal that although aboriginal people are more likely to abstain from drinking, they were almost twice as likely to drink alcohol at a hazardous level on a single occasion and during their lifetime when compared with non-indigenous Australians (National Drug Strategy Household Survey Report, 2011). Overall, these statistics suggest that, globally, indigenous populations have more extreme experiences with alcohol and drug-related use when compared to dominant cultural groups.

Impact of alcohol and drug use

Inherently related to these statistics are the many negative outcomes associated with severe alcohol and drug use. International and domestic literature is replete with examples highlighting this fact. For example, mortality rates amongst those who abuse alcohol and other drugs have been reported to account for nearly a quarter of all deaths in the United States alone (Centre for Disease Control and Prevention, 2012; McGinnis et al., 1999). Findings produced for the United Kingdom and Europe indicate that the mortality rate among drug users is higher for those that abuse a drug, with the main cause of death in those that use opiates attributable to overdose (Bargali et al., 2006; Lehman & Simpson, 1982). Psychological impacts have also been documented in the international literature, with over one third of those who abuse alcohol and over one half of those who abuse drugs having a co-morbid mental illness (Reiger, 1990). Additionally, for those that abuse or depend on alcohol, co-morbidity with at least one other psychiatric disorder can extend across the lifetime (Kessler et al., 1997). As well as psychological impacts there are numerous adverse effects of alcohol and drug abuse on an individual's physical wellbeing. Using data from the World Health Organisation, a recent comparative review suggested that there are at least 80 physical disease and injury conditions associated with alcohol and drug abuse (Rehm et al., 2009).

Aside from the negative effects that alcohol and drug abuse have on the individual, research implicates alcohol and drug abuse in a wide range of issues, including the disruption of intimate relationships, onset of mental illness in children,

and effects on an individual's ability to participate in education and employment. For example, in the context of an intimate relationship, heavy alcohol and drug use has been found to have a negative impact on a partner's health, family and social functioning (Marshal, 2003) and increase the occurrence of intimate partner violence (Stuart et al., 2008). Between married couples, a history of parental alcoholism has been implicated in divorce (Sher, 1997). Furthermore, divorce is more likely to eventuate in alcoholic couples when compared with non-alcoholic couples (Leonard, 1999). Similarly, in Aotearoa New Zealand, a recent birth cohort study found that individuals with five or more DSM-IV alcohol abuse/dependent symptoms (AAD) were 1.9 to 3.8 times more likely to commit violence against an intimate partner when compared with individuals without AAD symptoms (Boden et al., 2012).

Children that are directly exposed to parental alcohol and drug abuse suffer from a range of problems, and carry these throughout much of their lives. For example, several studies have found that children of heavy drinkers are at increased risk of developing mental health issues, most commonly anxiety and depression (Kuperman et al., 1999; Maynard, 1997; Ohannessian et al., 2004). Similarly, the intergenerational transmission of alcohol and drug abuse symptoms and behaviour is such that children of alcohol abusers are disproportionately more likely to develop drug abuse symptoms (Melchior, 2010; Sher, 1997) and these symptoms have been found to increase in severity with increased exposure to paternal alcohol abuse (Sher, 1997). In Aotearoa New Zealand, Lynskey and colleagues found that children who were exposed to alcoholic parents were at higher risk of developing psychiatric disorders than children of non-alcoholic parents (Lynskey, Fergusson & Horwood 1994).

Impact for Maori

Nowadays, it has been noted that Maori carry a greater burden of problems associated with alcohol and drug use in Aotearoa New Zealand (Alcohol Liquor Advisory Council, 2008). This is not only in terms of over-representation in alcohol and drug use statistics and associated negative outcomes, but also in relation to the overall more youthful status of the Maori population compared to other ethnic populations in Aotearoa New Zealand. This means that more Maori are likely to be exposed to alcohol and drug-related issues as this is also the age group for which

many alcohol and drug-related issues commonly occur (Alcohol Liquor Advisory Council, 2008). Furthermore, broader health and social inequalities between Maori and non-Maori are consistent and compelling (Reid & Robson, 2007). For example, in comparison to non-Maori, Maori have much lower health status in many areas of wellbeing (Crengle, 2009; Ministry of Health, 2006; Robson & Purdie, 2007), overall lower standards of living (Jensen et al., 2006; Robson, Cormack & Cram, 2007), higher rates of mental health difficulties and substance abuse (Baxter, 2007, 2008; Baxter, Kingi, Tapsell & Durie, 2006), and greater exposure to discrimination and racism (Harris et al., 2006). Similar health and social inequities are reported for other indigenous populations the world over (Gracey & King, 2009; King, Smith & Gracey, 2009).

Historical perspectives related to Maori health and wellbeing including alcohol use

The causes for these health and social inequities are complex, and it has been suggested that contemporary inequities and vulnerabilities for Maori are probably best understood in reference to historical influences, beginning with colonization (Reid & Robson, 2007). Unlike other nations, Maori did not have experience with alcohol prior to colonial contact (Hutt, 1999; Mancall, 2000). Moreover, Maori, particularly those from the northern regions, were clear in their aversion to alcohol, as can be evidenced in its Maori name '*Waipiro'* or 'stinking water' (Mancall, 2000). However, due to a number of factors, including the economic benefits from trade and the use of alcohol to pay for Maori labour, the demand for alcohol increased over time (Hutt, 1999). By the mid 1800's alcohol abuse by Maori had become a problem in many areas of Aotearoa New Zealand (Robertson, et al., 2002).

Although Maori freely participated in the use of alcohol, Maori leaders at this time were cognizant of the effects of alcohol and consistently voiced their concern over the use of alcohol amongst Maori (Ward, 1974; Durie, 2001). The response by parliament was to amend the Sale of Spirits Ordinance to prohibit all Maori from purchasing liquor. However, many Maori opposed the discriminatory nature of these changes on the basis that the changes did not also apply to non-Maori (Ward, 1974). This created a divide amongst Maori. Many Maori believed that they were entitled to self-determination, including personal decision-making over the use of alcohol.

Eventually, Maori leaders were forced to compromise by permitting the sale of alcohol within particular Iwi (tribes) (Durie, 2001). Ultimately, all Maori were able to continue to partake in the consumption and purchase of alcohol should they choose to do so.

During this same period Maori formalised an agreement to co-govern Aotearoa with the signing of the Treaty of Waitangi (Orange, 1989). Two versions of the Treaty were created, one in Maori and one in English. Crucially, content within the two versions of the Treaty differed around significant issues such as authority and sovereignty (Orange, 1989), and debates about these differences in understanding continue today. However, it is commonly believed that in signing the Treaty "Maori expected the Treaty to be the start of a new relationship with Britain – one in which they would play an equal role" (Orange, 1989, p. 33).

While there remains contention around whether Maori knew the nature of the ensuing relationship and whether all Maori agreed to the terms set out in the Treaty (Pocock, 1998) it soon became apparent that Maori were being adversely and unequivocally affected by the new relationship, with the established colonial government not keeping up 'their end of the bargain' (Orange, 1989; Durie, 1998, 2001). The progression of colonisation came at many costs for Maori, including, for example, significant loss of land, language and stability of cultural traditions and practices across time (Durie, 1998). Furthermore, arguments have also been put forward by some history commentators suggesting that alcohol was deliberately used as a tool to take possession of Maori land as a means of disrupting the foundation of Maori life (Te Puni Kokiri, 1995). This is consistent with Churchill's assertion that colonisation is based on dehumanising indigenous peoples through a range of processes from neglect to genocide, and paternalism to romanticism (Churchill, 1996). In any case, it is evident from the literature that alcohol use amongst Maori is deeply intertwined with social, political and historical factors. Accordingly, contemporary approaches to alcohol and drug treatment with Maori are often based on a foundation of knowledge which incorporates an understanding of these factors. Such approaches are outlined further below.

Predominant addiction approaches

In consideration of the information and issues outlined above, there is increasing interest in the development of treatment approaches and models which may be suitable for use with Maori who are dealing with alcohol and drug use related issues. While abstinence remains a popular treatment method in the alcohol and drug field, 'harm reduction' models are also popular, particularly in community alcohol and drug treatment settings. Harm reduction models assert that "the primary goal of treatment is to reduce or minimize the harm associated with on-going or active drug use" (Marlatt, 2001, p. 16) and can be an appropriate treatment method when abstinence is not possible or not preferable to the client. In reviewing the literature on these approaches, meta-analytic research indicates that abstinence based treatment for addictions are more effective with adjunctive medical therapies (such as Naltrexone or Acomprosate) (Rosner, Leucht, Lehert & Soyka, 2008) or in conjunction with behavioural contingency (rewards for abstinence) programmes (Stitzer & Vandrey, 2008). With regard to the treatment of severe drug abuse, harm reduction has been shown to be an effective intervention; it includes needle syringe exchange programmes (Wodak & Coney, 2006), as well as opioid substitution therapy (Connock et al., 2007). However, while evidence exists for the efficacy of these approaches in international settings, little is known about the application of these approaches to addressing alcohol and drug abuse among Maori in Aotearoa New Zealand, particularly where these models have been adapted for Maori or applied alongside Maori oriented frameworks.

Literature on the Maori service providers and efficacy of Maori and indigenous intervention

In a comprehensive review of Maori addiction treatment between 1980 and 2008, it was shown that the genesis of specific Maori alcohol and drug services originated at a bicultural service at Tokanui hospital in the 1980's (Cave et al., 2008). The authors explain that these humble beginnings are best viewed in the context of the wider socio-political context of the time. This was a time when, politically, Maori were beginning to gain traction in their attempts to regain authority or self-determination in accordance with the principles of the Treaty of Waitangi, and accordingly, the provision of bicultural services for Maori within mainstream services had become a real possibility. Since these early beginnings, the number of institutions

employing a specific Maori approach in the provision of alcohol and drug-related services had grown to 45 across the country at the time of the review, (Cave et al., 2008). At this time, the predominant Maori health models utilised by these institutions when surveyed included: Te Whare Tapa Wha, Powhiri Poutama, Te Wheke, and Whanaungatanga (Cave et al., 2008).

International literature regarding culturally appropriate interventions has indicated that ethno-cultural factors are a crucial part of health (and other) rehabilitation processes. In particular, cultural interventions appear to be most important for indigenous populations that have undergone psychological, cultural, social and political assimilation (Dawn, 1993; McCormick, 2000; Spein, Sexton & Kvernmo, 2007). In Aotearoa New Zealand, literature indicates that culturally congruent models in health intervention are important for enabling individuals to connect, or re-connect with their cultural identity (Huriwai, 2002). The impetus for this claim came from earlier research which found that Maori were five and a half times more satisfied with Maori focused health treatment than with non-Maori focused treatment (Huriwai, 1998). Support for providing Maori focused services has also been reported from research within 'Te Hoe Nuku Roa' (a large health and social study of Maori households in Aotearoa New Zealand) which found that Maori who identified more strongly with their culture had better general health than those who did not (Te Hoe Nuku Roa, 1996). Moreover, Durie (2001) asserts that 'secure' cultural identification is important for promoting good health as well as aiding in treatment and therapy (Durie, 2001).

In the treatment of substance abuse Huriwai explains that connecting positively with cultural identity enables individuals to experience cultural pride and affirmation which together act as a 'buffer' to further substance abuse (Huriwai, 2002). In a recent review of practice models employed by Maori alcohol and drug practitioners, treatment providers reported that incorporating a Maori model that respected the 'whole' person contributed to a trusting and safe therapeutic relationship (Abacus, 2004). Furthermore, the inclusion of culturally appropriate models for Maori in addiction services has been encouraged by both Maori and non-Maori treatment providers (Robertson et al., 2002, 2005, 2006). However, despite the information provided by the studies described here, there currently exists a lack of client-focused research that is related to alcohol and drug treatment programmes which currently

cater to Maori clients. That is, available research which particularly focuses on Maori consumer (clients) perspectives and experiences of programmes which incorporate Maori models and approaches is very limited.

Maori models and approaches to wellbeing

Culturally appropriate models or approaches for Maori are those which are based upon, or at least incorporate values, principles and practices consistent with a Maori worldview. An overview of the literature pertaining to a Maori worldview shows that Maori conceive of person-hood as a system of interconnections. For example, a Maori view of personal and communal well-being is captured by Durie:

> "Healthy thinking from a Maori perspective is integrative not analytical; explanations are sought from searching outwards rather than inwards; and poor health is typically regarded as a manifestation of a breakdown in harmony between the individual and the wider environment" (Durie, 1998, p.71)

Extending from this view, Maori models of health and well-being take a holistic approach that reflects the importance Maori place on the collective. This view stands in contrast to the 'traditional' 'Western' bio-medical approach to health that has been adopted by many Western countries (White, 2005) in which the individual is the locus of treatment. That is, the consideration of external factors such as the nature of collective relationships, the social environment, or a spiritual realm to health (for example) are believed (by those who adhere to such models) to be mostly irrelevant to treatment approaches.

To reflect the holistic nature of Maori approaches to wellbeing, a popular health model introduced by Mason Durie (1985), *Te Whare Tapa Wha (The four sided house),* proposed that wellbeing for an individual comprised four interacting dimensions. These dimensions are known as: Te Taha Hinengaro (the dimension of mental/emotional wellbeing), Te Taha Tinana (the dimension of physical wellbeing), Te Taha Whanau (the dimension of the family/extended family) and Te Taha Wairua (the dimension of spiritual wellbeing) (Durie, 1985). No one aspect is more important than the other, and balance across the dimensions is necessary for overall good health. This 'Te Whare Tapa Wha' model has been widely adopted throughout the health

sector in Aotearoa New Zealand and is evident in most areas of health policy and many areas of health practice today (Ministry of Health, 2002).

A holistic Maori worldview (particularly that related to health and wellbeing) is often contrasted to traditional Western approaches to wellbeing that focus primarily on the individual as the solution to problems. For example, many traditional psychological therapies are based on working with individuals (one-to-one) as opposed to viewing individuals as belonging to a wider collective, or viewing mental health as part of a broader holistic context of wellbeing that incorporates both relationships with others and with the environment (Durie, 1998, 2001). However, while it may be suggested that Maori and traditional Western approaches to the individual and therapy contrast, it appears there is some growing evidence to suggest that these approaches can be combined to work well for Maori (e.g., Bennett, 2009). This appears to be particularly so when these approaches incorporate important Maori values and principles such as those outlined below.

Maori Tikanga

Within any world-view are guiding principles that enable those who hold this view to make sense of, and interact with, the environment around them. For Maori, these principles are collectively known as 'tikanga' and can also be described as the "tools of thought…packages of ideas which help to organise behaviour" (Mead, 2003). Tikanga (also known as 'cultural customs and rules') is derived from knowledge that has been handed down generationally either verbally or through observation. Mead (2003) further describes these ideas and practices as a 'pool' of knowledge, which also includes other important aspects in Te Ao Maori (the Maori world). While there are many different values which underpin tikanga, only two key concepts will be covered here.

Whanau

The whanau (family) is an integral part of being Maori. Huriwai explains that a typical Maori family in the 18-19th centuries resembled more of a 'domestic group' "interconnected by kinship ties that lived and worked as a social and economic unit on a daily basis" (Huriwai, 2001, p. 1038). Kinship ties often extended into relations

further than the nuclear family to include hapu (sub-tribe), iwi (tribe) and waka (navigational canoe) affiliations (Moeke-Pickering, 1996). Despite the impact of colonisation on Maori societal structures, these types of extended kinship ties remain strong for many Maori today. Recently, these connections have also been extended into non-familial ties that "express a common mission" (Durie, 2003, p. 13). In these contexts the function of the whanau is communal in nature and described by Huriwai and colleagues (2001) as "providing a framework in which co-operative and collective values can be expressed and practiced" (Huriwai et al., 2001, p.1039). The importance of whanau is further emphasised in Cram and colleagues (2003) qualitative assessment of how Maori talk about health. Participants in this study explained that the whanau was the basic structure of support because "whanau buffers its members from the wider world, including experiences of illness, treatment and hospitilization" (Cram, Smith & Johnstone, 2003, p. 4). Specifically, the positive effects of these 'buffers' were explained by Durie through his assertion that particular values emanate from within the whanau, such as: manaakitanga (support and caring); tohatohatia (sharing resources); pupuritaonga (guardianship of gifts); whakamana (enabling/empowering family members); and whakatakato tikanga (positive planning for the future) (Durie, 1998).

Whanaungatanga

Closely linked with the concept of whanau, is the concept of whanaungatanga. Huriwai defines this as inter and intra group relationships, where "dynamic process of establishing and maintaining links and relationships" occur (Huriwai et al., 2001, p. 1039). Moreover this process is dynamic because there is an expectation amongst whanau members to both provide support to one another and to be supported (Durie, 2001; Mead, 2003; Patterson, 1992). Over time these bonds strengthen and the intention to assist one another is expressed through "loyalty, obligation and commitment, an inbuilt system [which] made the whanau a strong stable unit" (Pere, 1994, p.26). Thus, these processes don't just occur randomly; they are a process initiated by intent amongst family members to provide for one another.

Transmission of values through whanau

Passing on information about Maori values and practices through the family system (such as those described above) is an important means of educating future generations. The transmission of information in this way is not only through 'passive' observation and involvement, but can also be facilitated by tuakana/teina roles within the family. In Maori, a tuakana literally refers to a senior sibling, whereas a teina is the junior sibling (Calman & Sinclair, 1999), however these roles are fluid and can be applied to any member of the whanau (or even the wider Maori population) where differences in seniority (of age and/or knowledge) apply. These roles are also developmental, for example, when teina have received and expressed a satisfactory level of knowledge, they then become the tuakana for another generation of teina. Within the whanau this creates a cycle of learning and intergenerational transmission of knowledge and practices, and also serves to strengthen whanaungatanga (or relationships) because in essence "it is love and caring for family members" (Tangaere, 1997, p.50).

Many therapeutic programmes which cater to Maori incorporate important values and principles such as these described above (as well as others not described here). However, little research has been conducted with Maori clients of such programmes, and as a result evaluation studies which include Maori 'consumer perspectives' on the efficacy of these types of programmes are rare. The current research aims to contribute to the literature in this area by gathering information from Maori clients of a local alcohol and drug treatment service on their experiences of Maori approaches being utilised at that service.

The Present Study

Higher Ground Drug Rehabilitation Trust

The current research was conducted at the Higher Ground Drug Rehabilitation Trust (Higher Ground), located at Te Atatu Peninsula, West Auckland. Established in 1984, the aim of the Trust is to provide rehabilitation services to those who are severely dependent on alcohol and drugs. Rehabilitation is provided in a residential setting over 18 weeks and abstinence must be adhered to throughout the programme by the residents (which clients become known as once they are admitted to the treatment programme). Within the programme, residents refer to each other as 'peers'.

A recent report conducted for Higher Ground revealed that people of European descent comprise 68% of admissions, followed by Maori (28%) and people of other ethnicities (4%). Overall, for those that were admitted to Higher Ground, methamphetamine was the most prevalent type of drug to which residents were addicted (51%), followed by alcohol (25%) and Cannabis (17%) (Raymont, 2012).

All residential clients participate in a standard programme based on the '12 steps' for recovery of addiction. The '12 steps' for recovery were originally developed for those with severe alcohol addiction – it was known as "Alcoholics Anonymous" (Wilson & Smith, 1939). The authors explain that the 12 steps are "a group of principles, spiritual in their nature, which is practised as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole" (p.15). For example, the first step states: "We admitted we were powerless over our addiction and that our lives had become unmanageable" (Wilson & Smith, 1939). Today, the utility of the 12 steps is such that they have informed treatment programmes for many other addiction services (e.g., Crystal Meth Anonymous, 2012; Narcotics Anonymous, 2012).

The '12 steps' to recovery are delivered within a 'therapeutic community' environment at Higher Ground. The organisation explains that the community operates within well-defined behavioural and ethical standards. Expectations are communicated through community based sanctions for both good and bad behaviour. In order to successfully integrate into the community, newer members must learn the importance of taking responsibility for one's behaviour. Experiencing success and failure in this environment allows an individual to gain insight into their behaviour. When the community provides feedback, the individual experiences the consequences of their behaviour. This is an important influence for lasting change (Higher Ground, 2012).

Increasingly, research supports the utility of the therapeutic community for the treatment of addictions (Rawlings & Yates, 2001). For example, research has implicated the therapeutic community as an integral aspect of recovery in residential settings for reducing drug abuse and anti-social behaviour, particularly in opioid users (De Leon et al., 1999), increasing the chances that the individual could participate in education and employment following treatment (Bale et al., 1980) producing positive psychological change, changes in perceived health status, decreased rates of

recidivism (Fernandez et al., 2008) and long term abstinence from alcohol and drugs (De Leon, 2000). Recently, research has also indicated that infusing a therapeutic community with Maori values, beliefs and processes contributes to the overall therapeutic milieu and provides feelings of safety and cultural resonance for Maori especially in terms of exploring new notions of self (Adamson et al., 2010).

The Maori Programme at Higher Ground

The present Whanau programme began at Higher Ground in (2006) under the guidance of two Maori facilitators who continue to run the Maori Programme. In the initial days, 1.5 hours a week were set aside for the group; today, the group is allotted 20 hours per week across 3 days. The number of clients participating in the whanau group has also varied; at present about two thirds of residents attend.

A canvas of the available literature surrounding Maori centred rehabilitation revealed that the whanau group is one of only a few programmes to be developed and facilitated by the same individuals for this amount of time. The programme grew out of the experience of the Maori focus unit at Hanmer Springs in the late 1980's. It developed with advice from local Kaumatua [Maori Leaders] and with input from the participants.

A central feature of the whanau group is the focus on the collective. For many Maori, a collective approach to both the positive and negative aspects of 'life' is a *normal* way of life. Moreover, Maori approaches to treatment reflect this principle and are renowned as holistic frameworks that incorporate multiple aspects of an individual's experience into a treatment setting. When interacting with those in the whanau group, the facilitators incorporated this philosophy within the broader aims of Higher Ground to "foster personal growth". This includes a number of specific processes (outlined below) but has also extended to the inclusion of the facilitator's family into the rehabilitation setting. Ultimately, combining personal and group process was a necessary and useful way to meet the needs of Maori clients and ensure that there was an equal amount of emphasis on the rehabilitation aims of Higher Ground.

While at Higher Ground, there are several opportunities within the treatment programme where clients can select to either attend a 'mainstream' rehabilitation activity or a Maori focused component (within part of the overall treatment

programme). For example, on a Friday afternoon they may attend either a Spiritual group or Whanau group.[2] Participation in Maori focused components is open to both Maori and non-Maori, but is strongly focused on fostering understanding and practice of Maori values and principles, including positively enhancing Maori cultural identity among Maori clients. The Maori components have expanded to include opportunities to learn, practice and experience tikanga based activities such as powhiri (traditional formal welcome) and karakia (prayer). Further culturally-focused ceremonial activities used in the Whanau group at Higher Ground are described below as these are referred to by participants in this study and later throughout this report.

The 'Paua Ceremony' is used to describe the transition that clients are encouraged to make during their time in rehabilitation. Originally adapted from a children's book, the participants are likened to the paua such that they have an inner beauty similar to the beauty inside the paua shell. However, the beauty is encased in addiction and negative experiences which have disfigured their outlook and experience of life. These experiences are then likened to the rough outer shell of the paua. The facilitators of the Whanau group explain that being a part of rehabilitation allows the clients to go on a journey through which they can shed their exterior and reveal their inner beauty. This has also been adapted into a play which the participants can be a part of and perform for their families upon graduating.

The paua theme is also used in other ways to emphasise the inner beauty discovered through rehabilitation. To elaborate on this theme the facilitators have incorporated the paua into the story that is told through the pou (carving). The pou is a carving in Higher Ground which is a depiction of a taniwha (mythical creature) that is likened to the 'demon' of addiction. Being a sea-borne creature, the carving also depicts a hook through which the taniwha is pulled upward toward the surface. The pou becomes an integral part of the participants' journey during graduation (a celebration of their completion of the programme at Higher Ground) as they place a piece of a paua to the back of the pou. By doing this, the beauty of the paua is juxtaposed with the ugliness of addiction and also serves as a tangible reminder to

[2] More recently residents not involved in the whanau group spend time in individual commitment work or physical exercise and there is no alternate group activity.

participants of their ‘belonging’ at Higher Ground while on their journey through recovery.

A further ceremonial activity in the Whanau group is the ‘handing-on’ of a taonga (treasure) among peers. In both the mainstream and Whanau groups, leadership is endorsed as an integral part of the journey to recovery. However, for those in the Whanau group, seniority amongst peers is recognised by wearing a taonga as a necklace. Adornment of the taonga is preceded by a ceremony in which the taonga is officially handed from one peer to another as the whakapapa (genealogy/ancestry) of the taonga is read aloud to all the peers in the Whanau group. The handing-on of the taonga occurs when the receiving peer is deemed by the community to have attained the seniority (achieved the amount of progress) necessary to ‘qualify’ for wearing the taonga. The amount of time that any one peer wears the taonga varies as it is determined by their progress through the overall rehabilitation programme.

Finally, a ceremony that is held less frequently is the Whakamaumahara (Remembrance) ceremony. This is intended for clients who have experienced significant loss and have not addressed the psychological impact that this has caused. The ceremony usually takes place at the beach where the group take part in a karanga to call in the ‘spirit’ of the person being addressed. The client then reads a letter outlining the experience they have not received closure on. Once the letter is read, it is burned and a karakia is spoken over the group. The group also gets the chance to respond before the ceremony is closed.

The current study

The current study was part of a larger study evaluating the overall treatment programme being delivered to clients at Higher Ground. With regard to the Maori focused components, Higher Ground were interested in two specific areas: 1) gathering a full description of the components (and related objectives) and 2) clients’ experiences of the Maori components (including whether the components are meeting their needs).

Method

This study used a Kaupapa Maori, qualitative, semi-structured interview design to gather information from clients of Higher Ground regarding the Maori components of the treatment programme currently being delivered. Currently, qualitative methodologies are recognised as a context driven approach that enables the researcher to provide a "complex textual description of how people experience a given research issue" (Mack et al., 2005). Within Psychology, qualitative research has become a popular method for exploring research questions either in isolation or in conjunction with quantitative methods. Qualitative methodologies are also considered by some authors to be preferred over other research methodologies when working within a Maori world view with Maori people (Walker, Eketone & Gibbs, 2006).

Kaupapa Maori Research (KMR) was initially developed out of a broader indigenous movement in Aotearoa that questioned non-Maori research methodologies founded on westernized positivist conceptualisations of experience (Cram, 2001; Smith, 1999; Smith, 2003). Within this dominant non-Maori framework 'knowledge' is narrowly defined and only serves to perpetuate the hegemonic 'status quo' (Gramsci, 1971; Smith, 2003). Needless to say, in response to this, Maori were increasingly uncomfortable and suspicious of what appeared to be a predominantly invalidating and exploitative approach (McNicholas & Barrett, 2002; Teariki & Spoonley, 1992). Ultimately, this led to Maori exercising the right to self-determination or *tino rangatiratanga* (Pihama, Cram & Walker, 2002; Durie, 1998, 2001, 2003) by developing a comprehensive framework aimed at enhancing the quality of life and social outcomes for Maori and legitimising a Maori worldview that conceived of and handled knowledge differently (Barnes, 2000; Smith, 2003).

In light of the aims of this study and the needs and expectations of Maori around the development of knowledge, an important consideration was to ensure that these aspects were addressed appropriately. To meet these demands, KMR principles were incorporated and adhered to throughout the duration of the study. For example, that the use of whakawhanaungatanga (establishing and maintaining relational connections) guided the contact between the researcher and the participants. Establishing these connections was particularly important in the initial days of the research so that all the participants were aware of the current study and the identity of the researcher. The researcher ensured that he was introduced to the participants by

taking part in one of the regular powhiri, where he could offer a mihi [speech] of his whakapapa and the purpose of the research. This was also important as it conveyed an intention to be a part of the community for the duration of the research and allowed the researcher to experience an integral part of the Whanau group. To maintain these connections it was important that the researcher also held regular meetings kanohi ki te kanohi (face to face) with the facilitators and other interested members of the Whanau group. In this respect, this particular study fulfilled the philosophy behind KMR. It is important to note that KMR is not understood as a prescriptive framework describing how to do research but rather that it is a philosophy that is primarily concerned with what the research does and the effects that the research has (Eketone, 2005).

Procedure

Qualitative data were gathered via semi-structured interviews. Potential participants from the Whanau group were initially informed about the broader aims of the research by the researcher then invited to volunteer by staff at Higher Ground. In total, 20 clients offered to participate, from which 12 were able to be interviewed in the timeframe available. Participants from each phase (P) of the Higher Ground Programme were interviewed (P1 = those who are in the first six weeks of recovery, P2 = those who in the second six weeks of recovery, P3 = those who are in the third six weeks of recovery, and Aftercare (refers to those participants who had completed the 18-week programme but were still engaged in an aftercare programme run by Higher Ground). A range of both female and male, and Maori and non-Maori clients participated (see Table 1).

Table 1.

Ethnic and gender make-up of by phase (P1, P2, P3 and Aftercare)

Ethnicity & Gender	**P 1**	**P2**	**P3**	**Aftercare**	
Maori male	2	1	1	2	
Maori female	1	2		1	
Non-Maori male				1	
Non-Maori female				1	
Totals	3	3	1	5	12

Interview questions were semi-structured and open-ended to encourage discussion among clients about how they experienced the components (see Appendix 1). At the beginning of each interview, the participants were provided with more information about the research which also included information about consent. Interviews were digitally recorded and notes were taken throughout. The focus of each interview centred on the strengths and weaknesses of the Whanau group including participant opinions of Higher Ground staff. Based on this information participants were also asked to suggest any improvements to the Whanau group. All interviews were conducted face to face and ranged from 20 to 50 minutes in length and were completed in the one session. The research was approved by the University of Auckland ethics committee.

Once interviews were completed and transcribed, thematic analysis was used to explore any common patterns or variations among the experiences of each group. This was carried out following guidelines recommended by Braun and Clarke (2006). Interviews were analysed using an inductive, data driven approach. With regard to analysis, transcribed data was read and re-read to elicit codes and then once this was

complete, organised into tentative/working themes recognising common patterns or variations. These themes were then reviewed and collapsed or expanded as appropriate throughout the process of data analysis. The key objective of data analysis was to identify key themes in the experiences of clients within the Maori components of the treatment programme at Higher Ground. The process of reviewing and refining themes was carried out in conjunction with the supervisor for this study in order to assist with validity.

Results

The following section outlines the five main themes and associated sub themes identified by the researcher. Words inserted in [ ] are either translations of Maori words or words used to provide context to the preceding or succeeding text.

Understanding addiction through Maori symbolism and activities was helpful for my recovery

The majority of participants mentioned the importance of regularly relating the content of the Whanau group to their previous and current experience with addiction. This was done through the use of symbolism and activities that were drawn from Maori understandings. For example, some participants indicated that understanding and addressing addiction was done with the use of analogy and expressed through the taonga (treasure), or pou (carving). Having a tangible item such as the taonga gave participants "strength" through the rehabilitation process as they were able to grasp it if they needed to. Similarly, the paua attached to the pou served as a reminder of their journey through Higher Ground and the personal development they had achieved along the way. Participants also commented on the intangible aspects of analogy, such as the paua story, and how this story represented their growth and development over the course of the programme. For example, one participant described this as follows:

> *He's [the facilitator] explained it to us, like… paua was a grandchild of the God of the sea and laid at the bottom of the ocean being picked on. He holds this paua shell up and on the outside, the rough side he explains, you know, this was me when I walked in through those doors. I was rough and rigid and broken almost and [he] turned it around and shows us the nice side and said, you know, this is you now gone through*

> *your journey, you know, you've got colours, you've got beauty, everyone's got beauty within* - WG04

Cultural practices, such as haka (traditional war dance), waiata (singing) and karakia (prayer) were also used to contextualise the recovery process. These were developed specifically for Higher Ground and reflect the struggle residents have with addiction. The following participant commented on what they considered to be some of the helpful aspects of learning the haka:

> *[The Haka] It starts off with waipiro [alcohol] and then how the addiction brings us down, and then we go down to the ground and then like we are looking for a way out, so then we are sort of looking for ways out of our addiction… then it just explains that we are trying to anchor ourselves and travel on a waka [canoe] of recovery… It helped me with my anger, because that was what I was in there for, to search out a solution* - WG06

Participants also explained that the haka and paua play were activities in which all the peers in the house were exposed to on significant occasions such as a graduation. For those in the Whanau group, this was an important way for them to acknowledge the achievements of their peers whether they were in the Whanau group or mainstream group.

While the benefits of Maori symbolism and activities in recovery were clearly described by most participants, a few participants did experience some aspects of these less positively. For example, some indicated that there was not enough time to learn everything they needed to know. For these participants this increased the anxiety they felt about being in the rehabilitation programme and in the Whanau group. For others, the limited amount of time to learn was understood retrospectively as a necessary 'evil' due to Whanau group only comprising a limited portion of the overall rehabilitation programme.

The powhiri was an integral aspect of my rehabilitative process

Many participants mentioned that the powhiri was important for establishing a connection with the institution and their peers. For some participants the powhiri was the only way they felt any connection to Higher Ground in their initial days:

> *I remember when I was first welcomed in and its quite emotional it actually gives you a sense of being a part of the place…for the first couple of days before it happens you sort of don't feel a part of the community until you're officially welcomed in [with the powhiri]*- WG02

Not only was the powhiri important in the initial stage of their recovery, participants also indicated other ways in which the powhiri enabled them to progress through rehabilitation. For example, most participants spoke about how apprehensive they were upon entering the Higher Ground programme. However, they went on to report that regular involvement in the powhiri built their self-esteem and confidence which assisted them to move through their rehabilitation and participate in the Whanau group to a higher degree. Some participants also indicated that the seating arrangement was a reminder of how far they had progressed in the group, as the seating is organised according to seniority and participants are placed accordingly throughout the room. The following participant described the benefits of being able to track their progress through the Higher Ground programme through their attendance at the weekly powhiri:

> *The powhiri was good because that was about the newcomer coming along and it also grounded me because I was also one of those people, you know I was a newcomer at one stage as well and it always grounds you to where you're at in the programme* – WG06

Included in many accounts of the initial days in Higher Ground were comments regarding information about the Whanau group. For instance, some participants indicated that they were made aware of the Whanau group in the pre-admission stage by staff whereas some participants indicated that they were only made aware of the option to join the Whanau group by their peers in the second week.

Benefits of connecting with my Maori identity

Many participants commented on the benefits to be gained from (re)connecting with their Maori identity. The opportunity to connect with their whakapapa [ancestry] and develop a sense of pride in being Maori was considered to be a particularly important part of their pathway to recovery.

Connecting to my whakapapa

Every participant of Maori descent expressed how they had, either intentionally or not, become disconnected from their Maori ancestry and cultural ways of being. Some commented on how disconnection from their Maori identity was enabled in part by their mixed ethnicity. For example, one participant described how their fair appearance made it easier for them to identify more strongly with their non-Maori culture/heritage and be seen as a non-Maori by others.

> *Because of my fair skin it was easier, I could easily [fit in as a pakeha] because the connotations… that went with Maori I just didn't want to be judged* – WG01

The quote above also alludes to another sentiment expressed by some participants that they were embarrassed to be Maori due to the negative societal connotations around being Maori while growing up. Other participants explained that they had a negative experience with Maori members of their family in their formative years and this resulted in an intentional distancing from their Maori family. Yet others had become distant from their Maori identity through adoption into non-Maori families or the separation of parents, sometimes resulting in being brought up in another country with no influence from their Maori family.

With regard to these experiences, all Maori participants indicated that being within the Whanau group created an opportunity for them to come to a point where they were ready to reconcile their past disconnection with their Maori identity. For example, the following participant described learning about the importance of making a connection with his biological 'whanau':

> *Helped me connect more with my family… I was whangai'd [adopted] out to my grandparents… I spent a lot of time on the Marae with my grandparents, but I sort of lost it all… it*

> *[the Whanau group] sort of made me want to try and connect back and re-learn my family history* – WG02

Interestingly, non-Maori participants also noted that the Whanau group facilitated Maori clients to be validated in their identity as Maori. For example, an appreciation of the effects of cultural disconnectedness inspired one participant to give a deeper analysis of the problem. For this participant, cultural disconnection appeared to have contributed to or compounded "every other sort of problem they [Maori] have in the outside world". By acknowledging the benefits of cultural reconnection and possible positive outcomes associated with this, the participant commented that:

> *They [Maori] can leave Higher Ground feeling that they do have more of a sense of being their Maori self, and if that helps to feel more a part of society or a greater sense of completion as a person, then that's very important* – WG05

Several Maori participants also explained that they had become active in establishing new connections with their Maori family as a result of being in the Whanau group. This included making trips to Marae, talking to the elders in their family and researching their family history books. For many, the motivation to make these connections was due to confidence they had developed to operate from a Maori world view (which they had learnt within the group). Others had made amends for past grievances and were prepared to move forward. For one participant, the impetus to re-connect came out of the realisation that he could no longer recall the geographical markers associated with his Iwi:

> *I sit there and go 'oh man I should know that, oh I should be able to say that at the end of the mihi. You know, where I'm from and what my awa is and what's my maunga'* – WG09

Learning about my Maori side has given me pride

Of the many outcomes associated with learning about and reconnecting with their Maori ancestry, the development of a positive identity as Maori was highlighted. For example, some participants indicated that through this learning and reconnection,

they became more confident and proud about 'being Maori'. For one participant, this feeling grew in spite of feeling shame from a very young age:

> *If anyone asked me if I was a Maori or Pakeha I would always, as a child growing up, I always said Pakeha. Now I'm proud to stand up and say I'm a Maori* – WG01

Several of the participants commented on how the Whanau group had encouraged them to continue learning once they had finished in rehabilitation. Having an increased sense of pride facilitated this, as well as an interest in encouraging cultural learning in their children. For example, the following participant indicated that he was considering taking te reo[Maori language] lessons and felt that it was important to include his children:

> *I am putting a lot of thought into, in the future I might go and take te reo lessons and get my children involved in it as well* – WG10

The Whanau group environment enhanced my progress through rehabilitation

All of the participants alluded to the positive environment of the Whanau group as being integral in the recovery process. For many of the participants this began with the personal qualities of the facilitators but also extended to the values and teachings that the facilitators brought to the Whanau group.

Positive characteristics of the facilitators

For all participants, the facilitators were instrumental in their development in the Whanau group. Participants held them in very high regard, which for some stemmed from the facilitators' admission that they themselves had been in recovery for a combined total of more than 40 years. Other participants were cognizant of the way in which the facilitators were easy to approach, non-judgemental and patient with any of their personal issues or issues related to understanding the content of the Whanau group. Some participants also appreciated having both a female and male facilitator available as this was important if they had a preference for either. Others felt that they could identify with both. Many participants spoke strongly about the positive characteristics they saw in the facilitators:

> *I just think that they are so dedicated to the 'cause', I think that they are beautiful people* – WG01

> *I think for me, a lot of it comes from [facilitator names] ... I don't know there's something about those two. I find that I can really, you know, I'll actually listen* – WG08

> *I think [facilitator names] are just wonderful and I think [one of them] in particular, [was] great support when I had troubles at Higher Ground* – WG05

Transmission of positive values

Participants also indicated that they appreciated the family values that the facilitators brought into the group. This was most obvious to participants when the facilitators' family was included into the Whanau group at Higher Ground or on marae trips.

> *The main reasons why I enjoy it so well is how they, you know, they make it, what is it, like literally a Whanau group, a family group and they include all of us. You know, [one facilitator] will work with the women and [the other facilitator] will work with the men and then together it's just a powerhouse* – WG08

Other participants indicated that they appreciated how genuine the facilitators were toward their issues and toward the wider aims of the Whanau group. This was particularly important for those within the aftercare phase of treatment as this showed that the facilitators genuinely cared for them and wanted to help them progress through recovery after leaving the Whanau group and Higher Ground:

> *I just like the on-going support that they offer and I go to Higher Ground regularly anyway, both genuinely care about my well-being and are there if I need them* – WG01

As well as the emotive and personal connection to the facilitators, participants also commented on the importance of having all of the activities and processes explained to them in a way that they could understand, especially in relation to what they were doing and why they were doing it. Some participants remarked that this was

important as it helped them to build confidence, whereas others felt it was important to know that there was a reason to what they were doing.

There was a real sense of family in the Whanau group which was helpful through recovery

Comments made by some participants indicated they felt a strong sense of support in the Whanau group which for them mimicked the support that they might receive in a family. This was modelled by the facilitators when they incorporated their family into the Whanau group and through the acknowledgement given to every participant from the time they became a part of the group. This was also apparent to some participants by the way in which problems, both individual and collective, were handled as a group.

> *We all come together, there's a lot of support in Maori group, like if someone's struggling we all work together as a team for instance, just like team building which I find is more support. Like if you're stuck on something we all go through it, starting from the beginning until we all get it right, so it's like a whole team not a part team for instance* – WG11

Having a sense of deeper connectedness with peers was particularly important to some participants as they felt that this created an environment in which every person, Maori or not, was accepted implicitly. Participants also commented that they felt a deeper connection with their peers in the Whanau group as opposed to the connections that they had made with their peers that weren't in the Whanau groups as they spent more time together and shared more intimate times together. For one participant, the deeper connections made in the Whanau group were going to be important in the future as they continued in recovery outside of Higher Ground:

> *Forming bonds with some people that are in the Whanau group is going to help me in my recovery in the long-term. 'Coz it will, you know it's good to get a good base of recovery friends* – WG10

Leading and being led [tuakana/teina] was an excellent way for me to learn and grow

The majority of the participants commented that they felt that leading newcomers in the whanau provided them with confidence to participate in a Maori world. Many participants provided anecdotal accounts of how anxious they felt knowing that one day they too were going to have to lead a karanga, waiata, powhiri or haka. However, over time, participants went on to explain that they became more comfortable as they were taught by others in the group and were given repeated exposure to the activities that they were expected to eventually lead. This was particularly true for one participant who felt encouraged when she saw a non-Maori participant performing a karanga. Participants also commented on how they had realised that they were in a leadership role and came to a point where they wanted to take on the responsibility to lead:

> *Being asked to actually step up and do that has been really beneficial for me building confidence and self-esteem and just learning that I can do things that are expected of me again and being asked to fulfil roles, being asked to mentor the younger peers through, you know, teaching them the mihi and teaching them the haka* - WG09

A contrasting comment came from another participant, more steeped in her Maori ability, who was initially frustrated that she had to wait her turn to lead. However, this participant eventually realised that there were other ways to lead without having to take the lead role:

> *To support my peers by leading in songs, stepping back [from leadership] with doing the haka and supporting my senior peers that way instead of just telling them how to do it –* WG07

There was also a comment from some participants, that although both the mainstream and Whanau groups required peers to lead, the system in the Whanau group was somewhat distinct:

> *They won't put you as a head checker [in the mainstream group] if you're in your first week here, but it doesn't necessarily fall in at a certain time level corresponding to*

your, you know, the amount of time you've been in here. Which is, the good thing I like about that in the Whanau group is that you're going to fulfil every one of those roles – WG09

Personal change

I experienced closure

For some participants, the Whanau group provided a unique way to process past grievances. Prior to being a part of a whakamaumahara [letter burning ceremony], the participants had felt the burden of loss which was linked to their current difficulties with addiction. For one participant, this came as a complete surprise as she was not expecting the ceremony to have that much effect on her.

That resentment was completely let go and I still feel that way today [free of it]… I was carrying that around all those years – WG01

Similar accounts were given by participants who were not directly involved in the ceremony. These participants described what they believed to be the important aspect of the ceremony based on what they had observed in their peers:

I guess it's just a finally say goodbye in a proper way to lost ones… or even just to let your anger out… releasing resentment – WG02

For one participant, closure over a significant loss came when she was involved in the karanga [ceremonial call] for the powhiri. Prior to the karanga, she had considered being a part of the whakamaumahara ceremony however to her surprise she had a distinct feeling that the spirit of the lost person was with her in that moment which was "*very comforting and very real*" – WG05

I pushed through my personal boundaries

All participants, at some level, had experienced an amount of discomfort during their initial days at Higher Ground. For all participants, the Whanau group provided a challenge to them to do something different than what they were used to. In many accounts, the experience was likened to being 'thrown in the deep end' and intimidating. Participants also indicated that they shied away from the 'spot-light'

which was a primary reason for their substance use. However the satisfaction of completing something that they had never thought was previously possible was very fulfilling, especially for those that were anxious and uncomfortable about speaking in front of other people:

> *What really stands out for me is facing my fear standing in front of everybody, at the end we asked to hold the patu [Maori weapon] and my whole self-consciousness and my critic telling me that you look stupid, you shouldn't be here, but overcoming that was a good experience* - WG04

The same participant also felt that this aspect of the Whanau group was distinct, especially for the male participants. The Whanau group provided avenues through which males could express controlled aggression such as performing the haka. For this participant the haka became a way to illustrate the different aspects of his journey through addiction. This was particularly beneficial to participants who were struggling with issues related to anger and self-control as they were able to express themselves through the haka appropriately. However, the 'performance' aspect of the Whanau group was challenging to some participants. Standing in front of others seemed unfair to a participant until, in retrospect, he was able to appreciate the reasons why it was done this way. For non-Maori, there is the added pressure of feeling like they didn't belong (often a self-perception, not from others) which added another dimension to the already high pressure environment:

> *I often did have that feeling of "I'm not Maori", and I didn't sort of want to come across as a bleeding heart white liberal. But I took it for what it was and I enjoyed it* – WG05

Overall, many participants indicated that experiencing the feeling of success with something that they never thought they could do gave them confidence and increased their self- esteem. This feeling grew even further the longer they stayed in the Whanau group and repeated the activities. Additionally, many participants indicated that they would have liked more Whanau group time and activities to be available. For instance, one participant wanted more time to practice what he had learned, whereas another participant wanted more te reo Maori. Another participant explained that he felt the marae trip should be a trip to 'real' marae where the

participants could interact with the people of that marae to enhance their experience. Participants also indicated that they would like to see the Whanau group expand into other things such as carving or a trip to a kapa haka tournament. For this participant, a kapa haka trip would enable those that were interested to see how they become a part of kapa haka following treatment. One participant also indicated that she would have loved the opportunity to include her family into the Whanau group at appropriate times, although she understood the complexity of the rehabilitation environment and the demands that could place on Higher Ground and her peers.

I enjoyed giving back to others

For some participants, it became obvious very early on that they had more knowledge about 'things Maori' than some of their peers, and because of this they were able to help/give back to others in the group. For example, a few participants found that they were able to help others work through learning waiata and improve their pronunciation. Another participant felt that it was important for her to be involved with graduation ceremonies because she strongly wanted to give back to the people she had connected with:

> *It feels really good to give someone something of your-self* – WG08

However not all participants found that helping others was a positive experience. For the Maori participants more acquainted with Maori protocol, the Whanau group did not always stick to protocol and felt too repetitive. In making this point the participant also conveyed that she understood why the Whanau group was run this way:

> *There's only so much we can do because there's always people coming and going… you've got to balance it out from the newcomer to the person that's been here all that time* – WG07

Discussion

This study provides important information about the perceptions and experiences of clients who take part in the Whanau group during their time in the Higher Ground rehabilitation programme. It was clear from the interviews that all

participants in the Whanau group provided by Higher Ground were positive overall. It was also clear that the rehabilitation process is a challenging process that is complex and inextricably bound together with personal, inter-personal and situational factors.

Overall, this report endeavoured to understand how the Whanau group came to be established at Higher Ground and the subsequent development. There are a number of key aspects that the whanau group brings to the rehabilitation process that are not available or accessible to the mainstream programme. In saying that, there are many areas in which the Whanau group overlaps with the 'mainstream' group. The most salient example of this is the powhiri as this is an occasion in which all those at Higher Ground are involved. This is a valuable intersection because there is the possibility that the personal growth and experience gained by those in the Whanau group may be similarly experienced by those who are not in the Whanau group as a result of being involved in the powhiri.

Overall, the opportunity for participants to reframe their identity in a number of ways was strongly facilitated by positive experiences of the Maori components of the programme. Involvement with Higher Ground and the knowledge gained about their Maori ancestry and 'things Maori' exposed the participants to the opportunity to increase their knowledge of themselves and cultural ways of being. This has enabled them to build a foundation upon which they can continue to develop once they have continued beyond Higher Ground. Of equal importance were the reports from non-Maori that they were experiencing similar personal changes to Maori participants. Capturing this dynamic is important for demonstrating the applicability of Maori models of health, and indeed a Maori world view in the rehabilitative sector. This is not to say that non-Maori now affiliate with Maori tikanga and kaupapa in the same way as Maori, although this may well occur. Rather, the important message from this study is that Maori have a vast amount of cultural knowledge and practices to draw from, and a lot to offer which may assist in understanding and addressing the complexities of difficulties such as addiction.

Limitations and future directions

There are a number of limitations of the study that give caution to conclusions that may be drawn. First, the current study cannot be viewed as representative of all participants in the Whanau group due to the small number of people recruited for the

sample. This was inescapable as there were significant time constraints involved. The small sample is particularly apparent in terms of the spread of participants across the different phases within the Whanau group. In saying that, the researcher is of the opinion that the information gathered here is rich and meaningful, and can give significant insights into the Whanau group and the experiences of its members, especially given that this have never been previously investigated at Higher Ground.

Secondly, although every effort was made to ensure that there was no bias during the participant selection phase, there is undoubtedly the possibility that those who volunteered were only those that found the Whanau group to be a positive experience. This is a constraint of any research that is bound by voluntary participation. Therefore, in considering the findings of this study it is important to keep in mind that it is possible that this study did not consider the opinions of those who may not have enjoyed their time in the Whanau group as well as a larger study may have.

Besides these issues, this study has raised some important questions for future research. Firstly it is unclear what the rate of retention is within the Whanau group and whether Whanau group involvement by clients will influence the likelihood of participation in the broader processes of rehabilitation from alcohol and drug addiction. Secondly, an issue raised in the literature, and one that is apparent here also, is the uncertainty around any long term 'change' that participants may have experienced during their time in the Whanau group. Future research aimed towards investigating these aspects of recovery from addiction would make a useful contribution to the field.

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Appendix A

Interview schedule

DEPARTMENT OF PSYCHOLOGY

Faculty of Science

Human Sciences Building

Floor 6, 10 Symonds Street

Telephone 64 9 3737599 ext 88557

Facsimile 64 9 3737450

The University of Auckland

Private Bag 92019, Auckland 1142, NZ

REVIEW OF THE MĀORI COMPONENTS OF THE HIGHER GROUND DRUG REHABILITATION TRUST ALCOHOL AND DRUG REHABILITATION PROGRAMME

INTERVIEW SCHEDULE

Semi-structured interview schedule:

This is a guide for the general areas to be covered. Further (related) questions can be asked following these prompts.

Karakia, mihimihi/introductions - as appropriate

Residents:

Tell me a little about how much involvement you have had with the Māori components of the rehabilitation programme.

What has been your experience of the Māori components?

> Did you find any part(s) particularly helpful to you in your recovery? Tell me about these.
>
> Did you find any part(s) particularly unhelpful? Tell me about these.
>
> Are there any changes to the Māori components you would like to see? Tell me about these.

Tell me about how you came to be interested in attending the Māori components.

> What attracted you to the Māori components?

How do you think the Māori components fit in with the wider rehabilitation programme?

Tell me about any other feedback or comments you'd like to make about the Māori components.

Karakia/closing – as appropriate

Appendix B

Participant information sheet

DEPARTMENT OF PSYCHOLOGY

Faculty of Science

Human Sciences Building

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Private Bag 92019, Auckland 1142, NZ

REVIEW OF THE MĀORI COMPONENTS OF THE HIGHER GROUND DRUG REHABILITATION TRUST ALCOHOL AND DRUG REHABILITATION PROGRAMME

PARTICIPANT INFORMATION SHEET (CLIENTS)

Tena koe

Ko Te Arawa te Waka me te Iwi
Ko Ngati Pikiao me Ngati Makino nga Hapu
Ko Matawhaura te Maunga
Ko Rotoehu te Moana
Ko Waitaha me Te Takinga nga Marae
Ko Waitaha me Ohau nga Awa
Ko Ngatoroirangi te Tupuna,
Ko Simon Waigth ahau

My name is Simon Waigth. I am a student at The University of Auckland, where I am enrolled in a Bachelor of Arts (Honours) degree. I am doing this research as part of my Honours dissertation (research report), and I am being supervised by Erana Cooper (Ngāpuhi, Ngāti Hine), Clinical Psychologist and Lecturer at The University of Auckland.

The aim of this research is to explore the experiences of clients who have attended the Māori components of the rehabilitation programme at Higher Ground. I am hoping to find out what your experiences of the Māori components have been like (e.g., opportunities to learn te reo or waiata, or be involved in other tikanga-based activities), especially in relation to how helpful or beneficial you found the components, and any other feedback you might like to provide about the components. You are invited to participate in my research about this, and I would appreciate any assistance you can offer me. In order to participate, you must meet the following selection criteria:

- **You have been attending the Māori components of the rehabilitation programme during your stay at Higher Ground (at least one session, but preferably more).**

I will be conducting confidential interviews with people who volunteer to participate. The interviews will include talking about your experiences of the Māori components of the rehabilitation programme. Interviews can take between thirty minutes to one hour, and might possibly go up to one and a half hours at the most. If you choose to participate, the interview will take place in one of the offices or activity rooms of Higher Ground, and the interview will be set at a time that is most convenient to you. You can say as much or as little as you like, and at any time of the interview you do not have to answer any questions you do not want to. You also can decide to change your mind about participating and end the interview at any time, without any

questions being asked. The interview will be recorded with a digital recorder and then transcribed by me (Simon). You can ask for the recorder to be turned off (and turned back on if you like) at any time during the interview. You also will be able to look at the transcript of your interview and offer suggestions for changes if you think they are needed, up to two weeks after the transcript is given to you. You will be able to withdraw parts or all of your information up to a month after your interview. You will be given a copy of your interview to keep should you like to receive one.

All identifiable information that is provided by you, such as your name and address, will not be seen by anyone, for any reason, other than the researchers, and only we will know the identity of the participants. Extracts from the information you provide may be quoted in the report for this research, and in possible publications or presentations about the research. This will always be done in a way which preserves your anonymity (no one will be able to identify you). Your interview data and consent forms will be stored securely and separately, and destroyed ten years after the research is finished. There is a possibility that the researchers may continue to do research in the future on the same or similar topics to this one. With your permission, I would like to be able to use your interview for other related research projects in the future during this time (ten years).

There is a very small chance that you may become upset when talking about your experiences of the Māori components of the rehabilitation programme. If this occurs I can help access support for you from the clinical and support teams available at Higher Ground (for example, you may like to talk with your case manager). This is unexpected but important to note so that you are aware that support is available for you in relation to your involvement in this research. This research also may identify health-related issues that you may be dealing with, and these will need to be taken into account if a referral to other health service providers is required.

Should you have any concerns about any aspect of this research, but do not wish to talk with me about this, you may contact my supervisor Erana Cooper or Associate Professor Douglas Elliffe, Head of the Psychology Department, or the Chair of the Ethics Committee at The University of Auckland, at the addresses supplied below.

Thank you very much for taking the time to consider being involved in this research. I am hoping that this study will contribute towards having a better understanding of the best ways to provide Māori-focused services to

men and women who are undertaking alcohol and drug rehabilitation programmes. I welcome you to take in this research, and will contact you again soon to see if you are interested in taking part. In the meantime, if you have any queries or wish to know more, please phone me at the number provided below, or email/write to me at:

Department of Psychology
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737999 ext 88557
Email: swai007@aucklanduni.ac.nz

My supervisor is:

Erana Cooper
Department of Psychology
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 86869

The Head of Department is:

Assoc. Prof. Douglas Elliffe
Department of Psychology
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 85262

For any queries regarding ethical concerns, please contact:

The Chair
The University of Auckland Human Participants Ethics Committee
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 87830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 14 May 2012 for (3) years, Reference number 8120

Appendix C

Consent form

DEPARTMENT OF PSYCHOLOGY

Faculty of Science

Human Sciences Building

Floor 6, 10 Symonds Street

Telephone 64 9 3737599 ext 88557

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The University of Auckland

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CONSENT TO PARTICIPATE IN RESEARCH (CLIENTS)

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF TEN YEARS

Researchers: Simon Waigth and Erana Cooper

Title of Project: Review of the Māori components of the Higher Ground Drug Rehabilitation Trust alcohol and drug rehabilitation programme.

I agree to take part in this research.

I have been given, and have understood, the explanation of this research project. I have read the Participant Information Sheet and I have also had an opportunity to ask questions about this research and have them answered.

- **I understand that my participation in this research is entirely voluntary.**
- **I understand that my participation in this research will in no way affect the services being provided to me (the rehabilitation programme) by the Higher Ground Drug Rehabilitation Trust.**
- **I understand that I will be taking part in a confidential interview about my experiences of the Māori components of the rehabilitation programme.**
- **I understand that this interview is likely to take between 30 minutes and one hour. If I want to talk for longer, the interview may take up to a maximum of one and a half hours of my time.**
- **I understand that I may withdraw from the interview at any point I choose, and that I am under no obligation to answer any particular questions that I may not want to.**
- **I understand that should this research identify any health-related issues I may be dealing with, these will need to be taken into account if a referral to other health or support service providers is needed.**
- **I agree that my interview can be digitally recorded and transcribed by the researchers, and that my data will be stored in a secure electronic location on a computer at The University of Auckland and/or a locked filing cabinet at The University of Auckland.**
- **I understand that I may ask for the digital recorder to be turned off (even just temporarily and then turned back on) at any time during the interview.**
- **I understand that I may review my interview transcript and suggest changes if I want to, up to two weeks after it is given to me.**
- **I understand that I may withdraw any or all of the information I provide at any time up to a month after data collection, without giving reason.**
- **I agree that extracts from the information I provide may be quoted in the report which will be written about this**

research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.

- **I agree that Simon Waigth and Erana Cooper may keep the data from this research for use in future related research projects, if relevant, for up to 10 years.**
- **I understand that I will receive a summary of the findings of this research should I wish to, and I provide my contact details below so that I may receive this.**

Contact details:

……

……..

Name:

(please print clearly)

Date:

Signed:

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 14 May 2012 for (3) years, Reference number 8120.