"Understanding the needs of sexually abusive rangatahi"

A process evaluation of the SAFE Rangatahi treatment programme

for Maori adolescents who engage in sexually harmful behaviour

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This thesis is submitted in partial fulfilment of the requirements for the

degree of Doctor of Clinical Psychology.

The University of Auckland

2016

Abstract

This thesis presents the findings of a process evaluation on the SAFE

Rangatahi programme, a community treatment programme designed for Māori

adolescents who have committed sexual offences against adults or children.

Qualitative methods including interviews and observation of group therapy and

outdoor wilderness therapy excursions were carried out over a ten month period.

Several other sources of information were collated in an attempt to document

programme processes and function including SAFE's policy and procedural manual,

pamphlets and brochures, and the agency website.

A total of 23 participants were interviewed, including seven rangatahi, nine

whānau, three kaimahi (staff) and four key stakeholders associated with the Rangatahi

programme.

The findings of this study are important because they give credibility to the use

of cultural initiatives with sexually abusive Māori youth. This study illustrates that sex

offender treatment programmes need to accommodate the cultural needs of those who

participate and failure to do so may result in disparate outcomes for its users and

increase the risk to the community.

Acknowledgements

Table of contents

Glossary of Maori Terms

This section provides an outline of the key concepts used throughout this thesis. These definitions are specifically used within the context of this study and derived from the Māori dictionary (Moorfield, 2005).

Iwi	Tribe or a large group of people descended from a common ancestor and associated with a distinct territory
Kaiako	Teacher, instructor
Kaimahi	Staff, worker
Kapa haka	Māori cultural group, Māori performing group
Karakia	Prayer or incantation
Kaumatua	Elder man or woman. An elderly person of status within the whānau
Kaupapa	Topic, plan, purpose, agenda
Kuia	Elderly woman, grandmother, female elder
Mana	Prestige, authority, control, power, influence, status
Manaakitanga	Hospitality, kindness, generosity, support – the process of showing respect, generosity and care for others
Marae	The open area in front of the wharenui, where formal greetings and discussions take place
Matua	Father, parent, uncle
Mau rakau	Arm with a weapon i.e. tiaha; in this context used as a distraction technique to channel young person's negative energies.
Morehu	remnants or followers of Ratana movement
Pākeha	English, foreign, European, exotic
Pepeha	Verbalised tribal affiliation
Powhiri	Welcome, rituals of encounter, welcome ceremony on a marae
Rangatahi	Younger generation, youth

Takahi	To trample, stamp, abuse, disregard
Tane	Husband, male, man
Tapu	Sacred, prohibited, restricted
Tauiwi	Foreigner, European, non-Māori
Te kakano	The seed, grain
Tikanga	Correct procedure, custom, protocol, the customary values and practices that have developed over time
Tino rangatiratanga	The Principle of Self-determination
Whakaaro	Thought, opinion, plan, understanding, idea, intention
Whakapapa	Genealogy, lineage, descent
Whakatauki	Significant saying
Whakawhanaungatanga	Process of establishing relationships, relating well to others
Wananga	To meet and discuss, consider
Whānau	Family
Whanauake	SAFE word used to describe the process used to farewell graduating rangatahi and whānau from the programme
Whanaunga	Relative, relation
Whangai	Bring up, foster, adopt, raise
Wharenui	Meeting house, large house – main building of a marae where guests are accommodated

Chapter 1 Introduction

New Zealand adolescent sexual offenders are now recognised as committing over twenty percent of sexual abuse in our communities (Ministry of Justice, 2009; Statistics New Zealand, 2009). Over the last two decades, the psychological effect of sexual abuse on a victim and their families has resulted in the development of comprehensive treatment services for sexually abusive adolescents. While these types of interventions are essential in reducing the number of victims in our community, the efficacy of these services is equally as important to establish. Whilst research has been conducted into the effectiveness of several mainstream adolescent treatment programmes in New Zealand, there is yet to be a study looking at the success of programmes specifically designed for Māori youth who have engaged in sexually abusive behaviour.

New Zealand introduced its first adolescent sex offender programme in Auckland in 1988 (Lambie, McCarthy, Dixon, & Mortensen, 2001). Since then, various nationwide residential and community based treatment programmes have been developed. New Zealand currently has eleven community treatment programmes available for this population with branches located through out the North and South islands. Each of these programmes offers a variety of services aimed at keeping communities safe from sexually harmful behaviour. These programmes include specialist services for adolescent sexual offenders with intellectual disabilities and developmental delays, dedicated female programmes, cultural programmes for youth of Māori and Pacific descent, and social work services. In general, adolescents referred to one of the above programmes can receive treatment for up to two years and are offered a programme incorporating

individual therapy in conjunction with group, cultural, family, and outdoor wilderness therapy (Geary, 2007).

The proposed research is a process evaluation of the Auckland SAFE treatment programme for Māori rangatahi (adolescents) who are sexually abusive. Māori adolescents represent one third of the clients currently referred for treatment at SAFE in Auckland and these numbers are expected to increase due to the growing population of Māori youth (Ministry of Health, 2005c; SAFE Network, 2008). The Māori adolescent treatment programme within SAFE was developed in response to the high number of Māori clients referred to them, and the organisation's awareness that Māori youth require a specialised team of individuals experienced in sexual abuse prevention within a Māori community to work with them (SAFE Network, 2008). This research is therefore critical because at the time of data collection, the SAFE Māori adolescent programme was fully operational in the community and it is important to understand the processes which make this programme function well and if it does work well. Furthermore, by assessing the Māori adolescent programme's original goals, its successes, failures, strengths, and weaknesses; staff can identify areas within the programme requiring further development as well as activities and processes which should be preserved. Moreover the findings of this research project will be significant in clarifying whether the Māori adolescent programme is accepted by its users which in turn could lead to more effective and efficient services for this population.

Chapter 2

Literature Review

General offending among adolescents

The 2006 census data shows that adolescents (10 to 19 years) constitute approximately eight percent of the New Zealand population (Statistics New Zealand, 2007). Despite this population appearing small in size, New Zealand Police figures show that this group alone contributes significantly to the crime statistics, with the 17 to 20 year old age bracket possessing the highest Police apprehension rates in 2007 (2109 per 10,000), followed by the 14 to 16 year old age group (1,540 per 10,000) (Ministry of Justice, 2009; Statistics New Zealand, 2009). It is likely that these figures are underestimates as they do not include unreported youth crimes or youth offending dealt with under the 1989 Child, Young Persons, and their Families Act (Soboleva, Kazakova & Chong, 2006). While the number of arrests for crimes commonly associated with adolescents such as property offences, disorderly behaviour and drug and alcohol related offences declined or stabilised between 1992 and 2007, the number of apprehensions for violent offences has increased for both child (5 to 9 years) and adolescent groups (Ministry of Justice, 2009; Statistics New Zealand, 2009). It is unclear exactly what is driving this trend, however, the research both internationally and within New Zealand attributes this movement to youthful populations having both greater exposure to the risk factors associated with criminality (Doone, 2000) and less access to the protective factors which would normally buffer such risks (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Bakker, Hudson, Wales, Riley, & Westaway, 1998; Marie, Fergusson, & Boden, 2009).

Gender and ethnic differences in offenders are also evident in the literature with the 'Child and Youth Offending Statistics in New Zealand Report' indicating that 83 percent of cases prosecuted against young people involve a male perpetrator (Soboleva, Kazakova & Chong, 2006; Ministry of Justice, 2009). Furthermore, criminal justice data shows that Māori are over-represented at every stage of the criminal justice process. For example, in 2007 Māori youth were three to five times more likely to be apprehended for a criminal offence than non-Māori (Ministry of Justice, 2009). In addition Doone (2000) wrote that Māori, "were more likely to be prosecuted, more likely to be convicted, and more likely to be sentenced to imprisonment". As a result, Māori made up 14 percent of New Zealand's general population and 51 percent of the prison population. Cunningham, Triggs, and Faisandier (2006) also found that Māori were 1.3 times more likely to be victims of crime than the total New Zealand population and were more likely to be victimised on multiple occasions.

More recent analysis of the criminal justice data has attempted to explain the high rates of Māori apprehensions with researchers contributing these statistics to three factors; population size, risk factors, and bias. Webb (2011) for example suggested that the Māori population is much younger than the New Zealand average with a median age of 23.9 years compared to 37.1 years for the rest of New Zealand (Statistics New Zealand, 2013). This may bias results when analysing Māori offending as young people aged between 14 and 30 years have the highest level of contact with the criminal justice system compared to any other age group (Soboleva, Kazakova & Chong, 2006).

Doone (2000), Fergussion, Horwood, and Lynsky (1993), and the

Department of Corrections (2007) have argued that criminal justice statistics

accurately mirror the social and economic shortcomings in which Māori offenders

live. Māori have disproportionately more adverse life experiences and circumstances

when compared to non-Māori, therefore they are more susceptible to the risk factors

that contribute to criminal conduct. Marie, Fergusson, and Boden's (2009) study also

found that having a secure Māori identity mitigates the effects of exposure to

childhood adversity and decreases an individual's chance of being involved in

criminal activity, however, being of mixed Māori identity does not. Doone (2000)

wrote that the main risk factors that contribute to criminal conduct include:

1. Having fewer social ties and fragile parent-child relationships

2. Mixing with antisocial peers who possess harmful attitudes

3. Higher exposure to childhood, family and social adversity

4. Problems accessing treatment

5. Poor self-management and self-regulation skills

6. Poor attendance and performance at school and

7. Lacking cultural pride and positive cultural identity

Other researchers argue that the high apprehension rates for Māori are the

result of a complex interplay of differential offending rates and direct and indirect

discrimination within the New Zealand criminal justice system and society more

broadly (Morrison, 2009). Police apprehension figures show that individuals of Māori

ethnicity have different apprehension, prosecution, conviction, sentencing, and

reconviction rates than non-Māori. Analyses of these figures show that young Māori

are more likely to be apprehended and more severely punished then non-Māori

youth with similar social backgrounds and criminal histories (Fergusson, Horwood &

Swain-Campbell, 2003). Jackson (1988) added that crime statistics might also

reflect public concerns about crime and the Police response to that concern. For

instance, if Police respond to public concern about a type of criminal activity which

attracts significant numbers of Māori membership (e.g., gangs), then the increased

resources in this area may lead to more arrests, resulting in an increase of Māori

crime statistics.

Although the theory about adversity and that of discrimination appear to

present polarised positions, it is highly probable that they would interact, where one

set of processes makes the other more likely and vice versa (Department of

Corrections, 2007).

Webb (2011) wrote that there are many researchers who ignore the

longstanding historical and cultural factors that may impact on Māori offending.

Māori have a social history of inequality, marginalisation and deprivation.

Furthermore, previous governments have not always had the best interests of Māori

in mind when developing policies. Jackson (1988) proposed that the criminal justice

system needs to be restructured because the over-representation of Māori in the

system suggests that it is not working for Māori. He also recommended that a justice

system for Māori based on Māori cultural frameworks of knowledge should be

developed.

Sexually abusive behaviour

It is pivotal to define what is meant by the term sexually abusive behaviour

as the behaviours that constitute sexual offending have varied over time and place as different cultures and societies adjust and redefine what is meant by abnormal sexual conduct (Ryan & Lane, 1997). In addition, the definition of sexually abusive behaviour among child and adolescent populations is less clear as they are still developing and therefore, "their motivation, intention, and sometimes normative adolescent behaviours are not understood" (Rich, 2003, p. 21). Furthermore Rich (2003) suggests that media significantly contributes to how ideas and information is conveyed about sexual conduct, especially in this era of social change.

Despite the variations in definition, what is consistent throughout the literature is the existence of three interacting and overlapping elements pertinent to sexually abusive behaviour: consent, equality, and coercion (Ministry of Justice, 2009; Rich, 2003; Sandler & Freeman, 2007). Sexual abuse for adolescent populations is therefore defined as, "any sexual behaviour that occurs without consent, without equality, and/or the result of coercion" (Rich, 2003, p.22). The SAFE Network's definition adds that it, "is any activity where someone older, bigger, more mature or more knowledgeable about sexual matters abuse their power". (SAFE Network, 2008, p.1). An issue with many of the adult definitions for sexual offending is that it excludes sexual behaviours that do not require direct contact with a victim such as showing pornography to a child, photographing a child in sexual poses, viewing sexual images of children on the internet (SAFE Network, 2008); obscene phone calls; voyeurism; lewd and sexual hand gestures; mooning (Rich, 2003); sexting (Ahern, Kemppainen & Thacker, 2016) and secretly filming and redistributing sexual encounters online without one participant's consent (Collins, Martino, & Shaw, 2011). Whilst it is debatable whether some of the above

14

behaviours constitute sexual abuse, what is evident is the definition will continue to evolve as technology advances and societal norms adjust (Collins, Martino, & Shaw, 2011; Huesmann, 2007).

Furthermore Rich (2003) proposes that even though it is possible to define sexually abusive behaviour, it is not always possible to understand it, and clinicians must therefore be cautious not to minimise or pathologise all sexual behaviours. Sexual behaviour is common among adolescents all over the world including New Zealand. For instance, the Ministry of Health 'Our Childrens Health report' found that 20 percent of New Zealand students were sexually active and that up to 17 percent of 13 year olds and 50 percent of 17 year olds had engaged in sexual intercourse (Ministry of Health, 1998)

Child sexual abuse (CSA)

Incidence of CSA. The reports on the incidence of childhood sexual abuse offer mixed results. However, most researchers acknowledge that the figures are likely to be superficial, representing only a small proportion of victims (Ministry of Justice, 2009). A large meta-analysis of 65 CSA articles spanning over 22 countries including New Zealand, determined that almost eight percent of men and 20 percent of women had suffered from some form of sexual abuse prior to the age of 18 (Pereda, Guilera, Forns, & Gomez-Benito, 2009). Females were also found to be three times more likely to be victims of sexual abuse than males (Pereda et al., 2009), which some researchers have suggested could reflect the presence of gender inequality in society (Ministry of Justice, 2009). In a recent report which aimed to identify actions required to better prevent and respond to sexual violence in New Zealand, it was suggested that young Māori women were almost twice as likely to

experience sexual violence, followed closely by young Pacific women (Ministry of Justice, 2009).

Outcomes. Childhood sexual abuse is by nature threatening and interferes with a child's personal and social development (Cole & Putman,1992). Childhood sexual abuse has been associated with psychological disorders such as major depression (Chen et al. 2010; Dinwiddie et al., 2000; Kendler and Aggen, 2014) anxiety disorders (Chen et al. 2010; Dinwiddie et al., 2000), conduct disorder, eating disorders (Chen et al. 2010), and post-traumatic stress disorder (Briere and Elliot, 1994; Chen et al. 2010; Huang et al., 2008). Child sexual abuse has also been linked to increased suicidal thinking/behaviours (Chen et al. 2010; Dinwiddie et al., 2000; Jakubczyk et al. 2014; Joiner et al. 2007; Lopez-Castroman, et al. 2015), increased psychiatric hospitliations (Barbe et al., 2004), substance abuse (Bohn, 2003; Chen et al. 2010) increased sexualised behaviours (Kendal-Tackett, Williams & Finkelhor 1993) and higher reported rates of lifetime traumatic events (Bohn, 2003; Raghavan and Kingston, 2006).

A history of sexual abuse is also associated with a lifetime diagnosis of multiple somatic disorders including functional gastrointestinal disorders, nonspecific chronic pain, psychogenic seizures, and chronic pelvic pain. When sexual abuse was narrowed down to rape; victims were more likely to receive a lifetime diagnosis of fibromyalgia (Paras et al., 2009)

Some factors that make the development of psychopathology more likely include the age of the victim when abused, their gender, social context, and gene–environment interactions (Castellini et. al, 2014). Williams (1993) added that the impact of PTSD on victims was dependent on the severity of the abuse inflicted, if the abuse had been disclosed

16

and if the disclosure process resulted in negative outcomes. The victims who experienced negative outcomes were more likely to dissociate and therefore exhibit restricted memory related to the abuse (Williams, 1993). The mediators that may influence the development of later psychopathology among child sexual abuse victims include "neuroticism, impulsivity, emotion dysregulation, body image, and hypothalamic–pituitary–adrenal axis" (Castellini et. al 2014, p71).

Authors such as Kendal-Tackett, Williams and Finkelhors' (1993) argue that there is no evidence for "core symptoms" or a "conspicuous syndrome" in children who have been sexually abused because the children in this study manifested an assortment of symptoms and pathological behaviours, and a large proportion expressed no symptomology at all.

Gender and age differences were also evident in the literature; Boys were more likely to exhibit externalising behaviour as a result of sexual abuse for instance aggression, delinquency and hyperactivity whilst girls were more likely to present with internalising behaviour including mood disorders, problematic eating behaviours, abuse of substances and cutting (Briere and Elliott, 1994).

An area of research that has gathered momentum over recent years is the impact of CSA on neurological development and processes. Perry and Szalavitz (2007) discuss how experiences of severe childhood trauma including sexual abuse can significantly impact on the brain's development. These authors hypothesised that many of the adverse symptoms associated with sexual abuse can be explained by an overactive stress response system brought about by the trauma endured at a young age, when the brain was still developing. Furthermore, these authors suggested that repeated patterns of behaviour in early life can create associations

which guide an individual's behaviour in a dysfunctional way. For example, if an individual was sexually abused on a regular basis as child, it is possible that the memories associated with the experience such as scent, sights, and smell, will combine together to create a set of memory templates. Therefore, when exposed to any of these associations, a victim may unconsciously act out the behaviours they experienced as victims (Perry and Szalavitz, 2007).

Perpetration characteristics. What is clear from the available evidence is the effects of CSA are extensive and varied. Some researchers have argued that victim outcomes are dependent on several variables including the type of abuse experienced by the victim (particularly if penetration occurred), the duration and frequency of the abuse, whether force was used, the relationship of the perpetrator to the child (Rich, 2003), as well as the victim's access to parental support (Briere and Elliott, 1994). The literature also shows that not all children who have been sexually abused go on to experience adverse symptoms, with most studies on the impact of sexual abuse finding that a substantial group of victims have little or no symptomology (Briere and Elliott, 1994., Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia (1992). Finklehor (1990) suggest that these findings could be due to victim denial and/or methodological issues but are more likely attributable to the fact that these children actually suffered less serious outcomes because they had adequate psychological and social resources to cope with the stress of abuse.

Furthermore young victims abused by other children were less likely to consider the experience as sexual abuse than when the offender was older (Allen, Tellez, Wevodau, Woods, & Percosky, 2014). These children however, experienced comparable emotional adjustment concerns to children whose perpetrators were

teenagers or adults (Allen, Tellez, Wevodau, Woods, & Percosky, 2014). These
results suggest that regardless of whether a child perceives their experience as
sexual abuse they are at just as much risk as victims of older perpetrators to develop
poor mental health and interpersonal difficulties in the future.   The research
examining the impacts of father-daughter incest versus brother-sister incest is still
relatively limited, though most research has assumed that the negative effects of
father-daughter incest are much worse for a victim than brother-sister incest (Cyr,
Wright, McDuff, & Perron, 2002; Rudd and Herzberger, 1998). Rudd and Herzberger
(1998) reported that sibling incest was as serious as father-daughter incest because
the use of threat and force with resultant pain or injury for both groups of perpetrators
was nearly equal in nature. These authors also shared that victims of father-
daughter incest reported feeling emotionally betrayed by the non-abusive parent
because they did not stop the sexual abuse and essentially failed to protect them
from the traumatic experience.

Sexually abusive adolescents internationally

It is widely acknowledged that the extent of sexual offending is
underreported to governmental agencies and like all other types of crimes, many
incidents of sexual offending go unreported for various reasons including a
reluctance by victims to report the crime because of fear or shame, psychological
denial, and cultural and familial perceptions of what constitutes sexually abusive
behaviour (Stanko, 2008; Weinrott & Portland, 1996). Despite this, numerous
international and local New Zealand studies have attempted to quantify the
prevalence of sexual offending. For instance, Mason and Erooga (1999) concluded
that between 25 and 33 percent of all sexual abuse in Europe is committed by young

perpetrators aged between 10 and 20 years of age. Furthermore, Newman, Negendank, Poortinga, and Benedek's (2009) report established that one in five sexual assaults in the United States of America is committed by an individual under the age of 18.

Masson and Erooga (1999) and Ryan (2010) advise caution when interpreting the above criminal statistics because they only reflect the cases dealt with by child protective services, figures for young people over the age of criminal responsibility, and excludes individuals who were dealt with at a family and community level.

An important study in this area by Weinrott and Portland (1996) examined juvenile sexual aggression in the United States of America between 1973 and 1992 using data collected from self-reported sex crime surveys and law enforcement records. The self-reported sex crime surveys established that over seven percent of juvenile offenders who participated in the study were under the age of 17 years when they committed a sexual crime. These figures were in line with a Swedish self-reported sex crime study, which reported an adolescent sexual offender rate of around six percent per annum (Kjellgren, Wassberg, Carlberg, Langstrom, & Svedin, 2006). Furthermore, Weinrott and Portland's (1996) analysis highlighted that figures presented in the self-reported sex crime surveys underestimated the true rate of sexual offending when compared to the law enforcement records. The law enforcement data showed the number of arrests by an individual aged less than 18 years of age for forcible rape was approximately 15 percent and for other sex offences 17 percent (Weinrott & Portland, 1996). The incongruence between self-reported crime figures and official criminal statistics has also been noted in New

Zealand literature with most authors attributing these results to methodological issues (Fortune & Lambie, 2005; Jackson, 1988; Shedler, Mayman, & Manis, 1993).

Keelan and Fremouw (2013) critically evaluated 21 studies that compared adolescent sex offenders who abused children to those that abused peers or adults. These authors found that nearly all of these studies lacked standard definitions of child or peer offenders for example some studies used just age to classify a child offender, others used age discrepancy, some used both (age and age discrepancy) while others had no clear definition at all. This lack of consistency in definitions is problematic because it hinders the capacity to draw conclusions across studies. Other weaknesses identified by the authors that impacted on the generalisation of findings include the use of small sample sizes, a failure to compare and differentiate child sex offender data to peer and mixed sex offender data.

Sexually abusive adolescents in New Zealand

New Zealand figures show that the adolescent population contributes significantly to the New Zealand sexual crime statistics, with the 10 to 20 year old age bracket accounting for nearly 22 percent of New Zealand's sexual apprehensions in 2009 (Ministry of Justice, 2009; Statistics New Zealand, 2009). Several community studies conducted within New Zealand have found similar results. For example, in their study of 497 Dunedin women, Anderson, Martin, Mullen, Romans and Herbison (1993) established that nearly one third of the group reported having an unwanted sexual experience before the age of 16, and that within this group, over 25 percent of the perpetrators were aged less than 18 years at the time of the incident (Anderson et al., 1993). This is fairly consistent with a later study conducted by Lambie (1998) which established that 35 percent of the 88 adult males

sexually abused as children recall their abuser as being within the adolescent age range. Whilst these figures are alarming, it is believed that the actual reported number of sexual offences committed by this age group is merely the 'tip of the iceberg', with many victims choosing not to disclose their sexual experiences (Stanko, 2008; Weinrott & Portland, 1996).

Gender, age group and ethnic differences are also evident in the sexual crime statistics. Statistics New Zealand figures (Statistics New Zealand, 2009., Statistics New Zealand, 2013) reveal that between 2005 and 2014 the majority of adolescent sexual offending was committed by males (Figure 1), with the 21 to 30 year old age group committing the most sexual assaults, followed by the 17 to 20 year old age group (Figure 2). Pākehā adolescents had the highest rates of sexual offending, followed by Indian, Māori and Pacific Island youth. Youth associated with Asian, Other and Unknown ethnicities committed the least number sexual assaults in this period (Figure 3).
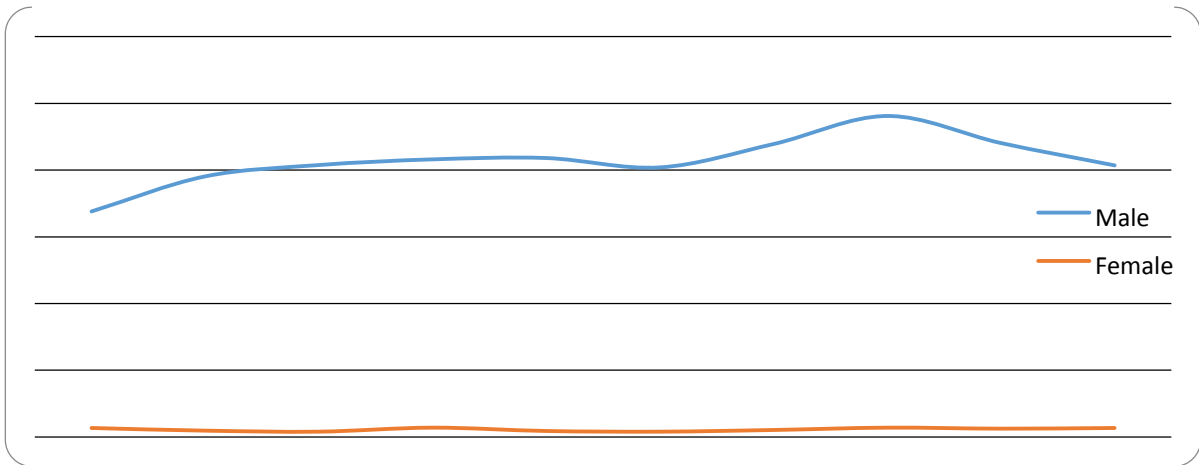
Figure 1:Total number of sexual offences committed by males and females aged between 10 and 30 years between 2005 and 2014 (Statistic New Zealand, 2009 & 2014)
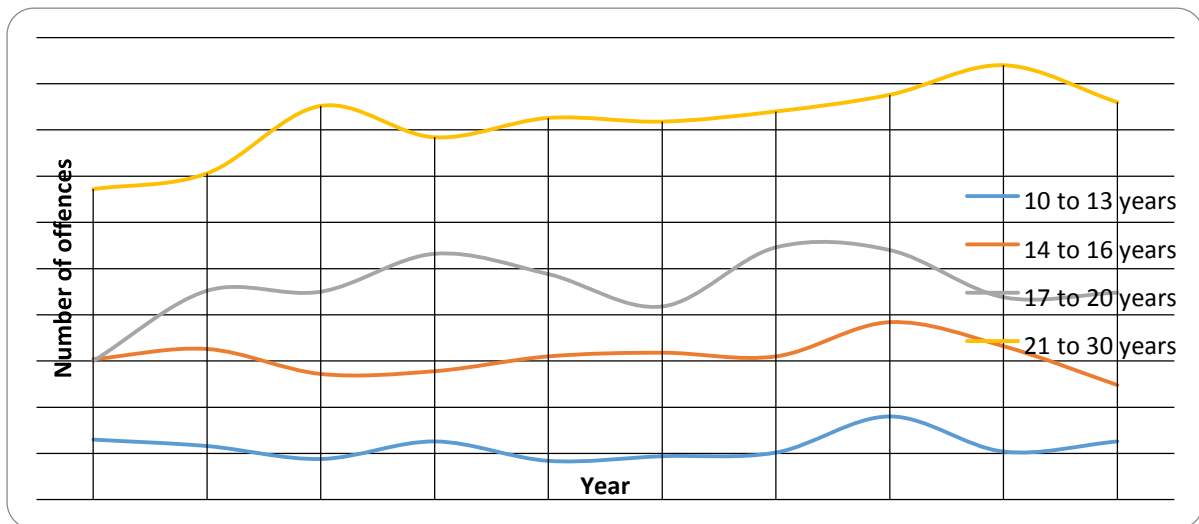
Figure 2: The number of sexual crimes committed by the different child/adolescent age groups between 2005 and 2014 (Statistic New Zealand, 2009 & 2014)
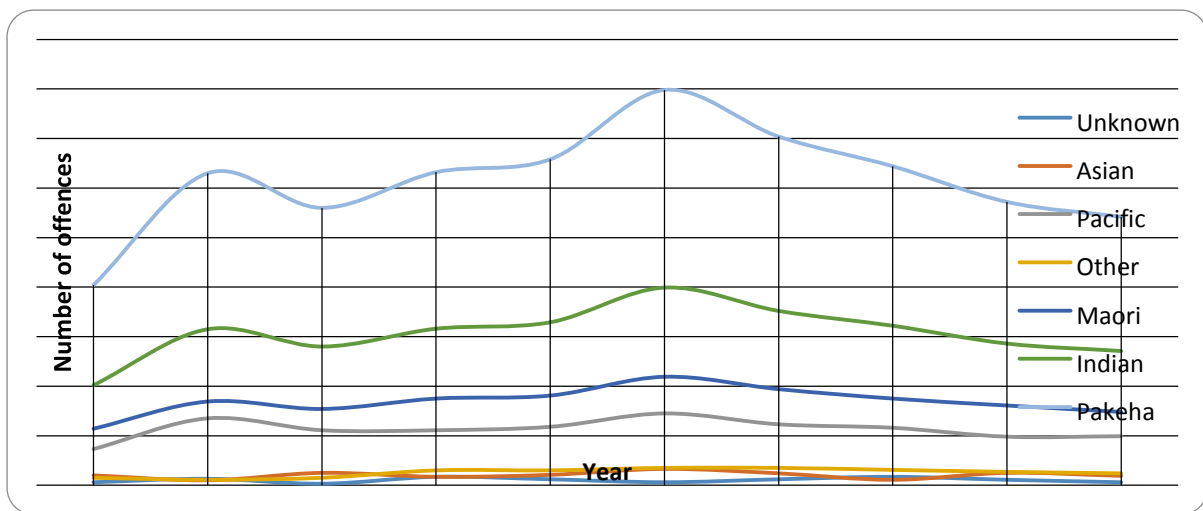
Figure 3: Number of sexual offences committed by different child/adolescent ethnicities between 2005 and 2014 (Statistic New Zealand, 2009 & 2014)

When a child aged between 10 and 13 years of age is apprehended for a sexual crime in New Zealand, they are either referred on to the Police Criminal Investigation Bureau or Police Youth Aid. They may also be subject to the Child, Young Persons, and Their Families Act 1989 which means they either fall under Care and Protection Services or avoid criminal proceedings altogether if an alternative solution is found (Soboleva, Kazakova, & Chong, 2006; Geary, 2007). While 14 to 16 year old youths apprehended for sexual crimes could face similar proceedings as the younger age group, they can still face prosecution in Youth Court, and if the sexual offending is serious enough, cases can be transferred to District or High Courts (Soboleva, Kazakova, & Chong, 2006). Adolescents 17 years or older are dealt within the adult court system (Soboleva, Kazakova, & Chong, 2006; Geary, 2007).

Origins of sexual offending

Over the last century many researchers and theorists have attempted to understand the origins of sexual offending among adolescent populations. Historically sexually abusive actions displayed by adolescents were either perceived as "a natural stage of puberty" (Lambie & Seymour, 2006), a symptom of conduct

disorder, anti-social behaviour, or the consequence of substance abuse (Underwood, Robinson, Mosholder & Warren, 2008). Over time however, these ideas have slowly faded, with many researchers now attempting to explain such behaviour through different theoretical lenses.

Social learning theory. According to the social learning theory, individuals learn new patterns of behaviour through direct experience or observational learning. Bandura (1978) argued that children learn from the models around them including parents, family members, peer networks, social media, TV etc. It is hypothesised that children watch these models, encode their behaviour and at a later stage, go on to imitate the behaviour observed. Bandura (1978) acknowledged that not all children go on to copy observed behaviour, however those that do, are likely to be motivated by what they may gain (reward) or lose (punishment) from the experience. Bandura (1978) hypothesised that if the consequences of an individual's behaviour is positively reinforced, they are more likely to continue engaging in that behaviour.

Social learning theory has also been used to help explain sexually abusive behaviour as many sexual offenders were victims of sexual abuse themselves (Bennett & Fineran, 1998; Finkelhor & Browne, 1986; Jespersen, Lalumière, & Seto, 2009; Worling, 1995). It has been proposed that witnessing or experiencing acts of sexual aggression during the early stages of development can result in children exhibiting similar behaviours towards others in their adolescent years (Levenson, Brannon, Fortney, & Baker, 2007; Underwood et al., 2008). This was evident in Burton's (2003) regression analysis of 74 sexually abusive youth. The young people in this study were more likely to act out what was done to them and use the same methods used against them to victimise others. Worlings (1995) study of adolescent

sibling incest offenders found similar results with the researcher hypothesising that the sexually aggressive behaviours learned through their own experience of victimisation were directed at siblings because they were accessible and the abuse helped many of them to cope with the chaotic environment from which many of these adolescents originate from. Another theory proposed by Worling (1995) is these youth are acting out some form of retribution for the rejection or abuse they experienced or are modelling the poor communication skills, violence and rejection taking place within their own family relationships.

In a study of 6628 students attending a public school in Switzerland, Aebi, Landolt, Mueller-Pfeiffer, Schnyder, Maier, and Mohler-Kuo (2015) found that 3 percent of males and 0.6 percent of females admitted they had sexually coerced another person, "to undress, perform some sexual act(s) or touch another person's private parts against their will" (Aebi et al., 2015). A small proportion of this group reported a sexual victimisation history of which those who experienced sexual contact were 4 times more likely to exhibit sexually coercive behaviours than those exposed to non-contact sexual abuse.

Underwood, Robinson, Mosholder and Warren (2008) added that adolescents re-enact the sexual behaviours inflicted on them by their aggressor in order to, "reduce their own feelings of hopelessness and powerlessness as a victim" (Underwood et al., 2009, p. 919). Researchers have termed the above situations as the "sexually abused to abuser hypothesis," or "victim to victimiser hypothesis".

Social learning theorists argue that when an adolescent is exposed to sexual aggressive pathology by parents, caregivers, or important role models, it creates maladaptive concepts and beliefs of what constitutes appropriate sexual behaviour

(Underwood et al., 2008). Children who experience frequent sexual assault at a young age may view sexually deviant behaviours as the 'norm' and as a necessary part in the act of intimacy (Underwood et al., 2008). Jespersen, Lalumiere, and Seto (2009) added that the "victim to victimiser" relationship is based on imitation, conditioning and beliefs about the acceptability of adult-child sexual interactions (Jespersen et al., 2009).

Newman et al., (2009) is cautious about the social learning theory of sexual offending stating that sexual abusive behaviour is not as simple as 'cause and effect' as witnessing violence and sexually aggressive behaviours does not always eventuate to sexual offending and most victims of sexual abuse do not go on to become sexual offenders (Bentovim, 2002). Additionally the victim becoming the victimiser is controversial as most of the data in this field of study is derived from prison populations, indicating a bias towards the most extreme cases of offending (Lambie & Seymour, 2006).

Furthermore researchers argue that social influences, particularly different forms of media and the anonymity of the internet, act to promote sexually abusive behaviours (Ezzell, 2009; Rice, 1986; Sigurdsson, Gudjonsson, Asgeirsdottir & Sigfusdottir, 2010; Shim, 2007). Aebi et al., (2015) added that the evolution of modern technology means that non-contact sexual victimisation including the use of smart phones and phone applications (apps) are additional risk factors to consider when working with sexually abusive adolescents (Aebi et al., 2015).

The evolution of technology has resulted in explicit material being easily accessible by younger populations. This was evident in Lo and Wei's (2005) study of 2001 Taiwanese middle school and high school students. The authors established

27

that over 40 percent of adolescents had been exposed to internet pornography at least once, with boys having greater exposure than girls. These youth used internet pornography more often than traditional sources such as magazines, comics, and books. Lo and Wei (2005) reported that, "exposure to internet pornography relates to greater acceptance of sexual permissiveness and the greater likelihood of engaging in sexually permissive behaviour" (Lo & Wei, 2005, p.233). This was supported by Ybarra, Mitchell, Hamburger, Diener-West, and Leaf's (2011) study that looked at the correlation between exposure to explicit material and sexually aggressive behaviour in 1588 10 to 15 year olds in the United States. Ybarra et al., (2011) found that participants intentionally exposed to violent x-rated material were up to six times more likely to engage in sexually aggressive behaviour over a 36 month period. They hypothesised that sexually abusive behaviour occured as a consequence of exposure to explicit material because viewing violent pornography that is perceived as rewarding may reinforce an individual's appetite for sexually aggressive behaviour.(Ybarra et al., 2011). This relationship was evident in this study regardless of the medium used to view the xrated material (i.e. internet, movie or magazines). These authors state that when assessing sexually abusive youth, rather than exploring if they have viewed pornography, it is more important to identify the content of pornography being viewed by these youth.

An early study conducted by Rice (1986) found that images of sex and violence in the media stimulated aggressive tendencies in some individuals. This finding is supported by Shim's (2007) study which examined the effects of sexual media content on sexist/stereotypical attitudes and the influence of anonymous viewing conditions. They found that when participants were anonymous, they were

more likely to choose sexually intense and thematically varied films than when they were in the non-anonymous condition. In addition, when sexual explicitness was combined with sexually degrading factors, participants exhibited strong hostile thoughts and antipathy towards women (Shim, 2007).

The causal implication drawn from the correlation between the media and sexual offending has been heavily debated by researchers. There is a lack of credible evidence supporting this association because becoming hostile and lacking empathy towards women after watching a degrading film does not always lead to sexual offending (Bensimon, 2007).

Attachment. According to interpersonal theorists, "early in life we form strong attachments to our caregivers and the quality of these attachments determines our expectations of ourselves and our relationships" (Nolen-Hoeksema, 1998). John Bowlby (1982) and Mary Ainsworth (1978) argue that children who have secure attachments to their caregivers are confident that their needs will be met by their caregiver and therefore have the courage to explore the world around them. As these children mature, they expect other relationships to also be secure and therefore seek out and form strong relationships with others. Children with insecure attachments are not confident that their needs will be met by their caregiver and therefore behave in either an anxious, clingy, angry or hostile manner in the caregiver's presence (Ainsworth, Blehar, Waters, & Wall, 2015., Nolen-Hoeksema, 1998).

Several researchers claim that sexually abusive behaviour in youth is caused and maintained by an insecure attachment and intimacy deficits (Marshall, 1989; Ward, Hudson & Marshall, 1996). Marshall (1989) argued that sex offenders

29

fail to develop secure attachment bonds in childhood therefore they do not learn the interpersonal skills and self confidence necessary to achieve intimacy with their same aged peers. This was supported by Ogilvie, Newman, Todd, and Peck's (2014) meta-analysis of 30 studies and 2798 offenders. This study established that nearly all of the violent offenders possessed an insecure attachment style. Violent offenders and rapists preferred a high level of independence in an attempt to avoid forming close attachments to others (Dismissive-avoidant attachment) whilst child sexual offenders were at the opposite end of the spectrum, seeking out high levels of intimacy, approval and responsiveness from others (Anxious attachment; Ward, Hudson & Marshall, 1996).

In Lightfoot and Evans' (2000) study of 20 youth who had engaged in sexually coercive behaviour involving children, it was determined that a severe disruption to attachment in the form of an unstable caregiver relationship was predictive of sexually abusive behaviour and poor adjustment. The most common causes of disruption included multiple experiences of rejection as a consequence of mothers who were emotionally unavailable to their children due to postnatal depression or being in a violent relationship, contact with inconsistent primary caregivers or being exposed to parental violence resulting in a child being separated from their family (Lightfoot & Evans, 2000).

Hummel, Thomke, Oldenburger, and Specht (2000) looked closely at 36 male adolescents who had committed sexual offences against children. From this sample, 16 had a history of sexual abuse and 20 had no history of sexual abuse. A variable that distinguished the two groups was those who had a history of sexual victimisation also experienced the loss of one or both of their parents before the age

of 14 years leading to considerable attachment disorders among these youth. Furthermore, these youths' perceptions of themselves, their parents, and step parents often led them to avoid contact with peers their own age and in some instances befriend older men who they had never met to fulfil their attachment needs (Hummel et al, 2000), ultimately putting themselves at a greater risk of sexual harm. Hummel et al., (2000) also noted that the non-abused group used fondling more than the abused group which the authors thought may be due to attempts by the young person to engage in sexual contact with another person for the first time. The abused group on the other hand performed more mature, genital sexual acts which may add credibility to the "victim to victimiser" hypothesis.

Family systems theory. Family systems theorists argue that when a member of a family has a psychological disorder, or in this instance, engages in sexually abusive behaviour, it is not a problem within the individual but rather the behaviour is an indication of, "a dysfunctional family system" (Nolen-Hoeksema, 1998). This theory is supported by Bentovim (2002) who reported that adolescent sexual offenders were more likely to live in a pervasive family environment where extensive neglect and violence toward a maternal figure was common. In the longitudinal study of 224 sexually abusive males, Salter et al. (2003) established that sexual abuse on its own was not enough to predispose an individual to sexual offending, rather experiences of parental emotional rejection, interfamilial violence, neglect and a lack of material care increased an individual's risk. Keelan and Fremouw (2013) compared adolescent sex offenders who offended against children with those who abused individuals of the same age or older. Their study determined that peer offenders used more force during their offence than child sex offenders and were

more likely to originate from families where supervision was sparse and domestic violence and criminal activity frequent.

These findings were supported by Worling's (1995) sibling incest research which added that these offenders were more likely to have been exposed to a negative family environment including exposure to marital conflict, parental rejection, significantly more physical punishment and an overall dissatisfaction with family relationships. In addition, these youth were more often victims of childhood sexual abuse and have younger children in their families. Worling (1995) suggests that these offenders engage in sexualised behaviours with siblings in order to cope with their negative family environment. In this sense, they reach out to their sibling for comfort, nurturance and support. This, combined with the advent of adolescent puberty, increases the risk of these youth sexualising their relationships with siblings.

The findings by Worling (1995) are supported by the Rudd and Herzberger (1998) study which compared brother-sister incest to father-daughter incest. This study added that in most instances, parental care was absent due to the death or unavailability of a father figure in the family and mothers were often described as "ineffectual; often hampered by alcoholism, mental illness, spousal abuse, or even themselves abusive" (Rudd & Herzberger, 1998, p.924). Rudd and Herzberger (1998) found that many victims reported disclosing their abuse to parental figures but that these reports were not acted upon. Some victims also indicated that they chose not to disclose their abuse to parental figures because they feared that it would result in increased abuse (Rudd & Herzberger, 1998). The victims reported feeling powerless to stop the abuse as they lacked the necessary psychological resources

and support which would enable them to successfully break free from their abusive situations (Rudd & Herzerger, 1998).

Cognitive theory. Cognitive theorists claim that, "deviant sexual behaviours are associated with distorted thinking patterns which serve to deny, justify, minimize, and rationalize an offender's actions" (Eastman, 2005, p.36). Quayle and Taylor (2004) in their book "Child Pornography: An internet problem" state that offenders view, interpret and respond to their social world in a problematic way. These authors suggest that these individuals' problems are the result of their "inaccurate thinking processes rather than a lack of processing activity". This is supported by Richardson's (2005) study which included 54 sexually abusive adolescents from Britain who completed the Young Schema Questionnaire. It was established that 74 percent of these offenders identified the presence of early maladaptive schemas (Richardson, 2005). Seven predominant maladaptive schemas were identified including: emotional inhibition, social isolation/alienation, mistrust/abuse, entitlement/self-centeredness, insufficient self-control/self-discipline, abandonment/instability and defectiveness/shame (Richardson, 2005). These findings suggest that a large majority of sexually abusive youth experience distortions in thinking which may result in them being more likely to suffer from psychological difficulties in the future (Apsche, Evile, & Murphy, 2004).

Deviant or preparatory sexual fantasies are also considered cognitive distortions because they are an imaginative internal process accompanied by withdrawal from the immediate demands of the external world. Digiorgio-Miller (2007) found that sexually abusive youth have higher numbers of deviant sexual fantasies than non sexually-abusive youth, however, the youth participants in this

study were in residential settings and therefore may be at higher risk of re-offending and likely to possess greater cognitive distortions than sexually abusive youth in community settings. Hunter and Becker's (1994) study added that the literature investigating deviant sexual arousal among adolescent sexual offenders is still relatively new and even though deviant arousal plays a significant role in adult populations, there is no evidence to support the relevance of this model among adolescent groups. This is supported by Racey, Lopez, and Schneider (2000) who reported that sexually abusive adolescents' views towards sexual contact with children were no more permissive than those held by adolescent non-sex offenders.

Moral reasoning has also been widely discussed among cognitive theorists. Piaget and Kohlberg argued that children's moral reasoning and judgement evolves as they grow older and become more cognitively mature (Nolen-Hoeksema, 1998). Kohlberg argues that moral reasoning is divided into three levels; pre-conventional, conventional, and post-conventional. Researchers in this area report that sexually abusive youth show a lower level of moral development around sexual issues when compared with non-sexually abusive youth (Beerthuizen & Brugmans, 2012), and that for many of these youth, moral development had "frozen" leading them to reason predominantly at the pre-conventional level (Ashkar & Kenny, 2007). Ashkar and Kenny's (2007) study of 16 incarcerated male offenders from a maximum security adolescent detention facility in New South Wales, Australia, took this even further stating that the level of moral reasoning used by offenders depended on their context. They found that sexually abusive youth were more likely to respond from a pre-conventional level of reasoning when in sexual offending contexts, and more likely to use conventional moral reasoning when responding in non-sexual contexts (Ashkar & Kenny, 2007). Furthermore Beerthuizen and Brugman's (2012) study of

24 Dutch juvenile men aged 14 to 23 who were incarcerated at youth detention centres for sexually abusive behaviours found a moderately strong relationship between length of incarceration and conventional reasoning. The longer an adolescent was incarcerated, the better their conventional reasoning was. Beerthuizen and Brugman (2012) attributed these results to these adolescents having greater access to the therapeutic services and support systems available to them in prison settings.

Additionally, empathy and sympathy are important aspects of social interactions and these emotions play a pivotal role in pro-social behaviour. Wispe (1986) defined sympathy as the, "heightened awareness of the suffering of another person as something to be alleviated….sympathy intensifies both the representation and the internal reaction to the other's predicament" (cited in Eisenberg & Strayer, 1990, p.5). Literature relating to sexually abusive youth is primarily concerned with an offender's lack of sympathy for their victims, and their incapacity to place themselves in the shoes of those they target. Hanson (2003) reported that different types of sexual offenders have deficits in different domains. For instance, rapists understand the harm that they inflict on their victims but do not stop because of hostile intentions, while other sexual offenders struggle to understand the harm they cause others (Hason, 2003). However, Hanson (2003) proposed that some of the latter group maybe aware of the consequences of their behaviour but are too ashamed to admit it.

McCrady (2005) argued that many offenders are able to empathise with their victims, which illustrates that it is likely not the emotional component of empathy that is at fault in sexually abusive adolescents but more likely a unique distortion in how the adolescent processes their thoughts. This is supported by Pithers (1999)

study of 10 child abusers and 10 rapists who as part of therapy were placed in victim empathy groups. A consequence of this intervention was that both the participants' level of empathy towards their victims increased, and their cognitive distortions justifying their sexually abusive actions reduced.

General criminality. As noted at the beginning of this chapter, many adolescents who sexually offend have prior convictions for non-sexual offences (Caldwell, 2007; Lambie & Seymour, 2006). Researchers also argue that sexually abusive behaviour for some youth is closely related to their engagement in antisocial behaviour.

In their evaluation of 305 juvenile sex offenders aged 11 to 17 years old, Fehrenbach, Smith, Monastersky, & Deisher (1986) established that juveniles who committed 'hands-off' offenses were more likely to have committed a similar crime at least once before referral. These findings are supported by Groth's (1977) study which included 26 boys aged 15 to 17 years old and 37 adult offenders convicted of rape and child assault. This study found that a large proportion of this group admitted to previously taking part in anti-social sexual crimes despite these crimes often being dispelled from their criminal record because the police, family, or neighbour with whom they disclosed their offending to perceived the anti-social behaviours as being irrelevant (Groth, 1977).

Deficits in interpersonal and social skills among sexually abusive youth have been widely debated in the literature. In the past, adolescent sex offenders were generally characterised as socially isolated individuals (Carpenter, Peed, & Eastman, 1995; Underwood et al., 2008), lacking assertiveness and basic social skills including being immature for one's age, impulsive, having difficulty establishing

and maintaining close friendships with others their own age, and being anti-social (Underwood et al., 2008). However, this categorisation of adolescent sexual offenders has been challenged by researchers such as Lambie and Seymour (2006) who noted that these deficits have also been found in delinquent adolescents and completely absent in some sexually abusive adolescents' altogether.

Fehrenbach, Smith, Monastersky, and Deishers (1986) study supports Lambie and Seymours (2006) statement that the social explanation for the deficits in interpersonal and social skills among sexually abusive youth is too simplistic. These authors reported that two thirds of their sample of sexually abusive youth reported being socially isolated, one third reported that they had no friends and another third stated that they had a couple of close friends but none of whom they were close too. Furthermore only 55 percent of the adolescents were achieving academically at their age group level at school and between 23 and 30 percent of this group had been reported by teachers to be exhibiting problem behaviours at school. This was supported by Miner and Crimmins (1995; cited in Righthand & Welch 2004) who added that, "isolation and poor social adjustment were distinguishing characteristics of adolescent sex offender groups".

Racey, Lopez, and Schneider's (2000) looked into this further in their study and explored the social skills, cognitive distortions, sexual knowledge, and cue perception of 36 convicted adolescent sex offenders and 38 non-sex offenders. They found that sex offenders were more likely to misinterpret important non-verbal cues from others which may help to explain why these individuals chose to initiate and/or continue their sexually inappropriate behaviour (Racey et al., 2000). However, all subjects in this study performed poorly when attempting to identify cues from

naturalistic social interactions suggesting that cue perception is problematic for all types of offenders. Furthermore, these authors also found that the participants' perceptions of their social skills and sexual knowledge did not differ between the two groups however offenders in the community were more confident in their social skills and knowledgeable about sexuality than the sexually abusive peers.

Sigurdsson, Gudjonsson, Asgeirsdottir and Sigfusdottir (2010) investigated the background of young sexual offenders using Beech and Ward's etiological model of risk. It was determined that the factors that distinguished sexually abuse youth from non-sexually abusive youth was a history of sexual exploitation or abuse, poor self-regulation and association with delinquent peers. McCrory, Hickey, Farmer, and Vizard (2008) examined the files of 237 youth referred to a service for sexually harmful behaviour and determined that children who exhibited these behaviours prior to the age of 10 years (early onset) were more likely to have experienced maltreatment from an early age, presented with early risk factors indicative of neuropsychological problems including a difficult temperament, hyperactivity and poor intellectual functioning, and had more frequent contact with mental health services. These authors therefore argue that these risk factors predispose these youth to an antisocial presentation and sexually harmful behaviour is therefore an early manifestation of all of these risk factors interacting simultaneously.

Personality traits. Several studies argue that three personality risk factors increase a male adolescent's chances of engaging in sexually abusive behaviours. These include: hostile-masculinity, egotistical-antagonistic masculinity, and psychosocial deficits (Underwood, Robinson, Mosholder & Warren, 2008; Hunter, Figueredo & Malamuth, 2004). Male adolescents exhibiting hostile-masculinity traits

have deep desires to be dominant over females because they have negative perceptions of women and are fearful of female interpersonal rejection. Egotisticalantagonistic masculinity represents a, "stereotypically masculine sex role orientation and the tendency to aggressively seek dominance in sexual competitions with other males" (Hunter, Figueredo, & Malamuth, 2004, p.141). Adolescents in this instance would prefer casual sex as opposed to a committed relationship. Psycho-social deficits suggest that a male would be experiencing problems with social interactions as well as their emotions. The adolescents with psycho-social deficits in the Underwood et al., (2008) study were described as being highly competitive, aggressive and threatening towards other males and would use sexual coercion when interacting with females (Underwood et al., 2008). It is important that we now move from the origins of sexual offending to understanding the methods used to assess sexually abusive youth.

Assessment

The two main aims in an assessment of sexually abusive youth are to assist clinicians in treatment planning and to identify whether the young person is at a high risk of re-offending (Fanniff & Becker, 2006; Worley, Church & Clemmons, 2011). The latter is important to address because it informs decisions such as what treatment is necessary and if the young person would be best placed in a residential or community setting. Allandyce and Yates (2013) found that unlike adult offenders who tend to target specific victims, sexually abusive young people are more prone to vary their victim type and, "are heterogeneous in their individual offending patterns, some will move between and within victim age, gender and relationship dimensions"

(p.264). These authors state that a comprehensive assessment process is therefore

necessary with these offenders to elucidate their level of risk.

Fanniff and Becker (2006) report that there are three methods used to

achieve these assessment goals; Self-report measures, objective physiological

assessments, and risk assessments. Self-report measures are designed to assess

deviant sexual interests, cognitive distortions, and other difficulties associated with

treatment planning; objective physiological assessment measures have been

developed to assess sexual interest; and risk assessment instruments completed by

therapists use the information gathered from a clinical interview and other relevant

data, for example the ERASOR (Viljoen, Elkavitch, Scalora, & Ullman, 2009)

Self-report measures. Because many adolescents have difficulties

verbally disclosing their sexual thoughts, urges and fantasies in an interview context

(Kaplan, Krueger, & Vince, 2011), questionnaires and surveys including the

Adolescent Cognitions Scale (ACS) and the Adolescent Sexual Interest Card-Sort

(ASIC) have been developed to gather this additional information. The ACS is

designed to, "assess the cognitive distortions juveniles may endorse that support or

justify inappropriate sexual behaviour" (Fanniff & Becker, 2006, p. 266) and the ASIC

is a self-report measure of sexual interest.

Fanniff and Becker (2006) report that self-report measures possess several

issues which impact negatively on an instruments validity and reliability. For

instance, the ACS's test-retest reliability and internal consistency have been found to

be inadequate and the language used on some of scales are not user friendly. They

suggest that the use of Likert scales would help to improve the instrument's reliability

(Fanniff & Becker, 2006). The ASIC on the other hand has good reliability and

internal consistency but has the potential to conceal an individual's thinking, feeling, and character (dissimulation) and therefore may only be useful for adolescents who openly disclose their sexual interests (Fanniff & Becker, 2006).

A potential issue that could arise in both of these measures is the participants could respond to questions in a manner that makes them look favourable to others (social desirability bias), therefore these measures would likely benefit from the introduction of a social desirability scale (Fanniff & Becker, 2006).

Another problem identified with these measures in the study by Tiderfors, Arvidsson, and Rudolfsson (2012) is that self-report measures completed by treatment participants do not always match up with estimates made by therapists. Tiderfors et al., (2012) compared the self-ratings of adolescent males who had sexually offended with estimates of the same adolescents made by professionals. The study found that the agreement between self-reports filled out by the adolescents and estimates made by the professionals was low, however, the two groups did appear to agree on items in the scale that could be explained in observable behavioral terms such as anger. These authors attributed this incongruence in responses to the, "use of different information, roles, time-frames and specific behaviors" (p.146). The disagreement in responses may also be explained by deficits common in this group such as their tendency to respond in a socially desirable way or the result of neuropsychiatric deficits.

Tiderfors et al., (2012), Worley, Church and Clemmons (2011) and Pullman and Seto (2012) recommend that because of this incongruence an integrated approach is most effective with this group. In this sense self-report measures should be complemented with clinical interviews, or an assessment by professionals, a

questionnaire assessing an individual's atypical sexual interests, the collection of

relevant information pertinent to an individual's risk and other psychometrics. In

doing so, treatment options can be tailored to meet the needs of each client.

In addition to the clinical interview, assessors must also include

interviews with family members and consideration of other relevant documents

(Worley, Church & Clemmons, 2011). Worley, Church & Clemmons (2011) suggest

that the relevant documents should include past treatment reports which provide

insight into the family's reaction to their child's sexual offending, the family's history

and interactions with mental health services, child services, and legal organisations.

This information is important because it helps to clarify any contradictory reports

provided by the youth and their family. Furthermore these authors propose that

family interviews provide valuable information about predisposing and precipitating

factors that may have influenced the adolescent's index offending and their potential

to re-offend. This process also gives assessors an understanding of a family's

motivation and commitment to treatment and protective factors pertinent to the youth.

Objective physiological assessment measures. Research looking closely

at assessment tools that measure sexual interest through physiological response in

youth are limited with mixed results. One such method uses a plethysmograph,

which measures blood flow to the penis, and for sex offenders is used to measure

the level of sexual arousal when exposed to sexually explicit material. The Abel

Assessment for sexual interest (AASI) is another measure which, "measures the

viewing time to various categories of pictures as a measure of sexual interest"

(Fanniff & Becker, 2006, p.267), and the Polygraph is not a sex offender specific

instrument but is used with this population to determine if the young person fully disclosed their sexual offending (Fanniff & Becker, 2006).

Fanniff and Becker (2006) report that assessors must be cautious when using these instruments with young people for several reasons. Firstly the plethysmograph has problems with accuracy because participants are able to suppress their arousal during testing or deny particular sexual interests but score highly in testing (Fanniff & Becker, 2006). Furthermore, they state that the plethysmograph is appropriate with a limited group of individuals however the reliability and validity of plethysmograph is not clear and these authors, "question the clinical wisdom of exposing juveniles to stimuli involving children" (p.270). Furthermore Fanniff and Becker (2006) report that additional research is needed to assess the validity of the AASI and to determine dissimulation among young people who deny their offending behaviour(s). In addition, there is currently little research exploring the relationship between polygraphs and sexually abusive youth.

Risk assessment instruments. In their summary of Seto and Lalumiere's (2010) meta-analysis, Pullman and Seto (2012) reported that adolescent sex offenders are at risk of engaging in other general forms of delinquency as well as sexual offending. Only a small minority of this group are specialised offenders who are at primary risk of sexual recidivism. When assessing and treating adolescent sex offenders it is therefore important to distinguish between the two because approaches that work for one group may be less efficient and effective for the other group. Pullman and Seto (2012) stipulate that assessment of this unique group of offenders should always begin with a validated risk tool. This will give assessors an immediate estimate of adolescent sex offenders who are at a higher risk to reoffend

therefore, "a higher priority for treatment and surveillance services" (Pullman & Seto, 2012, p.207).

The two most well-known tools specifically designed to assess the risk of sexually abusive adolescents are the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Hempel, Buck, Cima & Marle, 2013; Viljoen, Elkavitch, Scalora & Ullman, 2009) and the Juvenile Sex Offender Assessment Protocol-II (JSOAP-II; Fanniff & Letourneau, 2012; Martinez, Rosenfeld, & Cruise, 2015). Other risk measures include the Youth Level of Service/Case Management Inventory (YLS/CMI; Viljoen, Elkavitch, Scalora, & Ullman, 2009), Hare Psychopathy Checklist: Youth Version (PCL:YV; Viljoen, Elkavitch, Scalora, & Ullman, 2009), Static-99 (Viljoen, Elkavitch, Scalora, & Ullman, 2009), Youth Level of Service/Case Management Inventory (YLS/CMI; Viljoen, Elkavitch, Scalora, & Ullman, 2009), Juvenile Sexual Offence Recidivism Risk Assessment Tool-II (JSORRAT-II; Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, & Lawerance, 2007), Juvenile Risk Assessment Scale (JSAR; Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, & Lawerance, 2007), Structured Assessment of Violent Risk in Youth (SAVRY; Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, & Lawerance, 2007) and The Adolescent Clinical Sexual Behaviour Inventory (ACSBI; Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, & Lawerance, 2007., Hempel et al., 2013).

Research investigating the validity and reliability of the ERASOR and J-SOAP-II have provided mixed results. The ERASOR scale is used by assessors to estimate the short-term risk of sexual reoffending in youth aged between 12 and 18 years. The current protocol consists of 25 risk factors that are grouped into the following headings; Sexual interest, attitudes and behaviours, historical sexual assaults, psychosocial functioning, family/environmental functioning and treatment (Worling & Curwen, 2001). Several researchers agree that when compared to other risk measures, the ERASOR has the most

promising predicative validity (Hempel, Buck, Cima & Marle, 2013; Viljoen, Elkavitch, Scalora & Ullman, 2009), which has been attributed to the fact that this instrument focuses more on dynamic factors rather than static risk factors because, "unlike static risk factors, dynamic risk factors are amenable to deliberate interventions" (p..221). The ERASOR also includes items that assess cognitive domains such as sexual deviance. As noted earlier, deviant sexual thoughts are proposed to play a significant role in the initiation and maintainence of sexual offending in adolescents (Hunter, Goodwin & Becker, 1994; Seto & Lalumiere, 2010).

Viljoen, Elkavitch, Scalora, and Ullman (2009) researched the predictive validity of the ERASOR, YLS/CMI, PCL:YV, and the Static-99 in a sample of 193 adolescents. The youth in this study were followed for an average of 7.24 years after discharge from a residential sex offender treatment program. The results showed that none of the tools significantly predicted sexual reoffending, although the ERASOR showed the most promise in predicting sexual reoffending. The Static-99 did not accurately predict long term sexual reoffending or non-sexual offending in adolescents. The YLS/CMI and PCL;YV significantly predicted, "non-sexual violence, any violence, and any re-offense, neither however, predicted sexual reoffending" (Viljoen et al., 2009, p.996). These authors suggest that different approaches may be needed to assess the risk of sexual and nonsexual reoffending among sexually abusive adolescent populations.

The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) scale assesses sexual recidivism in boys aged 12 to 17 years with a history of sexually coercive behaviour. The current protocol consists of 28 items divided into four scales: sexual drive/preoccupation (scale 1), impulsive/antisocial behaviour (scale

2), intervention (scale 3), and community stability/adjustment (scale 4). Fanniff and Letourneau (2012) reviewed nine studies which examined the psychometric properties of the J-SOAP-II with 73 males aged between 12 and 17 years. These authors reported that only scale 2, impulsive/antisocial behaviour, demonstrated acceptable internal reliability and internal validity. The psychometric properties of scales 1, 3, 4, and the total score were found to be characterised with significant limitations suggesting that the use of these scales with sexually abusive adolescent populations is unreliable. Martinez, Rosenfeld, and Cruise (2015) examined the accuracy of the J-SOAP-II across two separate settings: a medium security correctional setting and an unlocked residential sex offender treatment program. These authors found no significant differences in predictive accuracy between the two sites, however, non-institutionalized youth demonstrated stronger predictive accuracy for the J-SOAP-II total score and its component scales than institutionalized youth. These results suggest that the J-SOAP-II is more valid for use with adolescents who have not been institutionalized.

Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, and Lawerance (2008) and Hempel et al. (2013) examined the predictive validity of the J-SOAP-II, JSORRAT-II, SAVRY, ERASOR, JSAR, and the PCL:YV. Both of these studies concluded that none of the instruments were able to significantly predict an adolescent's sexual aggressive risk during treatment or following their discharge. The J-SOAP-II was however able to predict non-sexual aggression during treatment and serious non-sexual violent offences following discharge. Furthermore, Viljoen et al. (2008) found that youth aged 15 years and younger were more likely to be incorrectly judged as being at high risk for sexual and non-sexual violence following

discharge than older youth when using risk assessment instruments. The authors

state that these results may reflect the fact that the young person is still

developmentally immature therefore their sexual deviance and identities may not

have completely formed. Therefore, the assessor needs to rely on the behaviours

they have observed, rather than the use of scales. Hemple et al., (2013) added that

the risk factors in many of the scales listed above were generalised from adult

literature rather than determined by empirical evidence relevant to juvenile

populations. It is proposed that this may lead to inaccuracies in the prediction of risk

because juveniles are still developing their personality, cognitions, and moral

judgments; processes that require considerable flexibility (Hemple et al., 2013,

p.222)

Several studies have also attempted to assess the predictive validity of risk

assessment measures with minority populations. Chu, Ng, Fong, and Teoh (2012)

compared the predictive validity of three risk assessment measures (ERASOR,

JSOAP-II, YLS/CMI) for sexual and non-sexual recidivism in 104 sexually abusive

male youth in Singapore. Results showed that the ERASOR is suited for predicting

sexual and non-sexual recividsm in a Singaporean context. The J-SOAP-II and

YLS/CMI showed significant predictive validity for non-sexual recividsm. In another

study with minority populations, Martinez, Flores, and Rosenfeld (2007) used

retrospective coding of the J-SOAP-II with a group of 60 sexually abusive

adolescents of mostly Latino and African American descent in the United States of

America. Their study found moderate to high levels of predictive validity for the

JSOAP-II total score and most of the subscale scores as predictors of sexual

reoffending, although there appeared to be some variability among the individual

subscales. These authors attribute the variability to the static items in the assessment lacking predictive power in ethnic minority groups. They suggest that sexual disobedience and anti-social behaviours are more useful in predicating reoffending among Caucasian offenders rather than offenders from ethnic minority groups (Martinez et al., 2007). These findings therefore support the inclusion of dynamic risk-assessment items when assessing risk in sexual abusive ethnic minority youth. To date, no studies have been completed assessing the predictive validity of risk assessment measures with Māori adolescent populations.

The methods used to assess sexually abusive youth aswell as the problems commonly associated with these methods have been briefly discussed above. It is important that we now move onto discuss the approaches used to treat youth who engage in sexually harmful behaviour.

Treatment for sexually abusive adolescents

The economic burden sexual abuse places on society (Lambie, Geary, Fortune, Brown, & Willingale, 2007; Nisbet, Rombouts, & Smallbone, 2005), together with research identifying the adverse effects of sexual abuse to both the victim and offender's quality of life has resulted in an increase in research and treatment services for adolescent sexual offenders (Bouman, de Ruiter, & Schene, 2008; Steptoe, Lindsay, Forrest, & Power, 2006). In an extensive literature review of adolescent sex offender treatment programmes, Nisbet et al., (2005) established that five types of treatment approaches are commonly used with adolescent sexual offenders including: individually orientated, combination approach, residential based programmes, community-based programmes, and multi-system approaches (Nisbet et al., 2005). Nisbet et al., (2005) also noted that despite some adolescent sexual offenders having

similar offending histories, they often receive different treatment packages depending on the settings in which they are seen (Nisbet et al., 2005).

Sexually abusive youth typologies. Many researchers in the area of sexual deviance propose that sexual offenders are selective in the types of victims and/or offences they engage in (O'Brien & Bera, 1986. Sloan & Schafer, 2001, Worling, 2001). This has led to the formation of a specific classification system which considers offender characteristics. The development of adolescent typologies has huge implications for treatment providers as these systems offer clinicians a framework to work from, and at the same time "reliable typologies can be used to predict an adolescents level of risk and guide the appropriate treatment for clients" (Lambie & Seymour, 2006, p.179).

The desire to separately classify adolescent sexual offenders from adult offenders was first expressed in 1986 by O'Brien and Bera. Prior to this development, adolescent sexual offenders were assessed, categorised and treated using adult sexual offender classification systems. O'Brien and Bera's (1986) sexual offender typology derived from the Programme for Healthy Adolescent Sexual Expression (PHASE), which was an outpatient family-centred programme for the assessment and treatment of adolescents who behaved in sexually inappropriate ways. O'Brien and Bera (1986) reported that all the adolescents involved in the PHASE programme were able to fit into one of seven categories; naiive experimenter, under socialised child exploiter, pseudo-socialised child exploiter, sexual aggressive, sexual compulsive, disturbed compulsive, and the group influenced. Each will be discussed briefly in the table below:

Table 4: Table summarising the seven categories in O'Brein and Bera's (1986) sex offender typology

Native Experimenter	These adolescents are young (11 to 14 years) and tend to have minimal anti-social behaviours in their history. They are deficient in their knowledge of sex and sexual development and their offending behaviours are usually determined by situational opportunities.
Under socialised child exploiter	These adolescents suffer from chronic social isolation and have significant difficulties establishing and maintaining friends in their own age bracket. Consequently they gravitate towards younger children and have little history of anti-social behaviours when in social situations.
Pseudo-socialised child exploiter	These adolescents are usually older (16 to 18 years), possess good social skills in most instances but tend not to engage in intimate situations while with peers. Similar to the two categories above, they have little or no history of anti-social behaviours in social situations and these adolescents may also be victims of childhood abuse.
Sexual aggressive	These adolescents have a long history of anti-social behaviours and impulse control problems. Their offending behaviour involves the use of force, threats, or violence resulting from exposure to a dysfunctional family environment.
Sexual compulsive	These adolescents usually engage in repetitive, sexually arousing behaviours that the adolescent perceives as addictive and therefore difficult to control. They originate from families that lack parental boundaries and the parents are often described as emotionally withdrawn.
Disturbed compulsive	These adolescents' sexual offending behaviours are impulsive and unrealistic. In most instances, these adolescents will suffer from a range of difficulties including a history of psychological difficulties, exposure to family abuse, substance abuse, or learning problems.
Group Influenced	These adolescents are usually young and their sexually offending behaviours are influenced by the presence of a peer group. Similarly to the first three categories, these adolescents have no history engaging in antisocial behaviours that are notable by the law.

O'Brien and Bera's (1986) seven tier classification system for sexually abusive adolescent offenders was greatly received by researchers and people working with this cohort at the time, however, as noted by Lambie and Seymour (2006), the authenticity of the categories are questionable as there has been limited research exploring the reliability or validity of the tool.

Worling's (2001) study, which utilised the California Psychological inventory scores of 112 male adolescent sexual offenders, proposed four categories of classification for this particular population: antisocial/impulsive, unusual/isolated, over controlled/reserved, and confident/aggressive.

Table 2: Table summarising the four categories in Worling's (1996) sex offender typology

Antisocial/Impulsive	These adolescents frequently engage anti-social behaviours. They tend to lack empathy when hurting others and show little affect aside from anger and hostility. Their anti-social behaviours are perceived as impulsive due the young person being unable to control their desire to perform an action that will hurt another.
Unusual/Isolated	These adolescents are emotionally disturbed and insecure. Their emotions constantly fluctuate and they often feel vulnerable to danger or being injured.
Over controlled/Reserved	The parents/caregivers of these adolescents are over controlling resulting in the young person appearing socially withdrawn.
Confident/Aggressive	These adolescents are honest and outgoing however they prone to acting out towards others.

These categories differed significantly from O'Brien and Bera's (1986) classification system as Worling's (2001) groupings solely focus on an individual's personality traits as opposed to their offending behaviours. Importantly, Worling

(2001) suggests that adolescents who possess either the antisocial/impulsive or unusual/isolated personalities are more likely to reoffend in the future.

Another adolescent sexual offender typology system developed in 2001 by Sloan and Schafer, classified adolescents in a correctional setting according to how knowledgeable they were about sexual/non-sexual behaviours and development, as well as their personal morals and values. The typologies that they developed included:

1. Adolescent sexual offenders who understand what is meant by appropriate behaviour and the importance and need for boundaries, rules, and laws.

2. Adolescent sexual offenders who are educated in a dysfunctional setting and in turn do not understand the importance and need for rules/laws. These adolescents however are motivated to contribute towards society and therefore with adequate training and education, their chances of reoffending are low.

3. Adolescent sexual offenders who understand societal rules/laws and the rules governing their behaviours however they choose to ignore them. These adolescents negative behaviours are expected to increase unless they receive appropriate training and education.

4. Adolescent sexual offenders who are new to the justice system do not fit into any of the categories listed above. These adolescents are often critical and cautious when engaging with staff and are vulnerable to the influence of their peers.

While some research suggests that typologies are valuable because of their ability to provide an indepth understanding of the deviant sexually abusive behaviors required for treatment intervention and satisfactory supervision (Righthand & Welch, 2005;

Sandler & Freeman, 2007); others advise caution due to the lack of evidence that supports the presentation of a typical adolescent sexual offender (Almond & Canter, 2007., Almond, Canter & Salfati, 2006). Furthermore, the characteristics used to categorise these youth have also been found in generally delinquent adolescents and are completely absent in some sexually abusive adolescents altogether. Additionally, Underwood et al., (2008) pointed out in their study that not all sex offenders are socially inadequate like those described in typologies, in fact some sexual offenders are optimistic and pretentious individuals who use manipulation and charm to groom their victims and engage in inappropriate sexualised behaviour. Furthermore it is important to note that the research is limited by the lack of non-clinical studies that have been undertaken in this area (Lambie & Seymour, 2006; Ryan & Lane, 1997).

Treatment effectiveness. Most research relating to the treatment of sexually abusive adolescents suggests that participation in offence-specific treatment programmes leads to enhancements in individual functioning including: improvements in psychosocial functioning and offence related attitudes (Edwards, Whittaker, Beckett, Bishop & Bates, 2012); reductions in internal distress, psychological disorders and externalising deviant behaviours (Apsche & Ward, 2002; Apsche et al., 2004); low sexual recidivism (Borduin, Henggeler, Blaske & Stein, 1990); and improved interpersonal skills and enhanced family relations (Yoder, Hansen, Lobanov-Rostovsky & Ruch, 2015) etc. Furthermore Rich (2003) adds that successful psychotherapy with this population is not clear-cut. Despite this, he stated that the low sexual recidivism data suggests that, "treatment aimed at juvenile sexually abusive behaviour largely works" (p.256) and the question is therefore not

whether treatment is really effective, but rather what the best treatment method would be and how to provide it.

In his book "The Treatment and Rehabilitation of Sexually Abusive Youth" Rich (2003) notes that treatment efficacy is dependent on several important factors. Firstly, an understanding from clinicians that the assessment and treatment process is continuous and from the first point of contact through to discharge, clinicians will be continuously assessing a client's needs, treatment progress and risk. Furthermore treatment is, "based on and driven by criminogenic and mental health factors as well as forensic principles" (p.240) and all of these factors need to be considered simultaneously if the holistic needs of these young people are going to be adequately met. Moreover, therapists must be conscious that children and adolescents who engage in sexually abusive behaviours are complex individuals whose developmental trajectories shift and evolve at every stage of treatment. Rich (2003) also states that the process needs to be collaborative with the young person actively participating and making decisions about the treatment process and "not simply someone to be worked on or whose success or failure is purely his or her own responsibility" (p.256).

Several authors have attempted to explore what factors make treatment successful for sexually abusive youth and what factors may hinder an individual's treatment progress. Kimonis, Fanniff, Borum, and Elliott's (2011) study included 158 treatment providers who work directly with juvenile sex offenders. The providers reported that a young person's peer and family situation (support, prosocial relationships, parents' belief in the efficacy of, and willingness to participate in treatment) as well as juvenile characteristics (motivated, belief in the efficacy of

therapy, resilient personality, positive attitude toward authority, and hope for the future) are positive indicators of a youth's responsiveness to treatment (Kimonis et al., 2001). These findings were supported by Eastman (2005) who added that adolescent sex offenders who completed treatment had fewer problems with self concept and acknowledged fewer instances of sexual abuse in their histories when compared to adolescent offenders who failed to complete treatment or were just commencing treatment. Furthermore, Kimonis et al., (2011) found that poor treatment responsiveness was strongly associated with an offender's unwillingness to change their deviant sexual interests/attitudes, as well as family members being reluctant to support relevant evaluations/treatment programmes pertinent to their child's sexualised behaviours. High deviant sexual interests/attitudes may be further related to treatment dropout as these strongly influence a young person's motivation to engage in, and complete, treatment (Kimonis et al., 2011). Additionally, Eastman (2005) also proposed that individuals with low self-esteem are more likely to be consumed with their own shortcomings, and therefore lack the emotional energy and motivation to focus on sex offender treatment.

Individual based treatment approaches. The documented individual treatment approaches used with sexually abusive youth include cognitive behavioural therapy (CBT), mode deactivation therapy (MDT) and psychodynamic therapy.

Cognitive behavioural therapy uses evidence-based practice to identify dysfunctional cognitions and how these impact on an adolescent's physiology, feelings, and behaviour. Several researchers argue that CBT has been helpful at managing atypical sexual interests and improving self-regulation; has assisted with

schema change for young people with personal, interpersonal, and social difficulties;

and provides a framework for understanding internal sexual scripts that serve as

guidelines for inappropriate sexualised behaviour (Krahe, Bieneck & Scheinberger-

Olwig, 2007; Richardson, 2005; Pullman & Seto, 2012).

In addition, Apsche et al., (2004) reported that CBT is effective with

adolescent male sex offenders with severe personality disorders. The participants in

this study were 10 male sex offenders aged between 11 and 18 years of age residing

in a residential treatment centre. All of the participants in this study had prior

unsuccessful treatment outcomes at another specialised treatment facility. Cognitive

behavioural therapy helped to reduce participants' internal distress resulting from

psychological disorders and it also reduced externalising deviant behaviours by

increasing awareness of the relationship between aggressive cognitions and

aggressive behaviour. In an earlier study by Apsche and Wards (2002), CBT was

found to be less effective in the treatment of adolescent sex offenders than mode

deactivation therapy (MDT), a therapy which incorporates CBT, dialectical behaviour

therapy, and functional analytical psychotherapy (FAP). As with CBT, MDT was

found to be effective at reducing internal distress, psychological disorders, and

externalised deviant behaviours (Apsche & Wards, 2002). It is important to note,

however, that the small sample size makes the generalisation of these results

difficult.

Psychodynamic therapy in the context of adolescent sexual offending

focuses on subtle shifts of consciousness (Rich, 2003) and emphasises the

importance of stable relationships. The core aims of psychodynamic therapy with

juvenile sexual offenders is to, "understand the roots and effects of their everyday

interactions with the aim of producing useful information and results" (Rich, 2003,

p.291). Because therapy is targeted towards a younger audience, the

psychodynamic concepts are generally less abstract with more emphasis placed on

therapy-client interaction to provide support and direction to the client (Rich,,2003). It

is important to mention here that CBT and psychodynamic therapy are similar in the

sense that they offer a framework and model for therapists to work from, however,

most therapists working with sexually abusive populations will work eclectically,

taking relevant ideas from each of these models and moulding them together to

match their client's needs (Rich, 2003). Furthermore, working solely from an

individualistic treatment modality is unhelpful for sexually abusive adolescents

because family systems are not considered in dynamic and CBT therapy approaches

(Rich, 2003). This is problematic because children and adolescents are strongly

fused in their family and community systems, therefore failing to consider how these

systems impact on the young person will not be beneficial long term (Borduin,

Henggeler, Blaske, & Stein, 1990., Worley, Church & Clemmons, 2011., Yoder,

Hansen, Lobanov-Rostovsky, & Ruch, 2015).

     Systems based treatment approaches. Worley, Church, and Clemmons

(2011) report that the families of sexually abusive youth are similar to juvenile

delinquent families. An ecological, system based treatment approach that includes

parental involvement works best with juvenile delinquent families, therefore this

approach would likely be of benefit to the families of sexually abusive youth.

Systemic treatments must address a broad range of risk factors that sexually abusive

youth are exposed to in their family environments. In a study of 81 adolescent males

adjudicated for sex crimes, Yoder, Hansen, Lobanov-Rostovsky, and Ruch (2015)

established that the more a family is involved in treatment, the greater likelihood that

the young person will successfully complete treatment. The authors state that if

family members are included in treatment family-orientated goals and outcomes should also be identified and incorporated into the treatment process. This study did not, however, find a positive relationship between family service involvement and recidivism which suggests that, "the effects of family services may not be sustainable" (Yoder et al., 2015, p.269). It is suggested that these findings highlight the limited support available to sexually abusive youth post-treatment and the authors recommend that step-down care and support may be an essential tool for sexually abusive youth post treatment completion. This study also found that youth who were living at home at the time of treatment were less likely to re-offend, "because youth who live at home have reduced probability of demonstrating behaviour problems, live closer to systems of care, and receive treatment in correspondence with immediate familial or social supports" (Yoder et al., 2015, p.270). These authors go on to state that these results give strength to the idea that whenever possible, sexually abusive youth should remain in the home environment.

Worley, Church, and Clemmons (2011) report that adequate supervision and safety planning outside and within the home of a sexually abusive adolescents are important components of treatment success. Parents and caregivers play an important role in this process as they are responsible for ensuring that the young person adheres to their safety plan during and after treatment has commenced. The intense supervision required by most treatment programmes and courts creates significant stress for parents who accept this responsibility. Therefore it is important that family members are supported and guided with this process.

Multisystem therapy (MST), a family based treatment modality delivered by

practitioners in the community, has been compared with individual cognitive

behavioural therapy (CBT) delivered by professionals within the juvenile justice

system to determine which modality is the most effective with this population.

Borduin, Henggeler, Blaske, and Stein (1990) compared two groups of sexually

abusive adolescents allocated to either an MST or a CBT group at an outpatient

treatment facility. The participants in both conditions received on average between

37 and 45 treatment hours and recidivism data was collected on each of the 16

participants three years after completing treatment. Their findings suggested that the

treatment effects were more long lasting for the offenders who received MST than

those who received CBT. Individuals who received CBT were also found to be

engaging in ongoing deviant behaviour. The authors attributed the low recidivism

rate among the MST group to the therapists placing greater emphasis on systemic

variables when treating deviant behaviour (Borduin et al., 1990). The model also

allowed practitioners to directly address the dysfunctional behaviour and

relationships within the environment in which it naturally occured.

These findings were supported by Letourneau, Henggeler, McCart,

Borduin, Schewe, & Armstrong's (2013) study. These authors set out to determine if

favourable 12 month outcomes obtained in a randomised effectiveness trial with 124

sexually abusive juveniles assigned to a MST group were sustained 12 months later.

The findings of this study showed that with the exception of one participant, the

favourable outcomes found 12 months into the study were sustained 24 months

later. This included, "decreased problem sexual behaviour, self-reported

delinquency, and out of home placements were sustained" (Letourneau et al, 2013,

p.983). These authors attributed these findings to the fact that the MST practitioners were community based therefore they delivered therapy in a "real world community treatment setting". Being based in a community setting leads to sustained improvements because the young person is still actively participating in their natural environment and can continue to attend local schools and workplaces, have greater access to family and friends who may be able to support the treatment process and they can immediately practice the skills and competencies learnt in his or her natural environment (Borduin et al., 1990, Yoder et al., 2015).

Group work. Group work with sexually abusive adolescents has also been widely discussed in the literature, with most noting that participation in group processes is mostly positive for its young participants (Edwards et. Al., 2012; Rich, 2003; Yalom, 2005). Similar findings are also evident amongst adult populations with researchers such as Billing (2007) concluding that group cohesion facilitated openness and accountability among its members.

An extension of group work is the use of outdoor wilderness experiences with sexually abusive adolescents (Somervell & Lambie, 2009; Geary, 2007). Somervell and Lambie's (2009) study involved an exploratory investigation of the function and process of wilderness therapy camps within SAFE Auckland's treatment programme and established that both adolescents and therapists found wilderness therapy beneficial for four reasons: it enhanced inter-personal relationships, improved adolescents' views of themselves, the intensity of the experience facilitated engagement in the therapy process, and most importantly it aided in disclosure. Whilst Somervell and Lambie (2009) acknowledged that these themes are integral on their own, they also noted that these themes were interdependent. For example,

the intensity of the experience facilitated, and was dependent on, forming inter-personal relationships. Furthermore, these experiences posed many difficult challenges which forced participants to reassess their physical and emotional abilities and in turn change their perceptions of themselves and others.

Treatment and Māori culture

Research relating to the treatment of individuals of Māori descent in general is still very sparse. However what is evident in the current literature is that Māori-centred therapies assume that strengthening an individual's cultural identity during therapy will lead to improvements in an individual's overall wellbeing (Durie, 2003; Huriwai et al, 2001; Moeke-Pickering, 1996; Stuart and Jose, 2014). Documented Māori-centred therapies involve the introduction of tikanga practices into treatment including karakia (Barlow, 1991), whakapapa (Huriwai et al, 2001), whakawhanaungatanga (Love, 1999), oral traditions and mythology (Cherrington, 2002).

Several researchers have found that strengthening an individual's cultural identity leads to improved retention rates and greater life satisfaction (Huriwai, Sellman, Sullivan & Potiki, 2000; Umana-Taylor, Diversi & Fine, 2002). This is supported by Owens' (2001) study, which established that a successful youth offender-based treatment programme for Māori addressed a wide range of factors including opportunities to rediscover identity, whakapapa, te reo Māori, tikanga, and history. More importantly, they suggest that an offender treatment programme would benefit from being delivered by people who share similar life experiences to the offenders i.e., a previous criminal history. Furthermore for both Maori and non Maori, having family members present and participating in a community sex offender

treatment programme significantly increased respondents willingness to make

positive changes in their life (Billing, 2007; Geary, 2007)

Barriers to family involvement in treatment

It is important that family are considered as partners in a young person's

mandatory treatment requirements, and that barriers to family involvement be

considered (Borduin, Henggeler, Blaske, & Stein, 1990., Worley, Church &

Clemmons, 2011., Yoder, Hansen, Lobanov-Rostovsky, & Ruch, 2015). Yoder and

Brown (2015) examined the perspectives of 19 treatment providers on factors that

deter the families of sexually abusive youth from engaging in treatment. It was

identified that families who were inadequately prepared for stress and experienced

subjective barriers, were less receptive to the treatment process as it left these

vulnerable families in a crisis state. If resources are reorganised to prevent families

entering crisis, they would have greater links with rehabilitation services, families

may engage in treatment services earlier following an initial disclosure, and the

services may be more affordable and accessible for families.

A challenge faced by the parents of adolescents in treatment is dealing with

the stigma surrounding their child's offending. It was found that when families

experienced widespread societal judgement, their motivation to engage in treatment

decreased (Yoder & Brown, 2015). Families may also fear that engagement in

services would result in societal retribution or further ostracism, preventing them from

participating in these programmes. Additionally, the embarrassment and negative

reactions of friends, neighbours and family leaves many parents feeling isolated and

secretive. Therapists therefore need to validate the experience and feelings

expressed by the parent and help the youth and parent to begin discussing the

offending behaviours including the youth's role in the situation (Yoder & Brown, 2015). Societal stigma could likely be reduced through educating communities on the realities of low recidivism rates and the effectiveness of treatment for sexually abusive youth (Yoder & Brown, 2015). Furthermore, educating communities about the families of these youth may also be helpful. Subjective barriers prohibiting engagement for the families referred to this study were associated with economic disparities, therefore treatment needs to be more affordable to improve family engagement in treatment.

Some other challenges faced by sexually abusive youth include greater exposure to a multitude of risk factors (potential victims, drugs and alcohol, etc.) which could impact on their progress through treatment. Furthermore, a parent's attitude towards sex offence specific therapy may influence a youth's attitude to treatment and for families where the perpetrator and victim are from within the same family, it is often difficult to balance support between the sexually abusive youth and victim. Positive working relationships between the parents, child and treatment clinicians can reduce restraints on engagement to treatment by both the youth and family.

Additional barriers faced by parents involved in treatment include having to frequently travel long distances to participate in treatment, the impact attendance has on employment and finances, feeling blamed and judged by treatment staff, parental resistance to treatment being mandatory, and the therapist inexperience or resistance to working with the families of adolescents who commit sexually harmful behaviours (Yoder & Brown, 2015). Worley, et al., (2011) reported that motivational interviewing is helpful in overcoming these barriers. Furthermore, participation from

parents should include identifying important family needs which can be acknowledged in family therapy sessions. Parents may also benefit from addressing personal issues in individual therapy or from learning from other parents and families in group or multi-family group therapy. By getting their own support, parents are better equipped to support their child through the treatment process.

Summary of previous literature

New Zealand Police figures show that adolescents contribute significantly to the general crime statistics, with many researchers also acknowledging that these figures are likely to be underestimated as they do not include unreported youth crimes or youth offending dealt with under the Child, Young Persons, and their Families Act 1989. The number of arrests for violent offences has increased for both children and adolescent groups which researchers attribute to youthful populations having greater exposure to the risk factors associated with criminality and less access to the protective factors which would normally buffer such risks.

Most crime committed by young people in New Zealand involves a male perpetrator and Māori are over-represented at every stage of the criminal justice process. The high rate of Māori apprehensions have been attributed to three factors: demographics, risk factors, and bias. The Māori population is much younger than the New Zealand average with a median age of 23.9 years. This is important to understand as young people between 14 and 30 years of age have the highest level of contact with the criminal justice system than any other age group. Māori have disproportionately more adverse life experiences and circumstances when compared to non-Māori, therefore they are more susceptible to the risk factors that contribute to criminal conduct. Other researchers argue that the negative outcomes for Māori are

the result of a complex interplay of differential offending rates and direct and indirect discrimination within the New Zealand criminal justice system and society more broadly. Māori also have a social history of inequality, marginalisation and deprivation and to add to this, previous governments have not always had the best interests of Māori in mind when developing policies.

Sexually abusive behaviour for adolescent populations is defined as "any sexual behaviour that occurs without consent, without equality, and/or the result of coercion". It is "any activity where someone older, bigger, more mature or more knowledgeable about sexual matters abuse their power". It is proposed that the definition will continue to evolve as technology advances and societal norms adjust.

It is widely acknowledged that the extent of sexual offending reported to governmental agencies are under-estimated and like all other types of crimes, many incidents of sexual offending go unreported for various reasons. Research also shows an incongruence between self-reported crime figures and official criminal statistics with most authors attributing these results to methodological issues.

New Zealand figures show that the adolescent population contributes significantly to the New Zealand sexual crime statistics. Gender, age group and ethnic differences are also evident in the literature with a majority of adolescent sexual offending being committed by males aged between 21 and 30 years of age. Pākehā adolescents had the highest rates of sexual offending, followed by Indian, Māori, and Pacific Island youth.

Over the last century many researchers and theorists have attempted to understand the origins of sexual offending among adolescent populations. The literature review identifies and discusses several theories, which help to explain why

young people may engage in sexually abusive behaviours. These include social

learning theory, attachment theory, family-systems model, cognitive principles, the

influence of media, etiological model of risk, and personality risk factors.

The two main aims of an assessment for sexually abusive youth are to assist

clinicians in treatment planning and to identify if the young person is at a high risk of

re-offending. Three methods are used to achieve these goals: self-report measures,

objective physiological assessment, and a risk assessment.   Each of these methods

have limitations that impact significantly on their validity and reliability. An integrated

approach that includes a combination of assessment tools is most effective approach

with this group.

The economic burden sexual abuse places on society, together with

research identifying the adverse effects of sexual abuse on both the victim and

offender's quality of life has resulted in an increase in research and treatment services

for adolescent sexual offenders.

Most research relating to the treatment of sexually abusive adolescents

suggest that participation in offence-specific treatment programmes will lead to

enhancements in individual functioning. The documented individual treatment

approaches used with sexually abusive youth include cognitive behavioural therapy

(CBT), mode deactivation therapy (MDT) and psychodynamic therapy.

Family involvement in treatment of sexually abusive youth has been linked

with positive treatment outcomes. Treatment must address a broad range of risk

factors that sexually abusive youth are exposed to in their family environments.

Family involvement is also important because parents and caregivers are

responsible for providing adequate supervision and ensuring that a young person

adheres to their safety plan. The documented system based treatment approaches include Multisystem therapy (MST), group work and outdoor wilderness experiences.

Research relating to the treatment of individuals of Māori descent is limited, however, Māori centred therapies assume that strengthening an individual's cultural identity during therapy will lead to improvements in an individual's overall wellbeing. Documented Māori centred therapies involve the introduction of tikanga practices including karakia, whakapapa, whakawhanaungatanga, oral traditions, mythology and Māori performing arts.

The most effective treatment approach noted in the literature for sexually abusive youth is an integrated approach that weaves together individual, family systems, group work and cultural therapy.

Some barriers to treatment for families include resistance to the treatment process; exposure to risk factors which could impact on treatment improvements; financial strains; and therapists struggling with the therapeutic process.

Chapter 3 Programme Description

This chapter provides a description of the SAFE Rangatahi programme as it operated at the time of the evaluation to provide the background for the research findings. The description was derived from information obtained in SAFE's policy and procedural manuals, pamphlets and brochures and the agency website. When the data was collected, the Rangatahi programme did not have a separate policy and procedural manual in place, therefore additional information was obtained from interviews with programme users, kaimahi and researcher observations. Where possible, the researcher has used the interviewee responses to describe how the Rangatahi programme operated. It is important to begin by describing how the Rangatahi programme was formed.

The formation of the Rangatahi team

The specialised Māori team, Te Kakano (The Seed) was formed over 2002 to 2003 in recognition of the specific needs of Māori clients, and to demonstrate SAFE's commitment to developing indigenous models of treatment. Specialised treatment programmes were developed for tāne (Māori men) during 2003 and rangatahi (Māori youth) around 2005. The two kaimahi facilitating the Māori programme were recruited from within the Auckland SAFE site, and according to one kaimahi, Te Kakano was formed without prior consultation with the two kaimahi involved.

> *"Originally when it started I was still on the mainstream programme, then the Māori team came out of that...in fact nothing was discussed it was just the Māori team was formed and it was, "Okay, you're working with that Māori"(K)*

Initially the two kaimahi in Te Kakano worked together across the tāne and rangatahi populations, however, over time it was agreed that it would be more functional for one kaimahi to manage the tāne population, and the other take the

rangatahi. This appeared to be an informal process which was initiated due to convenience and practicality. This in turn led to the development of two separate programmes within Te Kakano; the Tāne and Rangatahi programmes, which were facilitated and managed by two different therapists.

> *"At that time my colleague and I were still working across Māori youth and adults... I was becoming frustrated and I didn't want to work with the adults anymore and he wanted to work with the adults so we came to an agreement that I'll do the youth work and he would do the adult work. And so we just carried on"(K)*

At the time of data collection, the Rangatahi programme was one of the two programmes operating out of the Te Kakano team. Te Kakano appeared to have a degree of autonomy within SAFE and the kaimahi reported that the Tāne and Rangatahi programmes also worked independently of each other.

Overview

At the time in which data was collected, SAFE offered three adolescent treatment programmes:1) A mainstream programme for adolescent male offenders of all ethnic groups; 2) A special needs programme for adolescent offenders with intellectual disabilities; 3) Rangatahi programme for adolescent offenders who identify as being of Māori ethnicity

The SAFE Rangatahi Programme is a specialised treatment programme developed for Māori youth and facilitated by Māori staff. This programme was developed in response to SAFEs awareness that treating Māori adolescents who were sexually abusive is a sensitive area requiring a specialist team of individuals experienced in sexual abuse prevention within Māori communities. The programme offers treatment to Māori males between 10 and 17 years of age for up to two years, however, the duration of treatment is dependent on the individual needs of each

adolescent. For instance, an intellectually disabled or developmentally delayed client could remain in the programme for up to three years. The rangatahi accepted into treatment are regarded as medium to high-risk offenders. Those who are considered low risk are referred for counselling and psychological treatment in the community.

At the commencement of treatment, rangatahi were allocated kaimahi who tailored a therapy plan targeting an adolescent's sexually harmful behaviour(s) whilst incorporating kaupapa Māori values. Treatment included individual and group therapy sessions, family system reviews involving the rangatahi, their family and other support people, and an annual three to four day wilderness therapy camp. .

Kaupapa of the programme. The kaimahi stated that the main kaupapa of the Rangatahi programme is consistent with SAFE's overall mission statement: to prevent their clients from engaging in sexually harmful behaviours in the future. At the time of data collection, the Rangatahi programme did not have its own procedural manual available. This meant that the rangatahi programme goals were generated from the perspectives of the kaimahi. These are discussed further in chapter 7.

Referral procedures. According to the Rangatahi programme staff, over 90 percent of the annual rangatahi programme referrals were made by CYF workers while the remainder were made by the Youth Courts, the Community Corrections Service, concerned whānau members, child mental health agencies, and nongovernmental community organisations. Most of the referrals were made from within the Auckland region, however SAFE also accepted referrals from areas where no other suitable services are available, such as Northland, Bay of Plenty and the Hawkes Bay.

Most of the rangatahi's treatment was fully funded by CYF services, however, some rangatahi particularly those who were referred by Community Corrections, were only partially funded and whanau had to cover incidental costs such as transportation.

Adolescents were allocated to the Rangatahi Programme if their referral information indicated they were of Māori descent. If an adolescent was referred and identified as being of mixed Māori ethnicity, their Māori ethnicity was prioritised and they were allocated to the Māori team.

When Child Youth and Family services (CYFs) was the referrer, a CYFs social worker would contact programme staff to ensure their client met SAFE criteria, fill out the SAFE referral form, and then provide background information on their client. This background information included a brief description of the client's harmful sexual behaviour(s), Police statements, and evidential reports. During the referral phase, CYFs remained in contact with the programme staff and continued to act as a mediator for the whānau. If a rangatahi was accepted into the programme, a CYFs key worker remained with them for the duration of treatment and attended bi-yearly family system reviews as an external support person.

Assessment. Assessments are undertaken to clarify an individual's suitability for SAFE, their therapeutic needs in relation to their offending behaviours, and level of responsiveness to treatment. Assessments in the Rangatahi programme took place over four sessions and were carried out by two kaimahi. The kaimahi from within the Rangatahi programme performed most of the assessments, however when this was not possible, staff from other SAFE teams (i.e., Youth and Pacific Island teams) were recruited to assist with the process. The kaimahi reported that they

71

preferred to use staff from the other SAFE adolescent programmes (mainstream or Pacific) in the above instances because they understood the needs of the adolescent clients and their family members.

> *"all I know is Māori staff assess Māori clients which is good but our resources are also quite low in the Māori team so we've had to work alongside tauiwi which is not a problem for me"(K)*

Kaimahi reported that they determined a rangatahi's level of risk by conducting interviews with the rangatahi and their whanau; case consultation with professionals from within SAFE and other external agencies and analysis of psychometrics such as the Child Behavior Checklist (CBCL), the Million Adolescent Clinical Inventory (MACI) and the Trauma Symptom Checklist for Children (TSCC). In addition, staff reported using their own clinical judgement and general risk assessment tools such as the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), the juvenile sexual offender assessment protocol (J-SOAP), and Evaluation of Suicide Risk among Adolescents questionnaires to further inform their decision. At the completion of the assessment, kaimahi collated the above information with the documentation supplied by referrers and completed a comprehensive assessment report. This report is made available to whānau and external agencies and includes offender treatment recommendations, suggestions on the intensity of treatment required, and level of supervision needed. The kaimahi reported that they did not use any cultural specific tools to help them with the above decision because they "didn't know of any".

Treatment

Once funding is secured and whanau consent to their child participating in the programme, the rangatahi were allocated to an individual therapist. The process of

client allocation is undertaken by the Te Kakano team leaders who determine which Kaimahi will act as the rangitahi's key worker based on their caseload.

The rangatahi participate in one weekly individual therapy session with their key worker and one group session. The researcher was unable to observe individual therapy sessions due to client confidentiality issues, however the kaimahi reported that these sessions usually focused on addressing immediate client concerns and modulated work provided in the SAFE programme workbooks. The SAFE workbooks are a series of eight therapeutic books written by SAFE to increase selfawareness around the issue of sexual offending. The books use a Cognitive Behavioural Therapy (CBT) framework as they encourage the rangatahi to look at how they think, feel, and behave. The completion of the workbooks is client driven however the rangatahi are guided through the modules by their key worker. The family system reviews involving the rangatahi, their family and other support people were held every three months. The hui (meeting) focused on reviewing the rangatahis progress and safety plans, addressing system based concerns and planning ahead. The kaimahi reported that Maori tikanga were also woven into this process (karakia, whakawhanaungatanga, pepeha) and rangatahi were encouraged to share their learning with whanau, for instance introducing Te whare tangata model and cycle of offending. The kaimahi reported that in the past, family system reviews were held both in the whanau home and on SAFE premises. At the time of data collection, the home based system reviews no longer occurred due to budget restraints, timing and kaimahi being unable to leave the SAFE premises due to heavy caseloads.

Therapeutic approaches. The kaimahi use a range of therapeutic approaches when working with the rangatahi. The most frequently used mainstream approaches used included Transactional Analysis, CBT, DBT, behaviour modification, psychodynamic and narrative therapies and family systems approach. Some of the Māori therapeutic approaches identified and utilised by the staff were Te Whare Tapa Wha, Powhiri, and Poutama models and Te Whare Tangata. Te Whare Tangata was identified as the core cultural model used by the kaimahi. This model was specifically developed by the SAFE kaimahi therefore significant efforts have been made to use the kaimahi responses to explain how this model works*.*

Te Whare Tangata. Te Whare Tangata (The house of the people) is a cultural framework used by the Rangatahi programme to address sexually harmful behaviours among Māori youth. Kaimahi reported that the idea initially came from tauiwi (Pakeha), and was adapted by kaimahi to suit the rangatahi population. The staff stated that they created the model because they were tired of using Māori models of health which the clients had difficulty connecting to. Furthermore, kaimahi wanted a core model that was simple and acted as the foundation for other Māori models to build from.

> *"I've had exposure to quite a few other Māori models. Because all I was doing was cut and paste and its sort of like well wait a minute; I can't do that all the time...there needs to be the base and then go out again. I've got the wharenui, that's the base and then we can bring in the Tapa Wha, Te Wheke, Whanaunga. Like using the Whare Tapa Wha you've got mind, body, whānau, and spirit. You could do that with the boys but it really doesn't have any meaning to them"(K)*

Te Whare Tangata uses the carved meeting house, the wharenui as a model. For Māori, the wharenui is a powerful symbol of identity and community (Durie, 2001; Moko-Mead, 2002; O'Connor & Macfarlane, 2002). It is seen as the most important

building within a marae setting and is often referred to as sacred because it is an architectural representation of the physical body (often that of an important tribal ancestor).

As shown in figure 4, the tekoteko (carved figure) positioned on the top of the roof at the front of the wharenui is the head, and the maihi (front barge boards) are the arms stretched out wide to welcome the people. The amo (short boards) located at the front of the wharenui represent the legs, the tahuhu (ridgepole) which is a large beam running down the length of the building depicts the spine, the heke (rafters) are the ribs and internally, the poutokomanawa (central column) can be interpreted as the heart.
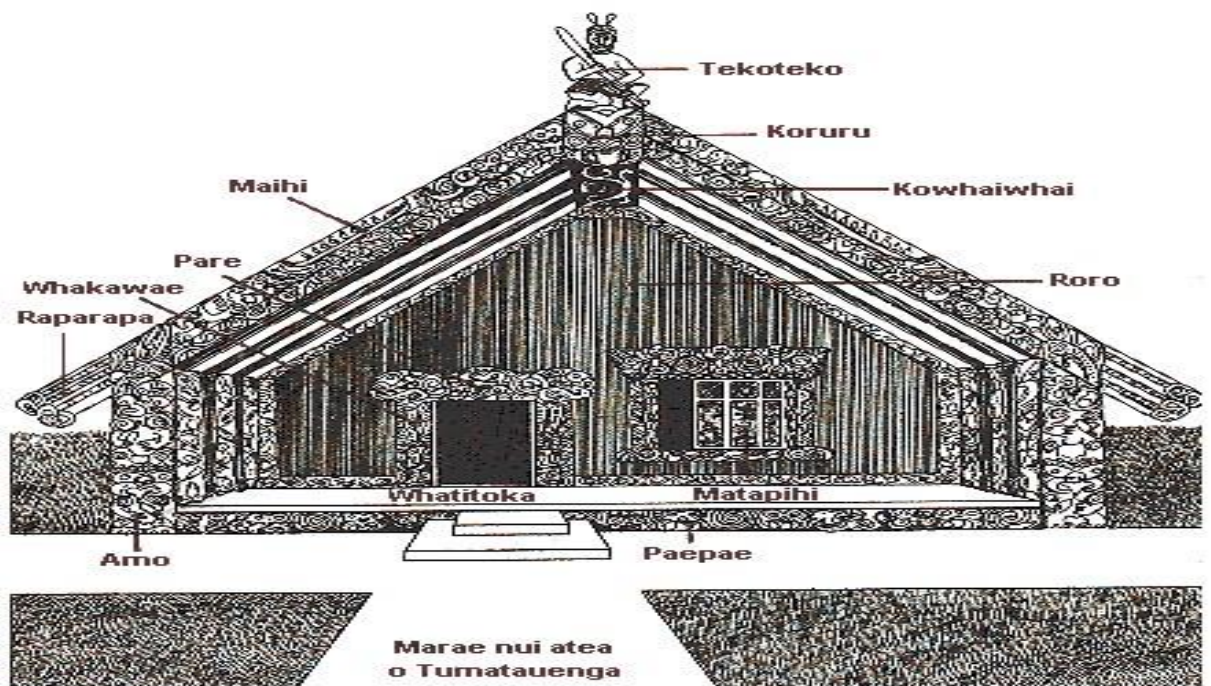
Figure 4: Parts of the wharenui. Source: Education-Resources. http://education-resources.co.nz/whare-nui.html

The Kaimahi reported that they chose to use the symbol of the wharenui because

"*when you break down what a wharenui is, the boys can grasp it, they know what it is. For those who have never ever been to one before, you show them pictures and they get the idea" (*K).

The aim of Te Whare Tangata is to reconnect rangatahi and their whānau back to traditional Māori values using the wharenui. Since all of the rangatahi whakapapa back to a wharenui, the model is personal to each of them. The kaimahi incorporated the traditional Māori values by posing questions such as: what can you do in the wharenui, and what can't you do? This generated answers including: you can use the wharenui for tangi or special occasions; you cannot wear shoes, sit on pillows, eat drink or smoke in the wharenui etc. By asking this question, staff were able to introduce values such as whanaungatanga (relationship, sense of family connection), manaakitanga (hospitality, kindness, support), and tikanga (custom, protocol). Table 4 illustrates how each of these values is described and integrated into treatment by kaimahi.

Table 4: Traditional Māori values and how kaimahi incorporated these values into treatment

Value and description	What it looked like	How was it incorporated
Whanaungatanga Sense of belonging, cultural identity	Whānau support Exploring connections	• Encouraging rangatahi to learn their whakapapa • Encouraging whānau involvement • Rangatahi to present pepeha when a new person is introduced to group or system reviews • Māori oral traditions passed down by kaumatua and kaimahi
Manaakitanga Showing respect and kindness to others	Staff hospitality Rangatahi operating in a supportive, cohesive environment	• Kai provided to all participants during treatment sessions and at special occasions • Encouraging the helping and sharing of information

Tikanga General behavioural guidelines for daily life and interaction	Rangatahi operating within the confides of SAFE rules Adhering to the SAFE safety plans Rangatahi using Māori protocol to ensure spiritual safety and protection Rangatahi living a transparent lifestyle	• Clear rules, boundaries and consequences. • Safety plans consistently presented/reviewed and transgressions challenged by kaimahi and other rangatahi • Karakia facilitated by rangatahi to open and close all treatment sessions • Honesty encouraged, dishonesty challenged

The kaimahi followed this up by drawing a parallel between the wharenui and their victims asking: if your wharenui represented your victim(s), what can you do and what can't you do? Furthermore, staff indicated that you could generate additional discussion by switching the representation of the victim to the rangatahi themselves, their whānau, friends, and community. For instance the question could be changed to: if the wharenui represented yourself, what can you do and what can't you do?

Staff reported that teaching the rangatahi Māori values was important to their treatment progress because all of the rangatahi, regardless of their prior exposure to the Māori culture, had distorted Māori worldviews and these views often supported their sexually harmful behaviours.

> *"All the boys worldviews are the same, the core is not there. We find they may know what the Māori values are but they don't understand the real meaning of the values, like they would say the word Mana means to be tough but its more then that so we teach them that and how those distortions play a part in their offending" (K)*

Summary

Te Kakano (Maori programme) was formed without prior consultation with the two kaimahi working with the Maori clients at the time. Initially the two kaimahi in Te Kakano worked together across the tāne and rangatahi populations, however practicality and functionality led to the kaimahi splitting up and one taking on the tāne population, and the other the rangatahi. This led to the development of two separate programmes within Te Kakano; the Tāne and Rangatahi programmes.

The SAFE Rangatahi Programme was developed for Māori youth and facilitated by Māori staff. The programme offered treatment to medium to high-risk Māori males, aged between 10 and 17 years of age for up to two years. Treatment included individual and group therapy sessions, system reviews with the rangatahi/whanau/support people and attendance at an annual wilderness therapy camp. The SAFE workbooks were also used to supplement the individual therapy sessions. The main aim of the Rangatahi programme is to prevent recidivism however the Rangatahi programme did not have its own procedural manual available therefore the goals were generated from the perspectives of the kaimahi.

Over 90 percent of the annual rangatahi programme referrals were made by CYFs and most referrals to SAFE were made from within the Auckland region, however SAFE also accepted referrals from areas where no other suitable services were avaliable. Adolescents were allocated to the Rangatahi Programme if their referral information indicated they were of Māori descent.

Assessments took place over four sessions and were carried out by two kaimahi. Other SAFE adolescent programme staff were sometimes recruited to assist with assessments when staffing issues arose. A rangatahi's level of risk was

determined through clinical interviews, case consultation with professionals, psychometrics, staff using their own clinical judgement and general risk assessment tools such as the ERASOR. At the completion of the assessment, a comprehensive assessment report was written up which outlined treatment recommendations, suggestions on the intensity of treatment required, and level of supervision needed. The kaimahi did not use any cultural specific tools to help them to complete the risk assessment because there were none available at the time.

Te Kakano team leaders allocated rangatahi to kaimahi for treatment based on caseloads. The kaimahi used a range of mainstream and Maori therapeutic approaches when working with the rangatahi. Te Whare Tangata was identified as the core cultural framework used by the staff. It is a cultural model that was created because kaimahi were tired of using Māori models of health which the clients had difficulty connecting with. Furthermore, kaimahi wanted a model that was simple, addressed sexually abusive behaviour and acted as the foundation for other Māori models to build from. Te Whare Tangata uses the carved meeting house, the wharenui as a model because it has relevance to all of the rangatahi. The aim of Te Whare Tangata is to reconnect rangatahi and their whānau back to traditional Māori values such as whanaungatanga, manaakitanga, and tikanga. Parallels were drawn between the marae, these values, sexually harmful behaviour, victims, the rangatahi themselves, their whānau, friends, and community.

The kaimahi reported that teaching the rangatahi Māori values was important because all of the rangatahi had distorted Māori worldviews and these views often supported their sexually harmful behaviours.

Chapter 4 Methodology

In the past, research evaluations have been used as a tool to reduce ineffective government programmes and fine-tune the accountability of existing ones. In recent times, in addition to evaluating treatment outcomes, researchers have also been interested in understanding a programme's function (Patton, 1997). This change in thinking came about as evaluators became aware that it is just as important to know what parts of a programme are responsible for its outcomes (Patton, 1997). In addition, treatment programmes vary significantly and are not always implemented as planned, therefore understanding the processes that take place within a programme is essential when considering its overall value (Billing, 2011; Patton, 1997).

Process Evaluation

An evaluation that examines a programme's processes is known as a formative or process evaluation. A process evaluation is defined as, "an analysis of the processes whereby a programme produces the results it does" (Patton, 1990, p.60). Process evaluations attempt to explain why things happen in a programme and how users experience it in order to understand a programme's strengths, weaknesses, successes, and failures.

For the current study, a process evaluation was considered to be the most appropriate evaluation approach because process evaluations provide immediate feedback to programme facilitators to assist in programme development. In addition, at the time in which the data was collected, the SAFE Māori adolescent treatment programme had only been operating for a short duration therefore it was not plausible to collect outcome data.

A process evaluation is useful for exploring the internal dynamics and components of a programme. However, this evaluation was also guided by theoretical frameworks which impacted on the assumptions and worldviews that influenced how this research was conducted, and directed the decision processes used by the researcher. The theoretical frameworks that were used in this study were utilization-focused evaluation and Kaupapa Māori research (Barnes, 2002; Bishop, 1999; Patton, 1997; Rangahau, 2015; Walker, Eketone, & Gibbs, 2006).

Utilization-Focused Evaluation

A utilization-focused evaluation is defined as, "an evaluation done for and with specific, intended primary users for specific, intended uses" (Patton, 1997, p.23). Since evaluations take place with real people who bring with them their own personal values; Patton (1997) argues that effective evaluations should reflect its users and be of use to them, in turn increasing the likelihood that they will apply the evaluations' findings and implement its recommendations. In order to achieve this however, the researcher needs to establish a working relationship with intended users early on, in turn, giving users the opportunity to determine what is needed from the evaluation. Utilization-focused evaluation does not advocate any particular evaluation content, model, method, theory, or even use when evaluating programmes. It instead offers a process for assisting primary intended users in selecting the most appropriate content, model, methods, theory, and uses for their particular situation.

The current research is specific to individuals of Māori descent (intended users) and it is therefore important to acknowledge how Māori culture and ideas were considered in the current study.

Kaupapa Māori Research

Traditional researchers in New Zealand have developed a culture where the colonial Westernised values are seen as superior to other worldviews (Bishop, 1999). In order to achieve this, Maori values, knowledge and ways of doing have been belittled and undervalued. Bishop (1999) argues that traditional research involving Māori populations has been of little benefit to Māori as they tended to address the agenda and concerns of the researchers who were predominantly of non-Māori descent. Furthermore, traditional research has misrepresented Maori understandings and knowledge by over-simplifying, grouping and commodifying ideas so the knowledge could be easily understood by the colonisers. As a consequence, Maori experiences and the meanings that these experiences have for Maori have been misrepresented by the, "authoritative voice of the methodological expert" (Bishop, 1999, p.2). Bishop (1999) argues that the misconstrued cultural practices and their meanings are now part of New Zealand's myths and legends and are believed by both Maori and non-Maori alike.

As a result, Maori people are concerned about researchers, particularly who is overlooking them and the control (or lack of) that Maori have over the research process and its outcomes. From this discontent emerged Kaupapa Maori research which challenges the Pakeha worldview in research and the dominance of individualist research (Barnes, 2002; Bishop, 1999).

Kaupapa Māori research has been defined as, "research by Māori, for Māori and with Māori" (Rangahau, 2015). It theoretically acknowledges Māori cultural, political, and social realties, and seeks to redress power imbalances and bring concrete benefits to Māori (Walker et al., 2006). It also considers Māori worldviews

and ideologies and acknowledges that the term Māori is broad and diverse, including multiple realities, dialects, protocols and political and organisational representations (Barnes, 2002; Walker et al., 2006). Walker et al., (2006) also stipulated that information collected by researchers needs to be treated with respect and that incorporating Māori concepts is necessary to ensure Māori protocols are maintained (Walker et al., 2006). Some of the key principles that drive Kaupapa Māori research are:

Tino Rangatiratanga – The Principle of Self-determination. This relates to sovereignty, autonomy, control, self-determination, and independence (Pihama, Cram, & Walker, 2002). It emphasises the importance of Maori doing research for Maori and reinforces Māori being in control of their own culture, aspirations and destiny (Pihama et al., 2002). Bishop (1999) adds that the research process involves investment from both the participants and the researcher(s) and the investment should be "reciprocal and could not be otherwise" (Bishop, 1999, p.4).

Taonga Tuku Iho – The Principle of Cultural Aspiration. This principle asserts the validity and legitimacy of Te Reo Māori, Tīkanga (Carpenter & McMurchy-Pilkington, 2008), and Mātauranga Māori (Pihama et al., 2002). This principle also refers to the "customs or rules that tell us how to behave" (Bishop, 1999, p.5) in the research process including seeking guidance from kaumatua and ensuring that the research process is participatory and participant driven.

Kia piki ake i ngā raruraru o te kainga – The Principle of Socio-Economic Mediation. This principle acknowledges the issue of socio-economic disadvantage among Māori and the negative impacts this has on individuals, children and families (Pihama et al., 2002). It acknowledges that Māori have the initiatives to address these

issues. It also asserts the need for Kaupapa Māori research to be of positive benefit to Māori communities (Rangahau, 2015).

Whānau – The Principle of Extended Family Structure. The principle of Whānau acknowledges the relationships that Māori have with other Māori and the world around them (Rangahau, 2015; Walker et al., 2006). Whānau, and the process of whakawhanaungatanga are an important part of Māori culture and identity (Pihama et al., 2002) because it enables Māori connection to past, present, and future relationships (Walker et al., 2006). This principle acknowledges the, "responsibility and obligations of the researcher to nurture and care for these relationships and also the intrinsic connection between the researcher, the researched, and the research" (Rangahau, 2015; Walker et al., 2006). The principle of āta also relates to the concept of whānau because it specifically speaks to the importance of building and nurturing relationships. "It acts as a guide to the understanding of relationships and wellbeing when engaging with Māori" (Rangahau, 2015)

The above principles were incorporated into the research process in a way that was culturally responsive and useful to participants. The next section will describe the research methods used to collect and analyse the data gathered for this study.

Qualitative Evaluation and Research Methods

Qualitative research is appropriate when evaluating processes because the methods employed give researchers insight into the programme's functioning through the eyes of its participants. Qualitative methods, including interviews and group observations, are particularly valuable when conducting process evaluations

because researchers are able to explore programme dynamics whist gathering rich information about the programmes functioning (Patton, 1990). In addition, group observations provide further information about the group processes and functioning that otherwise would not be available through other methods of data collection. Interviews are also suitable because the approach allows the researcher to capture subjective experiences from the participants within the context of their perceptions and cultural understandings.

Evaluators who, "attempt to make sense of a programme without imposing pre-existing expectations on the programme's setting" are using an inductive approach (Patton, 1997, p. 279). This study used an inductive approach to analyse the qualitative data gathered. In this regard, this study did not aim to test a theory, rather it was concerned about generating new ideas from the data collected (Thomas, 2006). Furthermore, given that this evaluation incorporated kaupapa Māori concepts, and focused on a population with whom research is limited, an inductive approach to collecting and analysing the data was appropriate.

Thematic Analysis. Thematic analysis helps to make sense and gain meaning from the data, and is compatible with inductive approaches to research. It was the chosen method of data analysis in this study because the analytic process is flexible and organises and describes data sets in detail.   More importantly, thematic analysis does not require the data to fit into an existing framework or theoretical approach. It is defined as "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79).

Methods used

In qualitative research, the researcher acts as an 'instrument' to gather the data and document participant views. In order to do this, the researcher needs to interact with the participants and therefore it is important to understand how the 'instrument' may influence the data collection phase given their own values, culture, and background.

Researcher orientation

I am of Māori and Samoan descent. My father is a first generation Samoan from Upolu, Fasito'outa, Samoa. My mother is Māori from Oaonui, a rural community in the West of Taranaki, North Island, New Zealand.

I was born in New Plymouth, Taranaki and raised in the central suburb of Bell Block. The cultural diversity of the Taranaki region where 16 percent of the population identify as Māori and 2.8 percent as Pacific Islander (Statistics New Zealand, 2006), meant that growing up, I had more exposure to the Māori community then the Pacific Island community. My whānau were also heavily involved with the Ratana Church as my grandfather was the Takiwa (minister) of the Taranaki region. My eagerness as a child to be close to my grandfather led to me accompanying him to local marae, hospitals, and the homes of Ratana morehu to help those her were unwell or in need. These experiences were extremely humbling and in turn provoked my desire to work with Māori people. At the same time, my experience of having to help raise my new born sister from the age of 13 years has also strongly influenced my interest in working with child and adolescent populations.

I was interested in this particular research because I have always been intrigued by the overrepresentation of young Māori males in the New Zealand justice system. Over the years I have attempted to understand these statistics, and in turn, welcomed research which showed processes within the New Zealand court system that were biased towards Māori offenders. I therefore wanted to be involved in a project that enabled me to better understand the needs of Māori adolescent offenders and their whānau. I was also interested in how the processes within treatment programmes specially designed for this population may influence its users.

Prior to commencing this research and my clinical training, I had very limited experience working with Māori offenders and absolutely no experience working with Māori adolescents who were sexually abusive. Therefore, to gain a better understanding of this population before data collection commenced in 2010, I attended a four day wilderness camp with the SAFE Māori adolescent team with their consent. This experience was invaluable as it gave me the opportunity to meet the adolescents in a less formal environment, and at the same time, get a sense of the dynamics that take place between the SAFE staff and the adolescent participants. I was also able to observe the disclosure of offending processes and how the wilderness experience was used as a tool to facilitate this process. More importantly, the camp reinforced the fact that it is imperative not to judge these young men, and that it is a rare privilege to hear their stories and treatment developments. 'Mucking in' during camp also enabled me to establish whakawhanaungatanga with the staff and develop a sense of reciprocal trust and familiarity in them.

I became involved with SAFE through my academic supervisor, Associate Professor Ian Lambie. In 2010, I met with the SAFE Māori adolescent staff to

discuss the implementation of my research. I was officially welcomed into the programme during a group therapy session in which I participated in a whakatauki. This process was seen as important because it enabled me to formally introduce myself to the boys in a culturally appropriate way. It also gave me the opportunity to meet the boys who I had not encountered during the wilderness camp. Throughout the consultation and data collection phases, I regularly checked in with the Māori adolescent staff to ensure the kaupapa of this research was 'participant driven' and collaborative.

As this research focused on Māori participants, I regularly participated in a peer Māori and Pacific Island research group made up of other students engaged in a Psychology PhD, Doctorate, Masters, or Honours projects. In addition, I established a research support network comprising of my whānau and Māori academics from the Taranaki and Auckland regions. My decision to establish supportive networks from the Taranaki region came about because I quickly became aware, that because of the heavy nature of this research, I needed to keep myself culturally and spiritually safe and therefore surround myself by people from the Taranaki region who had a greater understanding of my spiritual needs. The discussions that took place with the groups mentioned above were confidential and did not include any conversations about the research participants or their families. They instead included guidance around tikanga, Maori models, research methodology and emotional support in the form of whakamoemiti and "cups of tea" when feeling overwhelmed.

Objectives

This research aimed to 1) Explore the programme's strengths and weaknesses; 2) Identify the Māori models of practice used by staff, 3) Describe the limitations of the programmes operation and 4) Investigate processes that may enhance the programme.

The SAFE Auckland branch was used in this study because it was the only community treatment programme available to sexually abusive adolescents in the Auckland region.

Research Design

Participant Criteria. Four separate study populations were involved in this research including: SAFE Rangatahi programme staff, SAFE Māori adolescent clients participating in the Rangatahi programme, Whānau of the Māori adolescent clients and Key stakeholders associated with the SAFE Rangatahi programme.

SAFE Rangatahi programme staff. The programme staff included the clinicians of the SAFE rangatahi team who were employed by the Auckland SAFE agency for more than 6 months.

SAFE Maori adolescent clients. The Māori adolescent clients included individuals aged between 15 and 17 years of age, who had participated in the SAFE rangatahi programme for at least 6 months. This included both past (inactive) and present (active) clients.

Whānau of adolescent clients. The whānau of adolescent clients included biological, adopted, whangai, and foster parents who had participated in family group conferences and family review sessions for at least 6 months. This included the caregivers of both active and inactive clients.

Key stakeholders associated with the programme. The key stakeholders included professionals from outside of SAFE who had regular involvement with the Māori adolescent programme. This included CYF case workers, youth residential care workers, and sex offender therapists.

Interview Development.

Four separate semi-structured interview schedules were developed by the researcher as a direct result of the literature review and in consultation with the researcher's supervisor and the SAFE Māori adolescent programme staff (see Appendix A).

Prior to each of the interview schedules being developed, the researcher met with the SAFE Māori adolescent staff to ensure that the questions they wanted to pose to each of the participant groups were included and that the information gathered would be useful to the service at the conclusion of the research i.e,. utilisation-focused approach. Through this process, a draft semi-structured interview schedule was developed and used as a template. The researcher, with the assistance of the researcher's supervisor, further refined the schedule until a final draft schedule was approved by the SAFE Māori adolescent staff. The draft schedules were then piloted on three individuals of similar age, ethnicity, family structure, and work background to the study participants, which led to further alterations in the interview schedules. These participants were identified through

family and friends and were approached after consent was obtained from their caregivers.

All the interview schedules generally focused on four key areas: 1) The participants' perceptions and understanding of the programme. 2) The programme's strengths/benefits and weaknesses/detriments. 3) The participants' views on if the program met their individual and cultural needs. 4) Recommendations for future improvements. In addition to the above questions, the staff were asked to describe and discuss the programme goals and the therapeutic and treatment approaches they used within their roles. The whānau and key stakeholders were also asked to discuss their perspective of the programme through their experience of having direct contact with SAFE.

Programme Documentation. Several other sources of information were collated in an attempt to document programme processes and function. These included: SAFE's policy and procedural manuals, pamphlets and brochures, and the agency website.

Ethics. Ethics was obtained from the University of Auckland Human Participants Ethics Committee for a period of 3 years, from the 11 November 2009 to the 11 November 2012. Ref: 2009/453.

Participant Recruitment

The kaimahi were identified by the SAFE directors who informed the staff about the study. The researcher also attended the Te Kakano team meeting and Rangatahi programme staff meeting where concerns and interest in the research

were discussed. The details of interested kaimahi were then passed on to the researcher to follow up.

The rangatahi were recruited into the study through the Rangatahi programme staff. The adolescents who were active in the programme were informed about the research during their weekly one to one session with their therapist. The inactive adolescents, who had left the programme due to graduating or dropping out were approached by a Māori adolescent programme staff member. The interested clients' details were then passed onto the researcher for follow up. Most of the inactive clients were difficult to situate because they had relocated and their contact details were out of date. Several of the inactive whānau who initial expressed interest in the project later turned down participation because they felt their youth, "had moved on and participation may reignite distressing feelings for these young men".

The whānau members were recruited into the study through the Rangatahi programme staff and were informed about the study either by phone or during attendance at the programme site. All the whānau of non-active clients were phoned by a Māori adolescent staff member. With consent, the interested whānau members' details were then passed onto the researcher for follow up.

A list of key stakeholders was identified by the Māori adolescent programme staff. The stakeholders were sent information about the research via email, and those who registered interest were followed up with a phone call. Several of the stakeholders had moved on from their respective agencies at the time of data collection. Therefore, their new contact details were found by internet search, and contact initiated by e-mail where possible. Those stakeholders who indicated interested in the study by reply email were followed up with a phone call.

All of the participants who took part in this study had an opportunity to discuss the study with the researcher. They were informed that their participation was voluntary and understood that they could withdraw from the interview at any time without giving a reason. They were also informed that they could withdraw their data up to one month following their interview without reason by contacting the researcher who would destroy the data by wiping audio tapes and shredding hardcopy data sheets. Participants were also informed about the limits to confidentiality and reminded that their decision to take part in the study would not impact on their relationship with the SAFE Rangatahi programme. The participants also consented to the interview being audio-taped and transcribed.

Data Collection

Several methods were used to gather data for analysis. These included direct programme observations (group and wilderness therapy) and face to face interviews.

Direct programme observations. Direct observations offered insight into the programmes physical and social environment. This method also allowed the researcher to learn about the programme's processes whilst making the least disturbance to the participants' regular activities. Direct observations took place during weekly group sessions, a wilderness therapy camp, and a one day outdoor excursion. Through these observations, the following were examined:

1. How staff incorporated Māori ideologies into the programme.

2. How participants reacted to the different programme activities.

3. Challenges for participants during the programme activities.

4. Verbal and non-verbal communications between participants which may have impacted on an individuals' experience of the programme (includes client to client, client to staff, staff to staff).

Observations were noted in a group context and no individual observations were recorded.

Weekly Group Sessions. Direct group observations from 28 two-hour weekly group sessions over a 7 month period (June 2010 to December 2010) were recorded. All of these sessions were attended by the researcher in order to develop and maintain relationships with the participants.

Throughout the data collection phase, several new clients entered the programme. The staff informed these individuals about the research prior to entering group and the researcher introduced the study during the whakatauki for all new clients and visitors. Several of the new clients did not give permission their child to participate in this study but they gave consent for the researcher to be present at weekly group session. These particular client interactions were disregarded from analysis.

The researcher did not facilitate any group sessions or intervene during group discussions. Instead, they were a silent observer, only participating in tikanga practices and group discussions when asked to by the staff or adolescent clients.

At the end of each group session, the researcher would debrief with the Māori adolescent programme staff about issues that came up during session that needed further clarification. This process was important to minimise subjective biases that may have occurred during documentation of the participant observations. In this

regard, all the data that were collected during direct observations were regularly cross-checked and validated for consistency by the Māori programme staff.

Notes were not recorded during session as that this may have influenced the clients' behavior. Therefore, all note-taking was conducted directly after sessions. These were typed into a computer journal and stored on a removable external hard drive which was locked away in a filing cabinet for confidentiality purposes.

Wilderness therapy camp/outdoor excursion. One wilderness therapy camp and one outdoor excursion were also attended in addition to the wilderness therapy camp attended prior to starting this research project. Because of the handson nature of these activities, the researcher's role changed to a participant-observer where the researcher participated in group bonding activities such as rafting, but did not facilitate any of the disclosure therapy sessions which were incorporated into the camp/excursion. This method allowed for the observation of the life of the group, by sharing in the activities of the group. At the same time, the activities facilitated whakawhanaungatanga and helped the adolescents feel more comfortable with my presence during the disclosure therapy activities. During the disclosure exercises, the researcher acted as a silent observer to maximise objectivity.

Interviews. Face to face interviews took place with individuals from the four study populations stated earlier. The interviews were conducted over 7 months around the time that the direct observations took place. The interviews were recorded using an audio recording device and were electronically encrypted for confidentiality purposes.

All adolescent interviews took place on the Auckland SAFE premises, during work hours as this was convenient to both the adolescents and the researcher. Some of the whānau interviews also took place on SAFE premises, however most were interviewed at their home during work hours as most of the families resided outside of the Auckland region and only travelled to the area to attend family group meetings.

Given that these meetings were inconsistent, it was decided that it would be more convenient to conduct the interviews at the whānau home. It was also hypothesised that whānau would feel more comfortable in their home environment and this would facilitate the collaborative interview process. For safety reasons, when interviewing at private homes, the researcher was accompanied by a second person who waited in the car and was told to enter the property if the researcher had not made contact with them in an hour. This option was never needed. The key stakeholder interviews took place at the stakeholders' workplace, during work hours and the SAFE staff were interviewed on premise during work hours. These premises were chosen due to convenience.

After the interviews, all participants were provided with kai (food) and a $20 gift voucher (petrol, movie, food) as a way of thanking them for participating in the study.

Data Analysis

The interviews ranged between forty minutes and two hours. They were transcribed into a Microsoft word document by an independent transcriber familiar with the Māori language. Having a transcriber competent in the Māori language was important for translation purposes as many of the participants used Māori words and

phrases throughout their interviews. For privacy reasons, the independent transcriber signed a confidentiality clause.

When the transcriptions were complete, a thematic analysis approach was used to analyse the key themes which emerged from the interviews. Braun and Clarke's (2006) thematic analysis guideline was used to help guide this process. This involved reading through the transcripts and noting ideas about the data; systematically working through the entire data set identifying aspects in the data that formed repeated patterns; when all the data had been initially coded and collated by three researchers (including myself); the different codes were sorted into potential themes; the themes were refined further by systematically excluding themes that did not have enough data to support them or combining several themes into one. The themes were then collated into table form, re-coded again by the three researchers and debated until a consensus on a theme was reached. This process took a total of 5 hours.

The quotes that were taken from the transcripts for inclusion in the body of this thesis were also cleaned so errors such as "um, yep" were removed and long quotes were compartmentalised so the fundamental points were emphasised and not lost in lengthy statements. The revised quotes were checked with the two researchers involved in thematic analysis process to ensure that they were not misconstrued after they had been cleaned. Furthermore, the participants' quotes were coded so it was clear to the reader which of the four study populations had made the statement, for example (K) stands for Kaimahi, (KS) stands for Key worker, (R) stands for Rangatahi and (W) stands for Whanau.

Chapter 5 Participant Description

A total of 23 participants were interviewed including seven rangatahi, nine whānau, three kaimahi, and four key stakeholders.

Rangatahi Participants. All of the interviewees were male, aged between 15 and 17 years of age (see Table 4.1). The most common forms of sexually harmful behaviour they had engaged in were inappropriate touching and oral sex. In addition, a majority of the victims were children under the age of 12 years (Sexual Offending against a Child - SOC), with several rangatahi reporting they had more than one child victim (SOCs). The least common forms of sexual offending were penetration and exhibitionism against an adult victim (Sexual Offending against an adult - SOA).

The amount of time a rangatahi had attended treatment at SAFE varied between six to 18 months and at the time that the data was collected, six of the participants were actively participating in the rangatahi programme and one had graduated. While all participants were of Māori descent, all indicated they were of mixed ethnicity with links back to the Pacific Island (PI) and European (EU) nations.

The amount and types of exposure the rangatahi participants had to their culture prior to entering SAFE varied. Most of the rangatahi acknowledged that the last time they had participated in something Māori was at Intermediate School and this involved Kapa Haka. Of these rangatahi, all of them stated that before entering the programme, they were unable to speak any Te Reo Māori, could not recall their whakapapa or pepeha, nor identify anything synonymous with the Māori culture (Marae, tangi, tikanga, etc). Only two of the rangatahi reported that they had extensive exposure to the Māori culture prior to entering SAFE. Both of these

participants stated that their Te Reo Māori proficiency was high and that they were actively involved in their respective Māori communities. Only one of the seven rangatahi recruited into this study reported that they were not interested in pursuing their Maori identity further. When whānau were asked how much exposure their rangatahi had had to their culture, they all stated that their rangatahi were active in their Māori communities and were interested in further developing their understanding of their Māori identity. Their views appeared to be at odds with what most of the rangatahi had reported.

In addition, five of the seven rangatahi reported that they were residing in residential care facilities including Barnados' group homes, Child Youth and Family (CYFs) residences, and Youth Justice Residences because of SAFE's placement restriction which stipulate that during treatment the rangatahi are not permitted to live in a home where the victim also resides or with children under the age of 12 years. All of the five rangatahi residing in residential care facilities had either a victim or sibling under the age of 12 years living in their family home pre-treatment. Only two of the rangatahi were living with their whānau while receiving treatment at SAFE. Both of these participants acknowledged that they were under strict supervision when at home and that their whānau home had changed dramatically since commencing treatment. For both individuals, these changes included shifting from a rural Māori community to Auckland, being raised in a one parent family as opposed to a collective community, and living in a home where whānau support is sparse due to its location.

Table 5: Demographics of rangatahi participants

Age	Ethnicity	Months at SAFE	Sexually Harmful behaviour	Active client	Previous Māori experience	Placement
15	Māori, PI	12	SOCs	Yes	Minimal	Residence
15	Māori, EU	9	SOCs	Yes	None	Residence
16	Māori	12	SOC	Yes	Minimal	Residence
16	Māori	12	SOA	Yes	Extensive	Whānau
15	Māori, EU	6	SOCs	Yes	None	Residence
15	Māori, PI	12	SOAs	Yes	Minimal	Residence
17	Māori, EU	18	SOC	No	Moderate	Whānau

Whānau Participants. There were nine whānau participants of which six reported that they were of New Zealand European ethnicity and three stated that they were of Māori descent. The whānau members' relationship to the rangatahi also varied; four of the whānau interviewees reported they were a biological parent to one of the rangatahi, two stated they were a whangai (foster) parent and three indicated they were a CYF residential caregiver.

Eight of the nine whānau participants reported that they had either no or minimal exposure to the Māori culture prior to entering SAFE. In spite of this revelation, all of the whānau stated that they were supportive of their child entering the SAFE adolescent Māori programme because they felt it would either complement or enhance their child's worldview. For example, a mother of Māori descent shared that her extended whānau preferred her son to attend the SAFE Rangatahi programme because he would be learning in an environment he was already accustomed to.

"Learning Māori is his thing, not my thing...the whānau back home rather he came to a Māori Programme than a Pākeha one. They reckon because he's a Māori boy, more understanding with the Māori's than in the Pākeha world. I think that's all it was, cause they're real Māori's too. It's more cultural understanding"(R)

The idea of a 'better cultural understanding' was also discussed by all of the New Zealand Pākeha whānau members. They reported that they felt incapable of supporting their child's cultural development and that their son would therefore be better off attending a Māori programme because it exposed him to elements of his culture which he no longer had access to.

"No problem with him going into a Māori specific programme. I think actually it was better because he doesn't have a lot of Māori things in his life cause his father's not around...so that I thought he would fit a bit better" (R)

Kaimahi Participants. There were a total of three kaimahi working in the Rangatahi programme, all of whom participated in the research. Two kaimahi worked primarily with the rangatahi population, while the other worked across both the Tāne and Rangatahi programmes.

All kaimahi in the Rangatahi programme identified as Māori and affiliated with different tribal regions throughout New Zealand. Staff had varying levels of Te Reo Māori and tikanga experience. The kaimahi all held or were working towards professional training in social work or counselling. Two of the kaimahi had more than five years experience working with sexual offender populations and one had just under two years in the field. In addition, all of the staff reported to having had experience working as a counsellor or social worker in areas other than sexual offending.

At the time of the research, there were two females and one male working on the programme. The age of the Kaimahi also varied with two being described by participants as being "adults" and the other as a "kuia" (elderly female).

Key Stakeholder Participants

At the time of data collection, the key stakeholders were working in a variety of roles across different agencies. This included CYFs social workers, referrers from residential treatment programmes working specifically with sexually abusive youth, and CYFs child advocates. All of these participants reported that they either worked closely with a rangatahi client prior to being referred to SAFE or throughout their treatment at SAFE. In addition, two of the four key stakeholders reported that they had either been employed or undertaken work experience at SAFE prior to taking up roles at their respective agencies.

Summary

The participant descriptions highlights that all of the rangatahi were of mixed ethnicity and that they and their whānau had limited exposure to the Māori culture prior to entering the Rangatahi Programme. In addition, most of the rangatahi reported that they were living in residential care during treatment. A majority of the whānau members reported that they were not of Māori descent however were still supportive of their adolescent attending a treatment programme specifically designed for Māori youth. All kaimahi identified as being of Māori descent, had varying levels of Te Reo Māori and tikanga experience, and two of the three kaimahi had more than five years experience working with sexual offender populations.

Chapter 6 Kaimahi and key stakeholder perspectives

This chapter presents the perspectives of the kaimahi and key stakeholders who took part in this research. The participant perspectives were separated into three themes: things that work, things that don't work, and areas for improvement. The themes were further broken down into sub-themes: clinical practice, staffing and programme issues. Table 6 shows how the themes link to the kaimahi and key stakeholder perspectives.

Table 6: Table illustrating the themes that emerged from kaimahi and key stakeholder perspectives

Theme	Sub-theme	Participant perspectives
Things that work	Clinical practice	Maori models of treatment lead to better treatment outcomes
		Working with whanau is important
		Modulated workbooks provide structure for the kaimahi and rangatahi
	Staffing	Kaimahi model positive relationships
		Older, experienced kaimahi add a positive dimension to the programme
Things that don't work	Clinical practice	The referral process and system reviews were disorganised
		Poor communication between kaimahi and key stakeholders
		Cancelling wilderness therapy experiences negatively impact on treatment delivery
		Clinical boundaries and expectations extend beyond the workplace for staff
	Staffing	The kaimahi feel culturally undervalued
		The kaimahi lacked autonomy

		The cultural diversity of clients is difficult to balance during treatment
		The kaimahi are overworked
	Programme issues	The kaupapa of the Rangatahi Programme is unclear
Areas for improvement	Clinical practice	Clinical meetings within the whānau home or marae setting would improve clinical practice for staff
		Kaimahi want greater access to experienced cultural supervisors
		Cultural competencies could be enhanced through ongoing professional development
	Staffing	Kaiako can be sourced from the community to teach traditional practices that align with client safety
		The programme would benefit from employing more kaimahi
		The induction process for kaimahi needs to be thorough
	Programme issues	Reorganising teams and sharing team resources could enable greater communication and discussion.
		Maori treatment modules and resources would be helpful
		Improved information sharing with external agencies is important

Things that work

Māori models of treatment lead to better treatment outcomes. The kaimahi and key stakeholders reported that the programme is clinically effective because it was developed specifically by Māori for Māori using Māori models of practice. Participants reported that this philosophy is effective because it offers clients and referrers an alternative to fully westernised models of treatment.

Furthermore, participants believed that using kaupapa Māori philosophies as a baseline for treatment would lead to better outcomes for clients because the client's therapy and cultural needs were being met simultaneously:

> *"I think for us, if we have a Māori boy who falls you know within the catchment area of the SAFE Māori program, we have an absolute belief that they should be worked with by that team because they (staff) have a greater understanding of these boys" (K)*

> *"I know that their delivery of treatment is not the same as the mainstream SAFE program. It is culturally appropriate and more interweaved of those aspects of Māori practise. I think that we would expect that they are much more likely to have better outcomes under that model, that has been my experience anyway" (KS)*

> *"I think the strengths are that they provide a Māori model of practice for kids with their whānau and that's usually beneficial for those families and those boys" (KS)*

Working with the whānau is important. Kaimahi stated that the programme is clinically effective because therapy emphasises the rangatahi within their family system, rather than working from an individual perspective. The kaimahi reported that this approach was helpful when attending to whānau issues, which may have been preventing treatment progress.

> *"I think the strength is being able to guide our boys and their families through their hard times, now that seems airy fairy but that's actually what we have to work with before we can even get to the hard stuff, the whānau issues…cause we can't work with a boy without the whānau...when they see we are here to tautoko them, they start trusting us and are less resistant" (K)*

Modulated workbooks provide structure for kaimahi and rangatahi.

Several of the kaimahi reported that the set programme modules used with the

adolescents and their whānau during treatment were helpful because the booklets were simple and visually appealing for the clients. In addition, staff indicated that the modules gave their therapeutic practise structure and simplified the process of monitoring a client's progress:

> *"I'm very grateful that I got into this field of work and seen modules that our boys can understand because they are very visual and that's really been helpful, not only for me but also for the boys"* (K)

> *"I say again having those modules set up for me, we don't follow it by the book but it's actually there so you can glimpse at it and work it to fit and actually know yep this boy's done this work, you know victim empathy stuff and the cycle of offending…you got their goals and it's there, that's helped me"* (K)

Kaimahi role model positive relationships. A strength of the programme that was discussed by all of the key stakeholders was that the kaimahi demonstrated and reinforced positive male and female interactions. Furthermore, several of the key stakeholders made reference to the staff modelling values such as co-operation and support:

> *"I think their other strength is in their staff, particularly* ...[the two key workers]. *They've got a lovely way of working together, I think they bring great strength to that work"* (KS)

> *"The strength I think is* ...[the two key workers], *they have a wonderful strength together. They complement each other really well and they support each other...the boys see it and can model it"* (KS)

Older, experienced, kaimahi add a positive dimension to the programme. In addition to modelling positive relationships, the kaimahi reported that their individual traits and previous experiences positively impacted on the rangatahi and

their whānau. In particular, staff referred to the programme employing older clinicians with diverse Māori backgrounds and how these characteristics facilitated the process of respect:

> *"Myself and* [the female therapist] *working together where you've got a person of an older generation which actually works ten times better than the western concept that youth workers or the people working with youth should be young people. And I think just her presence as a kaumatua brings another dimension, which brings in the values of respect. You've got the gender thing or you could say gender modelling; you've got the age modelling. Yeah, because not only are we working with the boys but we're also working with the families which helps out quite a lot. Then you've got a knowledge base of Te Ao Māori from* [the female therapist]*... and where I come in with the western models, so it's that combination" (K)*

Several key stakeholders also supported this view, with one sharing how the age and experience of one the kaimahi coupled with their inclusiveness of Māori protocol impacted on his ability to feel included in the treatment process:

> *"I first met the older therapist when we had a few reviews together. It was really good, like she would offer me to open the karakia, so that Māori process was set from the get go in our relationship. She was like a kuia to me so it wasn't just a professional relationship. We were Maoris' and she made me feel like I had a role so that was cool" (KS)*

Things that don't work

The referral process and system reviews were disorganised. A clinical issue that was acknowledged by all of the key stakeholders was parts of the programmes operation appeared disorganised, particularly the referral process and system review meetings. Participants reported that the referral process didn't work well because the programme lacked the adequate personnel to overlook and drive the process. As noted by one key stakeholder, the process often felt cumbersome, as they had to go to great lengths to ensure the process progressed smoothly:

"I've got to give some time to plan it because I got to get it right. I actually can't be leaving this to the last minute or assuming that up there [SAFE Auckland] *some processes are going to be happening. I really need to drive this end and make sure that it's set and clear otherwise nothing eventuates or we have to wait longer. This doesn't happen in the SAFE mainstream group because there's a clearer management structure" (KS)*

Furthermore all the key stakeholders reported that system review meetings appeared disorganised because the kaimahi appeared to be doing admin work in addition to their roles as clinicians. As noted by one participant, this frequently led to kaimahi arriving late to scheduled meetings:

"System reviews have a disorganisation element to it, staff came late for meetings and for me it's that role stuff. You know it's not clearly someone's role to be involved in that frontline process which is problematic so you have a clinician running from one place to the next place trying to be all things for everyone which I think is impossible" (KS)

Other key stakeholders shared experiences of kaimahi being ineffective in facilitating system reviews because of poor documentation practices. In particular, participants made reference to notes not being taken during meetings, meeting objectives not being clearly outlined, and client progress not adequately projected. This in turn left key stakeholders feeling that meetings were unproductive and that they had to be overly proactive to ensure their clients' needs were adequately meet. One participant indicated that this negatively impacted on his clients' motivation to adhere to the programme because he wasn't sure if he was progressing well or what the kaimahi expected of him:

"I struggled with the systems reviews at times and so did my client. Luckily I took down my own notes so I was able to bring that agenda to marry us up a pathway. I done that quite often and I found that even though we had a few

systems reviews they still never really had that right, like we'd have an agenda and something to review at the next meeting and when it came to the next one that wasn't put up. You know I pushed it and I challenged it but there still wasn't a regular template and for me it should have been because he's not over there now, he's over here or if he's not where he should be, we can understand why. And if you don't have that agenda then you're just winging it. For me I'm used to starting off with the old one, where are we? What's happened? What hasn't happened? And create out of that what next, where to from here? That didn't seem to happen. For me personally it was wasting time and for my client I think he lost a bit of motivation out of that. His drive to finish the programme got luke-warm" (KS).

Key stakeholders experienced poor communication. A clinical issue reported by most of the key stakeholders was they experienced ineffective therapist key stakeholder communication, which in turn impacted on the therapist-key stakeholder relationship. In particular, several participants reported that important aspects about the programme were not disclosed throughout the duration of their involvement with SAFE including the kaupapa of the programme:

"To be honest I didn't realise it was a Māori program, I just thought it was main stream, general program with Māoris in it, so I don't know if that wasn't made clear to me or I just generalised it. I didn't realise till you mentioned that. I wasn't told that and my client's been at SAFE for almost two years. Maybe they thought I knew that but I didn't" (KS)

Another key stakeholder took this even further and reported that the nondisclosure of information impacted on their understanding of how the programme operated, the therapists' expectations, and key stakeholders involvement in treatment. The key stakeholder felt that the poor communication skills practiced by the kaimahi left them feeling incapable of supporting and monitoring their client's treatment progress.

"what are their expectations and within those expectations where can I fit in? You know, cause my client and I had a good relationship and I could fit in somewhere surely so I could assist the process but that wasn't forth coming.

109

And I didn't know whether or not that was how the program operates or you know I am only involved for the review; you know it wasn't clear to me. It would have been good for me to know this is what he is going to be doing this month. You know, this is what is expected of him this month so there will be something for me to say to him. Oh where you at? How's it all going? I would've liked to be involved with some of that stuff so that I could support him or understand him or encourage him but that was missing" (K)

Cancelling wilderness therapy experiences negatively impact on treatment delivery. The kaimahi reported that wilderness therapy experiences were often cancelled at short notice due to limitations on staff resourcing and lack of backup plans. A view shared by all of the kaimahi was that these cancellations significantly impacted on the delivery of treatment as important treatment modules could not be comprehensively covered due to limitations in timing.

"I think the cancellations of camp last minute had a huge impact because in the end we had to modulate that piece of work, I think we did one victim empathy, because we had to put it in a module form and could only do it in our group time. We couldn't actually do the work in full because we only had a time frame of an hour and a half. We had to keep in mind that the boys were going back home for good so I guess in essence they didn't really get the full experience as opposed to being on camp where they would have had that full experience. The first one was cancelled due to personnel issues....but I mean there's other people here in the agency that I'm sure we could have tapped into, why can't we second somebody?" (K)

Clinical boundaries and expectations extend beyond the workplace for staff. Some of the kaimahi reported that they struggled clinically because their workplace responsibilities extend beyond the SAFE organisation. As the programme was developed by "Māori for Māori", the staff feel that they are accountable to their whānau and the wider Māori community, which in turn increases pressure for the Rangatahi programme to be successful. Furthermore, the staff suggested that their clinical boundaries were often challenged as they frequently crossed paths with their clients and their whanau in their respective Māori communities. As noted by one

kaimahi, occasions where they happen upon clients are inevitable and exacerbate the feeling that work is never-ending. They also suggested that it is possible to maintain clinical boundaries in these situations by acknowledging professional limitations when the interaction occurs.

> *"I think it's good to be accountable but I think that's the difference with Māori working in a tauiwi service. Māori have triple whammies really where we have to be accountable to our people, to the community, to our clients, and to our families. Which is quite different to how tauiwi might view it, they just go home 9 to 5 they finish whereas we don't finish because the truth is, the reality for us is we often see some of our clients and families at hui, at tangi but we can still acknowledge them but be really clear at the time around what's appropriate. I think that's the beauty of Māori therapists, they are able to do that. I can't say hello to you because I'm seeing you…that certainly doesn't enter my head, you know"* (K)

The kaimahi feel culturally undervalued. An issue that was highlighted by all of the kaimahi was they often felt undervalued and exploited in their role as Māori therapists because their skills, uniqueness, and cultural expertise were often overlooked. In particular, all of the kaimahi felt that their salary did not correctly reflect their value, as they all possessed specialised cultural knowledge attained through living and working in Māori communities. Furthermore, staff reported feeling frustrated that management failed to acknowledge the quantity and clinical complexity of the clients involved in the Rangatahi programme.

> *"I know that the psychologists get more pay than the Māori team however our team is unique and I know that pretty much we're the only ones out there who are doing this mahi in the whole of the Auckland region, and yet we're not paid according to how we work and the work we do with the amount of people. And knowing very well that a lot of the people in the other teams just cannot work with our people the way we do, so I feel that we're kind of undervalued. And I get that feeling of tokenism every now and then and that really grots me"* (K)

111

"I think they need to acknowledge your life experience and your experience as Māori. You know the experience as a Māori being in this field of work and acknowledge that others might have three years doing a thesis whereas you and I may have three years just living it so that needs to be acknowledged you know" (K)

All of the kaimahi stated that the lack of acknowledgement over time by management has made them selective with their clinical motivation and cultural knowledge.

"I think one of the things that's been really hard for me is they haven't really acknowledged the skills of Māori therapists. I think I can offer a lot and I've just cut off some of that because I know that it's not acknowledged so why should I put myself out there? So I only give to clients what I know I can give but I certainly won't give any more, I will not allow myself to be used, you know, not in terms of the way that we work" (K)

Kaimahi lacked autonomy. The kaimahi stated that the allocation of clients to therapists had changed considerably over the years and consequently matching clients to staff based on similarities and kaimahi skills/interest no longer occurred. The allocation process was instead decided by the Te Kakano team leaders.

"When it was just me and the other therapist, we'd talk about boys, I would take more of the violent stauncher boys and the other therapist would get the majority with mental health issues. Now it's the team leaders making that decision... before we had a system where they worked out the hours that you worked in proportion to your case load and how many clients you would see. The cases were discussed then everybody decides, "Oh, wait a minute this boy would be suited to such and such because" (K)

The cultural diversity of clients is difficult to balance during treatment. A programme issue that was evident during the interviews was that the kaimahi held

contradictory views on the quantity and quality of Māori kaupapa that should be taught to clients. Two of the kaimahi stated that a "one size fits all" approach that exclusively uses kaupapa Māori principles and practises is ineffective because most of the rangatahi had limited or no exposure to their Māori culture prior to entering SAFE.   One participant took this further by reporting that delivering an exclusive kaupapa Māori programme would work well with clients who were raised in full immersion Māori communities, but suggests that most of his clients would struggle in this type of environment. This participant indicated that it is more practical to deliver a programme that acknowledges the clients' Māori culture and how this fits into a westernised worldview.

> *"when you ask the boys about their cultural needs, what does that mean really? Because even the boys don't know what their culture is and so we're just hanging onto the threads that they know about their culture. I think I've learnt not to be too heavy on them about their culture because they don't know, so we just take it a step at a time, just say look this is what we know when you leave here you can take whatever you've learnt and you can go with what we've shared with you, that's [not] all we've got, but I believe that's all we can give because we can't give too much, it's too much unless they've been brought up tūturu Māori or in the language. A lot of our boys haven't, some have…Balance, finding that balance, walking the fine lines that's what I call it. It's hard. It would be good if we got one programme that fits all but no it's not the reality.   I still like the balance of having the two because the reality for a lot of our boys they have to live in that world. They really do. It's lovely to have a Māori world, I love my Māori world but the reality is they also have to live in the Pākeha world and that is what we see. They struggle, they don't struggle living in it, they struggle being comfortable in it. In both worlds actually" (K).*

This view was shared by another kaimahi who reported that children of mixed cultural ethnicity are often overlooked, and are forced to choose one culture over another when undertaking treatment. This participant suggests that a failure to acknowledge and attend to a client's ethnic diversity can have serious implications

for the client's whānau system. Furthermore, this participant suggests that an exclusive kaupapa Māori programme does not account for the changing Māori demographic and this may impede a client's cultural needs.

> "I've always fought for our children who are of mixed marriages because I think sometimes they just fall and, or its either that or they get taught to choose one or the other and I think that's not good for them you know so I I've always fight because their voices are silent. I know our people, there's all Māori or nothing at all which I don't agree in, and the other one also, well you know, throw away your Pākeha but you can't do that. I think that's also takahi on their mana, the mana of the parent that's not Māori … The reality, they have the full reality of life what it might be for our kids today not how it was two generations ago. I know working with Māori on their own is good but my take on that is we are not working specifically with Māori kids, they are Māori with Pākeha parents so I still believe whole heartedly myself you can work [with] both and I think not everybody agrees with that, but that's where I sit, because I've seen with some of these Māori boys turn on their own parents and that's not okay" (K)

One kaimahi argued that the rangatahi should be exposed to a full Kaupapa Maori programme during treatment because in doing so they will be able to build a stronger cultural identify and a better sense of self. This will enable them to navigate through the SAFE programme and life with greater ease.

> "I feel that the more exposure they have to more cultural things, the better. Even though I know that the boys come from diverse backgrounds, I just believe that if we're gonna practice things Māori, lets do it good, lets do it well and expose them to it you know...It's about building a strong cultural identity so they can stand strong in their own skin" (K)

The kaimahi are overworked. The kaimahi reported that they all carried heavy clinical caseloads which were difficult to manage and maintain. The kaimahi acknowledged that this outcome is made worse by the limited availability of Māori clinicians trained in the field of sexual offending.   Additionally, two of the kaimahi suggested there appeared to be a workplace culture among therapists that they must

work at optimum levels at all times. As noted by one kaimahi, this expectation was

unrealistic and most likely straining on a therapist's wellbeing.

> "There's not enough people for the amount of boys we get, we cram all our
> mahi so we're just flat out for that time. I just see it as not being very healthy
> to be able to work. It's like you're expected to work at peak level for that entire
> time and there's no give. I just think somehow, someone, something's gotta
> give eventually. And I wonder if the staff here are just so used to working like
> that, but for me, I just can't do that." (K)

Several key stakeholders supported the views of the kaimahi, stating that

they also observed highly stressed therapists with heavy clinical caseloads. These

participants suggested that in view of these observations, they often spoke among

themselves (workplace colleagues) and considered referring clients to other

treatment programmes where clinical caseloads were better managed.

> "In the past at times, the stress of that team and high work load there's been
> these conversations about should this kid just go into the mainstream or
> maybe somewhere else?" (KS)

The kaupapa of the Rangatahi programme is unclear. A programme issue

that became very evident at the time of the interviews was all of the kaimahi had

difficulty recalling the programme goals and were unclear in which direction the

Rangatahi Programme was proceeding. One kaimahi acknowledged that the

ambiguity of the goals often gave the impression that the programme was not

evolving.

> "It's not clear on where the programme, what direction its going. Yeah, it's sort
> of like you're not going forwards, you're not going backwards, you're going
> nowhere" (K)

In addition, some the kaimahi had difficulty recalling how the kaupapa of the

Rangatahi programme differed to the mainstream adolescent programme. When

prompted, only one kaimahi was able to say that the Rangatahi programme goals differed to the mainstream programme because it integrated Maori culture into its treatment services.   Even after prompting, the other kaimahi were only able to recall how the programme goals centered around decreasing sexual recidivism during and post treatment. The staff attributed their inability to recall the programme goals to several things. Firstly, one of the kaimahi stated that the process of establishing the programme goals was omitted when Te Kakano was originally formed.

> *"There weren't any goals because it had just come out of mainstream...we just carried on still doing western models. It wasn't till the other therapist came on, probably two or three years later that we spoke about a Māori model for the youth" (K)*

Other staff suggested that it was due to not being informed about the programme's rationale early on, and the kaupapa of the programme changing without consultation with Rangatahi team members.

> *"yeah that's something I haven't quite got a hold of yet, understanding how the programmes are run, how the programmes were formed and why; you know the purpose and our goals for the programme" (K)*

> *"We set goals when I first started at SAFE but instead of going with one kaupapa, it got changed without us knowing, so then all of a sudden it was like, what the hell are we doing? There were people making decisions on behalf of our team that wasn't discussed?" (K)*

What could be improved?

Clinical meetings within the whānau home or marae setting would improve clinical practice for staff. All of the kaimahi felt that their practice would improve if clinical meetings concerning the client and their whānau could be held within the clients' home or in a marae setting. The kaimahi reported that from past

experience, clients who have had this opportunity have successfully completed the programme. The kaimahi acknowledged that despite there being risks associated with home/marae based therapy, they and the clients benefit significantly from the process because the clients are more willing to engage because they feel safe and the clinicians are able to observe the client and their whānau operating in their own natural environment.

> *"Our weakness of the programme is actually working from SAFE. The group work, I don't mind doing that at SAFE. If it's the whānau work then, even individual therapy, it should be done in the home. But definitely all the whānau work should be done in the home. Well for me, it makes my job a lot easier, but at the same time it also raises a lot of fears. Like, "Oh, what am I going into?" But I guess one of the things that I've noticed, especially with all our high risk whānau is that... and I don't know but I'm almost 100 percent sure we've actually got a 100 percent completion rate with all the whānau that we've done in the home. And that's with the changes within the boys, and I guess the main things is how safe the whānau feel more in their own environment, and not only that but you get to see the environment that the boys come out of" (K)*

Another kaimahi stated that their clinical work would benefit from marae based whānau hui because it offers a comforting, informal environment where clinical terminology is not emphasised.

> *"through a wānanga on a marae for me because there I can be me and I don't have to talk the jargon that people think you should be talking but talking how it really is for our whānau cause our whānau don't know our jargon and I try not to talk jargon to them cause they don't know that" (K2)*

Kaimahi want greater access to experienced cultural supervisors. The kaimahi also reported that the cultural supervision provided by SAFE was inadequate and that their cultural practice and personal wellbeing would improve if they were

given access to external supervisors with greater cultural expertise. The staff reported that it would be ideal to have an older, experienced supervisor who was well versed in Māori tikanga including the diversity that exists among iwi. Several participants' reported that this is particularly important since the rangatahi have tribal affiliations with different Māori iwi all of which have different tikanga practises. Furthermore, an experienced cultural supervisor would ensure that the cultural components delivered by staff were safe for all involved including tauiwi who assist with the programme when staffing levels are low.

> *"We get cultural supervision by having supervision with our Māori team leader, but I prefer an outside source and someone with more experience...like a kaumatua for some guidance around cultural stuff. I feel that, in terms of tikanga, that we're sort of lacking and plus its kind of diverse throughout the different Iwi, so I'd like to know more about different Iwi and hear from more experienced people especially around tikanga and that... It depends cause if they've got clinical experience too that would be really awesome, but I know there are very few people, a kaumatua out there, who have worked in this sort of sector"* (K)

> *"if you're gonna practice a cultural form, then you need proper cultural supervision. You need to learn how to pull out all those traditional stories properly and all those things that actually adhere to the tikanga... But it might not come from a clinical perspective. All the stories that we tell our kids, they'll tell their kids"* (KS)

One kaimahi, however admitted that they are not permitted to use external supervision because of costs and restrictions placed on them by the Te Kakano team leaders. Furthermore the cultural supervisors who possess their desired requirements are a very limited resource and therefore need to be appreciated once found.

> *"I think giving us the freedom and resources and the mana to seek out those well grounded, well versed, wise Māori people. And I'm really mindful that we don't burn them out either but I think that's where we lack.*

We don't have that, there's not many of them and if they are, they are taken up" (K1).

Cultural competencies could be enhanced through ongoing professional development. The kaimahi reported that it is essential that they access continuous cultural professional development as this would expand their cultural competencies. They suggested that this could involve connecting and associating with other Māori working with Māori whānau. All of the kaimahi agreed that these interactions would enable them to share and discuss therapeutic ideas in a culturally sensitive environment. This process could also act as an alternative form of cultural supervision for kaimahi.

> *"In terms of Māori this is one of the things that I think I really need ongoing, you know you need the kai, and I guess that's mainly because the kai that I want is from older teachers especially in this field of work. I think we work in a field that's really new, it's old but it's new in terms of a discipline, I believe it's new for Māori. But in terms of the issue itself, its old and I think being amongst other Māori who not necessarily do the same work but have the same whakaaro around what is best for our whānau. Looking at our own models of working, that's what I would like to have more around. I just want to be able to sit with my own people and say what did you do?" (K)*

Furthermore, some of the kaimahi reported that professional development could include observing kaumatua reciting oral traditions which complement the clients' therapeutic work. One kaimahi suggested that kaumatua were ideal in this instance because they provide a depth and understanding which resonates well with the rangatahi. Furthermore having oral traditions and analogues/stories are an important part of Maori culture, history and whakapapa therefore having adequate supervision would help with the knowledge of these oral traditions.

"Having resources in terms of training with some of the oldies, cause even though we have a Māori model it's also good to have some stories, cause it's the stories that will encapsulate what actually goes on. More kaumatua, but I'm talking old you know; ones not around Auckland but the ones who really know their stuff. It's the stories and I think it happened on a camp a few years ago and we had this old guy come in, and the boys were just purrf! Yeah, he just had them eating out of the palm of his hand, and it was the stories; they were all sort of like, "Oh!" you know and that's what got the interest. I would prefer them because they have that old style of oratory. I suppose I could get up but then its sort of like I haven't got the presence" (K)

Kaiako can be sourced from the community to teach traditional practices that align with client safety. The staff acknowledged that the programme would be enhanced by bringing in a kaiako to teach traditional practices that clients can integrate into safety plans as alternative behaviours to sexually harmful conduct. In particular, the kaimahi made reference to the practice of mau-rakau and kapa haka. The staff stated that these traditions reinforce a culturally affirmative identity and teach the rangatahi positive values such as respect, discipline, and commitment and at the same time offer a physical outlet to displace emotions. The kaimahi acknowledged that the skills needed to teach traditional practices are specialised requiring experienced knowledgeable teachers, fluent in Te Reo Maori. They also shared that they do not have the time, headspace or knowledge to be able to teach these traditional practices themselves.

"So learning a bit about the goodness in our culture as well as relating it to keeping yourself safe so an example is mau rakau...learning the disciplines of mau rakau and understanding why our people learnt these skills and relating that to safety and keeping themselves safe for the future" (K3)

The programme would benefit from employing more kaimahi. All of the kaimahi stated that they were over-worked and that the programme would benefit

from employing extra staff, in particular, male Māori therapists and a Māori social worker. One kaimahi specified this even further by suggesting that an ideal Māori therapist would be professional, open-minded, and more importantly not inflexible in their cultural thinking.

> *"Definitely have another male. A male therapist because we're actually over worked. I mean ideally it would be good to have at least, between four to six, or four or five therapists. The ideal person would be solid, not flaky.*
>
> *Someone who's spontaneous, willing to learn and open minded; you know not somebody who's everything's gotta be tūturu Māori otherwise it just doesn't work" (K)*

Another kaimahi advocated that a Māori social worker could open up missed opportunities for the clients in the community.

> *"I think it can be made better if we had a Māori social worker, getting out and working in the community for us because we don't get the opportunity to get out into the community…Find out the best people out there, the best services out there, they can do that and come back and feed us back and then we can say okay your whānau can go here, here and here that might help you and then, at the moment we don't have that so that makes it hard" (K)*

The induction process for kaimahi needs to be thorough. Another staffing improvement suggested by two of the kaimahi was new staff require a thorough induction process which includes time to observe other therapists working with clients.

> *"For a new therapist I think it's really important to be able to sit and observe the work in all its forms, and that's sort of been difficult for me because of the management sort of issues the teams have had as well as being a newbie and trying to find my feet within the team, especially with well established staff. The induction process needs to be thorough otherwise it has the potential to make them run away screaming "Mum!" (K)*

Reorganising teams and sharing team resources could enable greater communication and discussion. Two of the kaimahi reported that reorganising and streamlining teams within SAFE would facilitate greater communication and enhance opportunities for client-based dialogue among staff. The kaimahi reported that the physical positioning of the teams (i.e., Māori room, mainstream youth room, mainstream adult and Pacific room) was not functional because the staff felt isolated from the other therapists who had expertise with youth populations.

> *"I feel that I'm actually cut off because I sort of can't keep running backwards and forwards to the other room. Actually, I think we could either have an open plan for the agency in general. I think it would be better having an open plan with the youth because not all Māori youth are all Māori. I think it's more because a lot of conversations happen when you're around a building or what you hear, and that's where you pick up. In the past that's how it has happened, how I got to where I am today. Just overhearing something, "Oh..." and then expanding something or you hear an idea and, "Oh, wait a minute that sounds great. What is that all about?" (K2)*

Another kaimahi supported these sentiments by reporting that greater interactions with the mainstream youth team would make sense because the teams have comparable system-based issues. This participant also shared that they felt disadvantaged by the positioning of the teams because clinical growth is limited.

> *"I think what could be done better is having more liaison with our Pākeha youth team to get ideas because I'm not getting fed so I feel like I just want to bust out and get the hell out. So you know have that two way process going with the adolescent teams, the mainstream and Māori. At the moment where kind of locked in our own teams. I'm not getting fed from the adult Māori team, I'm not getting any kai from them because they have a very different way of working. I'm not getting any inspiration from it; I'm not getting anything that clinically is helping me because you know the work is different. In actual fact, I feel like we're actually doing a lot more because we work with the families, we're not working with partners, we're working with the family, which is a different ball game. The family's so complicated honestly" (K1)*

Maori treatment modules and resource would be helpful. All of the kaimahi suggested that the programme could develop its own treatment modules and resources, addressing sexually abusive behaviours whilst incorporating aspects of the Māori culture. One participant, however, notes that this process would require many dedicated work hours, which were already very limited.

> "There are possibilities of having our own Māori modules, it would be really good, having the opportunity to bring in our own myths and legends. You know like when you're talking about sexual abuse Māori have their own stories but we just have not had the time to sit down and be creative" (K)

Improved information sharing with external agencies is important. The final improvement discussed by the key stakeholders was that the Rangatahi Programme needed to formalise communication processes with external agencies. In particular, key stakeholders suggested that formal brochures be developed, informing potential clients about the kaupapa of the SAFE Rangatahi Programme and client expectations before, during, and after treatment is complete.

> "I think it's always good to have information that you can give whānau saying this is what we're coming up to, you know this is some written information perhaps that supports that'. I think it would be really useful the more information you can provide both before and after the better and I think probably, that team relied largely on informal communication which is relationship based; and that's fine. We all do that but it's really important there's a formal strand". (KS)

> "Probably just an informed brochure or you know something that tells you specifically what the program is designed for, like you say it's a Māori one. I didn't actually realise that. Nothing in my file tells me that either". (KS)

Summary

The clinical practices that work well in the Rangatahi programme are the use of Maori models of treatment, modulated workbooks which provided structure for

both the kaimahi and rangatahi and working with whanau to attend to whānau issues which may be hindering treatment progress. Aspects that worked well about the staff in the Rangatahi programme were they acted as role models of positive relationships/values for the rangatahi and having kaimahi who were older and more experienced helped to reinforce core Maori values such as respect.

The clinical aspects that did not work well included parts of the programmes operation being disorganised, particularly the referral process and family system reviews. Communication between the therapist and key stakeholders was also problematic and this impacted on the key stakeholders understanding of the programmes operation, the therapists' expectations, and their involvement in the treatment process. Other clinical practices that did not work well include the cancellation of outdoor wildness experiences which resulted in important treatment modules being condensed and inadequately covered. Furthermore, the staff reported feeling overworked and undervalued in their role as Māori therapists. They also spoke of their workplace responsibilities extending beyond SAFE and their clinical boundaries often being challenged outside of work hours. Another clinical practice that does not work well was balancing and managing the cultural diversity of clients during therapy and the kaimahi feeling left out of the client allocation decision process. A significant programme issue identified by the kaimahi is the kaupapa of the Rangatahi programme is unclear and kaimahi had difficulty recalling the programme goals and were unclear in which direction the Rangatahi Programme was proceeding. Furthermore only one kaimahi was able to identify how the Rangatahi programme goals differed from the mainstream adolescent programme.

The kaimahi stated that their treatment outcomes would improve if clinical

meetings involving whānau were held at the clients' home or in a marae setting. They also indicated that their clinical practice and personal wellbeing would benefit from being given access to experienced cultural supervisors. Furthermore, the staff emphasised the need for continuous cultural professional development and that the programme could gain from employing more Māori male therapists and a Māori social worker. The kaimahi also suggested that kaiako could be sourced from the community to teach traditional practices that align with a clients' safety plan. Some staffing issues that could be improved include conducting a thorough induction process with new staff and reorganising team resources to enable greater communication and discussion. Finally, the kaimahi suggested that the programme could benefit from developing Maori treatment modules and resources.

Chapter 7

Rangatahi and Whānau perspectives

This chapter presents the perspectives of the rangatahi and whānau who took part in this research. The participant perspectives were separated into the themes of: things that work, things that don't work, and areas for improvement. The themes were further broken down into sub-themes: Maori framework enhances experience, Group work is effective, Kaimai characteristics facilitate engagement, Some group processes need work, Communication is poor, Increasing resources and Accessibility. Table 7 shows how the themes link to the rangatahi and whānau perspectives.

Table 7: Table illustrating the themes that emerged from rangatahi and whānau perspectives

Theme	Sub-theme	Participant perspectives
Things that work	Maori framework enhances experience	Knowing the programme was designed for Māori youth decreased anxieties
		Māori models of practice are effective particularly Te Whare Tangata model, whānaungatanga and karakia
		Involving whānau in treatment is important
	Group work is effective	It created a sense of universality, activities used helped to challenge preconceived assumptions/values and enhance bonds and life skills.
	Kaimahi characteristics	Therapists understood clients' cultural needs and having access to both genders was important for some. Having kaimahi who was of kaumatua status facilitated Maori cultural values such as

	facilitate engagement	respect and perseverance. The kaimahis relaxed style and use of humour created a sense of connective-ness
Things that don't work	Some group processes need work	Disclosure in group situation uncomfortable and kaimahi questions sometimes ambiguous and too quick
	Communication is poor	Communication with whānau could be improved
Areas of improvement	Increasing resources	Introducing Maori role-models and more Maori Kaupapa will help to strengthen identity
		Employing a new social worker
		Adjunct for whānau
	Accessibility	Home based meetings/satellite offices will decrease accessibility issues
		Tribal hui would facilitate whānau involvement
		Consistent funding for all rangatahi

Things that work

Knowing the programme was designed for Māori youth decreased anxieties. Most of the rangatahi reported that their anxieties decreased significantly when they were informed that they would be entering a specialised programme for Māori youth. Prior to entering SAFE, all of the rangatahi participants acknowledged that they had strong anxieties about their treatment pathway with most reporting that they were concerned about what SAFE was, what treatment may involve, and if they would be accepted by others already attending the programme. As noted by one rangatahi, knowing that he was going to a Māori programme was reassuring for him because it affirmed that he would be surrounded by individuals who understood him and were able to connect with him culturally.

"I guess knowing I was doing this programme made it a bit easier for me knowing that it was a Māori programme...like it would be easier to connect to Māori ways and they understand me" (R)

Another rangatahi stated that his family initially had concerns about his ability to progress in treatment; however, they were reassured that he would be looked after because the staff were of Māori ethnicity.

"At first my family were just thinking about the challenge for me to have one on one conversation with a therapist or psychologist. They were thinking if it was alright, you're alright, these people are Māori and they will help me out" (R)

Only one rangatahi participant expressed concern about entering a culturally specific programme. This participant shared that he felt uncomfortable acknowledging that he was part of the Māori programme because he was not raised in a Māori environment and was fearful others outside the programme would associate his involvement with racism.

"I felt weird just being with Maoris' and not with any other like Pākeha or Islanders or anything so I just felt a bit uncomfortable just being in a group with Maoris because I haven't been brought up Māori. I try not to bring it up that I'm in the Māori group because not everyone at the house is Māori so it's kind of racism" (R)

Māori models of practice are effective. Throughout the interview process, the rangatahi and their whānau were asked to identify therapeutic approaches that were influential to their treatment experience. The following responses relate to the therapeutic approaches that worked well and are coded into three areas: Te Whare Tangata is effective, involving whānau in treatment is important, and group related work is effective. Each of these themes is discussed below.

128

Te Whare Tangata model is effective. The first therapeutic approach identified by all of the rangatahi was the Te Whare Tangata model. All of the rangatahi found this model helpful and were able to correctly recount the symbolism behind the model and how it related to sexually harmful behaviour. For example, one rangatahi reported that the model helped him to understand the boundaries that exist when interacting with females and children as well as the consequences of violating these boundaries.

> *"The marae shapes a women...that's why they say never to hurt a woman and that women are tapu and so are children cause children come from women. That's why we are here cause we broke tapu" (R)*

The rangatahi reported that the model also encapsulated other important life lessons including: the importance of culture, history, and interconnectedness; the value of one's internal and external health; the significance of sustained whānau relationships; and an understanding of traditional values and how they exist in their everyday lives.

> *"They drew up a whare and it was a representation of a person and they went through all the aspects of a whare and the values, in and out. It showed what happens in and out of a whare like health, what happens in and out a family, the community or a person and I thought that was really cool. It was really related back to Māori cause it also went back to ancestry, history you know, the gods and stuff. I realised that everything is kind of related on the same basic aspects and everything's done by values...and has an expectation and everything has good and bad sides" (R)*

Te Whare Tangata model was also embraced by the whānau respondents with many reporting that they were impressed that the rangatahi were able to articulate the model.

> *"They also laid out very briefly the Māori process of working with the young people, it was to do with a whare and waka and I was quite impressed with that because one of the boys who is usually shy, he spoke up quite well about it so*

obviously it had lodged in his head and he felt comfortable enough to talk to others, I thought that was quite good" (W)

For several whānau members, learning about the model was empowering because it gave them access to accurate cultural information. As noted by one respondent, this was important because they had been raised in an urban environment where accessing Māori knowledge was limited and often misinterpreted.

> *"The therapists spoke about the marae and asked us what was the meaning of the marae was and about where we're from, they spoke about the marae and the inside of it, the outside of it...I didn't know anything about the marae cause I can't talk the language, I mean my mother brought me up here when I was two so I never learnt anything about Māoris. The information we thought we knew about the marae was wrong. It made us feel good when we were told the correct information" (W)*

Learning about whānaungatanga is important. The rangatahi reported that pepeha (verbalised tribal affiliation) presentations were important because the process helped to ease group tensions and it enabled respondents to form connections with their peers.

> *"We did our pepehas and the Māori culture of where we're from. It was like back in school days cause like every new person will introduce them self and say their pepehas and stuff. Made me feel more comfortable" (R)*

> *"I didn't know that* [another rangatahi] *was from the Coast as well...yep we are boys now, we stick together" (R)*

Other rangatahi spoke of how the therapists weaved the concept of family through their work and how this supported and guided them in their desire to reconnect with their whānau.

> *"In individual, my therapist has been encouraging me to learn about my own family and she has been helping me to talk about it... but she'll relate it back to family whatever work we're doing and then we'd get back into the ancestry stuff. She*

130

asks, do you want to see your family and would give me some family advice. It's good, it's cool" (R)

Some of the whānau reported that their sons' confidence had grown exponentially over their time in the programme, with one respondent attributing this change to their son finally embracing his whakapapa and Māori identity.

> *"The confidence that my son has in him that I've seen here since he's been going to SAFE program is overwhelming because he gets up and proudly speaks about his whakapapa and I know that is the side of him that's been pushed down in the past. So in that respect it's enhancing it and growing it" (W)*

While a majority of the whānau reported positive whānaungatanga experiences, one parent was perplexed at the suggestion that they may experience difficulties in the future because their son was Māori and they were not. This respondent goes on to report that the cultural differences between themselves and their son had never been an issue and staff had therefore created a fictional problem.

> *"my son's therapist seemed to think that because his father when he was alive was Māori, his grandmother's Māori, she seemed to think that he would have issues, like being I'm white and he's Māori and it's like well, why? We've never had an issue with it. We don't, I don't see a colour...It's like you're putting a sign on. I mean if that was a major problem that come up I would've been like well, okay we'll talk about this but my son never had an issue with it, so I don't see why she even brought it up" (W)*

Karakia is an important cultural practice. The respondents reported that a karakia was used to open and close treatment sessions and that the process was helpful because it emphasised wellness and inclusiveness. When asked about the function of the karakia, most of the rangatahi were able to articulate that it was a necessary process which ensured their safety when at SAFE.

131

"The main parts which is prayer will probably be the main one I need, makes everything that we do in here tika and safe" (R)

Most of the whānau also acknowledged that karakia was an important cultural practise used to guide the treatment process. The whānau reported that they were comfortable using karakia during meetings because the practise was never forced on them by the kaimahi. As noted by one parent, when the kaimahi asked permission to perform a karakia, they were acknowledging and respecting the cultural differences that existed between them.

"We'd normally start our meetings off with a little karakia just to welcome everybody, help everybody relax and be on the same page. Both of the Māori therapists have always asked, do you mind if we do a karakia prior to the meetings and things like that so just by asking me, they are respecting my European heritage...They could have just done it but they asked first" (W)

Involving whānau in treatment is important. Most of the rangatahi reported that having family involved and supporting the treatment process significantly influenced their participation in the programme. Many of the rangatahi reported that they enjoyed whānau meetings because it gave them the opportunity to show their whānau that they were progressing well and taking positive steps forward. Getting feedback from whānau about their progress was equally as important to the rangatahi participants.

"Quite cool having my family...They get to see what you're up to, what you're working on" (R)

"I liked the systems reviews cause it showed my progress, they talked about my progress on how I was going and I like to hear that I am on the right track and to finally see my family being proud of me and that I have changed" (R)

In addition, system review meetings were viewed as an important place for the rangatahi to rebuild a functional relationship with their whānau.

"I like doing work with my family and building a better relationship. The meetings have helped us talk like openly and more comfortably now" (R)

Although some of the rangatahi sometimes had difficulty sharing pieces of information with their family, they still appreciated their whānau's emotional support. For one rangatahi, having support from both sides of his family at system review meetings was something that he valued because it was an experience he had never had before.

"It feels like there's support from both sides, that's cool never had that before" (R)

For some of the whānau respondents, being involved in the treatment process helped them to shift towards a positive attitude about therapy. One respondent reported that they went from totally disregarding with the programme, to completely embracing the experience. The greatest change noticed by this respondent was their recognition that their sons' treatment pathway was a shared journey rather than an individual one.

"Actually I think I was pretty rude when I first came here. My sons' therapists probably got that part of me. I think I wasn't helpful when I first came here, all I wanted was "Oh just hurry up and get that over and done with, I wanna get out of here". That's all my thoughts were but I don't think like that anymore cause I know deep inside this is helping my son, not only helping him and helping me. It's a journey for both of us. Both for me and him, not just for my son. My son had to make a journey but I'm still there beside him. The staff made me realise that" (W)

133

Another whānau respondent shared these sentiments and declared that they had pre-conceived perceptions of the programme which were quickly eradicated by the kaimahi's manaakitanga.

> *"Well when I heard of the programme, I thought it was crap, you know a lot of shit. I said "Oh yeah there gonna tell us this" but they spoke to us, welcomed us and made us feel good. They tried to make us feel comfortable when we went there but it was just us. It was something that I wouldn't want to listen to, go to. Nah but I look forward to it now" (W)*

Group work is effective. Another therapeutic approach that worked well for the respondents was group work. This included weekly group sessions and outdoor wildness experiences.

Weekly group sessions created a sense of universality. The rangatahi acknowledged that the weekly group sessions worked well because all the participants were all attending for the same reason – to address their sexually harmful behaviours. This in turn created an environment where the respondents felt more comfortable imparting their personal information. As noted by one rangatahi, being part of the SAFE group was helpful because it gave him and his peers a safe place to discuss their offending behaviours. He also acknowledges that conversations about sex with people outside of the SAFE community would be anxiety provoking and most likely, less acceptable.

> *"You get to actually meet with people that have done the same thing as you; you can relate with everything. It's not as awkward as it would be in a normal community especially about the topic of sex. Like when you talk to people about this outside the community...I'm sure the boys here would feel quite tense about it. It's about the offending stuff as well but when you talk about it here it's for a reason. All the boys could feel it cause everyone has got the same experience, near the same experience so it's more easier to talk about it. It just makes it easier to express yourself" (R)*

In addition, several respondents reported that the group environment was inspiring and facilitated the disclosure process. For one rangatahi, presenting his cycle of offending was made less daunting after observing his peers disclosing theirs. He indicated that peer presentations were motivating because everyone shared similar experiences.

> *"Just seeing all the bros standing up doing it makes you, it gives you that urge just to get up and it makes you want to lay it out to the brothers that's the good thing about group... it makes it more easier for you to express it , get it out there cause everyone else is telling theirs so it makes it more easier" (R)*

Role plays during weekly group sessions reinforced values. Most of the rangatahi also spoke about the value of live action role plays during weekly group sessions, with most suggesting that the scenarios were memorable and that the experience often left them challenging their own preconceived assumptions and values.

> *"I liked some of the group activities, they're quite fun. We done this blind trusting thing around the chairs. We were talking about the topic of trust and like how you can trust someone, so we done a demonstration, we partnered up and then one person was blindfolded and then walked through a maze of chairs, while the other person has to guide them through. I realised I need to be a bit more openly trusting, like he'd say, okay take a big step and I was like take tiny steps**,** take a big step and I was "oh no, oh my god" (R)*

Outdoor wilderness camps enhanced bonds and life skills. All of the rangatahi who had experienced an outdoor wildness camp (n=6 rangatahi) reported that they thoroughly enjoyed the experience because it was fun and it enabled them

to form stronger bonds with other rangatahi. Most of the whānau also supported the

use of outdoor wildness camps with many suggesting that their son developed skills,

which would enable him to better function in the community.

"I liked camp, I like being with the boys cause it's fun. It wasn't just the camp we actually did more things like how we went rowing and black water rafting, White water rafting. It made it easier to bond with the boys, it showed us how the boys are outside group" (R)

"Every time they go out for their camps, it gives him life skills that he can use out here" (W)

One whānau member did not give their consent for their son to attend the

wilderness camp as it coincided with school exams and they were concerned that

their son would be pressured by peers and teachers to explain his absence.

"they were like wanting him to go to camps and things but it was always at exam time and I was just like "no way". You know, why couldn't they do the camps in the weekend instead of four days during school time. I think they should do it in the holidays or something would've been better and then it just doesn't put that pressure on them at school having to have an excuse like why aren't you there?" (W)

Kaimahi characteristics facilitated engagement. Most of the respondents

reported that the kaimahi's personal mannerisms and attributes made it easier for

participants to engage in treatment. In particular, respondents made reference to the

clinicians' ethnic understanding, age, use of humour, their gentle approach, and

gender.

Māori therapists understand the clients' cultural needs. Most of the

respondents reported that it was helpful having access to a Māori therapist because

they had a greater understanding of their cultural values and backgrounds. In

particular, the rangatahi spoke of the kaimahi being more appreciative of their needs

and less likely to judge them than Pākeha therapists.

> *"The mainstream group have a different approach to things. I expressed
> myself in that group just like I expressed myself here but they didn't
> understand. They couldn't relate back to my cultural needs. I felt out of my
> comfort zone like we are two different groups of people. I had a European
> therapist and it was kinda weird when he was asking about my own culture, I
> was answering him but I was going how do you know? How do you know?
> When you see like Māori' therapists they interact easier, we can talk normally
> but when it's like different races cause the Pākeha Europeans sometimes
> don't give us the benefits and often we are the low people but when it's Māori
> to Māori its equal respect. We come from the same place you know but when
> it is Māori to European, Māori you know are the bad ones, it's a mutual
> understanding with the Māori therapists" (R)*

The notion of better cultural understanding was also discussed by several

whānau respondents. These participants said that because the kaimahi were of

mixed cultural ethnicity they were better equipped to understand the challenges that

may exist for rangatahi of mixed race.

> *"I think being in a Māori programme helped him relax a lot more to be able to
> participate in the treatment. His therapist is a person who can understand my
> son's heritage because he's got two lines to sort of look at. On his Mum's
> side, he's Māori and on my side he's English. So there are two lines which his
> therapist can help him with" (W)*

Furthermore, a majority of the rangatahi stated that the kaimahi were

perceived as positive Māori role models and that they were responsible for making

them feel more optimistic about the present and the future. One rangatahi shared

how his perceptions of Māori evolved over time, and how he once thought that being

Māori meant being bad. He described how the kaimahi used famous Māori case

studies to challenge these beliefs.

> "Having a Māori therapist was good...helping me and showing me what is it
> like to be Māori, how to do things as a good Māori, what other people say
> about Māoris, like how they are bad and stuff. They said that not all Māori are
> bad. Like encourages me a lot more cause I used to think that Māori people
> are always bad and that's the way you have to be but then they actually show
> you the proper way that Māoris are like are actually, like the real, the good
> side of them rather than the people always seeing the bad side...like that fulla
> that shot the flag? Yeah like how he's changed a lot and like how he's been
> gone from a bad person to a good person. Being exposed to my culture has
> made me realise just how like good life can be and stuff...just, I don't know,
> like just appreciating the good things in life rather than the bad things (R)

Having an older therapist of kaumatua status was helpful. Both the

rangatahi and whānau respondents reported that the programme benefited from

employing an older therapist of kaumatua status because that person could be more

direct and it was well received well by all and their presence invoked important

values such as respect. In addition, one caregiver reported that they responded

more passively at a tense whānau hui because the older therapist was of kaumatua

status.

> "I've been to a couple of hui's where there's been some difficulty with families
> and the only way we can get around some movement is for SAFE to go to the
> family home and have a hui there where there's been a heavy cultural input
> and a lot of Māori spoken. The female therapist is right there but I think they
> respect her as an old either kuia as a kaumatua. She is definitely honest
> about, what the process is, where they hope it'll go, and the honesty about,
> look we need you people to be involved and not just leave your son sitting out
> on the edge" (W)

Several of the rangatahi also reported that the older female therapist

reminded them of a grandmother or kuia figure and this evoked feelings such as

138

respect and honesty. One rangatahi attributed the older kaimahi's directness to her being Māori and also suggested that this motivated him to get on with his work.

> "The older female therapist reminds me of my nans and my kuias from where I come from. In a good way it does yeah cause then it makes me get my work done cause she's got Māori ways, she's just like a Māori. Not shy, straight up, to the point" (R)

The kaimahi's humour and relaxed style created a sense of connectedness. All of the participants reported that the kaimahi's use of humour and relaxed style was helpful because it made them feel more connected to the kamahi and it was often used to ease potentially volatile situations. Most of the rangatahi reported that this environment made the treatment process enjoyable and motivated them to get on with their work.

> "they're kind of more laid back and you could joke with both of them, we can joke about one thing with the [male therapist] and then things we can't joke with him, we can joke with the [female therapist]. The work was laidback which was good because that helped me do my work, it helped me cause that's the way I feel comfortable learning and working so it was easy for me" (R)

Other rangatahi spoke of how treatment sessions were layered so distressing pieces of work were more manageable. One respondent reported that the kaimahi would begin these types of sessions with humour or fun activities before progressing on to the emotionally demanding work.

> "my therapist, he's a crack up...he's awesome, O for Awesome. Like he doesn't get to business straight away, he just has a bit of a joke around and then gets to it instead of rushing to the work...like on camp when we were going to do our disclosures we had a bit of a fun time beforehand and then got into work instead of just getting straight to it. It gets me motivated to do the work. I think of him as a mate" (R)

The kaimahi's humour and relaxed style was also observed by some of the whānau members. Several respondents noted that they had seen staff effectively use humour during complex meetings as a tool to break whānau tension and resistance. One whānau member took this even further by stating that the kaimahis' humility also attributed to their success in these situations.

> "I've seen the therapist operate at a quite teasy family hui to be honest. They coped with it very well and again we're talking about some pretty staunch family members.   I think there's also a level of humility because you know what it's like when people's families are not always the world's brightest and the kids have been taken off them, they look at all of us professionals as the busy-bodies who come and take them. I do notice with the two therapists, they approach on a level that they're just ordinary people too without the big therapist type thing, they are very natural and yet where the rubber hits the road and they have to say, look no, this is what is, they do it but they've layered it in very carefully" (W)

Another whānau member agreed with this view, reporting that the kaimahi's humour and carefree attitude facilitated an environment where she and her whānau allowed themselves to be vulnerable. She admitted that this is something she thought she was incapable of doing.

> "They really showed us how to be ourselves, you know the way they spoke. I mean we were laughing when we're having a meeting and that's never ever happened to us. We've never laughed at a meeting or opened up. I mean, usually when somebody comes to your house, you let them in your house and I feel that they look my house up and down but not them two, they just walk straight in. I mean cause they sat on the couch and that shocked me because I thought we were gonna sit on the table but they came straight in and sat on the couch, so I mean that made us feel comfortable...I would never open up to anyone, even my children were shocked. It's the way they spoke to me and the way they greeted us. They are not judgemental, we opened up to them and they made us trust them, they blend in with us. They didn't make us feel that we were strangers; they feel like family to me. My son, he's comfortable, I see he's comfortable and usually he backs off but he's really comfortable with them, I saw him like that so I said to myself oh well he trust's them so it made me see that they were nice people" (W)

140

Working with therapists of both genders is important for some. Several respondents reported that having a female therapist was helpful because her presence and nurturing manner enabled them to feel secure enough to let their guard down. This was of particular importance to many female whānau respondents because they observed the SAFE environment to be very male orientated.

> *"I had met the female therapist and she made things even more easier cause I had ladies to talk to instead of talking to the male therapist. Although the male therapist wasn't rude, it was me rude. Well I interacted with her cause she was Māori and being female too, I don't feel good talking to males and she made you feel at home and feel comfortable. It's just the way she spoke and all that, I know she's half Chinese but she was a real lovely lady. She makes you feel good" (W)*

Things that don't work well

Both the rangatahi and whānau respondents had great difficulty acknowledging aspects of the programme that did not work well. A majority of these respondents stated that the programme had no weaknesses and that the problems they had experienced while on the programme were the result of their own anxieties. Given that the programme was designed with Māori rangatahi in mind, great efforts were made by the researcher to identify cultural limitations of the programme. At the time of undertaking the research, no cultural limitations were identified by the respondents however four clinical issues were acknowledged and are discussed below. This included discomfort with the disclosure of personal information during group sessions; the ineffective use of ambiguous questions by kaimahi; the need to improve kaimahi-whānau communication practises, and the need to clearly outline the kaupapa of the programme to whānau at the beginning of treatment.

Disclosing personal information in group is uncomfortable for the

rangatahi. A clinical issue acknowledged by all of the rangatahi was they found

presenting their cycle of offending in a group setting very difficult. In particular, the

rangatahi stated that they struggled disclosing their personal stories because they

were uncertain how this information would be received by their audience.

> *"I don't like it when I present personal stuff, like our cycle of offending because it's quite exposing. I felt good after, I got it over and done with cause I needed to get it done for my progress but I still felt anxious about what my mum was thinking and what other people were still thinking in the family sessions" (R)*

On a positive note, all the respondents reported that they felt a sense of

achievement and relief when their presentations were complete. One respondent

indicated that the presentations helped him to appreciate that his adverse

experiences growing up were not isolated.

> *"Telling the boys about your family like how your life's been. What it's been like for you...like just say for example like drugs and alcohol and stuff...it's just like something I feel ashamed of... Quite cool aye cause like you find out that like other people have been through it as well and you didn't realise" (R)*

Several respondents also reported that they were uncomfortable disclosing

their offending behaviours at their first group session, with many suggesting that they

would prefer to reveal this information when they were better acquainted with their

peers. However, respondents again reported that this process was helpful in

hindsight because it created a transparent, supportive environment.

> *"It was good to get to know the boys more but we had to tell them what we did as soon as we met them but I reckon that helped us open up more and get to know each other" (R)*

The kaimahi's line of questioning is sometimes too ambiguous and

quick. Several rangatahi indicated that sometimes when the kaimahi were

attempting to explore their attitude and beliefs, they had difficulties understanding what they were asking of them. The respondents stated that the questions used by staff in these situations were unhelpful because the rangatahi had not been shown how to explore their emotions and the depth of the questions progressed too quickly.

> *"My therapist gets us to explain stuff in group, really in-depth and we don't know quite what it is, like when I'm asked to say what started feelings and then I wouldn't really know and then once I got the answers like, 'oh cause I was bullied' or something and then she said like to keep going and like to get deeper, like its gets harder to get deeper, it gets harder and harder. Next time if she just gave some examples or go back a step instead of going from saying how I felt and then going deeper" (R)*

Another rangatahi also felt this way, reporting that he became frustrated with the kaimahi because their line of questioning was swift and too complex. This in turn caused him to disconnect from the session.

> *"When I first met the Māori therapists, we had a bit of a korero and then I started getting mixed up with their words cause I couldn't understand them properly. I just got angry and then just shut myself down. It was just sometimes too many words and too fast and I just get frustrated and I just think they're intimidating me" (R)*

Communication with the whānau could be improved. Most of the whānau reported that when their rangatahi were referred or accepted into the programme, they received inadequate information about the kaupapa of the programme, particularly what the assessment process would involve and what the treatment pathway would look like.

> *"We weren't told anything it was just like, no you've got to go to SAFE and didn't even know what they were going to be doing there. We weren't told anything about the assessment, I didn't know if he was gonna get interviewed by people, if he had to draw pictures, nothing...I thought the programme was going to be 2 months and we'd go everyday and we'd just get onto it, deal with*

it and that would be the end of it. I didn't realize it was going to be 2 years"
(W)

In addition, Māori whānau were more likely to report that they did not receive an information pack and that they were perplexed by the information that was presented to them. As noted by one caregiver, this increased her frustration and added to an already stressful situation:

"I stopped going to SAFE at first cause I couldn't understand what was it about and I didn't know what was gonna happen. I was already angry and confused and this made it worse" (W)

These sentiments were supported by some of the rangatahi who added that their whānau were not informed about SAFE's kaupapa until time later

"my family didn't know quite know what was actually going on. They didn't know much, like they weren't told much information about it. Well they thought that it would be best for me if I come here so they were quite alright. I don't know I think like a few months after I was here...and then, I went back home for a visit and then, they found out"(R)

Several whānau respondents also indicated that they were not told anything about their sons' progress and there appeared to be an expectation that they would obtain this information themselves. These whānau members reported that they accepted this process and would wait for when their sons were ready to communicate this information.

"I didn't even really know what was happening, no one told me. I had to keep asking him and even that he really kept to himself. When I first asked him what it was all about, he didn't wanna talk about it cause he said to me he was made me cry heaps. Even now he still doesn't talk about what's been happening so I just leave it, leave it at that for him. As long as he's alright" (W)

144

The whānau respondents reported that they would often arrive at system review meetings only to discover that they had been cancelled. This was particularly frustrating for whānau members residing out of the Auckland area, with many indicating that these occasions were time-consuming and financially and socially inconvenient.

> "Sometimes I do think the communication could be improved. I've noticed that a couple of times we'd turn up and meetings have been cancelled so I come in from all this way and I mean not only for myself but his dad coming from down the line. It was very inconvenient. So not being informed ahead of time makes it very difficult. The meetings are usually 11'o clock in the morning till 12 or 1'o clock. If they could inform me before 9am or if they could phone me the night before that would be even better because then it would mean I can re-organise my day or just do nothing" (W)

Other whānau participants added that the kaimahi needed to better communicate when the rangatahi were not progressing well and assess whether a system based meeting was necessary at that time. As noted by one respondent, this would prevent whānau from being financially and vocationally put out.

> "Half the time I'd get there and we'd sit there for an hour and go, what was it about? Nothing was resolved like my son wasn't talking so it's like well why did you invite me to come here today? I have just taken a day off work to get here and you're telling me he's not talking so you could've just phoned me and said, we'll pass on that one, and maybe a bit later down the track we'll do it. That was annoying because I had to take time off work and buy a ticket and bus and it was for what? And even for our social worker, he was coming from out of Auckland and he would walk out of there and he'd just go, well that was a waste of time and I'd be like, yeah it was aye?" (W)

The participants also reported that there were times when the kaimahi failed to inform them about professionals attending group/whānau sessions. One respondent reported that this was frustrating because it caused whānau members to stop communicating.

145

"Cause when they came here we were all nervous at first cause it was the two SAFE therapists and a couple of other people that I didn't even know that were coming. One was from my son's care place, his social worker and the other one was the lawyer. We felt all tense especially when the lawyer spoke. Other times when they weren't here we were relaxed. When we had the second meeting here, well we just opened up. We felt good with the SAFE therapists, it's just that when the other three were here. I think if the other three weren't here, then things would've been alright. We wouldn't of been all tensed up" (W)

A few rangatahi also shared instances where unknown professionals attended the outdoor wilderness camps. A point that was highlighted by all of these respondents was they felt embarrassed disclosing personal information in front of these individuals and therefore hesitated with their disclosure and were left questioning the professionals' discretion. One rangatahi respondent stated that he was conscious that he was in a different iwi and was concerned about the confidentiality of the information being shared with the unknown professionals in attendance and the lack of discretion being afforded to them by having them present.

"At camp, I sort of got mad, not mad just fuck shamed. Shamed to tell my therapist my situation, they were complete strangers to me, I didn't want to tell them. Telling my therapist was the easiest because there was just one but there was a whole group on the second one, that one was harder. Two people at camp they weren't even part of our programme, started getting some doubts there and fuck, you know, pretty out of it and when you don't even know them and you're going to their iwi or their tribe and then they just like just meet you and they know what you've done, I reckon that's out of it. You know them even being around that was like oh fuck. When I say iwi I mean like coming from here into their tribe and then just being met and then she already knows most things about me like stuff like that. That's why I was like far out, is this lady staying in to listen too and I start having my doubts, I might see her on the street one day. She might just mention it. That will just be guttering...I didn't really want to say my speech, my disclosure" (R)

146

Areas for improvement

Introducing successfully rehabilitated Māori offenders and Maori cultural classes that strengthen whakapapa would be helpful. Several of the rangatahi respondents reported that the programme could be improved if they had the opportunity to meet other Māori adolescents who had successfully graduated from an offender based programme. Some rangatahi indicated that a SAFE graduate would be ideal, however, others felt it didn't matter as the purpose of this individual would be to act as a role model of perseverance and life after treatment.

> *"Probably going to a Marae and meeting other people that have offended, Māori ones, like role models and do some more whakapapa stuff" (R)*

One whānau respondent indicated that introducing Te Reo Māori and kapa haka classes into the programme could help some of the rangatahi to strengthen their whakapapa. This respondent reported that many of the rangatahi she had encountered at SAFE were missing out because they could not recall their genealogy or tribal affiliations.

> *"Have kōrero Māori classes, kapa haka, do Māori things. He does a lot of it now but I reckon it will help others that come here because I know a lot of people up here, a lot of the young Māoris that I've met up here don't even know nothing about Māori, rural Māoris. And I reckon heaps of them will know heaps after they've been through the Māori kaupapa's and all of that. I think cause they've been brought up in the city, they don't even know who their uncles and aunties are, their whakapapa. They're like lost souls cause I've met a lot of young boys here at SAFE through my son and I've asked them "Oh where are you boys from?" and they go "Oh, I'm from Rewa".   "What's Rewa?", "Where's Rewa?" Manurewa. They'll be lucky to know who their grandparents are" (W)*

Satellite offices or home based meetings would alleviate accessibility issues for some respondents. The rangatahi and whānau reported that the programme could improve if therapy sessions (both the weekly sessions and system reviews) were either held in satellite offices or in the client's home. Both the rangatahi and their whānau members spoke about the difficulties accessing SAFE services because of issues such as limited parking and the costs associated with transporting the rangatahi to and from their weekly treatment sessions. Several of the rangatahi based in the outer suburbs of Auckland suggested that access to SAFE services could be improved if SAFE held their treatment sessions in smaller temporary offices located in each of Auckland's main areas.

> "The programme was a bit far and the taxis weren't the best. They muck around sometimes they wouldn't show up or sometimes they'll be late or they take the longest route which made me late. SAFE should expand, make it have different places, have different locations, one out South, out west and then in the city so it's easier to get to" (R)

The idea of satellite offices was supported by several whānau members, who added that these types of offices are already used by other government agencies and could be made efficient if all the clients from the one area attended on the same day.

> "It would be good if SAFE was in South Auckland instead of them being at a base, they go out and you know, hold it in separate areas or at their homes or one night like at a church around here. Only cause that's where we have the CYFs meetings was at one of the church, or community house you know all the South Auckland kids can go on the same day" (W)

All of the whānau reported that holding system review meetings in the whānau home would be helpful because they would feel more relaxed and open up to the treatment process. The respondents also reported that staff would also benefit because it would give them the opportunity to observe the rangatahi in their own

148

natural environment. Furthermore, one whānau member stated that it would make sense for SAFE to progress towards home based system review meetings because it is something that is successfully practised by other government agencies such as CYFs. As noted by the respondent below, not all system reviews should be held in the whānau home but it would be helpful if one was held at the beginning of the treatment process to ease tensions.

> ”It would be nice too if they came here but not every time, just say in the beginning, probably would have made me feel more relaxed because you're actually on your place rather than theirs. With my son here too because actually that's what I did with his social worker I said to him, well you really need to come over here on days my sons here and just see what he's about, what he gets up to, what he does and that actually made it better. If his social worker can come from down the line then SAFE can do it” (W)

One whānau member who has had the opportunity to hold a systems review meeting at home stated that the experience changed their entire perspective of the programme. They indicated that prior to the staff visiting; they were disengaged, uninterested, and pessimistic about supporting their son's treatment pathway. They noted that a change occurred when the kaimahi came into her home and clarified the role and responsibilities of all the professionals working alongside their son for instance SAFE, CYFs, lawyer, and residential care people. It was then that her whānau system began to open up and trust in treatment process.

> “We had an FGC here for my son. We all talk more here than we did at SAFE. We had questions but we wouldn't ask, being in your own house we could.   I never used to look forward to SAFE meetings; I was going “oh, here it goes again, I got to go”. Well to me it was boring because I didn't know what the program was about until they came here and all of us listened...cause them coming here and explaining themselves and I mean that's good cause they've made us open up and no-one could make us talk about the things that we had inside us, we opened up to them and well I trust them. Before none of us would listen to each other but they made us change, they made us look at things differently, look at things in a good way. You know cause we were always negative” (W)

Tribal based hui would help all whānau members get involved in treatment. Several whānau members suggested that it would be helpful if the kaimahi travelled to their tribal regions on a few occasions to hold SAFE education days with their immediate and extended whānau members. Respondents reported that this would allow all whānau members involved in the rangatahi's care to be informed of their progress and be up to date with SAFE's treatment requirements. As discussed by one respondent, their son returns to his home town on a regular basis and spends most of his time moving between different family members. They reported that due to issues such as travel distance and illness, none of these whānau members had had the opportunity to attend Auckland SAFE meetings. They also reported that they were uncertain how they could adequately enforce and monitor their son's safety plan as the whānau had not been sufficiently informed. This respondent therefore suggests that a family gathering in their tribal home would be the ideal time for kaimahi to communicate information and support safety planning.

> "I wouldn't mind that, if we had to have a meeting back there in the East Coast. ..then the therapist can fill them in on what's been happening up here cause, I won't be able to fill them in on the personal side of my son. I think it would be a big thing cause it would be hard for me to get them up here especially that lot. His Koro and them especially cause even when he goes home, that's who he goes to is to him and that's where he's supposed to be partly but he goes all over the place cause the whole family's down there. They've actually wanted to have a family gathering but it will be hard for me to get my family to come from down there cause most of them work and it will be hard to get my Mum up here cause she's only just been through an operation so she wouldn't be to the full quick at the moment. I wouldn't want her to do travel cause she's old" (W)

Consistent funding for transportation could enhance the programme.

Some of the respondents reported that it would be helpful if consistent funding for

transportation was available for both the rangatahi and their whānau members. During the data collection phase, it became evident that not all the rangatahi were fully funded by CYFs and for those that weren't, funding for whānau transportation was heavily dependent on the resourcefulness of their social worker. The whānau members of the rangatahi partially funded by CYFs were more likely to experience difficulties transporting themselves and their child to and from therapy sessions with some reporting that they had endured significant hardship as a result. One respondent reported that they had received no financial assistance to attend meetings and that their attendance required them to take leave from work which had a financial impact, and resulted in them being unable to spend school holidays with their son.

> "I have never been funded a boat ticket or a bus ticket or anything to get over there, plus my half a day off work. You know, that's huge, it's lots of money, it's not just the boat ticket and that, it's the holidays as well. That means, I've lost a week and whatever of school holidays with my son. In the school holidays in the past, I could say to him, I can have a week off with you. Well I can't do that now. I know they fund my son to get there but it does say in one paragraph they would fund me to get there, but I never have" (W)

Another partially funded respondent spoke of having their transportation funding and social worker privileges unexpectedly cut when his SAFE treatment commenced and how it therefore proved challenging transporting him to therapy twice a week on two separate days.

> "I was talking about funding assistance. You know because my son moved up here about a month before me and about a month before his last court sitting, I thought he was under CYFs at that time and they were paying for everything while he was still on with that but when they finished with his referral stuff and started new here, that was the end of it. I thought that he might've at least had a social worker but they never had any of that in place for him... when we first started, he had two sessions a week which I wasn't very happy with cause we're coming on two different days too. It was stressful" (W)

Another parent also added that when their son stopped being funded by CYFs, his probation officer suggested that he catch public transport to SAFE. This parent opposed this advice as their son was new to the Auckland region and might have absconded from treatment. This respondent goes on to say that like their son's peers, they would have preferred it that he was transported to and from SAFE by taxi. Similarly to the respondent above, this parent also spoke of the difficulty they experienced at the beginning of treatment trying to get their son to therapy twice in one week.

> *"The other alternative was the probation officer wanted me to put him on the bus to send him here and I would never agree to that because he's new himself and I don't want him getting on a bus. I think that's the other thing they kept forgetting was, he wasn't from here and he won't know these bloody things. I don't want him walking around and get into trouble. When we first started, he had two sessions a week, which I wasn't very happy with cause we're coming on two different days too. Be good if he can come on the taxi like the rest of the boys. Yeah, would be good for me"* (W8)

A notion that was shared by all of the whānau respondents receiving partial CYFs funding was the process for obtaining any extra support (e.g., for transportation) was taxing, therefore they all stopped making an effort to get assistance.

> *"I've been given a letter from SAFE to take to WINZ and I couldn't get nothing out of them. Even the probation officers gave me a letter to take to WINZ. Couldn't get nothing out of them. Yeah, nah can't get access to it. They just said, no we can't help out in anyway which I thought was bloody rude...I just left it"* (W)

Employing a Maori social worker would be helpful. Some of the whānau respondents felt that the programme could benefit from employing a culturally

152

competent social worker. At the time of the interviews, the SAFE Te Kakano team did not have a social worker attached to their team and this was particularly evident to the caregivers working in the residential care facilities. One of the residential caregivers suggested that a social worker could assist the programme in many ways including mediating with schools and residential care facilities and note taking during meetings. In addition, the respondent suggested that a Māori social worker would be a better fit for their Māori boys because they possess a cultural understanding which the rangatahi respect and enjoy and that he, as a tauiwi caregiver, cannot imitate.

> *"They could do with a good social worker now, I'll tell you that. They've had a number over the years but they don't seem to stick but a good social worker would be a great person to help all of us, communicating good with the schools, coming in to see the boys at the home which we don't get. As you're probably aware there's a lot of social workers with good intentions but the culture fit doesn't fit with the young men sometimes and I can think one of my boys whose main social worker is a white Pākeha where as I think elements of his culture he would enjoy a Māori social worker to come and do some stuff with him. SAFE lack a good Māori social worker to tap into some parts of their cultural stuff cause I'm tauiwi and I got only a minimal understanding. Preferably somebody young but also with a bit of wisdom" (W)*

SAFE should also run an adjunct for whānau. A few whānau members indicated that a social worker could organise and facilitate a parent group where whānau could safely share and support each other through the treatment course. Social workers were seen as ideal facilitators because they held a neutral stance and therefore would not take criticism personally. As noted by the respondent below, being part of a group of individuals with similar experiences could help normalise their experiences in relation to their child's offending.

> *"I would actually like to meet the other parents there and see how they feel because it's so horrible emotionally, that you think that your child's done this and it's like, the emotions that you have to deal with yourself and do they feel the same way? What are the other parents thinking? How do they feel, are*

they angry? You know, what emotions are they having...maybe a social worker could do it so the SAFE therapists don't think that's it a personal attack on them". (W)

Summary

The rangatahi and their whānau reported that a Maori framework enhanced their treatment experience because it helped to decrease their resistance to the programme and the use of a Maori model/philosophies helped to strengthen participants' identity, wellness, sense of belonging and understanding around boundaries and consequences to behaviour. Emphasising the concept of whānau and involving them in the treatment process was important to the rangatahi because they were able to showcase their personal achievements and at the same time get valuable feedback from whānau. The above findings suggest that having a separate programme for rangatahi that incorporates Maori frameworks and philosophies may be of benefit to this population.

The programme users appreciated the kaimahis' personal attributes (humour, straightforward talk, gender) stating that these helped to put them at ease. Furthermore having access to kaimahi of kaumatua status helped to reinforce the Maori cultural frameworks that were promoted in the programme such as respect, connective-ness and perseverance.

Group work was effective at creating a sense of universality among the rangatahi and the activities employed by the kaimahi helped to challenge participants preconceived ideas/assumptions and enhanced their sense of connectiveness to other group members. However the rangatahi shared that some of the group

processes need further work, in particular the presentation of disclosures in a group setting and the kaimahis line of questioning that were at times, rapid and ambiguous. The communication between the kaimahi and whānau could also be improved. This could help to advance the transparency of the programme whilst maintaining participants 'buy in' into the process.

Areas of improvement include increasing resources for both the rangatahi and their whānau in the form of introducing Maori role models and kaupapa, employing a new social worker and providing an adjunct for whānau members. Improving accessibility through home based meetings/satellite offices, tribal hui and providing consistent funding for the rangatahi was also emphasised.

Chapter 8 Discussion

Process evaluations carried out on Māori sex offender treatment programmes are sparse and are limited to adult populations (Billing, 2009; Tamatea, Webb, & Boer, 2011). Only one process evaluation has been carried out on New Zealand adolescent sex offender treatment programmes (Geary, 2007), however this evaluation was restricted to youth involved in mainstream programmes. Whilst Geary's (2007) research endeavoured to include the views of Māori participants, it is unclear how applicable their experiences would be to Māori adolescents involved in a specialised Māori programme.   This current research therefore has an important role to play in advancing limited knowledge in this area.

This chapter will summarise the key findings from a process evaluation conducted on a sex offender treatment programme specifically designed for Māori youth in New Zealand. Where possible, it discusses the current findings in relation to previous research, and contextualises some of the findings to the Māori culture. The study's strengths, limitations, and recommendations are also presented.

Overview

This research focused on the cultural practices and processes used to treat Māori adolescents who had engaged in sexually harmful behaviours. The evaluation aimed to: 1) describe the limitations of the programmes operation; 2) explore the programme's strengths and weaknesses; 3) identify the Māori models of practice used by staff and 4) investigate processes that may enhance the programme.

Qualitative methods including interviews and observation of group therapy and outdoor wilderness therapy excursions were carried out over a ten month period. Several other sources of information were collated in an attempt to document

programme processes and function including SAFE's policy and procedural manual, pamphlets and brochures, and the agency website.

A total of 23 participants took part in an interview including seven rangatahi (adolescents), nine whānau (family), three kaimahi (staff), and four key stakeholders (external agency staff who worked directly with participants).

Key findings

Overall feedback about the programme from the rangatahi, whānau and key stakeholders was positive. The personal attributes of the kaimahi and the integration of a Māori framework were viewed as programme strengths by the respondents. Both the rangatahi and whānau members indicated that the programme helped them to understand that all behaviour has limitations and consequences, and that positive relationships are crucial to wellness. In addition, they noted that the kaimahi were responsive to acculturation issues and were mindful in how they integrated cultural concepts into the programme. In addition to the programme strengths, respondents identified perceived limitations to the programme as well as suggestions for programme improvement.

Culturally appropriate approaches with sexually abusive Māori youth are helpful for engagement. The fundamental finding of this research was that, despite participants possessing differing levels of cultural knowledge and experience, the Māori model and practices integrated into the programme were understood and embraced by the clients. The programme utilised a holistic approach to offending, as the respondents were encouraged to attend to their sexually harmful behaviours whilst nurturing a positive cultural identity and core relationships.

Numerous studies have acknowledged the benefits of culturally focused treatment programmes when working with indigenous populations (Durie, 2003; Fine, 2002; Huriwai, Sellman, Sullivan & Potiki, 2000; Stuart & Jose, 2014; Thakker, 2013). Durie (2003) proposed that for Māori, poor mental health and wellbeing stem from an insecure identity. Māori-centred therapies therefore assume that a confident identity is necessary for wellbeing and can act as a foundation for the healing process (Durie, 2003; Huriwai et al, 2001; Stuart & Jose, 2014).   This was evident in the Stuart and Jose (2014) and the Huriwai et al., (2001) studies, where a favourable Māori identity functioned as a protective factor for Māori mental health consumers, by indirectly enhancing clients' sense of self. Furthermore Billing (2007) and Tamatea, Webb, and Boers (2011) determined that promoting kaupapa Māori principles and practices during the treatment of adult Māori sex offenders have been shown to help individuals develop a meaningful identity other than that of a sex offender. Billing (2007) also reported that focusing on cultural strengths and resources can stimulate "hope for change and increase confidence in one's ability to change" (p. 122).

Whilst the above research is promising, Thakker (2013) and Sibley and Houkama (2010), concede that gaining an understanding of the specific clinical factors through which a cultural focused approach effects an individual's wellbeing is difficult. The current study offers some insight into the cultural processes and practices that were clinically helpful to a group of Māori adolescent sex offenders.

Māori models and practice. The ethnic diversity of the New Zealand population and obligations to the Treaty of Waitangi have highlighted the need for treatment programmes that are culturally responsive to its consumers (Tamatea, Webb & Boer, 2011). The use of Maori models and practices in the Rangatahi programme was apparent throughout data collection. The most recognised therapeutic approach used by the kaimahi in this study was the 'Te Whare Tangata' model. Most of the rangatahi were able to accurately recount the model's cultural symbolism and how it encapsulated sexually harmful behaviour suggesting that using Maori frameworks and philosophies during treatment may be of benefit to this population.

Although the use of the marae and traditional values to bring about a sense of order in one's life is well documented in Māori tradition (Durie, 2001), their use in the context of sexual offending is relatively new. In fact, Māori society has tikanga surrounding the tapu of an individual's body and the consequences of violating an individual's personal space (Durie, 2001; Moko-Mead, 2002; Webb & Jones, 2006), however little has been documented on how traditional Māori societies may have used traditional symbols and values to manage and contain sexual violations.

As noted in chapter 3, Te Whare Tangata uses the traditional marae and customary Māori values and beliefs to address an individual's sexualised behaviour.

Māori academics argue that the use of the marae in this context is suitable and symbolic because it is a vital part of Māori culture (Durie, 2001; Moko-Mead, 2002) and the marae is a fitting framework because the human communication, behavioural boundaries, and traditional practices that take place at marae gatherings remain consistent over time (Durie 2001, 2003). O'Connor and Macfarlane (2003) support this view, stating that for disenfranchised or marginalised Māori, the marae setting can act to reinforce one's Māori identity and restore their sense of purpose. This was evident among some of the whānau members who reported that being exposed to the Te Whare Tangata model re-exposed them to aspects of their Māori cultural heritage that was thought lost through the urbanisation process, for instance, being informed about the true function and structure of the marae.

Furthermore, karakia were used at the beginning and end of every treatment interaction. Barlow (1991) described karakia as, "pleas, prayers or incantation addressed to the gods ...[so they may intervene]... in the affairs of mortal men by providing comfort, guidance, direction, and blessings for them in their various activities and pursuits" (p.37). Karakia were performed in both English and Māori and more importantly, whānau acceptance and participation in the process was never assumed. In this sense the kaimahi were aware that a majority of the whānau were not of Māori descent; therefore it was important to invite participation rather than expect compliance. This caution likely stemmed from the view that non-Māori should also be shown manaakitanga (love and hospitalilty) by having their ethnic mana (prestige) respected (Barlow, 1991). William and Cram (2012) would argue that by showing consideration in this instance, the kaimahi were exercising kotahitanga, "which denotes group unity whilst respecting individual differences" (p.

52). The effectiveness of karakia in a clinical setting has never been proven by scientific research, but anecdotal evidence suggest that these methods have been helpful in increasing engagement and retention through greater cultural suitability and relevance among addiction service users (Huriwai, Sellman, Sullivan & Potiki, 2000), adolescent and adult Māori sex offenders receiving treatment in the community (Billing, 2007; Geary, 2007), and incarcerated Māori sex offenders (Tamatea, Webb & Boer, 2011).

The use of stories depicting successful Māori who had overcome adversity was also used on several occasions to challenge clients' negative perceptions of Māori. The rangatahi were encouraged to contemplate the idea that ethnicity does not dictate, conduct, or predetermine future aspirations. Many of the respondents reported that these concepts were initially unfamiliar and difficult to comprehend, however, once accepted their motivation to become a "good Māori" and finish treatment increased significantly. Cherrington (2002) suggested that using Māori mythology in a clinical setting is helpful because it is more meaningful to the individual and promotes Māori identity through the acknowledgement of Māori ancestors. Furthermore, Cherrington (2002) added that using Māori mythology allows clinicians to creatively explain an individual's personality traits and integrate concepts such as grief, change, and loss. Additionally, this author reported that Māori mythology is particularly helpful when working with young people and their whānau because it gives clients exposure to Māori families who were not perfect but have pushed through adversity in order to succeed.

Several of the kaimahi shared that the Rangatahi programme could benefit from expanding its cultural resources further. For instance engaging cultural experts

from the community to teach traditional Maori practices that clients can integrate into safety plans as alternative behaviours to sexually harmful conduct; developing treatment workbook modules and resources which address sexually abusive behaviours whilst incorporating aspects of the Māori culture; and developing an assessment tool that identifies client strengths, cultural values, culturally relevant risk factors and supports.

Whānau and Whānaungatanga are important. The Te Whare Tangata model emphasised several traditional Māori values with respondents in this study, acknowledging the concepts of whānau and whānaungatanga as being pivotal to a positive treatment journey.

Family involvement in the treatment of sexually abusive youth has been widely discussed in the literature (Anaforian, 2008; Billings, 2007; Campbell & Mores, 2013; Gallardo & McNeill, 2009; Greary 2007; Tamatea, Webb & Boer, 2011; Williams & Cram, 2012). Thomas (1997) wrote that family participation is essential in this context because "every adolescent enters treatment with a family attached" (as cited in Rich, 2003). This is consistent with Rich (2003) who added that "patterned family emotional, cognitive and behavioural scripts may be partially responsible for the enactment of sexual offending behaviour" (p.413). Several studies have also acknowledged that sexually abusive adolescents are more likely to complete treatment if their family are active in the treatment process (Worley, Church, & Clemmons, 2011; Worling & Curwen, 2000; Yoder et al., 2015).

From a Māori cultural perspective, researchers such as Durie (2003) and Love (1999) would argue that family involvement should always be considered in the

therapeutic context because the mana of an individual and their whānau are intertwined to the extent that they are inseparable. Moeke-Pickering (1996) also wrote that the formation of a secure whānau identity is likely to contribute towards an overall stable Māori identity. This relates to Durie's (2003) assumption that poor mental health can occur when an individual has inadequate relationships with others. Durie (2003) proposes that relationships should therefore be a core focus of change for Māori offenders as transformation can take place through "the resolution of hurts and the restoration of healthy patterns of interaction" (p. 72). Durie (2003) also acknowledged that this is particularly important as many Māori families do not have the "infrastructure, resources or cohesion to offer anything more than token responses to relatives in need" (p.149). Relationship difficulties, poorly developed social skills, and social isolation have been reported among sexually abusive youth (Rich, 2003). The concept of whānaungatanga, which emphasises the sense of belonging as a result of relationships and kinship ties (Moko Mead, 2002; Williams & Cram, 2012) was a consistent theme, which emerged throughout the data collection phase. Specifically, the adolescents' relationship with family and their wider community were carefully weaved through every facet of their work and in-treatment social interactions were dictated by the whānaungatanga process. Most of the participants reported an improvement in family relationships as a result of the programme. Furthermore, the rangatahi indicated that having family involved and supporting the treatment process gave them the opportunity to showcase positive progress and rebuild family trust. The whānau respondents reported that their involvement facilitated processes such as forgiveness, acceptance and togetherness. These findings give credence to the theory that family are a fundamental resource that support change for Māori adolescents (Huriwai et al.,

2001; Stuart & Jose, 2014) and that a resilient whānau are better equipped to protect and support its members from adversity at an individual and collective level (Campbell & Mores, 2013).

An important issue to note here is over three quarters of the rangatahi in the study were residing in fulltime CYFs residential care due to SAFE placement restrictions which stipulate that the rangatahi are not to reside in the same residence as their victim or with children under the age of 12 years. Because of this, interactions with primary family members were often infrequent. This study did not explore how living arrangements during treatment may have impacted on the adolescent-whānau relationship or the staff's capacity to deliver and maintain whānau based therapy. It is therefore recommended that this issue be explored further in the future.

Tikanga practice are individually tailored. The tikanga that the rangatahi were exposed to was also carefully considered and individually tailored by the kaimahi. This vigilance was thought necessary because the rangatahi were affiliated to different iwi whose tribal tikanga may have differed to the tikanga generally practiced at SAFE Auckland. The notion of 'attending to individuals' tikanga is another example of culture responsiveness and relates back to the idea of paiheretia which stipulates that Māori therapists "are not required to be experts in all aspects of the Māori culture or [possess the knowledge of their elders] but they do need to know how to enter the Māori world… through understanding a range of gate keeping roles occupied by individuals or agencies in respect of Maori knowledge and resources (Durie, 2003, p.52). Huriwai et al., (2001) reported that matching tikanga is an issue faced by many Māori mental health clinicians as many are left contemplating which tikanga to expose clients to: the therapist's, the client's or the

iwi's in which the organisation sits. Indeed this was an issue that weighed heavily on some of the kaimahi in this study.

Although the benefits of using a cultural approach have been outlined above, it is important to mention that for the kaimahi, working in a Māori programme also had its challenges. Firstly, many reported that their decision to work with Māori adolescent sex offenders was not a choice, but rather an expectation placed on them by their whānau and respective communities. Furthermore, the pressure to be successful and continue in their role as therapists despite experiencing adversity (e.g. feeling undervalued and overworked) in their job was high. These expectations have also been noted among Māori counsellors working in mainstream mental health organisations (Love, 1999). Love (1999) added that Māori counsellors can also experience conflict as a result of differing interpretations of counsellor-client boundaries and professionalism when compared with non-Maori clinicians.

These findings suggest that Māori therapists working with sexual offender populations need to be adequately supported and trained to work with this population. Because of the type of work, therapists in this area may experience high levels of stress and burn out (Sandhu, Rose, Rosthill-Brookes & Thrift, 2011), vicarious trauma, and potentially be at risk to clients (Billing, 2007). Feelings of discontent and experiences of high pressure were evident in this study, with the kaimahi reporting that their skills, uniqueness, and cultural expertise were often disregarded. Moreover the kaimahi appeared to lack autonomy over some of the programmes every day running such as client allocation. This process was instead controlled and facilitated by the Te Kakano team leaders. It is highly plausible that the Rangatahi programme staff's lack of clinical autonomy likely created a power

imbalance within the Te Kakano team resulting in further pressure on team dynamics and kaimahi wellness. In addition, the kaimahi indicated that the clients admitted to the rangatahi programme were clinically more complex than other adolescent sex offenders not referred to the programme, and their caseloads were often over stretched. These perspectives were empirically supported by a recent study conducted by Lim, Lambie, and Cooper (2012) in which it was established that Māori youth referred to a community treatment programme for sexual offending had significantly more complex needs than their Pākeha peers. In addition, Māori youth had considerably higher rates of internalising and externalising behavioural problems and were more likely to acknowledge a history of victimisation. Furthermore, some of the key stakeholders in this study stated that decisions were often made to refer Māori clients to other sex offender treatment programmes because the Māori clinicians at SAFE were carrying excessive caseloads. Lim, Lambie, and Cooper (2012) have reported that because of the issues noted above, professionals working with Māori adolescent sex offenders are likely to experience significant challenges designing and implementing programmes that are responsive to their complex needs.

Therefore, it is integral that kaimahi have consistent access to resources that will extend and reinforce their knowledge base, as well as increased access to clinical and cultural support. This view is supported by Lim, Lambie, and Cooper (2012) and Geary (2007) who stated that kaimahi working with this population would benefit from smaller case loads, and having access to greater resources including enhanced training and professional development. In addition, organisations working

with this population may benefit from hiring more clinically competent Māori therapists (e.g. Maori social worker) and at the same time increasing cultural competency training for non-Māori clinicians.

Access to adequate external cultural supervision with individuals who are well versed in diverse Māori tikanga and clinical experience was eagerly sought by the kaimahi as it was hoped that they could guide the cultural concepts delivered and ensure they were safe. Seeking out these valuable individuals was not permitted due to restrictions by management, costs and the difficulty sourcing these individuals. Given the challenges faced in regards to external cultural supervision; it is even more important that the kaimahi are connecting and associating with other Māori clinicians working in the field because these interactions could act as an alternative form of cultural supervision for Maori staff in the meantime.

Staff characteristics were essential to engagement. Staff attributes were identified as an important feature that positively impacted on the programme users (whānau and rangatahi) experience in treatment.

A strong client-therapist relationship during treatment was also imperative with many rangatahi perceiving the kaimahi as role models of positive relationships. Similar client-therapist relationship needs were also reported among mainstream sexually abusive youth receiving treatment in the community (Geary, 2007).

The kaimahi are culturally responsive. The feature that consistently made the programme processes successful was the kaimahi's responsiveness to acculturation issues. The kaimahi encouraged the rangatahi of mixed race to explore their Māori and non-Māori whakapapa, and find strength and support in these affiliations. Furthermore, the kaimahi, through their extensive clinical

experience and cultural competency, were able to identify issues that accompany youth of mixed race. In this study, they addressed these issues by acknowledging and building on all of the client's ethnic affiliations rather than just focusing on their Māori identity. In addition, the kaimahi identified the rangatahi's high acculturation to the Pākeha culture as a potential engagement issue. The kaimahi hypothesised that many of the youth would likely struggle in a full kaupapa Māori programme and therefore would progress better in a treatment programme that combined important aspects of tikanga Māori with westernised therapeutic theories and techniques, for instance performing karakia, whakawhānaungatanga process as well as using Te Whare Tangata and other therapeutic approaches such as CBT, DBT, Transactional Analysis etc.

Whilst some may argue that this type of programme is depriving its consumers of the potential gains of an all-inclusive kaupapa Māori programme, others would support the decision because the staff were actively attending to the subjective, complex, and dynamic diversity of their clients (La Roache, & Maxie, 2003). Thakker, (2013) has also suggested that assuming that all Māori offenders have the same overarching beliefs is therapeutically unsafe because it can lead to clinicians making assumptions based on stereotypes and generalisations. The above findings are supported by Tamatea, Webb, and Boers (2011), who acknowledged that sex offender treatment programmes should be adapted to accommodate the cultural needs of those who participate and failure to recognise an indigenous person's cultural affiliation and values may result in the offender feeling alienated and neglected (Huriwai, Sellman, Sullivan & Potiki, 2000).

An important issue to consider when working with young people of mixed

cultural heritage is highlighted in Gallardo and McNeil's (2009) study. These authors

emphasised the importance of identifying parenting styles and the messages

endorsed by parents about their adolescent's ethnic culture and experiences as a bi-

cultural child.   For instance, if a Māori client is brought up in Pacific family where

their Māori culture and identity is shunned and made fun of, the client is likely to have

difficulty engaging in a programme that encourages the client to embrace their Māori

identity. Gallardo and McNeil (2000) argue that understanding this discourse and

cultural conflict could be key to therapeutic success when working with indigenous

youth.

Cultural matching client to therapist. Firstly, most of the rangatahi reported

that seeing a Māori therapist had a positive influence on reducing their anxiety

because they believed that they would be less likely to pass judgment on their

personal circumstances and also understood the 'Māori way of being'. This was also

evident in Turner and Manthei's (1986) study where the Māori adolescents reported

that they preferred to have Māori therapists because they were impartial and more

understanding of their circumstances.

Research on the effectiveness of ethnically matching clients to therapists have

established mixed results. Some researchers report that the process results in better

treatment outcomes for its users (Tamatea, Webb & Boer, 2011; Brown, George,

Sintzel & Arnault 2009) as clients are reported to stay longer and improve faster

because of similarities in cultural beliefs and attitudes (Zane et al., 2005).

Furthermore, the ethnic matching of clients with professionals in a therapeutic

environment can challenge the clients' preconceived ideas of how people of their culture should behave and exist (Clark & Witkos, 2006).

Previous research into sex offender treatment programmes in New Zealand for Māori adolescents and their families affirmed the importance of specialised cultural services by reporting that Māori adolescent participants and their caregivers found the inclusion of Māori therapists "essential" to the client-therapist relationship and in turn in the therapeutic success (Geary, Lambie & Seymour, 2006). This is further supported by the Primary Health and Population Health Care researchers (Ape-Esera, Goodyear-Smith, and Nosa, 2009) who also found a positive association between ethnic specific therapists and increased client retention, utilisation of services, and therapeutic success.

Tamatea, Webb, and Boer (2011) and Geary (2007) were more cautious noting that ethnically matching Māori clinicians with Māori clients is ideal, however, it is often difficult to achieve because of the limited availability of clinically trained Māori clinicians (Geary, 2007). Furthermore, international research states that rather than ethnically matching clients to therapists, clients and therapists would be better placed according to similarities in understanding of problem behaviour, their willingness and interest to explore healthier coping strategies, and having shared treatment goals and expectations (Zane et al., 2005; Imel, Atkins, Baldwin, Owen & Baardseth, 2011). Despite the varied opinions on the effectiveness of cultural matching, what is clear is increasing Māori in clinical and managerial positions is necessary (Greary, 2007) and an important step towards arikitanga (power and authority) and better health for Māori mental health consumers (Barlow, 1991; Durie, 2003; Billing, 2007).

An unexpected finding of the current study was how the rangatahi's perceptions of the kaimahi impacted on their level of participation. Strong parallels were drawn between the kaimahi and relatives who had positively influenced an adolescent's life including respected kaumatua, aunt, or uncle. The rangatahi reported that because of this association in their private lives, during treatment at SAFE, they were mindful of their behaviour around the kaimahi of kaumatua status and were more relaxed around the other staff because they reminded them of aunties/uncles who were fun and put them at ease. Moko-Mead (2002) and Love (1999) would attribute these views to the whānaungatanga principle; in particular the idea that non-kin people can become like family through shared experiences. Western models of counselling may ascribe these associations as inappropriate and potentially the result of a breach in counsellor-client boundaries, while in the setting of the current study, it was found to be culturally appropriate (Moko-Mead, 2002; Love, 1999)

Tamatea, Webb, and Boer (2011) acknowledged that culture can affect how an offender perceives and interacts with a therapist. In particular, these authors reported that matua (older male) clinicians conjured up strong negative cultural attitudes among adult Māori sex offenders. While some clients have positive feelings towards these matua, these authors suggest that unrecognised cultural attitudes held by offenders towards these matua can compromise working alliances. For instance, some clients stated that matua clinicians invoked feelings such as anger and shame because they associated these individuals with negative authority figures present in their upbringings. Other clients admitted that they often agreed with the older therapists' clinical recommendations despite having an opposing view. This

deference towards authority has also been reported among Asian Americans in a study by Sommers-Flanagan and Sommers-Flanagan (2003). They wrote that, "Asian Americans expect a counsellor to be an expert and act with authority...and when faced with uncertainty, Asian Americans simply offer the most polite, affirmative response available" (Sommers-Flanagan & Sommers-Flanagan, 2003, p.385). Whilst this negative association towards matua may have been present for some respondents in this study, most indicated that they behaved deferentially toward staff of kaumatua status because they respected their age and extensive knowledge/experience.

   A relaxed therapeutic style is important. Having access to a clinician with a calm demeanour and casual approach to therapy was important to both the rangatahi and whānau members. Spending time building rapport in the early stages of treatment and slowly pacing or layering difficult pieces of work (i.e., cycle of offending and victim disclosures) decreased client anxiety and made the treatment process feel manageable. The benefits of a laid-back therapeutic approach were also noted by research participants in mainstream adolescent sex offender populations and Maori adult sex offenders (Greary, 2007; Tamatea, Webb, & Boers, 2011). Adding to a relaxed therapeutic environment was the therapists' use of humour. Whilst humour was used throughout the therapeutic process, it's use to diffuse emotionally charged situations was acknowledged and appreciated by all of the respondents. While some sex offender researchers advocate caution when using humour in a clinical setting, most have proposed that the careful integration of humour can lead to increased client-therapist rapport and create opportunities for therapists to explore clients' deviant sexual desires (Eisenman, 1992). In addition,

humour can be a helpful means for staff to cope with the challenges of working alongside sexually aggressive populations (Sandhu, Rose, Rosthill-Brookes, & Thrift, 2011). This was supported by Gallardo and McNeill's (2009) study which found that humour has been used to strengthen therapeutic alliances with indigenous people and is often used as a coping strategy by some native cultures.

Group processes

Peer relationships within the treatment programme were also emphasised and continually reinforced through weekly group sessions, pepeha and whānauake presentations, group role-plays, and outdoor wilderness experiences. Outdoor wilderness experiences were particularly popular in this study as the experience was enjoyable and created opportunities for the rangatahi to develop bonds with peers outside of the usual treatment environment. This finding was not unsurprising, given the importance of peer friendships among this age group. Literature outlining the use of group work when working with sexually abusive populations is mostly positive with authors such as Rich (2003) stating that "it's the preferred and predominant mode of treatment [among providers] because it's an effective means for delivering treatment messages; developing new ideas, behaviours, and skills; and bringing about change in participants" (p. 248). Other writers have found that positive change only occurred in the context of a group. For instance, Billing (2007) indicated that group support and shared group experiences facilitated the disclosure process and encouraged a group of tane to take responsibility for their sexually deviant behaviours. Others have indicated that groups provide a supportive environment where sexual offenders could learn basic relationship, communication, and social skills (Rich, 2003; Somervell & Lambie, 2009), whilst safely focusing on issues most relevant to sexual offending.

Barriers to treatment

The rangatahi, whānau and key stakeholders identified several barriers to the treatment experience including programme processes and the staff appearing disorganised (e.g. no pre-entry or interagency information available, inconsistent documentation practices during family reviews) and poor communication between the kaimahi and whānau/key stakeholders. Furthermore the whānau spoke of the difficulty accessing SAFE services due to transportation costs and whānau being located outside of the Auckland region.   Similar barriers have been identified in adolescent sex offender treatment literature both within New Zealand (Geary, 2007, Billing, 2007) and overseas (Borduin, Henggeler, Blaske, & Stein, 1990., Worley, Church & Clemmons, 2011., Yoder, Hansen, Lobanov-Rostovsky, & Ruch, 2015). Yoder and Brown (1995) acknowledge that failure to attend to these barriers may hinder family engagement in treatment which is problematic because the literature clearly shows that family involvement in the treatment process leads to better treatment outcomes for sexually abusive youth (Geary, 2007; Yoder & Brown, 2015). Furthermore even though there are costs and timing difficulties associated with attending tribal hui or holding system reviews in the whānau home, the participants in this study who experienced this reported that the system reviews within the family home completely changed their perceptions of the programme from negative and resistant to engaged and supportive.

Programme Recommendations

Along with programme recommendations it is important to acknowledge what can be learnt from how the Rangatahi programme itself was established. Although the

development of Te Kakano and the Rangatahi programme showed SAFE's recognition and commitment to the Treaty of Waitangi, it is important to realise that these programmes were formed quickly, with limited consultation from cultural experts throughout the programme development process. Berentson-Shaw's (2012) study found that it is important to use evidence-based research and Māori consultation when developing Māori health frameworks in a clinical setting.

Discussions with Māori experts and SAFE Māori clients is important in this context because they may offer a Māori perspective which may not be reflected in published data and these views may counteract possible bias held by SAFE clinical management. In addition, Durie (2003) stipulated that Māori health programmes will struggle to make any headway if they are put in place with little community ownership or control. Although the Rangatahi Programme has achieved substantial clinical outputs, it was evident throughout this research that the kaupapa and direction of the programme was unclear to the kaimahi, and staff tensions were high due to work stress and the internal dynamics/politics within the Te Kakano team. Although some may attribute these observations to workplace stressors and staff unaccountability, it is also important to consider how the stress and tensions currently experienced by kaimahi could be the result of poor programme planning. The programme recommendations resulting from the current study attempt to address these issues.

Based on the research findings, the following recommendations for the SAFE Rangatahi programme were made. These recommendations reinforce programme strengths and offer areas of improvement. Although some of these recommendations may be applicable to mainstream adolescent sex offender

programmes, great efforts were made to also include culturally responsive programme delivery recommendations.

1. When programmes or frameworks are developed for Māori adolescents or have high numbers of Māori adolescent participants, it is important that Māori are represented at a managerial and programme staff level. It is vital that Māori are included in organisational decisions and have input into programme design, deliverance and evaluation to ensure cultural appropriateness and accountability.

   a. Māori cultural experts, Māori consumer perspectives, and evidence-based research should also be considered in major decisions that will impact on the programme's operation.

2. The kaupapa, goals, mission statement and programme policy and procedures need to be discussed, refined, and formalised. These should reflect the importance of Māori worldviews, beliefs and practices. These operational documents should be reviewed and amended regularly as the programme evolves.

3. The programme should provide rangatahi and whānau with good pre-entry information and educational material that is simple, easy to read, and specific to the kaupapa of the SAFE Rangatahi Programme. Providing clients with generic mainstream documentation is a missed opportunity for SAFE to promote its commitment to the cultural diversity of its clients.

4. The programme needs to improve interagency communication through written protocols and greater clarification of agency roles and expectations to avoid confusion, ensure appropriate referrals and adequate support is allocated to the rangatahi and their whānau.

5. The client allocation process should be negotiated and involve input from all staff working within the Rangatahi Programme. This process will give staff the forum to deliberate and match their clinical skills to their client needs.

6. Given the complexity of the clients entering the rangatahi programme, it vital that the clinicians' client caseloads are kept small so the staff have adequate time to prepare and train.

7. The kaimahi continue to utilise, develop and review cultural practice and processes.

    a. The use of a simple symbolic Māori model which incorporates traditional values and fundamental processes and practices was generally understood and embraced by the clients.

    b. It is important that service users are invited to participate in these processes and that acceptance of cultural practices by clients is not assumed.

8. Given individual differences, treatment plans should be responsive to the diversity of individual Māori clients. Not all Māori youth like to be paired with someone of the same race or be involved in a programme specifically designed for Māori. It would therefore be helpful if cultural assessment questions were developed to identify which treatment programme would best suit a client's needs (i.e., Māori, Pacific or mainstream).

    a. When using tikanga procedures that differ to the service users, it is important that this distinction is clearly outlined to clients. It should not be assumed that all youth/whānau are aware of the diversity that exists between iwi.

b. It is important that the kaimahi are mindful of how their physical presence may positively or negatively influence a client's treatment experience and how these cultural associations could be used to get the 'best' out of individual offenders.

c. Clinicians must be cautious when using psychometrics that have been normed on non-Māori populations. It is important that clinicians also consider contextual and socio-cultural factors when developing a client's clinical formulation and treatment plan.

9. Assessment tools should identify client strengths, cultural values, and processes, as well as culturally relevant risk factors and supports.

10. The use of treatment modules and client workbooks provides structure and meaning to the treatment process.

a. If Māori frameworks are to be utilised by kaimahi, it makes sense to develop Māori treatment modules including client workbooks that are culturally responsive to clients. It is important that the information displayed in the modules and workbooks is culturally accurate and the process is guided by appropriate cultural dialogue

11. Easy access to treatment services will positively impact on service user participation. The kaimahi should offer satellite services or consider conducting treatment sessions at the clients' home or marae. Face to face meetings should begin as soon as possible and occur regularly throughout.

a. Conducting whānau education days in tribal regions will benefit clients from collective rural Māori communities. While this may have significant funding implications, the process will provide a forum where client

anxieties can be displaced and all whānau involved in the young person's care can be updated on SAFEs treatment requirements.

b. Regardless of where adolescents reside during treatment (e.g., CYFs residence or whānau home), all should receive funding for transportation to and from their SAFE appointments. This will enable regular, punctual attendance by clients.

12. In order to recruit and retain quality Māori therapists, it is recommended that the organisation:

a. Employ more Māori personnel that place value on cultural and clinical competence. These individuals do not need to be fluent in Te Reo Māori but they do need to have a thorough comprehension of the Māori culture and the issues facing Māori youth, for instance being of mixed ethnicity, Māori customs, traditions, values, roles and responsibilities.

b. The programme makes provisions for therapists to work with individuals from the community who can teach traditional practices that clients can integrate into safety plans such as mau rakau and kapa haka. Bringing in successful SAFE graduates during group may also be of benefit.

13. The programme needs to provide strong organisational support for its staff including effective clinical training and access to both clinical and cultural supervision. This will ensure competence and safety.

a. Cultural supervisors should be knowledgeable and be open-minded to the cultural diversity of the clients and kaimahi.

b. Providing cultural competency training to all organisational staff is also vital as non-Māori clinicians may work with Māori youth.

c. It is important that the pressures associated with being a Māori clinician (e.g., expectations from whānau/community and difficulties with confidentiality) are acknowledged by management and that opportunities to discuss how these pressures may impact on their professional and non professional lives are made available.

14. In order for the programme to function more effectively, several operational issues need to be attended to including:

a. Better communication between whānau and kaimahia about meeting cancellations, clarity about programme length, client progress and treatment expectations. If kaimahi are to conduct home based meetings, it is imperative that they inform whānau who will be attending.

b. Improved documentation practices during system review meetings including notes being taken and made available to attendees, and meeting objectives clearly outlined.

15. Ensure ongoing research and evaluation of the programme with a focus on cultural influences and processes in treatment.

Strengths and Limitations

A strength of this research is that it emphasises the perspectives of service users which are often overlooked in adolescent sex offender treatment studies. The data collected from the interviews is also 'rich' in detail and depth because a large number of Māori participants were recruited into the study and the interviews were in-depth. The findings of this study will in turn help to advance the limited knowledge in this area.

Although, gaining a wide range of service user perspectives was useful, a limitation of the current study was that a significant number of interview participants had left the programme due to graduating or dropping out (inactive clients), making their ongoing engagement in the research process difficult. During the data collection phase, significant attempts were made to engage as many of these clients however their contact details were either out of date or their whānau refused participation because they had "since moved on with their lives". It is important to note however that all the participants who agreed to participate in the research from the start, completed the entire research process.

The perspectives of the Te Kakano management are also absent from this study as they did not respond to attempts made by the researcher to engage them including emails and phone calls. The exclusion of these perspectives poses problems with internal validity, particularly in relation to whether the beneficial and detrimental inferences made about the programme are reflective of all SAFE rangatahi service users/kaimahi or just those who participated in an interview. Furthermore the Te Kakano management perspectives might have provided an additional unique insight into the programmes functionality. It is important that future research includes the perspectives of team leaders and if this not achievable, steps are made to understand why these individuals chose not to respond. This information may prove vital in understanding the programme's processes. Some ideas regarding the facilitation of their participation include arranging a hui with Te Kakano management, the researcher and the researchers supervisor in an attempt to negotiate their participation and asking SAFE management or a respected kaumatua to advocate on behalf of the research.

Another strong point of this research is the methods used to analyse the data. Rather than using qualitative analysis software, the researcher chose to perform qualitative analysis by hand, including formulating the themes and codes with two separate Māori colleagues. Klein and Olbrecht (2011) reported that although the above process is lengthy, the inclusion of different perspectives during the evaluation phase will likely produce new insights and theories not previously available to the researcher thereby improving the richness of findings and the reliability of outcomes. Furthermore, the data collected was often checked with programme facilitators and programme service users to ensure that the information collected and observed throughout the data collection phase was true and correct. Hammersley (2008) refers to the latter strategy as a kind of triangulation that enables researchers to "check the validity of descriptive inferences by comparing data sources which may threaten validity" (p. 24).

In addition, Māori consultation took place throughout the entirety of the research project. Great efforts were made to ensure kaimahi participated in the development and implementation of data collection procedures and Māori experts and colleagues were consulted during the data analysis phase. The significance of Māori participation and consultation is surmised in the charter of Indigenous Tribal People of the Tropical Forests (1993) which suggests that the "participation by indigenous people in the management of projects and an insistence that all investigations in indigenous territories should be carried out with indigenous peoples consent and under joint control and guidance" (Cited in Smith, 1999, p. 123). In addition, Durie (2011) added that, "active participation in research should not be

confused with being an object of research. Māori are interested in research design, the choice of methodology, protocols for involving others, and procedures for engagement with Māori individuals as well as Māori communities" (p.268). Furthermore, Durie (2011) reported that for participants, "working alongside experienced researchers will contribute to capability building, self-determination and greater autonomy" (p.268-269). What's more, throughout the entire research project care was taken to ensure that the views of the research participants were correctly represented and that final outputs were balanced and not harmful to Māori. This meant that the research process took much longer than expected as considerable time was spent reflecting and formally documenting the processes and perspectives obtained. Durie (2011) and Smith (1999) indicated that a sense of cultural responsibility coupled with fears that the research findings could be misused during dissemination (Billing, 2009) are issues that weigh heavily on many indigenous researchers working in the field.

Interpretation of the findings of this thesis is limited by the qualitative nature of the study, which does not allow for generalisations, and because of the paucity of research with which to compare these findings. It is important to note however that qualitative methods are particularly valuable when conducting process evaluations because researchers are able to explore programme dynamics whist gathering rich information about the programmes functioning (Patton, 1990).

In the quest to write a thesis that would benefit Māori, it is possible that certain aspects of the programme were more attended to that showed the programme and positive Māori experiences more favourably. However several steps were taken to ensure that research process was kept objective, including fully informing consenting

participants about the researcher's role and clarifying the kaupapa and research dissemination process with participants. Additionally, the researcher received supervision (including peer supervision) to consider the impact of their own values and bias on the research process. Furthermore strategies such as triangulation helped to minimise issues associated with validity and reliability.

Finally, the participants' awareness that they were being evaluated may have affected how they behaved during group sessions and also how they answered interview questions. It is likely that not everything that the participants reported was true and that some of their responses may have been influenced by their desire to please the researcher/kaimahi. In instances when it became evident a respondent may be making false statements or subjugating responses to keep others happy, statements were either directly contested during the individual interview or clarification was sought from the kaimahi. Furthermore, the researcher observed weekly group sessions for a period of seven months and also attended two outdoor wilderness experiences with the young men. It appeared that over time the group became more comfortable with the researcher's presence during these sessions. In the beginning, the group was observed to be compliant to demands during group activities but unresponsive to questions posed by staff. After eight weeks of continuous attendance, the group were actively socialising with the researcher, the kaimahi and each other, and were enthusiastically engaged in group activities. They were also responsive to the kaimahi's questions and would often challenge each other and the kaimahi when necessary. These behaviours remained consistent over the duration that the researcher remained in the group and only changed when new rangatahi were introduced to the group and this behaviour would indicate a certain level of comfort and therefore candidness with the researcher. As most of the

interviews were conducted after three months of group observations it was expected that participants would be comfortable with the researcher's presence and therefore more forthcoming with their responses. It was also hoped that the fact that the researcher was a young Māori individual may also have encouraged respondents to engage fully in the research process.

Recommendations for future research

An obvious direction for future research would be to examine the outcomes of the rangatahi programme including recidivism data (Billing, 2009). Furthermore, conducting an outcome and impact evaluation will also provide valuable information about the effectiveness and enduring changes resulting from participation in this programme. Combining all of these findings (process, outcome, and impact) will help to guide managerial decisions about the programme's future direction including its true function and worth.

It is important that the kaimahi are up to date with research highlighting the issues that may significantly impinge on Māori adolescent offenders including living as a mixed ethnic youth in a westernised society, issues with cultural identity, changes to whānau structures and living arrangements, cultural associations that could impact on treatment, educational expectations et cetera. Continually researching these and other lifestyle issues will help staff be more responsive to a young Māori offenders needs.

Future research should also make greater attempts to include the perspectives of programme management and inactive clients (graduates and drop outs). As noted earlier, these individuals may provide alternative perspectives not evident in this study or in the current literature.

The current study focused on the perspectives of Māori adolescents participating in the SAFE Rangatahi Programme. It is hypothesised that the experiences of Māori adolescents taking part in non-Māori sex offender treatment programmes would differ significantly. In order to get a broader understanding on what works and doesn't work for Māori adolescent sex offenders, it is recommended that qualitative research is undertaken with Māori youth participating in mainstream, special needs, and female only treatment programmes for comparison.

Most of the rangatahi in this study identified as being of mixed ethnicity who did not fully identify as Maori. The kaimahi in response chose to implement a treatment programme that combined important aspects of tikanga Māori alongside westernised therapeutic theories and techniques. This approach may not be the preferred choice of other Māori practitioners and for this reason it would be helpful to also undertake research exploring the strengths, weaknesses and limitations of a full kaupapa Māori programme. Given that there are very few, if any of these programmes currently operating in New Zealand, researchers may need to source this information from adult sex offender programmes, other offender-based programmes or develop one to then evaluate.

Research into how the cultural initiatives used by the kaimahi could be measured would allow the kaimahi to adequately track their client's cultural and offender based goals. Furthermore, investigating other traditional Māori practices that could be integrated into treatment would provide the kaimahi with culturally responsive treatment alternatives.

Conclusions

This thesis presents the findings of a process evaluation on the SAFE

Rangatahi Programme; a community treatment programme designed for Māori adolescents who have committed sexual offences against adults or children. The results indicate that traditional Māori processes and practices can help decrease sexually harmful behaviours among Māori youth. By carefully weaving tikanga Māori beliefs and processes with westernised therapeutic theories and techniques, the kaimahi were able to create a unique treatment environment that emphasised values essential to positive adolescent growth including whānau support, the maintenance of relationships, and the importance of a secure identity. Furthermore, the kaimahi's personal qualities and responsiveness to the issues facing Māori youth of mixed ethnicity significantly contributed to the programme's success.

The findings of this study are important because they help to give credibility to the use of cultural initiatives with sexually abusive Māori youth. This current study clearly illustrates that sex offender treatment programmes need to accommodate the cultural needs of those who participate and failure to do so may result in disparate outcomes for its users and increase the risk to the community.

Appendix A: Participant Information Sheets

DEPARTMENT OF PSYCHOLOGY
Human Sciences Building
Floor 6, 10 Symonds Street,
Telephone 64 9 373 7599
Facsimile 64 9 373 7450
Private Bag 92019 Auckland,
New Zealand

PARTICIPANT INFORMATION SHEET FOR ADOLESCENTS

PROJECT TITLE: Process evaluation of the SAFE adolescent program for Maori adolescents who are sexually abusive.

The study

You are invited to take part in a study to give your ideas about the Maori SAFE adolescent treatment programme. We are looking at how best to help young people who are attending the Maori SAFE adolescent programme and because you are attending the programme right now, we would like to hear what you think. We would like to learn from you about what things are helpful and what you think could be done better. By talking to you we hope to learn how to help you and other young people in similar situations.

Who will talk to me?

Luisa Ape-Esera would like to talk to you. Luisa is conducting her Doctorate of Clinical Psychology at the University of Auckland and she is being paid by HRC to do this study. Luisa is interested in learning how to improve treatment programmes for young Maori people in New Zealand who experience difficulties with sexually abusive behaviour.

Your Participation

We will be grateful if you would consent to an audio taped interview. The interview will take approximately 45 to 60 minutes. Your participation is voluntary and the services provided by SAFE as well as your relationship with the SAFE Maori Adolescent program will not be affected by your decision to participate in this research. You have the right to withdraw your data up to one month following your interview without reason. This can be done by contacting Luisa who will destroy your data by wiping audio tapes and shredding hardcopy data sheets. Luisa will be conducting the face-to-face interviews and will be exploring if the program meets your individual and cultural needs. In order to understand how the Maori Adolescent program works on a daily basis, Luisa will be observing different aspects of the programme including wilderness camps and group sessions. Although you may be present while Luisa is observing, she is examining the functioning of the program and NO individual observations about you will be made**.** There will be no forms for you to fill in and we know this takes up a lot of your time so we will be giving you a movie voucher at the end of the interview. If you wish to do so, you will receive a summary of the project findings at the commencement of the study.

Confidentiality

Luisa will be the only one who will know what you have said to her. We encourage you to answer the questions openly and honestly and we will keep what is said during the interview, between yourself and Luisa. However if you were to tell Luisa that you were either being victimised or had or are committing offences against someone and have not reported it to the relevant people (i.e. SAFE), Luisa will need to inform her supervisors (Dr Ian Lambie and Professor Fred Seymour) and the SAFE organisation.

The transcription of the tapes will be done under a confidentiality agreement. After transcription the tape will be erased. Study data will be stored in a locked cabinet or as encrypted electronic files for 6 years. Research analysis will be on anonymised data. If information you provide is reported or published, this will be done in a way that does not identify you as its source. If you wish to do so, you will receive a summary of the project findings at the commencement of the study.

Do you have any questions?

If you have any questions concerning Ethics or wish to know more please contact, Luisa Ape-Esera the Department of Psychology, University of Auckland; Tel 021 157 3222; E-mail: l.apeesera@auckland.ac.nz. Her primary supervisor is Dr Ian Lambie; Tel 09 3737599 Ext 85012; Email i.lambie@auckland.ac.nz. You may wish to contact the Head of the Department of Psychology: Associate Professor in Clinical Psychology Fred Seymour; Tel 09 373 7599 ext 88414 or 88557; Email: f.seymour@auckland.ac.nz

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide): **0800 555 050;**   Free Fax: (NZ wide) **0800 2787 7678 (0800 2 SUPPORT)** Email: **advocacy@hdc.org.nz**

THE UNIVERSITY
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NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

PARTICIPANT INFORMATION SHEET FOR CAREGIVER(S)

PROJECT TITLE: Process evaluation of the SAFE adolescent program for Maori adolescents who are sexually abusive.

You are invited to be part of a research project evaluating the SAFE program for Maori adolescents who are sexually abusive. This study is being conducted by Luisa Ape-Esera for her thesis in the Doctorate of Clinical Psychology programme at the University of Auckland. This project has been funded by the Health Research Council (HRC) and it aims to improve the services offered by the SAFE program for Maori adolescents who are sexually abusive.

How have you been selected for the study?
As a caregiver of a child who is currently participating in the SAFE Maori adolescent programme, we would like to learn from you what things have been helpful and what you think could be improved. This information will provide valuable feedback to the SAFE Maori adolescent staff and will assist in identifying changes that could improve the programme. It is also hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of Maori adolescent's that are sexually abusive.

Your Participation
We will be grateful if you would consent to an audio taped interview. The interview will take approximately 45 to 60 minutes. Your participation is voluntary and the services provided by SAFE as well as your child's relationship with the SAFE Maori Adolescent program will not be affected by your decision to participate in this research. You and your child have the right to withdraw your data up to one month following your interview without reason. This can be done by contacting Luisa who will destroy your data by wiping audio tapes and shredding hardcopy data sheets. Luisa will be conducting the face-to-face interviews and will be exploring if the program meets your individual and cultural needs. There will be no forms for you to fill in and you are not obligated to answer any questions if you don't want to. It is possible that you or your child may find talking or thinking about some of your experiences distressing. If this should happen or if you wish to discuss any issues arising during the interview, Luisa's supervisor, Dr Ian Lambie is available at the number below. In recognition of the time that participation in this study involves, parents and guardians will receive petrol vouchers and children will be given movie vouchers at the commencement of the interview.

Confidentiality
The transcription of the tapes will be done under a confidentiality agreement. After transcription the tape will be erased. Study data will be stored in a locked cabinet or as encrypted electronic files for 6 years. Research analysis will be on anonymised data. If information you provide is reported or published, this

will be done in a way that does not identify you as its source. If you wish to do so, you will receive a summary of the project findings at the commencement of the study.

Do you have any questions?

If you have any questions concerning Ethics or wish to know more please contact, Luisa Ape-Esera the Department of Psychology, University of Auckland; Tel 021 157 3222; E-mail: l.apeesera@auckland.ac.nz. Her primary supervisor is Dr Ian Lambie; Tel 09 3737599 Ext 85012; Email i.lambie@auckland.ac.nz. You may wish to contact the Head of the Department of Psychology: Associate Professor in Clinical Psychology Fred Seymour; Tel 09 373 7599 ext 88414 or 88557; Email: f.seymour@auckland.ac.nz

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide): **0800 555 050;** Free Fax: (NZ wide) **0800 2787 7678 (0800 2 SUPPORT)** Email: **advocacy@hdc.org.nz**

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PARTICIPANT INFORMATION SHEET FOR STAFF

PROJECT TITLE: Process evaluation of the SAFE adolescent program for Maori adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

You are invited to be part of a research project evaluating the SAFE program for Maori adolescents who are sexually abusive. This study is being conducted by Luisa Ape-Esera for her thesis in the Doctorate of Clinical Psychology programme at the University of Auckland. This project has been funded by the Health Research Council (HRC) and will evaluate current service goals, practice and processes at the SAFE adolescent treatment program for Maori adolescents who are sexually abusive.

How have you been selected for the study?
As someone who works at SAFE, we would like to talk to you about the strengths and weaknesses of the Maori adolescent treatment program. This information will then be used to improve the services offered by the SAFE Maori adolescent team. It is also hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of Maori adolescent's who are sexually abusive.

Your Participation
We will be grateful if you would consent to an audio taped interview. The interview will take approximately 45 to 60 minutes. Your participation is voluntary and your decision to participate will in no way affect your employment relationship within SAFE. You have the right to withdraw your data up to one month following your interview without reason. This can be done by contacting Luisa who will destroy your data by wiping audio tapes and shredding hardcopy data sheets. Luisa will be conducting the face-to-face interviews and will be asking you about your views of the Maori adolescent treatment programme at SAFE. As mentioned above, we are interested in finding out about your perceptions on the strengths and weaknesses of the Maori adolescent programme. There will be no forms for you to fill in and if you wish to do so, will receive a summary of the project findings at the commencement of the study.

Confidentiality

The transcription of the tapes will be done under a confidentiality agreement. After transcription the tape will be erased. Study data will be stored in a locked cabinet or as encrypted electronic files for 6 years. Research analysis will be on anonymised data. If the information you provide is reported or published, this will be done in a way that does not identify you as its source.

Do you have any questions?

If you have any questions concerning Ethics or wish to know more please contact, Luisa Ape-Esera the Department of Psychology, University of Auckland; Tel 021 157 3222; E-mail: l.apeesera@auckland.ac.nz. Her primary supervisor is Dr Ian Lambie; Tel 09 3737599 Ext 85012; Email i.lambie@auckland.ac.nz. You may wish to contact the Head of the Department of Psychology: Associate Professor in Clinical Psychology Fred Seymour; Tel 09 373 7599 ext 88414 or 88557; Email: f.seymour@auckland.ac.nz

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide): **0800 555 050;**   Free Fax: (NZ wide) **0800 2787 7678 (0800 2 SUPPORT)** Email: **advocacy@hdc.org.nz**

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PARTICIPANT INFORMATION SHEET FOR EXTERNAL AGENCY STAFF

PROJECT TITLE: Process evaluation of the SAFE adolescent program for Maori adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

You are invited to be part of a research project evaluating the SAFE program for Maori adolescents who are sexually abusive. This study is being conducted by Luisa Ape-Esera for her thesis in the Doctorate of Clinical Psychology programme at the University of Auckland. This project has been funded by the Health Research Council (HRC) and will evaluate current service goals, practice and processes at the SAFE adolescent treatment program for Maori adolescents who are sexually abusive.

How have you been selected for the study?
As someone who refers clients to SAFE, we would like to talk to you about your views of the service that the SAFE Maori adolescent programme delivers. This information will provide valuable feedback to the SAFE Maori adolescent staff and will assist in identifying changes that could improve the programme. It is also hoped that this information will contribute to the protection of victims and their families, and enhance the rehabilitation prospects of Maori adolescent's that are sexually abusive.

Your Participation
We will be grateful if you would consent to an audio taped interview. The interview will take approximately 45 to 60 minutes. Your participation is voluntary and your decision to participate in this research will in no way affect your working relationship with SAFE. You have the right to withdraw your data up to one month following your interview without reason. This can be done by contacting Luisa who will destroy your data by wiping audio tapes and shredding hardcopy data sheets. For reasons of convenience Luisa will be conducting the interviews and will be asking you about your perceptions on the strengths and weaknesses of the Maori adolescent programme. There will be no forms for you to fill in and if you wish to do so, will receive a summary of the project findings at the commencement of the study.

Confidentiality
The transcription of the tapes will be done under a confidentiality agreement. After transcription the tape will be erased. Study data will be stored in a locked cabinet or as encrypted electronic files for 6 years. Research analysis will be on anonymised data. If the information you provide is reported or published, this will be done in a way that does not identify you as its source. **Do you have any questions?**

If you have any questions concerning Ethics or wish to know more please contact, Luisa Ape-Esera the Department of Psychology, University of Auckland; Tel 021 157 3222; E-mail: l.apeesera@auckland.ac.nz. Her primary supervisor is Dr Ian Lambie; Tel 09 3737599 Ext 85012; Email i.lambie@auckland.ac.nz. You may wish to contact the Head of the Department of Psychology: Associate Professor in Clinical Psychology Fred Seymour; Tel 09 373 7599 ext 88414 or 88557; Email: f.seymour@auckland.ac.nz

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act: Telephone (NZ wide): **0800 555 050;** Free Fax: (NZ wide) **0800 2787 7678 (0800 2 SUPPORT)** Email: **advocacy@hdc.org.nz**

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

ETHICS COMMITTEE on the 12 November 2009 for a period of 3 years,

From 11/11/2009 to 11/11/2012 Reference: 2009/453

Appendix B: Consent Forms

THE UNIVERSITY
OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

Consent to participation in interview for adolescents

This consent form will be held for a period of six years

PROJECT TITLE: Process evaluation of the SAFE program for Maori

adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

- I have been given an information sheet and understand the explanation of this research project which involves a face to face, 45 to 60 minute interview with Luisa Ape-Esera.
- I have had the opportunity to discuss this study with the researcher and am satisfied with the answers given.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw from the interview at any time without having to give a reason.
- I understand that I have the right to withdraw my data up to one month following my interview without reason. This can be done by contacting Luisa who will destroy my data by wiping audio tapes and shredding hardcopy data sheets.
- I understand that the services provided by SAFE and my relationship with the SAFE Maori Adolescent program will not be affected by my decision to participate in this research.
- I understand that there are limits to confidentiality therefore if I speak about unreported offending, the researcher will need to inform her supervisor (Dr Ian Lambie) and the SAFE organisation to discuss what further action needs to be taken.
- I understand that Luisa will be observing different aspects of the programme including wilderness camps and group sessions and I understand that she is interested in observing the functioning of the program and NO individual observations about me will be made**.**
- I consent to the interview being audio-taped and transcribed.
- I understand that the audio-tape and transcription data will be kept confidential and that no material which could identify me will be used in any reports on this study. My personal details will not be entered on any of the study documents I complete or that are about me apart from this consent form which I understand will be stored separately from the research papers.
- I hereby consent to taking part in a face to face interview. Please tick

( ) I agree to take part in this research/evaluation project.

(   ) I understand that my interview will be audio taped

Name:

Signature:

Caregiver Signature: Date:

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

ETHICS COMMITTEE on the 12 November 2009 for a period of 3 years,

From 11/11/2009 to 11/11/2012 Reference: 2009/453

**THE UNIVERSITY
OF AUCKLAND**

NEW ZEALAND

Te Whare Wānanga o Tāmaki Makaurau

Consent to participation in interview for caregiver

This consent form will be held for a period of six years

PROJECT TITLE: Process evaluation of the SAFE program for Maori

adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

- I have been given an information sheet and understand the explanation of this research project which involves a face to face, 45 to 60 minute interview with Luisa Ape-Esera.
- I have had the opportunity to discuss this study with the researcher and am satisfied with the answers given.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw myself/my child or any information traceable to me/my child at any time up to one month following my interview without reason. This can be done by contacting Luisa who will destroy my data by wiping audio tapes and shredding hardcopy data sheets.
- I do not have to answer any question that I do not want to and I can ask for the audiotape to be turned off whenever I want.
- I understand that the services provided by SAFE and my child's relationship with the SAFE Maori Adolescent program will not be affected by my decision to participate in this research.
- I consent to the interview being audio-taped and transcribed.
- I understand that the audio-tape and transcription data will be kept confidential and that no material which could identify me will be used in any reports on this study. My personal details will not be entered on any of the study documents I complete or that are about me apart from this consent form which I understand will be stored separately from the research papers.

Please tick

( ) I agree to take part in this research project and that ……………….…………. who is under my guardianship may also take part in this research/evaluation project.

 (   ) I understand that my interview and the interview of …………………….….. who is under my guardianship will be audio taped.

Name:

Signature: Date:
DEPARTMENT OF PSYCHOLOGY

200

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

Consent to participation in interview for staff

This consent form will be held for a period of six years

PROJECT TITLE: Process evaluation of the SAFE program for Maori

adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

- I have been given an information sheet and understand the explanation of this research project which involves a face to face, 45 to 60 minute interview with Luisa Ape-Esera.
- I have had the opportunity to discuss this study with the researcher and am satisfied with the answers given.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw from the interview at any time without having to give a reason.
- I understand that I have the right to withdraw my data up to one month following my interview without reason. This can be done by contacting Luisa who will destroy my data by wiping audio tapes and shredding hardcopy data sheets.
- I understand that my decision to participate will in no way affect my employment relationship within SAFE.
- I consent to the interview being audio-taped and transcribed.
- I understand that the audio-tape and transcription data will be kept confidential and that no material which could identify me will be used in any reports on this study. My personal details will not be entered on any of the study documents I complete or that are about me apart from this consent form which I understand will be stored separately from the research papers.
- I hereby consent to taking part in a one to one interview. Please tick

(   ) I agree to take part in this research/evaluation project.

(   ) I understand that my interview will be audio taped Name:

Signature: Date:

Consent to participation in interview for external agency staff

This consent form will be held for a period of six years

PROJECT TITLE: Process evaluation of the SAFE program for Maori

adolescents who are sexually abusive.

RESEARCHERS: Luisa Ape-Esera, Dr Ian Lambie

- I have been given an information sheet and understand the explanation of this research project which involves a 45 to 60 minute interview with Luisa Ape-Esera.
- I have had the opportunity to discuss this study with the researcher and am satisfied with the answers given.
- I understand that taking part in this research is voluntary (my choice) and that I may withdraw from the interview at any time without reason.
- I understand that I have the right to withdraw my data up to one month following my interview without reason. This can be done by contacting Luisa who will destroy my data by wiping audio tapes and shredding hardcopy data sheets.
- I understand that my decision to participate in this research will in no way affect my working relationship with SAFE.
- I consent to the interview being audio-taped and transcribed.
- I understand that the audio-tape and transcription data will be kept confidential and that no material which could identify me will be used in any reports on this study. My personal details will not be entered on any of the study documents I complete or that are about me apart from this consent form which I understand will be stored separately from the research papers.
- I hereby consent to taking part in a face to face interview. Please tick

(   ) I agree to take part in this research/evaluation project.

(   ) I understand that my interview will be audio taped.

Name:

Signature: **Date:**

Appendix C: Question Proforma

Rangatahi Questions

Firstly, I am going to ask you a few questions about yourself so I can get to know a bit about you and your background.

- How old are you?
- What part of Auckland do you live in?
    - How long have you lived there?
    - If new to Auckland, where were you living before and how have you found living in Auckland?
- Who do you live with? (whanau/foster parents/residential facility)
- Are you still at school?
    - If yes, what school do you go to and what year are you in? ○ If no, how far did you get in school?
- If you are no longer at school, what are you doing now? Prompt with working/course/unemployed.
    - How long have you been working/attending course/unemployed?
- Have you had any thoughts on what you may want to do in the future?
    - If yes, have you thought about what and how you may go about achieving that goal? Prompt with training/education/work experience
- Can you tell me a little about how you like to spend your spare time? Prompt with cultural group/sports/hobbies/any interests.
- Before coming to SAFE, did you have many Maori experiences?
    - If yes, what were they?

Thank you for sharing that information with me. In this next part, I will be asking you some questions about your experiences within the Rangatahi programme.

1. How long have you been attending the Rangatahi programme?
2. Can you tell me some things that were going through your mind when you were told that you would be attending the Rangatahi programme?
3. Can you remember what your whanau/foster parents thought about you attending the Rangatahi programme?
4. What was it like for you when you first came to SAFE.   Prompt (location, building, reception area, staff, assessments, Maori protocols)
5. What activities have you taken part in through the Rangatahi programme? (individual, group, family sessions, review sessions, camp)
    a. What activities did you like and why?
    b. What activities did you dislike and why?
6. What cultural activities/components can you remember in the programme? (direct participation/observation)

a. Did you observe these things or take part in them?
b. What was it like for you taking part/observing these activities
7. What are the good things about attending the programme?
8. What are the not so good things about attending the programme?
9. If you could tell a friend 3 things about this programme that have been most helpful for you, what would they be and why were they helpful?
10. If you could tell a friend 3 things within this programme that have not been helpful for you, what would they be and why were they unhelpful?
11. From your experiences in SAFE so far, is there anything that could be done differently to make the treatment experience easier for you?
12. Do you think that your cultural needs have been met by SAFE?
a. If yes, in what way
b. If no, why not, what could SAFE do to meet these needs?
13. In what ways has having a Maori therapist affected your treatment?
14. What is it like for you having your family involved in the programme as well?
15. How have things changed for you since starting the programme? (individually/culturally)
16. How has exposure to your culture changed your offending behaviours?
17. Does what you learn in the programme strengthen your identity/sense of belonging?
18. When you think of this programme, what cultural things should be included and why?
19. Do you have any other comments about the programme that you would like to add?

Caregiver Questions

Firstly, I am going to ask you a few questions about yourself so I can get to know a bit about you and your background.

- Do you mind telling me what your relationship is to the young person who is attending SAFE?
- Does he live with you?
    - ○ If yes, who else lives in your household?
    - ○ If no, who does he live with?
- How long has ……… been attending the SAFE Rangatahi programme in Auckland?
- How long have you been involved with the Auckland programme?

Thank you for sharing that information with me. In this next part, I will be asking you some questions about your experiences within the SAFE Rangatahi programme.

- Can you tell me some things that were going through your mind when you were told that ……… would be attending SAFE?

- Did you or your family have any concerns about ………… attending the SAFE Maori programme?

    - ○ If yes, what were they ○ How were these concerns resolved

- Did your child have any concerns about attending the SAFE Rangatahi programme?

    - ○ If yes, what were they ○ How were these concerns resolved

- Can you tell me what it was like for you when you first became involved with SAFE? Prompt (referral process, information received, location, initial contact with staff, assessment input, Maori protocols used)

- What involvement have you had in the programme since ……. started with SAFE?   Prompt (initial assessment, family sessions, review sessions)

    - ○ Of things you have taken part in so far, which did you like being involved in? What was it about these activities that you liked?

    - ○ What did you not like being involved in? What was it about these activities that you didn't like?

    - ○ What could have been done better?
- In what ways has your involvement in the programme been helpful to you/your family/your child

- Have any of your experiences within this programme, not been helpful to you/your family/your child
- Have you noticed any changes in …….. since he started the programme? Prompt (Good/bad/thoughts/behaviours/culturally)   o How do these changes relate back to the programme

- Have you/your family made any alterations to your lifestyle to compliment these changes?
    - o   If yes, in what way o If no, why not
- Is there anything that SAFE could do differently to make the experience better for you and your family?

In this last section, I will be asking you some questions about the ways in which the programme meets your cultural needs

- Before your child started going to SAFE, did you have many Maori experiences? o   If yes, what were they?
- What cultural practises have you observed being used by the SAFE staff (direct participation/observation) o What was it like for you taking part/observing these practises
- Do you think having a Maori therapist has affected your child's treatment? Prompt: thoughts on Maori people/culture/identity?
- Do you think that your cultural needs have been met by SAFE?
    - o   If yes, in what way o If no, why not, what could SAFE do to meet these needs?
- Are there any cultural things that could be added to this programme?
    - o   If yes what are they
- Do you have any other comments about the programme that you would like to add?

Programme staff Questions

Firstly, I am going to ask you a few questions about yourself so I can get to know a bit about you.

- Do you mind telling me what your role is in the SAFE Rangatahi programme?
- How long have you been working for SAFE
- What kind of work/life experiences do you bring to your current job?

Thank you for sharing that information with me. In this next part, I will be asking you some questions about your experiences within the programme.

- What professional development have you received since commencing work with SAFE Auckland? (Prompt: job induction/orientation, performance reviews, training, individual supervision) o Do you have any suggestions for improvement?

- What cultural development have you received since commencing work with SAFE Auckland? (Prompt: cultural supervision, wananga)

  o Do you have any suggestions for improvement?

- What processes are in place within SAFE to ensure your self care needs are attended to? (Prompt: Opportunities for collaboration, supervision, opportunities, stress reduction, discussing personal impact of work, balanced caseloads, monitoring workloads) o In what ways can this be improved

- How can your current referral process be enhanced?
- What were the original goals of the Maori adolescent programme?
    - o How do these differ to the mainstream adolescent programme?

    - o How have the goals of the programme changed since its

      commencement?

    - o In your opinion, how could the programme goals be improved?

- Prior to an assessment interview taking place, what systems do you have in place for matching clients to staff? Prompt: staff allocated based on needs i.e. gender, risk level, background, complexity of case, special needs
    - o In what ways can this be improved?

- What therapeutic approaches do you use when working with Maori adolescents in your programme?
    - o How do these differ to those used with mainstream adolescents

    - o Are there any therapeutic approaches that could be implemented

      to improve treatment outcomes for you Maori adolescent clients?

- What is your opinion of the treatment models used in the Maori adolescent programme?
    - o What would you like more of? And why
    - o What would you like less of? And why
- What problems has the Maori programme experienced since it's implementation?
    - o How have these problems been resolved?
    - o Were they resolved adequately?
- What changes do you think have to be made to the Maori adolescent programme?
- In your opinion,

    - o What are the strengths of the programme? o What are the weaknesses of the programme? o What could be done better?

- What parts of the program have you found to be
- More useful for your clients? Why?
- Least useful? Why?
- Has the programme got any factors that are affecting its development at the moment? If so, then what needs to happen?
- What do you feel is the likely future of the Maori adolescent treatment programme?
- What factors do you see as affecting the successful continuation of the programme?
- How well do you think the programme has been accepted as part of the SAFE environment?
- Is there anything that SAFE could do differently to make your experience as a therapist better for you?
- So overall, what do you think are the factors that most contribute to successful treatment outcome? (Try and name 3).
    - o And why?
- Similarly, what do you think are the factors that contribute to poor outcomes? (Try and name 3). o And why?
- Thinking about programme operations, do you have any other concerns that have not been covered in this interview?

In this last section, I will be asking you some questions about the ways in which the programme meets your cultural needs

- What are the barriers to treatment for your Maori adolescents and their whanau?
  - How can these be resolved

- Do you think that your client's cultural needs have been met by SAFE?
- If yes, in what way
- If no, why not, what could SAFE do to meet these needs?

- Do you think that your cultural needs/expectations as a therapists have been met by SAFE?
  - If yes, in what ways o If no, why and what can SAFE do to address

    these needs? (Prompt: training, external support)
- As a Maori staff member how supported are you in this agency? (Prompt: In what ways and how is this demonstrated?
- Do you have any suggestions for improvement?

- Are there any cultural practises/ideas that could be added to this programme to improve its operation? i.e. What is missing?
- If yes what are they?

- Do you have any other comments about the programme that you would like to add?

Key Stakeholder Questions

Firstly, I am going to ask you a few questions about yourself and the organisation that you work for so I can get to know a bit about you.

- Do you mind telling me what your role is in your organisation?
- How long have you been working for ....?
- Can you tell me what type of services your organisation offers?
- What is the relationship between yourself and SAFE Auckland?
- How many clients have you referred to and from the program?

Thank you for sharing that information with me. In this next part, I will be asking you some questions about your experiences within the SAFE Maori programme.

- What are your services goals in relation to the SAFE Maori adolescent program?
- Do you feel that those goals are being met by SAFE program staff?
- Can you tell me some things were going through your mind when you were thinking about referring your client/s to the SAFE Maori adolescent programme in Auckland?
- Did your client/s have any concerns about attending the SAFE Maori programme?
    - If yes, what were they?/How were these concerns resolved
- Referral process (How this happens, Barriers, Improvements)
- Feedback received about client (How this happens, Improvements)
- Information received about the program
- Initial contact with staff
- What type of involvement have you had in the programme? Prompt (initial assessment, family sessions, review sessions).
- What problems have you experienced since you became involved with the SAFE Maori adolescent programme?
- From your experiences, o What are the strengths of the programme? o What are the weaknesses of the programme?
    - What could be done better?
- What parts of the program have you found to be more useful for your clients? Why? Least useful? Why?
- Is there anything that SAFE could do differently to make the experience better for your organisation?

In this last section, I will be asking you some questions about the ways in which the programme meets your cultural needs

- What cultural practises have you observed being used by the SAFE staff
- As a specialised Maori programme, what cultural practises do you expect to be taking place within the programme
- From your observations, have these cultural practises being taking place?
- Do you think having access to a Maori therapist and Maori ideology will affect your client's treatment?
- Do you think that your client's cultural needs have been met by SAFE?
    - If yes, in what way o If no, why not, what could SAFE do to meet these needs?

- Are there any cultural practises/ideas that could be added to this programme to improve its operation?
    - If yes what are they? • Do you have any other comments about the programme that you would like to add?

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