Mā te Whānau, ka Ora ai te Tangata: Māori Experiences in Recovery from Addiction

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Simon Waigth

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Abstract

Drug and alcohol addiction is a critical issue in Aotearoa New Zealand, and the over-representation of the indigenous population is of real concern. Currently, there are a number of addiction treatment options available but there is a notable lack of interventions underpinned by Māori models of health and well-being. Higher Ground, a residential addiction treatment facility in Auckland, offers clients an opportunity to participate in an adjunctive, Māori-centred group. This research aimed to explore the recovery experiences of past Māori residents and how the whānau group contributed to their recovery. Semi-structured interviews with 18 participants were conducted. Thematic analysis of transcripts identified five themes and nine subthemes. The themes were: learning how to transition from treatment to the community; understanding myself and understanding addiction; making changes to the relational aspects of life; strengthening my Māori identity; connecting to spirituality in recovery. Overall the findings revealed that participants managed recovery in some respects in similar ways to those who participate in mainstream programmes, and in other respects, in ways unique to their experience as Māori and their experience in the whānau group. This research supports extending the concept of recovery and treatment, especially for Māori, to include non-abstinence factors such as relational reintegration and identity development. This is the first study to explore the recovery experiences of Māori having participated in a culturally consistent group during addiction treatment. Therefore, it makes a unique contribution to both the theory and practice of addiction treatment and recovery in Aotearoa New Zealand.

~This thesis is dedicated to Brian & Ratahi Waigth~

Acknowledgements

The title of this thesis translates as: “through the family, a person can achieve wellbeing”. I chose this title because it represents an overriding theme in this research. Ironically, as I thought about my journey with thesis, and who I would like to thank, I realised this also applies to me. So this is where I want to begin, by thanking those closest to me; my whānau. Mum, Dad, Brendon, Sara and Nicola - in so many ways, this thesis represents your input into my life. Even if you don’t actually know what I have been doing all this time, I know for sure that you always had my back. For this, I am forever indebted to you all. So it is with great gratitude that I say, thank you, thank you, thank you.

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Table of Contents

Glossary

Māori	**English**
Ahau	I, me
Āpōpō	Tomorrow
Aroha	Caring, love, compassion, respect
Awhi	Embrace, care
Haka	Traditional warrior challenge
Hapū	Kinship group/tribe, sub-tribe; pregnant
Hikoi	Journey
Hongi	Pressing noses together
Hui	Meeting, gathering
Kai Hākari	Meal
Kaikōrero	Facilitator, speaker, orator
Kapa Haka	Performance/performance group
Karakia	Spiritual stimulation, prayer
Karanga	Ceremonial call
Kaumātua	Elder (male or female)
Kaupapa	Plan, proposal, topic, theme
Koha	Gift
Kōrero	Talk, speak
Kōrerorero	Discuss, discussion, conversation
Kōtahitanga	Together, as one
Kua mate	Has died
Kuia	Elder (female)
Mahi	Work, do
Mana	Prestige, authority, dignity
Manaakitanga	Hospitality, kindness
Manāki	To take care of, support, protect, look out for
Marae	Courtyard, meeting place; complex of buildings
Marae noho	Extended stay at a Marae
Mihi	Greeting
Noa	Neutral
Paepae	Speaking panel
Pai	Good
Pākehā	Non-Māori New Zealander descended from settlers
Pānui	Notices
Rangatahi	Youth
Rangatira	Chief, leader
Rangatiratanga	Self-determination

Reo	Language
Taha Hinengaro	Related to mental and emotional wellbeing
Taha Tinana	Related to physical wellbeing
Taha Wairua	Related to spirituality
Taha Whānau	Related to family connections and belonging
Tamariki	Children
Tāne	Man
Tangata	People
Taonga	Pendant/gift/treasure
Tapu	Sanctity; sacred, special, restrict
Tautoko	Support
Te ao Māori	The Māori world/view
Te reo Māori	The Māori language
Teina	Younger sibling
Tikanga	Cultural principles, practices and customs
Tuakana	Older sibling
Wahine/Wāhine	Woman
Whaiora	Participant/client/patient
Whakapapa	Ancestry/genealogy
Whakawātea	Ending
Whānau	Family (kin/extended)
Whanaungatanga	Establishing and maintaining relationships
Whare	House/home

Chapter One: Introduction

A paradox for many indigenous peoples across the globe is the contrast between their indigeneity and their contemporary social status. Increasingly, indigenous people find themselves overrepresented in social indicators such as unemployment, homelessness, incarceration and poor health. Traditionally, solutions to this state of affairs have been constructed from a non-indigenous perspective and have largely failed to address the pertinent, underlying issues. Recently however, there has been an increasing awareness of indigenous solutions from an indigenous perspective. A poignant example of this is in New Zealand (NZ) where there has been a literal renaissance in the development and implementation of Māori models of health within the addiction treatment sector. Although there is a long way to go, the foundations for indigenous models of health in the treatment of addiction have now been laid and the progress is slowly being documented.

This research is an extension of an honours research project conducted in 2012 through Higher Ground, a residential drug and alcohol treatment programme based in Auckland. In that project, Māori participants in the 'whānau group' (a Māori led programme, incorporating elements of cultural practice and values consistent with a Māori worldview) were interviewed to understand their experience of the whānau group and its relationship to their treatment experience. Having established a relationship through that project, I then approached Johnny Dow (Director) and Fiona Howard (Board member) to discuss the possibility of conducting further research. Both were supportive. In contrast to the earlier project, this research focusses on the recovery experiences of Māori. More specifically, how had participants desisted from substance use in that period, and in what ways has treatment within the whānau group contributed to their recovery experiences.

In this chapter the context of alcohol and drug addiction and treatment in NZ is described as it relates to Māori in particular. This will show that although there has been a growth in the provision of Māori centred practice in the addiction treatment sector, there is very little research that reflects the experiences of Māori clients over time, and in particular, the influence of Māori centred practice for Māori.

Initially, I will highlight the most recent statistics relating to alcohol and drug use in NZ, their negative effects for the general and Māori populations, the broader historical considerations related to Māori health and addiction, and literature showing the common experience of indigenous people with drugs and alcohol. Following this, literature surrounding addiction treatment will be presented, beginning with the international treatment

sector and then within the context of NZ. Finally, a broad overview of a Māori world-view and the ways in which this has been incorporated into treatment will be presented.

Alcohol and Drug Use in NZ

The most recent Ministry of Health survey relating to alcohol use (Ministry of Health, 2014) revealed that alcohol is the most commonly used recreational drug in NZ. For example, nearly all those who had been surveyed had consumed alcohol at least once in their lifetime (95%), whereas in the year 2012-2013 alone, 85.2% consumed alcohol at least once in that year. Amongst past year drinkers, 61.0% reported alcohol use at least once a week, and 7% reported daily alcohol use. Regarding the level of consumption, 12% reported heavy alcohol use every week (defined in the survey as more than six drinks on one occasion) however, only 8.4% reported drinking enough alcohol to feel drunk at least once a week. A possible reason for the discrepancy is that only a proportion of those who drank heavily felt drunk, indicating that they have a higher tolerance for alcohol, or that they have consumed more than six drinks over a long period of time, therefore minimising the physiological effects of alcohol.

In relation to seeking help for alcohol use, 3.6% reported seeking help to reduce their alcohol use in their lifetime and 1.5% of past year drinkers received help to reduce their alcohol use in that year. Interestingly, 2.5% and 1.3% respectively wanted to receive help but did not for various reasons. Furthermore, 12.5% and 6% respectively have had a friend, relative, doctor or other health worker show concern or suggest cutting their drinking down (Ministry of Health, 2014).

Regarding drug use, the Ministry of Health survey (2010) revealed that almost half (49%) of those surveyed have used drugs in their lifetime. Cannabis was the most popular recreationally used drug, with 47% of respondents indicating they had used cannabis at some stage in their life. Whereas, in the year 2007-2008 alone, 16.6% reported using drugs (excluding alcohol, tobacco and Benzodiazepine - BZP), and again cannabis was the most popular drug used during this time. In relation to the most used drug, cannabis, amongst past year users 39% reported using cannabis at least once a week and over 50% reported using cannabis at least once a month. Finally, 13.4% reported using cannabis daily which, for the purposes of contextualisation, equates to approximately 50,800 of the total population of NZ.

Returning to drug use in general, figures relating to help-seeking behaviour show that 4.5% of participants had received help to reduce their level of drug use at some stage in their lifetime. For these people, help was sought from either an alcohol and drug counsellor, family member, friend or general practitioner (GP). A further 2.6% reported that they wanted to get

help to reduce their drug use but were unable to for various reasons. Lastly, amongst past year drug users, 9.4% reported that a relative, friend, doctor or other health worker showed concern for their drug use (Ministry of Health, 2010).

Alcohol and Drug Use among Māori

To put the following statistics into perspective, due consideration must be given to the overall composition of the population in NZ. The most recent population statistics were reported in the 2006 census, showing that the total population was 4,027,947 (Statistics New Zealand, 2012). Of this number, people identifying as European comprised the largest group at 67.6%, whereas Māori, the indigenous peoples of NZ, only comprise 14.6%. Although the proportion of Māori in the total population is relatively small, the following statistics for alcohol and drug use reveal that Māori are over-represented in most areas including patterns of use, age of first use, and outcomes related to alcohol and drug use.

Overall, when compared with non-Māori, the most recent statistics reveal that Māori are significantly more likely to begin drinking alcohol and to have consumed enough alcohol to feel drunk (for the first time) at the age of 14 or below (Ministry of Health, 2014). Amongst past year users Māori were similarly overrepresented however, this was particularly apparent in the statistics relating to patterns of alcohol consumption. For example, Māori were more likely than non-Māori to consume a large amount of alcohol on at least one drinking occasion, three or more times a week, and between one and three times a week. Similarly, Māori were more likely to have drunk enough alcohol to feel drunk than non-Māori in the past year and in their lifetime. When combining alcohol with other substances, Māori were also more likely than non-Māori to consume alcohol with either tobacco or cannabis. These statistics are consistent with similar reports elsewhere showing the disparate levels of alcohol consumption between Māori and non-Māori on a drinking occasion (Bramley, Broad, Harris, Reid, & Jackson, 2003). Moreover, this pattern of alcohol consumption does not appear to have changed with the passage of time (Dacey, 1995).

In relation to help seeking behaviour overall, Māori have sought help to reduce their level of alcohol consumption at a similar rate to non-Māori. However, amongst past year users, Māori women were more likely than non-Māori women to have wanted help and not received it, and to have had someone show concern or suggest cutting down their alcohol use (Ministry of Health, 2014).

Overall, when compared with non-Māori, the most recent statistics (for the year 2007-2008) revealed that Māori were twice as likely to have started using drugs at the age of 14 or

younger, more likely to have used drugs in their lifetime, and more likely to have used drugs in the year 2007-2008. In particular, Māori were more likely to have used benzodiazepine 'party pills' and cannabis (Ministry of Health, 2010). In relation to cannabis, the high level of use amongst Māori has been noted for some time. Specifically, Marie, Fergusson and Boden (2008) showed that across all age groups, Māori were significantly more likely to have higher rates of cannabis use and dependence than non-Māori.

Lastly, in relation to gender, Māori women were more likely than non-Māori women to have driven whilst under the influence of drugs. Whereas Māori men were more likely than non-Māori men to have operated machinery whilst under the influence of drugs (Ministry of Health, 2010).

Recent international statistics produced for other indigenous cultures reveal a similar pattern of substance use and abuse to Māori. For example, in the United States the Native American Indian (NAI) population comprises less than 1% of the total population (Norris, Vines & Hoeffel, 2012). However, data from the most recent National Survey on Drug Use and Health show that for many substances, NAIs consume substances more frequently and more heavily than most other ethnicities in the United States. For example, NAIs are more likely to use illicit drugs, 'binge drink', and are nearly two times more likely to be diagnosed with a substance disorder (Substance Abuse and Mental Health Services Administration, (2012). Furthermore, while white Americans are more likely to use alcohol, NAIs are more likely to use alcohol heavily on a weekly basis and more likely to have an early onset of drinking (before the age of 15) than any other ethnicity (National Institute of Alcohol Abuse and Alcoholism, 2006). Similarly, the Aboriginal population of Australia comprise only 2.5% of the overall population, (Australian Bureau of Statistics, 2006) however recent statistics reveal that Aboriginal people, like Māori and NAIs, face an increasingly difficult challenge with substance use and abuse. For example, although aboriginal Australians are more likely to abstain from drinking, they are almost twice as likely to drink alcohol at a hazardous level at least once during their life time and at least once a week when compared with non-indigenous Australians (Australian Institute of Health and Welfare, 2011a). In relation to drugs there is limited comparative data available in Australia, nonetheless there is some evidence to show that a higher proportion of Aboriginal people (as a sub-population) have used illicit drugs in their lifetime (Australian Institute of Health and Welfare, 2011b). In relation to drug use in general, a recent survey reveals that almost half of the Aboriginal population have used illicit drugs in their lifetime (drugs that are illegal to possess), and almost a quarter had used illicit

substances in the past year (Australian Institute of Health and Welfare, 2011a). These statistics suggest that indigenous populations elsewhere have similar experiences with alcohol and drug related use, and compared to the dominant cultural groups, usage is at a higher level.

Impact of Alcohol and Drug Use

In relation to health risks, the World Health Organisation (WHO) states that alcohol is eighth among global risk factors for death, and third for disease and disability. The WHO also report that the quantified burden of disease and injury attributable to alcohol is currently estimated at 4.5% globally, and causally attributable to over 60 known diseases. Amongst males between the ages of 15-59, alcohol is the lead risk factor for death, mainly due to injury, violence and cardiovascular disease as a result of alcohol use (World Health Organisation, 2014).

An important contributing factor to the abundance of adverse health effects related to alcohol use is the pattern of alcohol consumption. For example, there is now strong evidence that an increase in the overall volume of alcohol consumed, or increase in the volume of alcohol consumed on any one occasion, increases the risk of adverse health outcomes (Rehm, Taylor, & Broom, 2009). Specifically, this risk links higher concentrations of alcohol in the bloodstream with an increase in intentional and unintentional injuries and specific diseases such as type-2 diabetes (Baliunas et al., 2009; World Health Organisation, 2014).

Similar to alcohol usage, drug use is also associated with negative impacts. However, there are inherent difficulties with producing reliable data on the adverse health effects for illicit drug use in particular, as a result of unknown volumes of illicit drugs in many countries. Also, there is a bias in the literature toward opioid, cocaine and amphetamine use as these substances produce more immediate and overt effects in the event of an overdose (Rehm, Taylor, & Room, 2009). In spite of these difficulties, the most recent report documenting the various adverse health effects of illicit drug use by the United Nations Office on Drugs and Crime (UNODC) estimates that there are between 102,000 and 247,000 drug related deaths per year, with the average age of drug related deaths being between 26 and 44 years. The evidence predominantly links opioid, cocaine and amphetamine use to mortality as it is difficult to overdose on substances such as cannabis (Bargagli et al., 2006; UNODC, 2016).

Psychological impacts as a result of alcohol and drug use are becoming more well-known and linked to almost all illicit drugs. The most common psychiatric diagnosis for alcohol and drug users is “substance dependence”. According to the American Psychiatric Association Diagnostic and Statistical Manual IV-TR (2000), dependence is defined as ongoing substance use with significant cognitive, behavioural and physiological problems

associated with substance use (American Psychiatric Association, 2000). For example, in the United States it is estimated that up to 20% of those that use an illicit drug will meet the criteria for substance dependence. Similar rates of diagnosis are reported in Australia (Glantz et al., 2008). Research further links substance use with other diagnoses. It has been estimated that one third of those who abuse alcohol and over one half of those who abuse drugs have a comorbid psychiatric diagnosis which can extend across the individual's lifetime (Kessler et al., 1997; Reiger et al., 1990).

Aside from the negative effects that alcohol and drug abuse have on the individual, research implicates alcohol and drug abuse in a wide range of additional social issues, including the disruption of intimate relationships, onset of mental illness in children, and effects on an individual's ability to participate in education and employment. For example, in the context of an intimate relationship, heavy alcohol and drug use has been found to have a negative impact on a partner's health, family and social functioning (Marshal, 2003) and increase the occurrence of intimate partner violence (Foran & O'Leary, 2008). In NZ, a birth cohort study found that individuals with five or more DSM-IV Alcohol Abuse/Dependent (AAD) symptoms were 1.9 to 3.8 times more likely to commit violence against an intimate partner when compared with individuals without AAD symptoms (Boden, Fergusson & Horwood, 2012). Furthermore, in relation to married couples, divorce is more likely to eventuate if an intimate partner consumes alcohol heavily when compared with couples where neither partner uses alcohol (Leonard, 1999).

Further effects of substance abuse have been documented, specifically in relation to children who are directly exposed to parental alcohol and drug abuse. For example, several studies have found that children and adolescents whose parents are heavy drinkers are at increased risk of developing mental health issues, most commonly anxiety and depression (Kuperman, Schlosser, Lidral, & Reich, 1999; Maynard, 1997; Ohannessian et al., 2004). Moreover, the intergenerational transmission of alcohol and drug abuse symptoms and behaviour is such that children of alcohol abusers are disproportionately more likely to develop alcohol and drug abuse problems themselves, and such problems increase in severity with increased exposure to parental alcohol abuse (Melchior, 2010; Sher, 1997). Lastly, a local example documenting a similar outcome showed that higher rates of psychiatric illness were found in children of alcoholic parents when compared with children of non-alcoholic parents (Lynskey, Fergusson & Horwood, 1994).

More broadly, substance abuse has a significant negative impact on society. For example, in NZ alone it has been estimated that the economic costs related to the use of alcohol is between 1.5 and 2.4 billion dollars per year (Devlin, Schauff & Bunt, 1997; Matheson, 2005). In a recent review of 14 high income countries (including NZ) it was shown that the cost of drugs and alcohol to society fell predominantly on health related costs such as inpatient treatment of alcohol and drug users (Mohaptra, Patra, Popova, Duhig, &Rehm, 2010; Slack, Nana, Webster, Stokes, & Wu, 2009).

Finally, drug and alcohol use is implicated in criminal activities and in some cases committing crime is a means to supporting further substance use. Alcohol use has also been shown to be directly implicated in acts of violence: of those physically or sexually assaulted in 2004 over half reported that the perpetrator was under the influence of alcohol (Connor, You, & Casswell, 2009). Similarly, on our roads, the Ministry of Transport (2012) reported that for the year 2010, 15% of all crashes involved alcohol or drugs and over 30% of fatal car crashes involved alcohol or drugs.

Impact for Māori

Māori carry a greater burden of negative association with alcohol and drug use in NZ (Alcohol Liquor Advisory Council, 2008). This is not only a result of the over-representation in alcohol and drug use statistics and associated negative outcomes, but also as a result of the overall more youthful status of the Māori population compared to other ethnic populations in NZ. The younger age group is where the most alcohol and drug-related issues occur (Alcohol Liquor Advisory Council, 2008).

Baxter, Kingi, Tapsell and Durie (2006), in the largest survey documenting the prevalence of mental health disorders in NZ, found over one in four (26.5%) Māori had experienced a substance use disorder in their lifetime up to the point of being interviewed for the survey. Amongst Māori the most frequently occurring substance disorders were alcohol related (24.5%), followed by drug disorders (14.3%). Furthermore, marijuana disorders (a subgroup of the drug disorders investigated) were a significant contributor to the overall drug disorder prevalence among Māori. For example, lifetime marijuana abuse was present for 12.8% of Māori, and marijuana dependence for 5.3%. Similarly, in the 12 months leading up to the survey, 8.6% of Māori had been diagnosed with a substance disorder. Within this subpopulation alcohol disorders were the most prevalent (7.4%), followed by drug disorders (4.0%). Lastly, marijuana abuse and dependence were by 3.0% and 1.5% respectively.

Heightening the negative impacts of higher use of alcohol and drugs usage among Māori are the consistent and compelling health and social inequalities between Māori and non-Māori in other areas (Reid & Robson, 2007). For example, in comparison to non-Māori, Māori have a much lower health status in many areas of wellbeing (Crengle, 2009; Ministry of Health, 2014; Robson & Purdie, 2007), overall lower standards of living (Jensen et al., 2006; Robson, Cormack & Cram, 2007), higher rates of mental health difficulties and substance dependence (Baxter, 2007, 2008; Baxter, Kingi, Tapsell & Durie, 2006), and greater exposure to discrimination and racism (Harris et al., 2006). Moreover, when comparisons are made between Māori and other indigenous cultures, the literature confirms that health and social inequities such as these prevail all over the world (Gracey & King, 2009; King, Smith & Gracey, 2009).

In summary, substance use, and disorders related to substance use are prevalent among Māori. More importantly, like other indigenous cultures, these occur in a broader context of numerous social inequalities, meaning Māori experience a higher burden when compared with non-Māori. The causes for this state of affairs are deeply rooted in history and in the following section some of these contributing factors will be explored.

Historical Perspectives Related to Māori Health and Wellbeing

In this section, a historical perspective of NZ will be explored to provide some context to current statistics. This will include a brief overview of colonisation, the Treaty of Waitangi, and the use of alcohol during this period in history.

The underlying causes for health and social inequities between Māori and Pakeha are complex; however many authors have suggested that contemporary inequalities and vulnerabilities such as those that exist for Māori are probably best understood in reference to historical influences, beginning with colonisation (Reid & Robson, 2007). Some of the negative effects of colonisation, in history and in contemporary society, will be described as they relate to Māori society and Māori identity. However, the main focus of this section is to describe the part alcohol has played in the process of colonisation and how the perception of alcohol amongst Māori changed during this time.

Colonisation and the Treaty of Waitangi

With the expansion of Europe into the South Pacific well underway by the 18th century, colonial interests turned to NZ. By that time, Māori are thought to have occupied NZ

for the preceding 500 years (Howe, 2003). Records indicate that the initial contact between Europeans and Māori was made in 1642 by Abel Tasman, followed by James Cook in 1769 who sustained contact with Māori as he surveyed the coast line of NZ (King, 2003). By and large, the contact between Cook and Māori was "as cordial and mutually respectful as he could have made it" (King, 2003, p.106.), although there are isolated incidents where violence between Cook and Māori – for various reasons – eventuated (Newman, 2010; King, 2003).

By 1840, contact between Māori and non-Māori had increased, such that a formalised agreement between Māori and the British Crown was reached to co-govern NZ with the signing of the Treaty of Waitangi. While this signposted a significant step in the relationship, there exist divergent theories about Māori and Pakeha motivations for signing the Treaty, the extent to which all Māori agreed to the terms set out in the treaty, and the understanding both parties had regarding sovereignty (McIndoe, 2015; O'Malley, Stirling & Penetito, 2010; Orange, 2011; Waitangi Tribunal, 2014). Due to differences such as these, the ensuing years were characterised by significant discord between Māori and the Crown, and although attempts to resolve the issues were made, by 1863 the path had been paved, culminating with what is now described as the New Zealand Land Wars (Orange, 2011; Wright, 2006).

For Māori, there have been significant short and long term consequences since the Treaty was signed. In the short term, Māori were excluded from parliament, and all political decisions for 28 years after the Treaty was signed (Makka & Fleras, 2005; Sinclair, 2000; Walker, 1992). This period also involved an unprecedented loss of land, largely due to the unjust confiscation of land (Sorrenson, 2014). In the longer term, the outcomes of these and many other injustices had devastating effects on Māori, including further land loss and the loss of language, and stability of cultural traditions and practices amongst Māori (Boast, 2012; Durie, 1998b; Orange, 2011; Sorrenson, 2014).

Recently several local authors have drawn attention to the experience of Māori during this time, and argued that subsequent intergenerational behaviours such as alcohol abuse are what you might expect in response to significant trauma (Reid, Moore & Varona, 2014). Drawing on the experience of indigenous people in America, historical trauma is now thought to be a way to link the contemporary experience of Māori with the past (Pihama et al, 2014; Wirihana & Smith, 2014). Within this literature, some authors have also begun to demonstrate how the loss of land and culture, where these are central to ideas of self and collective identity has led to significant losses of self and identity (Durie, 1998a; Moeke-Pickering, 1996;

Walters, Beltran, Huh, Evans-Campbell, 2011). For Māori, this has also resulted in significant levels of disconnection from whānau, hapu and iwi (Gilchrist, 2017).

Alcohol use Among Māori in History

During this same time-period, alcohol was being used for the first time in NZ. The point of introduction is not clear, however it probably occurred around the time fur traders and voyagers such as James Cook began experimenting with native flora as an agent for brewing beer (Hutt, 1999; Cook, 1779). For Māori this would prove to be significant, as, unlike many other people, they did not have experience with alcohol prior to European/colonial contact (Hutt, 1999; Mancall, Robertson, & Huriwai, 2000). More importantly, they had not developed any experience for dealing with the effects of alcohol on individuals or groups, should the need arise.

When alcohol was initially introduced, Māori expressed an aversion to it. This was evident in the Māori name for alcohol, '*Waipiro'* or 'stinking water' (Mancall, Robertson, & Huriwai, 2000) and the observations by visiting Europeans that Māori were not interested in alcohol to the extent of other Europeans (Bell, 1976). However, over time, alcohol use among Māori began to grow. This was due to a number of factors, including the economic benefits from trade with alcohol, the deliberate use of alcohol to pay for Māori labour, and the undeniable physiological effects associated with alcohol consumption (Hutt, 1999). McDowell (2015) and others have also argued that alcohol was used during this time as an instrument for colonial interests, as it was deliberately used as a tool to take possession of Māori land - further restricting Māori in the electoral process - and as a further means of disrupting the foundation of Māori life (McDowell, 2015; Te Puni Kokiri, 1995).

The effect of increased alcohol consumption in Māori communities did not go unnoticed by Māori leaders. Tribal leaders spoke forcefully about the effects of alcohol within their communities and the shame and hatred it had caused (Binney, 2012). In an attempt to make change, several petitions were made to parliament to curb the sale of alcohol in Māori communities. Within these petitions Māori leaders voiced their concerns. This was most evident in one petition in which alcohol, and its effects, were named 'taua nakahi nui', a name also given to Satan in the Māori version of the Bible (McDowell, 2015). Eventually parliament responded by amending the 'Sale of Spirits Ordinance' to prohibit all Māori from purchasing liquor. However, many Māori opposed the discriminatory nature of these changes on the basis that they did not apply to non-Māori (Durie, 2001; McDowell 2015; Ward, 1974). This created a divide amongst Māori, with many believing that they were entitled to

self-determination, including personal decision-making over the use of alcohol. Eventually Māori leaders were forced to compromise by permitting the sale of alcohol within particular iwi (tribes) (Durie, 2001).

Thus, despite being slow to warm to alcohol, many Māori eventually began to use alcohol more frequently. By the mid-1800s, the extent of alcohol use and the way in which it was being used had resulted in increased alcohol abuse among Māori in many areas of NZ (Te Puni Kokiri, 1995).

In summary, this brief survey of the socio-political context during the 18th century demonstrates how Māori society underwent significant change in a relatively short period of time. More importantly, these changes appear to have set the foundation for the contemporary experience of many Māori in relation to substance use and their experience of self and Māori identity. The significance of these issues to contemporary Māori society is such that copious resources are now devoted to resolving differences between Māori and the Crown. Until these differences are resolved, many Māori have recognised that they will continue to be adversely and unequivocally affected by this relationship (Durie, 1998a; 2001). Accordingly, contemporary approaches to alcohol and drug treatment have begun to realise the complexity of addiction amongst Māori by providing treatments based on a foundation of knowledge which incorporates an understanding of these factors. Such approaches are outlined further below, beginning with a description of the overall approach to addiction treatment in NZ.

Addiction Treatment and Recovery

There has been an increasing interest in the development of treatment interventions suitable for those struggling with alcohol and drug use-related issues. The most recent figures show that in NZ there are currently over 250 dedicated or ‘day treatment’ facilities for those needing help (Alcohol Drug Association, 2012). Within these facilities a number of interventions are used, many of which have been adapted from practices used internationally.

The evidence base supporting addiction interventions is large, and it is now clear that substance addiction can be treated. Within the literature base there is evidence for psychosocial, behavioural, pharmacological and peer support interventions. Against this backdrop, literature relating to recovery will then be introduced, which will include an exploration of pertinent issues and relevant theoretical considerations.

Treatment

Psychosocial interventions have become popular and are now widely considered as mainstream interventions for treating substance addiction (Barrowclough et al., 2001). Recently, Klimas et al. (2013) reviewed a range of evidence for psychosocial interventions such as Cognitive Behaviour Therapy (CBT) and Motivational Interviewing (MI), and found that these can help people to abstain from substance use, or reduce substance use for anywhere between one week and three months. However, the authors note that it is difficult to make firm conclusions about which of the intervention modalities included in their review are superior, given the differences in intervention variables and low quality of studies.

In other research treatment efficacy for psychosocial interventions is found to vary according to the specific substance involved with the addiction. For example, two meta-analyses of CBT found that CBT produced small but statistically significant treatment effects across the majority of the studies that were included, however greater effect sizes were observed in studies where CBT was used in the treatment of marijuana and cocaine addiction (Gates, Sabioni, Copeland, Le Foll, & Gowing, 2016; Magill & Ray, 2009; Dutra et al., 2008). Matching treatment to substances may not be relevant for all psychosocial interventions, as the evidence suggests that MI is an equally effective intervention for both alcohol and drug addiction (Rubak, Sandboek, lauritzen, & Christensen, 2005).

Treatment efficacy can also improve when interventions are combined. For example, a recent meta-analysis indicated that abstinence based treatments can be more effective when combined with Naltrexone or Acamprosate (Rosner, Leucht, Lehert & Soyka, 2008) or in conjunction with behavioural contingency programmes (rewards for abstinence, for example, ‘voucher economies’) (Stitzer & Vandrey, 2008).

Matching interventions to individuals and providing multiple interventions within a treatment milieu is a common approach taken to treating addiction within residential settings. Many residential facilities also employ a therapeutic community (TC) practice. A TC is an approach to residential care, providing environments that foster change in attitudes, behaviour and emotions through monitoring and reinforced daily regimens (De Leon, 1995). Research has accumulated to support TC in helping substance users achieve abstinence (Vanderplasschen et al., 2013), and in some cases where treatment is delivered within correctional facilities there has been a decrease in the level of offending (Gowing, Biven & Watts, 2002; Rawlings & Yates, 2001). However, the effectiveness of TCs has been disputed (Smith, Gates, & Foxcroft, 2006) and the ability for a TC to effect change may depend on the

time spent within a TC; although it may not be effective for some people regardless of time (Smith, Gates & Foxcroft, 2006). Commonly, psychosocial interventions are included in the treatment milieu within TCS, however evidence to show how this impacts treatment overall, is lacking.

An important issue not yet discussed is the criteria to determine whether treatment has been successful. Most commonly, an intervention is deemed to be effective only if substance abstinence can be attained by treatment users. While abstinence is a common goal, for some programmes and with some individuals, harm reduction may be the preferred outcome. An example of this is needle syringe exchange programmes and opioid substitution therapy (Connock et al., 2007; Wodak & Cooney, 2006).

Further complicating the process of treatment are the neglected individual, social and economic needs (such as those described earlier). That is, the goals of treatment may need to be broader than a focus on substance use if it is to be successful (Miller & Miller, 2009). Addressing needs such as employability, family relationships, discrimination and so on may also be necessary. As discussed below, for Māori and many indigenous peoples this is a pertinent issue. The presence of these broader needs means recovery can take many years, while some individuals may never recover at all (Dennis, Scott, Funk, & Foss, 2005). This has led some authors to acknowledge that treatment alone cannot sustain abstinence, or what is commonly referred to as recovery (Best et al., 2010). Thus, adapting treatment to the characteristics and needs of the client is a principle emerging from much of the literature, and forms part of the rationale for shifting treatment from a focus on abstinence to more holistic recovery paradigms where well-being and community integration are paramount (Best et al., 2010; Pearson et al., 2012). In the following section, some of the approaches to recovery which take this into account will be introduced alongside the research which is beginning to highlight this as an important aspect of change in the long term.

Recovery

For many people, a formal treatment regime is seen as the only pathway to resolve issues associated with addiction and achieve substance abstinence. This assumption can be observed in society, among individuals with addiction issues, in government policy and within treatment facilities. However, a growing body of literature demonstrates that addiction related issues can resolve ‘naturally’, with many people achieving abstinence in the long term, outside of formal treatment (Granfield & Cloud, 2001). In fact, on the basis of natural recovery studies and long term substance use follow up, some authors have shown that issues

related to substance use resolve, and abstinence is achieved, in more than 50% of people, leading them to suggest that recovery is the rule, not the exception (see White, 2008 for a full review).

The occurrence of natural recovery has led researchers to investigate the difference and similarities between those who attend treatment and those who do not. When such comparisons are made, these researchers have found the extent to which a person can overcome issues related to substance use, or recover, is based largely on the "environmental context, their personal characteristics and a range of perceptible and imperceptible resources available to that individual" (Cloud & Granfield, 2008, p.1972). Building on sociological theorists such as Pierre Bourdieu, these findings have led researchers to capture the varied pathways out of addiction within the theoretical construct of "recovery capital".

***Recovery capital*:** Granfield and Cloud (1999) define recovery capital as "a body of resources that can be accumulated or exhausted. How much and what types of resources a person accumulates and/or exhausts holds significant implications for the options available to that person" (p.197). Within this definition are four subtypes of recovery capital: *social capital, cultural capital, physical capital* and *human capital*.

Social capital refers to the benefits of resources and reciprocal obligations conferred on individuals by virtue of group membership. For example, group membership by way of family, social and intimate relationships. For a substance dependant individual, social capital can be seen to provide much needed emotional support or access to opportunities to aid in addressing substance addiction issues. Cultural capital refers to the cultural norms and an individual's ability to act consistently with those norms. This also includes the values, beliefs and dispositions of a particular culture. For substance dependant individuals, accepting the norms of a society is advantageous to overcoming addiction; however, familiarity with cultural norms varies across different groups of people. Physical capital refers to economic or financial capital that can be converted to money. This has an important role in providing opportunities, especially when treatment is required. For example, physical capital can be used to pay for treatment and help an individual maintain other financial commitments while in treatment. Human capital refers to human attributes which help an individual to function in society. In the context of treatment and recovery, heredity mental health and employability are intricately tied to one's ability to overcome substance dependence. In the context of this thesis, social and cultural capital is particularly relevant.

Research supporting social capital as an integral part of recovery is drawn from a number of sources. These include studies showing the mediating effect of pre-existing social networks on an individual's ability to recover (Granfield & Cloud, 2001), studies showing how recovery maintenance is strongly associated with peer and family support (Best et al., 2008; Litt, Kadden, Kabel-Cormier, & Petry, 2009), studies showing the influence of mutual aid peer support groups such as Alcoholic Anonymous (AA) (Kelly & Yeterian, 2008), and the predictive ability of social capital on addiction severity (Burns & Mark, 2013). Large scale longitudinal studies with alcoholics have also demonstrated the impact of social networks by demonstrating the positive effect of additional pro-abstinence peers on alcohol consumption behaviours (Stout, Kelly, Magill, & Pagano, 2012).

The ability for social capital to effect change in recovery can be partly understood through a lens of social identity. Several studies exploring this link have suggested the importance of recovery oriented groups such as AA in helping to create a recovery identity. This process is thought to involve the internalisation of norms, values, beliefs and language of recovery oriented groups, which then helps shape the individual's substance related behaviour (Best et al., 2016). The emergence of a new identity is thought to contrast to their previous, addict identity (Orford, 2001) leading to an increase in their sense of ability to overcome their addiction, and possibly counteract negative feelings of self-worth (Kreiner & Ashforth, 2004). Moreover, it has been suggested that alternative recovery identities help people to maintain a level of social mobility by identifying with groups where different opportunities are available to the individual (Buckingham, Frings & Albery, 2013; Haslam, Ellmeres, Reicher, Reynolds & Schmitt, 2010).

Related to this is Adams's (2008) social theory of identity and addiction. According to this theory, an identity is the sum of relationships people maintain with animate (e.g., people, groups of people), inanimate (e.g., places, landmarks) or abstract (e.g., God, the 'past') objects. The strength or 'intimacy' in these relationships is determined by the quantity and quality of transactions with these objects over time. Thus, people will identify themselves with objects to which they have a level of intimacy. Further to this theory is the idea that addiction occurs when, for various reasons, the relationship with a substance intensifies to the detriment of other relationships. More importantly, argues Adams, is the transfer of intimacy to the relationship with the substance through multiple transactions. For the addicted individual, the transactions and intimacy have a very similar appearance, function and

capacity to those found in relationships with people. Thus, their relational needs are largely met in the newly formed addictive relationship, from which an addictive identity emerges.

In summary, when attempting to understand how long term change can be sustained in addiction recovery, it is useful to consider the resources or recovery capital available to them when treatment ends. A subset of resources, known as social capital, is proving to be important in recovery alongside the subsequent changes in identity that occur during this process. In the following section, Māori models and approaches to wellbeing will be introduced. This will be followed by a section describing values which underpin these models, followed by another section demonstrating how Māori models of wellbeing have, in a similar way to the recovery literature presented here, emphasised the importance of social connectedness and identity in treatment and beyond.

Māori Models and Approaches to Wellbeing

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

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

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

To reflect the holistic nature of Māori approaches to wellbeing, a popular health model introduced by Mason Durie (1985), *Te Whare Tapa Wha (The four sided house),*

proposed that wellbeing for an individual comprised four interacting dimensions. These dimensions are known as: Te Taha Hinengaro (the dimension of mental/emotional wellbeing) Te Taha Tinana (the dimension of physical wellbeing), Te Taha Whānau (the dimension of the family/extended family) and Te Taha Wairua (the dimension of spiritual wellbeing) (Durie, 1985). No one aspect is more important than the other, and balance across the dimensions is necessary for overall good health. This Te Whare Tapa Wha model has been widely adopted throughout the health sector in NZ and is evident in most areas of health policy and many areas of health practice today (O'Hagan, Reynolds, & Smith, 2012).

Another widely adopted model of health is *Te Wheke* (literally, The Octopus), developed by Rangimarie Rose Pere (1994). In a similar way to Te Whare Tapa Wha this model acknowledges the interconnections between parts to make a whole. Pere incorporates those features described by Durie but also includes in addition to these, aspects such as Mana-ake (uniqueness), mauri (vitality), ha a kuia ma e koro ma (ancestral inspiration), whatumanawa (the healthy expression of emotions), and waiora (total wellbeing overall) (see also Love, 2004).

Within the field of mental health further developments in Māori approaches to health interventions have been made, including an approach known as *Powhiri Poutama*. This approach takes the concept of the traditional, formal Māori welcome (the powhiri) and uses that process to help restore health and well-being across the processes of intervention (Herewini, 2008). The steps of this process are karakia (prayer), mihimihi (greetings/ establishing of relationships), whakapuaki (bringing forth the issues/developing wellness flow), whakaratarata (expression of openness and trust/settling into the process), whakaoranga (working towards wellbeing/respect for life), whakaotinga (moving towards completion and new beginnings). Research on specific Māori practices and their role in healing and well-being for Māori have been offered. These include the specific role of waiata, haka and whaikōrero as expressions of emotions from sadness, grief and anger, to joy and happiness (Hata, 2012; Peapell, 2012; Wirihana & Smith, 2014).

As previously noted, a holistic Māori worldview (particularly that related to health and wellbeing) is often contrasted to traditional Western approaches to wellbeing that focus primarily on the individual as the solution to problems. For example, many traditional psychological therapies are based on working with individuals (one-to-one) as opposed to viewing individuals as belonging to a wider collective, or viewing mental health as part of a

broader holistic context of wellbeing that incorporates both relationships with others and with the environment (Durie, 1998a, 2001).

While it may be suggested that Māori and traditional Western approaches to the individual and therapy contrast, it appears there is some growing evidence to suggest that these approaches can be combined to work well for Māori (e.g., Bennett, Flett & Babbage, 2016; Cherrington & Rangihuna, 2000; Mathieson et al., 2012). This appears to be particularly so when these approaches incorporate important Māori values and principles such as those outlined below.

Māori Tikanga

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

Whānau: The whānau (family) is an integral part of being Māori. Huriwai explains that a typical Māori family in the 18-19th centuries resembled more of a 'domestic group' "interconnected by kinship ties that lived and worked as a social and economic unit on a daily basis" (2001, p. 1038). Kinship ties often extended into relations further than the nuclear family to include, hapu (sub-tribe), iwi (tribe), and waka (navigational canoe) affiliations (Moeke-Pickering, 1996).

Despite the impact of colonisation on Māori societal structures, these types of extended kinship ties remain strong for many Māori today. These connections have also been extended into non-familial ties that "express a common mission" (Durie, 2003, p. 13). In these contexts the function of the whānau is communal in nature and described by Huriwai and colleagues as "providing a framework in which co-operative and collective values can be expressed and practiced" (Huriwai et al., 2001, p.1039).

The importance of whānau is further emphasised in Cram's (2003) qualitative assessment of how Māori talk about health. Participants in Cram's study explained that the

whānau was the basic structure of support because "whānau buffers its members from the wider world, including experiences of illness, treatment and hospitalization" (Cram, 2003, p.4). To understand the mechanics related to these 'buffers' Durie offers a valuable insight to show how particular values emanate from within a whānau: manaakitanga (support and caring), tohatohatia (sharing resources), pupuritaonga (guardianship of gifts), whakamana (enabling/empowering family members), and whakatakato tikanga (positive planning for the future) (Durie, 1998a).

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

Manaaki/Manaakitanga: Related to the idea of providing for one another are the concepts of manaaki and manaakitanga. In many ways manaaki can be likened to the term 'hospitality' however there is more depth to the understanding of manaaki or manaakitanga than this. Māori place much importance on their interactions with other people, and have a preference for these to be respectful, caring interactions (Barlow, 1991; Mead, 2003; Patterson, 1992). The formal expression of manaaki or manaakitanga can be seen in ceremony such as powhiri (rituals of welcome) and hui (gatherings/meetings). A key aspect of these ceremonies is provision for the manuhiri (visitors). For example, Barlow (1991) explains that "the most important attributes for the hosts are to provide an abundance of food, a place to rest, and to speak nicely to visitors so that peace may prevail over the gathering" (p.63). This is not only to reduce the possibility of any potential conflict, but also to acknowledge the mana (authority, dignity) of the visitors by way of demonstrating meaningful respect and care.

Mana: Māori believe that every individual is endowed with certain qualities at birth. People are born with an increment of mana based on ancestral achievements or status (Mead, 2003). Mana is likened to status and described by Mead as the "creative and dynamic force that motivates the individual to do better than others" (p.51). However, Durie (2001) extends

this definition to include a spiritual element, transposed onto certain individuals by a community to ensure collective well-being. Therefore, in their endeavours throughout life, individuals must recognise their responsibility to the community. If an individual fails to uphold the mana they have 'developed' or been bestowed with, mana can decrease. Thus an important aspect of mana is the way in which it can be shaped by experiences. For those who carry mana in accordance with their own and others' expectations, personal and collective well-being is maintained (Mead, 2003).

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

Māori Service Providers and Efficacy of Māori and Indigenous Intervention

In a comprehensive review of Māori addiction treatment between 1980 and 2008, it was shown that the genesis of specific Māori alcohol and drug services originated at a bicultural service at Tokanui hospital in the 1980s (Cave, Robertson, Pitama, & Huriwai, 2008). According to these authors the 'humble beginnings' are best viewed in the context of the wider socio-political context of the time; a time when, politically, Māori were making significant progress toward regaining authority or self-determination in accordance with the principles of the Treaty of Waitangi. In his analysis of these matters, Durie explains that self-determination "is about the advancement of the Māori people, as Māori, and the protection of the environment for future generations" (Durie, 1998b, p.4). He further observes that the 'critical' milestone directing political focus toward Māori self-determination was with the 1984 Hui Taumata, the Māori economic summit. Importantly for Māori, this Hui ushered in a

new wave of thought in which it was believed that Māori should be invested with the resources to provide services to address significant Māori issues. Accordingly, the provision of bicultural services for Māori within mainstream services had become a real possibility.

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

Despite the positive growth during this time, there is a lack of accessible evaluative data relating to these services, and a notable lack of client-focused research relaying the experiences of Māori in Māori centred treatment. Notwithstanding, the earliest evaluation gauging the experiences of Māori in a Māori focused rehabilitation facility was conducted in 1997. Faisandier and Bunn (1997) piloted this research at the Queen Mary hospital Māori-focused unit. Following two years of data collection, qualitative analysis of interviews with Māori revealed they experienced significant improvements in quality of life, mood, anxiety and anger. Equally important, 'strength of identity' and 'more positive feelings about the experiences of being Māori' were also reported (as cited in Adamson, Deering, Hinerangi, Huriwai, & Noller, 2010). Since this time, similar themes of change have been recorded elsewhere at day and residential facilities catering to Māori clients. For example, in an evaluation of Nga Punawai Aroha, 91% of the participants felt that they had noticed significant lifestyle changes with regards to their attitude and behaviour; moreover, elements of the programme such as the karakia, waiata and tuhonohono were evaluated positively (McCracken, 1999). The experience of these participants supported quantitative data showing significant reductions in alcohol consumption in the short term and significant reductions in cannabis use in both the short and long terms (McCracken, 1999). Unfortunately, McCracken's evaluation showing the link between positive client experiences and quantitative outcomes in Māori centred treatment is one of very few. The lack of similar analyses is thought to be due to the preference amongst researchers to use qualitative research methods when interpreting the experiences of Māori in addiction treatment.

Developing momentum within the literature is the recognition that specific Māori processes used in treatment are an important part of the rehabilitative process. Typically these processes include powhiri, mihi, karakia and whakawatea, although these processes can vary in style between regions and between facilities. Analyses of self-reports amongst Māori in

treatment reinforce the importance of these processes. For example, participants refer to the powhiri (a formal welcome usually held within the first week) as a time to 'break the ice' and feel a sense of belonging to the institution (Warbrick, 2006; Waigth, 2012). Many participants recalled their initial fear of being a part of a powhiri but then went on to explain the confidence they developed as they became familiar with the process (Warbrick, 2006; Waigth, 2012). Related to this are experiences in leadership with powhiri, kapa haka or activities of day to day living. This is typically referred to as a tuakana/teina dynamic where the more experienced member(s) of the group lead those that are less experienced. For men this may eventuate when they are asked to lead a haka, or for women, leading the karanga. Similar to the powhiri, participants were initially fearful of these processes but realised that these roles were valuable for passing on knowledge, growing in confidence and growing in their ability to help and support others (Hughes, 2007; Waigth, 2012; Warbrick, 2006).

Inextricably linked to these processes were the participants' reflections on the underlying philosophies of a Māori worldview. Highlighted in many of the evaluations were philosophies such as whakawhanaungatanga, whakapapa, wairua, mana and tapu. For example, whakawhanaungatanga was referred to by many as a way of uniting the often disparate members of the group. Iwikau (2005) and Waigth (2012) have described this in relation to a unifying feeling within the group following activities such as karakia and waiata (Iwikau, 2005; Waigth, 2012). Whereas Paki (2010) observed that whanaungatanga was an important way to build relationships between staff and students.

Further emerging from the literature were references made to Māori identity. This was a particularly salient theme for Māori who had lost some previous connection to their Māori culture. For example, several evaluations have found that participants who lost connection with their Māori culture were embarrassed of their incompetence with Māori practices or embarrassed that they were Māori (Iwikau, 2005; Waigth, 2012; Paki 2010; Warbrick, 2006). However, through the process of treatment, and as a result of being exposed to Māori values and practices in a safe environment, many participants felt a stronger sense of connection to Māori culture and expressed a sense of pride (Iwikau, 2005; Paki 2010; Waigth, 2012; Warbrick, 2006). For some this provided the impetus to pursue further connections with their Māori culture by either taking Te Reo Māori classes, or establishing connection with their extended family or tribal area (Waigth, 2012; Warbrick, 2006).

The link between treatment and identity is consistent with the recommendation made by Huriwai that culturally congruent models in health interventions are important for enabling

individuals to connect, or re-connect with their cultural identity (Huriwai, 2002). For Māori, this claim has been supported by research showing that a connection with Māori identity is linked with better overall health outcomes (Boden, 2008; Ebbett, 2010; Marie, Fergusson & Te Hoe Nuku Roa, 1996) and enables individuals to experience cultural pride and affirmation which together act as a 'buffer' to further negative mental health outcomes (Muriwai & Sibley, 2015) including substance abuse (Huriwai, 2002). Furthermore, culturally congruent rehabilitation in general is supported and encouraged by both Māori and non-Māori treatment providers (Robertson et al., 2005; Robertson, Huriwai, Potiki, Friend, & Durie, 2002) as it can contribute to a trusting and safe therapeutic relationship (Abacus, 2004), lead to higher levels of treatment satisfaction amongst Māori (Huriwai, 1998) and increases in a subjective sense of well-being (Houkamou & Sibley, 2011). Research has also indicated that infusing a therapeutic community with Māori values, beliefs and processes contributes to the overall therapeutic milieu and provides feelings of safety and cultural resonance for Māori, especially in terms of exploring new notions of self (Adamson et al., 2010).

Further afield, international literature regarding culturally appropriate interventions has indicated that ethno-cultural factors are a crucial part of health (and other) rehabilitation processes, most notably because they are established on the accumulated knowledge, experience, wisdom and 'know-how' unique to a given culture, society and/or community (Harley, 2006). In particular, cultural interventions appear to be most important for indigenous populations that have undergone psychological, cultural, social and political assimilation (Dawn, 1993; McCormick, 2000; Spein, Sexton & Kvernmo, 2007). The underlying rationale of this assertion is clear; ultimately 'evidence based practice' rooted in western philosophies of epistemology is not sufficient for addressing the needs of colonised indigenous people. Novins and colleagues (2011) explain that, for many indigenous people, a notable absence in evidence based practices is any reference to the spiritual realm. Furthermore, Morgan and Freeman (2009) argue that the focus of treatment for indigenous people is the healing of a person in the context of a community alongside a perception that a disease is to be respected and not conquered. For those with the ability to 'heal', there is an obligation to share their knowledge and expertise with the community rather than using it to accumulate power and control.

Conclusion

Many therapeutic programmes which cater to Māori incorporate important values and principles such as those described above (as well as others not described here). Given the reality of alcohol and drug use amongst Māori and the way in which this appears to negatively and disproportionately affect Māori, treatment for Māori within a Māori worldview would seem a necessary means to begin to address this problem. However, little research has been conducted with Māori clients of such programmes and as a result studies which include Māori 'consumer perspectives' on the efficacy of these types of programmes are rare. Moreover, to the best of my knowledge, there are no long term follow-up studies gauging the experiences of Māori clients who have successfully completed Māori centred alcohol and drug treatment. Therefore, this research, building on earlier research conducted at Higher Ground Drug Rehabilitation Trust, aims to address the lack of research in this area through a qualitative analysis with this population.

Specifically, the questions guiding this research were: what is the experience of Māori with addiction as discharged clients of residential treatment? How do the participants (ex-service users) relate what they learned in treatment to their recovery beyond the residence? Where long term change has occurred, how has this been maintained?

A relevant consideration was the appropriate length of time elapsed since participants completed treatment. In the literature there is no consensus on this issue and the "long term" can vary between six months and sixteen years. For this research, participants were selected only if they have been discharged from treatment for at least one year.

This research, in gathering information about the efficacy of Māori centred alcohol and drug treatment, may be regarded as contributing, at least in some small part, to the obligations of both the 'Crown' and Māori towards addressing and reducing inequalities in health, as determined by the agreement and relationship principles set out by the Treaty of Waitangi (Alcohol Liquor Advisory Council, 2008).

Chapter Two: Method

When performing research, it is important to understand why a particular methodology was chosen by the researcher. This helps to clarify the researcher's 'lens' during collection, interpretation and presentation of the data. In addition, the choice of methodology needs to help the researcher achieve their aims. For this research there were two primary aims. The first, guided by the research question, requires a method that will capture the recovery experience of the participants in sufficient depth. Secondly, the method must help to maintain a practice of research that is consistent with the values, needs and expectations of Māori in relation to the production of knowledge. To these ends, a qualitative, semi-structured, kaupapa Māori (informed) interview design was selected. This section provides the methodology, or justification, for selecting the theory and method above, and outlines some of the key underlying principles to these concepts.

Methodology

Qualitative research

A common way for gathering qualitative data is conducting in-depth interviews or focus groups (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). These are often led by a researcher who asks questions derived from a broader research question, who is also armed with an array of probing questions to clarify statements made by participants. Once the data is gathered, observations of the data are made which then inform the researcher's findings and conclusions. Thus it is an inductive approach to research.

Questioning participants directly and via open-ended questions is a method of data collection that gives access to an individual's subjective experience of the world. This allows the researchers to understand the meanings people make of these experiences (Morrow, 2007; Mack et al., 2005). Accordingly, qualitative research is often used for psychological research (Morrow, 2007), in common with other disciplines where the investigation is of topics not well understood, or where research is lacking (Marshall & Rossman, 1999). Put another way, qualitative research is useful for helping researchers answer "how" and "what" questions (Creswell, 1998).

Qualitative methods have been identified by many authors as emancipatory methods, especially where questions of knowledge and legitimacy arise. For example, Smith (1999) observes that qualitative methods are useful for challenging positivistic assumptions, namely,

those which assert how reality, including human experience, is only that which can be observed and measured. Moreover, qualitative methods can be used to reflect on the position of values, power and control in the creation and legitimisation of knowledge (Bishop, 1996; G.H. Smith, 2003, Smith, 1999). Due to these and other qualities, many authors have also recognised qualitative methods as preferred methods when working with Māori, and within a Māori worldview (Walker, Eketone & Gibbs, 2006).

Questions of reliability and validity have been raised in the literature regarding qualitative methods of this nature. Chief among these are those who bring attention to the importance of objectivity in any scientific endeavour (Young & Arrigo, 1999). However, several authors have responded by asserting that qualitative methods bring a unique type of knowledge that cannot be accessed through quantitative means, therefore it cannot be dismissed.

For the reasons outlined above, a qualitative method of semi-structured interviews was chosen for this research, whereby participants were asked questions derived from the general aims of the project. Broad questions were used from a semi-structured interview schedule, and, where relevant, follow-up questions or probes were used for further information and for clarification.

Kaupapa Māori research

A further influence on this research was kaupapa Māori theory as it relates to performing research with Māori people. As with many indigenous cultures around the world, research brings to mind a number of negative connotations. In NZ, this stems from a number of factors, many of which lie in our socio-political history. According to kaupapa Māori theorists, the dominant non-Māori framework of said research had come to define knowledge narrowly which perpetuated the hegemonic 'status quo' (Smith, 2003). Needless to say, Māori were, and still remain, increasingly uncomfortable and suspicious of what appears to be a predominantly invalidating and exploitative approach to indigenous experience (Smith, 1999; Tēariki & Spoonley, 1992).

In an attempt to address some of these concerns, a comprehensive framework was developed with a view to enhance the quality of life and social outcomes for Māori, while legitimising a Māori worldview that conceives of and handles knowledge in a more culturally appropriate way (Barnes, 2000; Smith, 2003). However, due to the historical context in which it was developed, kaupapa Māori research (KMR) is not a prescriptive framework describing

how to do research; rather, it is a philosophy that is primarily concerned with what the research does and the effects of said research (Eketone, 2005).

To elucidate the philosophy of KMR, Walker and colleagues (2006) draw on several KMR authors to arrive at five principles. These principles include: 1) tino rangatiratanga – the right for Māori to exercise self-determination, sovereignty and power over the research agenda for the benefit of Māori (Pihama, Cram & Walker, 2002; Durie, 1998b, 2001, 2003); 2) Social justice – concerns the redress of historical power imbalances (Gibbs, 2001); 3) Giving recognition to a Māori worldview through practices consistent with that worldview (Bishop, 1999); 4) Incorporating te reo when appropriate (Powick, 2003); 5) A principle of whānau places importance on establishing and maintaining relationships (Bishop, 1999).

In practice, these principles can be applied in idiosyncratic ways, however, there are some requirements that a researcher should meet before conducting KMR. The first, and perhaps most controversial, is the requirement for the researcher to be of Māori descent and competent in te ao Māori. There is also a requirement for the researcher to have an attitude of service and respect for tikanga and practices (Pipi et al., 2004) which can sometimes mean disclosing personal information regarding familial affiliations or whakapapa. In the area of recruitment, it is expected that a meeting with an elder, affiliated to those who are participating in the research will be held, face-to-face. Initially, this hui will aim to establish a relationship, then address a number of important issues, including the appointment of a cultural supervisor, and a request for kaumatua support throughout the research.

This research project set out with the intention of being a fully kaupapa Māori research project. However, this could not be achieved in all respects. Therefore, the principles and processes outlined above were used to inform this research and drawn on to help guide my understanding, response and interpretation of the participants' experience. Specifically these included, kanohi ki te kanohi (face to face) hui with the programme facilitators and Higher Ground CEO to request permission for this research, and hui during the research process with the facilitators for guidance. During the interview process specific tikanga were followed to introduce and host the whaiora (participant), including karakia, mihi and whakawhanaungatanga. Food was also provided for whaiora as well as a koha (gift) to recognise their participation. The analysis was restricted in terms of how well I could bring an understanding of te ao Māori to bear on what the whaiora described, and the reality that many whaiora in this research described their experience, even of the whānau group, in non-Māori ways.

Positioning the researcher

Further emerging from qualitative methods is the need for the researcher to clarify their positions in relation to the research. This is seen by many qualitative researchers as a necessary declaration due to the influence of the researcher over the data; its collection, analysis and interpretation. Thus it is about declaring, for the sake of transparency, any views or experiences which may influence the researcher and any conclusions that are made about the data.

Firstly, as Māori, I am somewhat familiar with the cultural, social and historical realities of the participants through my own experiences, especially those from within my own whānau. This also includes the ways in which these realities are collectively understood and constructed by my whānau. This provides a unique 'insider' perspective (described below) which can elucidate participant experiences in valuable ways; however, it is a sword that cuts both ways. That is, there may be an assumption that my experiences as Māori, and the ways that they have impacted my understanding of the social world, bear a resemblance to the participants' experiences.

Furthermore, as Māori, the principles of a collective culture have a particular resonance with my life. In particular, I feel accountable to my whānau, and Māori more generally, for the way this research is conducted, presented and interprets the experience of the participants. Thus it is a very personal journey. However, this level of accountability may mean the conclusions are made with too much emphasis on how it will be received. As described elsewhere in this section, all necessary steps have been taken throughout this research to reduce biases of this nature.

The Research Setting: Higher Ground Drug Rehabilitation Trust

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

The most recent report conducted for Higher Ground revealed that people of European descent comprise 68% of admissions, followed by Māori (28%) and people of other

ethnicities (4%). Overall, for those that were admitted to Higher Ground, methamphetamine was the most prevalent type of drug residents were addicted to (51%), followed by alcohol (25%) and cannabis (17%) (Raymont, 2012).

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

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

While at Higher Ground, there are several opportunities within the treatment programme where clients can select to either attend a 'mainstream' rehabilitation activity or a Māori focused component (within part of the overall treatment programme). For example, on a Friday afternoon they may attend either a spiritual group or the whānau group. Participation in Māori focused components is open to both Māori and non-Māori, but is strongly focused on fostering understanding and practice of Māori values and principles, including positively enhancing Māori cultural identity among Māori clients. The Māori components were first introduced to the Higher Ground treatment programme in 2004 and have expanded to include opportunities to learn, practice and experience tikanga based activities such as powhiri (traditional formal welcome) and karakia (prayer).

When residents complete treatment, they are invited to transition into a post-treatment pathway prescribed by Higher Ground. Whaiora are made aware of the post treatment

pathway between the 10th and 12th week of treatment. The *Continuing Care Plan* (see Appendix A) is given to residents to complete, followed by a meeting with a member from the care team. During this time the Care team work with whaiora to identify possible triggers (to substance use), possible solutions and the nature of any support network whaiora may have built during treatment.

During this conversation residents are also asked whether they would like to remain in a post-treatment support house. At this stage, Higher Ground is affiliated to both Calgary and Wings support houses based in the community. Typically, residents remain with a support house for three to four months depending on their situation. Both houses have residential rules and expectations, however these are less formal than those within Higher Ground. For example, Higher Ground encourages whaiora to participate in as many meetings (AA or NA) as possible whilst a resident in a support house, although there are no negative repercussions if whaiora choose not to participate. While this is not obligatory, many who participated in this research chose a path similar to that prescribed by Higher Ground.

Participants

To participate in this research, several criterion were put in place to determine suitable participants. Inclusion criteria were the following: 1) Identifies as Māori; 2) successfully completed the full Higher Ground rehabilitation programme within the whānau group; 3) was discharged from Higher Ground residential facility at least 12 months previous; and 4) is still desisting from alcohol and drugs use. In accordance with the ethical procedures outlined in the ethics application, recruitment was initiated by Higher Ground through an internal staff member who is responsible for research liaisons.

During the recruitment phase it immediately became apparent that substance desistance, although ideal, wouldn't capture the true nature of recovery for those who have completed treatment. This fact is highlighted by Sellman (2009) who points out that only about 10% of people with addiction will have continuous abstinence following treatment in the long term. Having realised the likelihood of further substance use in recovery, I held the criterion of substance desistance lightly. In saying this, all participants reported abstinence in the two months preceding the interview, whereas all but two reported complete abstinence since treatment discharge.

The initial phases of recruitment were conducted by the research co-ordinator of Higher Ground. This involved the identification of candidates who met the criteria outlined

earlier. Following this, potential candidates were contacted and given the opportunity to participate in the research. Once the consent to be contacted was given by candidates, participant contact details were forwarded to the researcher who then proceeded to make contact. After an initial conversation to ensure they were still willing to participate, a suitable time and place to interview was arranged. Fortunately, Higher Ground offered the interview rooms on site as a place to conduct the interviews so most interviews were conducted there with a few exceptions.

In total, 18 participants were identified for this research. This included 12 males and six females between the ages 28 and 55. The average time since treatment discharge was three years however this does not include two participants who were nine years in recovery. Due to a relatively small population of people that have participated in the whānau group, further details about the participants will not be disclosed in order to protect anonymity, as per the ethics approval.

Interview Schedule

Given the similarities with an earlier research project, the interview schedule for this research was based on the interview schedule used in Waigth (2012) and realigned with the specific aims of this research. Interview questions were semi-structured and open-ended to encourage discussion among participants about their recovery experience (see Appendix B). For example, general recovery questions were: *Can you tell me about your recovery so far? What has been the most difficult/least difficult aspect of your recovery? How have you managed to reduce/cease drug and alcohol use since leaving Higher Ground?* More specific questions about recovery experiences were: *What was your experience of the whānau group? Did you find any part(s) helpful/unhelpful to your recovery? What would have been more helpful to you during your recovery?* Asking questions in this format also allowed for a flexible interview where probing questions such as '*could you tell me more about that?'* could be asked.

Procedure

Ethical approval for this research was granted by the University of Auckland Human Participants Ethics Committee (UAHPEC).

Following the consent procedure, the interview process began. All interviews were conducted face to face, and apart from one interview lasting 20 minutes, interviews were

between 50 and 90 minutes in length and were completed in the one session. Interviews were digitally recorded and notes were taken throughout.

As mentioned earlier, the philosophical principles of KMR were incorporated and operationalised throughout the duration of this study. For example, whakawhanaungatanga (establishing and maintaining relational connections) guided the contact between the researcher and the participants. Establishing these connections through whakapapa (genealogy) and the use of Te Reo Māori was particularly important during first contact with participants so that all the participants were aware of the researcher's identity as well as the purpose of this research. This was also extended through to the interview stage where hariru (greetings) were extended through a hongi (bringing noses together) and/or with a kiss. Food was also brought into the interview space where appropriate, and time was spent building rapport with participants through kōrero (talking). Concluding the interview, koha (gift) and karakia (prayer) were offered to participants. Koha was in the form of supermarket and petrol vouchers.

The interviews were also influenced by the training I had received to this point as part of the clinical psychology programme. Notable from this training was the use of empathic phrases such as *'that must have been a tough experience'* and reflective phrases beginning with *'it sounds to me as though'*… In a therapeutic context, phrases such as these aim to create a rapport by promoting the active listening skills of the interviewer to the interviewee. Although the influence of this training and these phrases are difficult to determine, it was noticeable given that the content of some interviews involved descriptions of difficult experiences in addiction.

In addition, the interview also included an open-ended question about the participant's treatment experiences. This was important to give context to their evaluative comments about the programme, and to build rapport.

Data Analysis

Interview recordings were transcribed either by the lead researcher, or a University of Auckland approved contractor that had signed a confidentiality agreement. Once transcribed, interviews were analysed using an inductive, data-driven approach. Specifically, thematic analysis was conducted to explore common patterns or variations among the experiences of each participant. This was carried out following guidelines recommended by Braun and Clarke (2006), and throughout, ontological and epistemological perspectives were drawn

from a critical realist perspective. This perspective is concerned with interpreting the lived experience of individuals, while acknowledging that the entirety of their experience cannot be captured fully (Denzin & Lincoln, 2000).

To become more familiar with the data, transcripts were colour coded by participant, printed off, read and then re-read. Following this, any data from the transcripts which appeared relevant to the research question were highlighted or marked. Transcripts were then read again, followed by further highlighting if necessary. Highlighted texts were then transferred to a separate word document and printed. These were then read and checked to ensure all relevant data was present.

Following this, data was then coded, with the aim of organising the data into more meaningful groups. Coding was performed manually as this allowed me to engage more fully with the data. Each code was written either as a single word or a brief sentence, depending on which described the segment of data more accurately. Overall, this process yielded a number of codes and also helped to refine the data down to a more manageable size.

The next step involved bringing together the coded data and organising it into potential themes. The first iteration of this process involved printing of the coded data and then re-organising them into groups of common resemblance. The groups were then given a name and designated as headings in a Word file. Coded data was then entered under these headings and printed off on completion. This process continued until coded data sat under headings which best described their content more generally. These headings were then designated as potential themes.

Given the number of themes by this stage, further refining needed to take place to bring the data to a more manageable size. To achieve this, the second iteration of this process involved a series of maps with potential themes as titles around the page. These themes were then shifted and altered to get headings which captured more of the coded data set. To ensure this part of the process was well directed, this stage involved revisiting the entire data set, codes and initial themes on numerous occasions. During this entire process regular meetings were held with my supervisor, in which he would provide feedback, suggestions and correction to ensure validity. Supervision was also conducted with a Māori researcher who had not previously been involved with the research in order to provide further feedback and guidance during this process.

Chapter Three: Analyses

This chapter presents the perspectives of tangata whaiora who participated in this study. Five themes and nine subthemes were identified using the qualitative analysis outlined earlier. The themes and subthemes include: 1) learning how to transition from treatment to the community; 2) understanding myself and understanding addiction (containing three subthemes); 3) making changes to the relational aspects of life (containing two subthemes); 4) strengthening my Māori identity (containing four subthemes); 5) connecting to spirituality in recovery. The themes are organised in a broad chronological order. That is, the themes are ordered from early, to late recovery. This also occurs to a lesser degree within themes.

Within the theme 'strengthening my Māori identity' there is a general progression of subthemes from experiences of Māori identity prior to treatment, within treatment and then in recovery. However, the concept and subjective experience of identity, while valid, can be difficult to represent and discuss. This is especially true when an experience can be interpreted as an identity experience in the absence of the word identity, much less, Māori identity. For example, whaiora often recognised and experienced certain aspects of the whānau group as an expression of important values in te ao Māori. Arguably, the experience of one's culture and values are identity experiences, although this isn't necessarily so. In light of this, great care was taken to ensure a balance between accurately representing the participants' experience while finding ways to accrue participants' experiences into broader themes and subthemes (see Table. 1 below).

Table 1: Themes and sub-themes derived from interviews with whaiora.

Learning how to transition to the community	Understanding myself and addiction	Making changes to the relational aspects of life	Strengthening my Māori identity	Connecting to spirituality in recovery
	Understanding myself Understanding addiction Shaping recovery in light of new understanding	Putting boundaries around relationships Making and maintaining positive, meaningful social relationships in recovery	My identity prior to treatment The whānau group helped me to connect to te ao Māori and my Māori identity Connecting to te ao Māori in recovery Connecting to te ao Māori helped me to feel proud of my Māori identity	

Learning How to Transition to the Community

This theme is concerned with the initial transition from treatment into long term recovery, some of the difficulties whaiora faced during this time, and the way whaiora managed the transition successfully. For most whaiora, the transition begins when they are placed into an after care residence, followed by a further transition to independent living (see Chapter Two). Moreover, the later transition into independent living often varies, as it depends on when whaiora leave the aftercare residence.

When whaiora described the transition, there was a tendency to give broad reflections in conceptual terms, as opposed to discrete events. This type of reflection may have been influenced in part by the passage of time since transitioning and the fact that the transition is the initial experience in recovery for many whaiora. Also, given that this discussion often occurred within the first 15 to 20 minutes of the interview, whaiora may not have felt they could share their transition experiences in detail at this stage when rapport had not been

sufficiently developed. Alternatively, whaiora may have just wanted to describe their experience in the least complicated way for the benefit of the interview.

For most whaiora, the initial transition into recovery residences was described as a realisation that treatment was a highly insulated reality; much like living in a treatment "bubble". When whaiora compared treatment to a "bubble", there was a sense that treatment is a place where whaiora can be shielded from the totality of their addiction so they can learn how to address their substance addiction in a safe environment. However, this environment left some whaiora unprepared for what they experienced in recovery. For example, the following whaiora learned that "recovery" and "life" were two distinct "balls" that they had to "juggle" simultaneously. The former concerned efforts to manage their addiction and the latter involved the management of more mundane daily experiences such as paying bills, working and living alone. More importantly, this was a new experience for these whaiora:

> Living life on life's terms, working, that kind of stuff, living on your own, paying bills, I found that hard… it's new to me – *whaiora 12*

> Its two different things, life and recovery, cause it's like what we do normally and naturally to what we do and it's a totally different life so yeah it's hard to explain but you're juggling two balls – *whaiora 6*

For a few whaiora, the initial transition into aftercare residence was also complicated by the presence of other residents at different stages of the recovery journey. For example, whaiora in the pre-treatment admission phase were housed with whaiora recently discharged from treatment. For the following whaiora, this dynamic was a central challenge to his initial recovery experience which served as a reminder that treatment was like a bubble when compared to the realities of recovery:

> When I went into recovery, it felt like just coming out of a bubble; and the challenges were having to live in the house with all the other people [at different levels of addiction recovery] – *whaiora 14*

When whaiora leave treatment and transition into an aftercare residence there is a notable decrease in structured daily routine. Beyond the aftercare residence, this structure decreases further and whaiora are required to implement and maintain daily routine completely on their

own. Several whaiora described the absence of structure as leaving them feeling lost and not knowing what to do:

> I really struggled when I came out. No structure. Everything was… all very structured [in treatment]. You knew exactly where you had to be at what time and how much time you had to do it… It was all based on that… and so when I got back home… it was just like, gosh, what do I do now? – *whaiora 3*

In amongst the difficulties of making the initial transition to the community, the most practical way for whaiora to manage was by implementing a structure to their recovery. While this did not address all their challenges, it was a way for whaiora to bring some order to the initial chaos they faced when venturing into the unknown. For the following whaiora, the importance of having a daily routine was found in the practice and repetition of activities so that they eventually became habitual. In the end, repeating activities in this way enabled him to him to feel more comfortable with recovery:

> And as a result [of treatment]… every morning now I've got this specific routine where I wake up and I pray, then I brush my teeth, then I have a shower and make my bed, and I make sure my room's clean and all that sort of stuff… I mean it allowed me to kind of practice things and that's what I've found in recovery… it's the acts of repeatedly doing actions which are unnatural and uncomfortable for me, and then consistently repeating them until they become habitual. And then all of this stuff, it becomes natural and it almost becomes automatic – *whaiora 5*

The initial transition was also the time when whaiora first learned how and when to apply the "tools" from treatment. The term 'tool' was often used to denote strategies (practical and cognitive) which helped maintain abstinence. For example, relaxation strategies are taught to help whaiora deal with stressful situations. However, despite being shown these tools, some whaiora were unsure how to use the tools properly. For example, the following whaiora tried various tools but found that he would often use the wrong tool in the wrong situation:

> They teach you how to collect tools, they don't show you how to really use them but they teach you that there is ways you can but where you're supposed

> to use them is different it would be like… you got an allen key and a sledge hammer. Whereas before I used a sledgehammer but should have been using the allen key… then… you might be using a crescent, that's all good, but you have got to find the right size – *whaiora 6*

For several whaiora, the confusion of selecting and implementing specific tools would lead them to imitate other whaiora and how they applied tools in their recovery. Occasionally, this worked. However, for the majority, recovery was about learning to adapt recovery to suit their specific needs:

> That is something that you have got to find yourself. It's like recovery now you have got to find your own way. You can't really do it anybody else's way you have got to do it yourself, because if you try and follow somebody else, it's not going to be very comfortable for you – *whaiora 6*

In summary, this theme described some of the challenges faced by whaiora when transitioning from treatment into the community. For some whaiora, the initial recovery experience of learning to manage life and addiction was new and made treatment appear like an insulated reality. The way many whaiora dealt with these challenges was to implement structure within a daily routine. A further challenge during this time was learning how to use the tools they learned in treatment. For some whaiora, this was a matter of trial and error, however in doing so, this led whaiora to realise the importance of adapting these tools to suit their specific needs as opposed to following the way their peers managed their recovery.

Understanding Myself and Addiction

This theme concerned the ways in which whaiora came to new understandings that helped them in their recovery. The theme will be presented as three subthemes. The first subtheme concerns how whaiora understood themselves and the second, how whaiora came to understand their addiction. A third subtheme concerned how these new understandings shaped their recovery.

Unlike the previous theme which captured experiences during the initial transition phase, the point at which whaiora developed an understanding of themselves and addiction

varied. Therefore, this theme should be read as though whaiora developed an understanding as they progressed through treatment as well as in recovery.

Understanding myself

Whaiora identified personal characteristics that were regarded as a primary cause or perpetuator of addiction. For some of these whaiora, they expressed these as a flaw in personal character. For example, a flaw in one's character was conveyed by the following whaiora as a core of personal self-seeking and self-centeredness:

> What I've really learnt is that my problem isn't my drinking, and what I've really learnt is my problem isn't my drug taking. What I've learnt is that the core behind all of that is that I'm self-seeking and I'm self-centred. So like I mean, someone like me places too much importance on how they feel, and they place too much importance on what they think – *whaiora 5*

For a few other whaiora, observations were made that related to their substance addiction that were identified as personal "blind spots", meaning, they were blind to the interaction between their emotions, behaviour and previous substance use. The following whaiora described how his internal experience was one of anger which, on reflection, he was "blind" to. To illustrate, he described several situations in treatment when he was irritated by the younger peers "acting staunch". The irritation would often escalate to rage; a very familiar experience given the frequency of anger in his past. In the context of treatment he was able to identify the role of substances in managing his anger and that in treatment his anger was often related to not being able to access substances:

> As I was saying before, some people really irritated me… young guys [in treatment] started getting all staunch [aggressive]… but it's only with words, but that feeling of rage, that's where it's blind… which is just a coping mechanism when you have an addiction – *whaiora 1*

A couple of whaiora reflected on their past and were able to deduce a familiar pattern of behaviour while they were actively using substances. For example, the following whaiora had come to realise how his addiction was the result of learning behaviours which became entrenched overtime:

> You have got to remember that we are addicts and entrenched, our learning through life has been entrenched. [For example] we learn a lot from our parents and if it's been entrenched in you that you see a lot of violence and anger… [at home] then that is how you will deal with it in later life – *whaiora 6*

A couple of whaiora also used metaphor to describe the internal aspects of their addiction. For example, one told the story of the "grapes". In this story, he likened the experience of addiction to the experience of being tempted to steal grapes at the supermarket. To begin, he describes an irresistible desire for the grape, and then checks to see if anyone is watching. If no one is watching, that would be a prime opportunity to steal the grape! Similarly, the desire to use substances is present during recovery. Like a grape its presence can be small nonetheless it can influence the whaiora's decisions about substances which are often made impulsively:

> You go into the supermarket, there are the grapes and, you're looking around, your old behaviour, look around you, looking, can't resist, you know, the grape, the grape, anyone looking? No. Grape, boom, that's where it all starts with that grape – *whaiora 4*

Another whaiora gave an account of his understanding by describing the process of realising his "internal experience". For this whaiora, the only way he could make changes in treatment and recovery were with an internal state of desperation. This was sufficient for him to surrender, which gave rise to a willingness to engage in treatment and try things he didn't believe would work. When faced with recovery, a similar process took place, which required a second state of desperation and surrender bought on by the realisation that Higher Ground was no longer there to help him manage his addiction:

> When I got out of Higher Ground there was a second kind of surrender and a second form of desperation where I realised that this wasn't going to keep me sober anymore, cos I wasn't here… so that desperation definitely… what I've learnt in here is that nothing teaches willingness like desperation. Because unless I was in a point of complete surrender and desperation I probably

> wouldn't have been willing to do all this stuff, which I didn't understand and I didn't believe in, and I didn't trust in, and I didn't think was going to work. But I did it anyway, and as a result my life is completely different in a much more positive aspect – *whaiora 5*

Understanding addiction

Some whaiora described the recovery journey as being shaped by a new understanding of addiction. To convey their understanding, the following whaiora would often identify addiction with a being or external force with agency. For example, some whaiora described addiction as 'Satan':

> You talk about cunning, powerful and baffling patient, the addiction and the drugs and alcohol, to me, really, that is Satan. He's a cunning, powerful, baffling patient. You know, he'll get you when you least expect it. When you slip, he's there to get you, take you out – *whaiora 4*

For a few other whaiora, external attributions to a 'disease' were made. For these whaiora, the disease was such that it was experienced as communicating messages which were contrary to their recovery/abstinence goals. For example, the following whaiora experienced the disease as one which told him not to engage in treatment and recovery, including messages telling him that he doesn't in fact have a disease:

> It's a disease that tells me that I don't have a disease. It tells me that I'm not an alcoholic. It tells me that I don't need to do this stuff. It tells me that I don't need to pray. It tells me that I don't need to go to meetings and it tells me that I don't need to help other people. Like I mean these are the thoughts that this disease kind of gives an alcoholic – *whaiora 5*

Externalising addiction in this way is a common feature of many 12-step programmes and appears to function as a strategy to distance individuals from their addiction. By doing so, whaiora appear to be more motivated to recognise their addiction and its effects, as it no longer carries a significant personalising, self-blaming element. This was particularly noticeable when a few whaiora went on to mention that they their disease was something they had to be aware of and manage for the rest of their lives.

Shaping recovery in light of new understanding

For whaiora who described new understandings of themselves and/or addiction, there were ways in which this contributed to their thinking about recovery. This subtheme concerns how these whaiora perceived their recovery in light of their new understanding and the ways in which their recovery journey was influenced accordingly.

For most whaiora, new understandings led them to an increased sense of vigilance and awareness during recovery. That is, whaiora were able to identify triggers which could lead them to use substances again. For example, having told the grape story, this whaiora explained how he no longer acted on impulse and was more self-aware and more able to maintain self-control:

> I'm aware of that [the way the desire to use substances is always present] and I have a better self-awareness now and better self-control. You know, I don't act off impulse like I used to in the past – *whaiora 4*

Most of these whaiora further emphasised the importance of vigilance during the initial phases of recovery when they transitioned into after-care residence due to the sudden experience of freedom. For example, this whaiora realised that there was nothing stopping her:

> [While in aftercare residence] I could have spun myself around in a little circle and gone out using, you know… there's nothing stopping you. All that time you're free to walk out that door and all that time you are free to go across the road and buy a five dollar drink – *whaiora 13*

For a few of these whaiora, remaining vigilant was emphasised during their peer-support meetings, especially at times when whaiora felt "strong" in their recovery. The following whaiora describes this in relation to a brief relapse at the beginning of her recovery. In particular, she identified how she took her abstinence during recovery for granted, which led her to believe she could relax the boundaries she had maintained during treatment:

> One thing I have learnt especially since this last relapse, you can never ever think for one minute; they say it in the rooms all the time, that you're only one drink or one drug away from relapse. And that's something that I always took

> for granted. I never, you know, until it [using substances] just went, smack in the face. By then [the time I realised I had used again] it's too late – *whaiora 3*

For a few whaiora there were specific strategies they developed in relation to realising the role of anger in their addiction. For example, having realised how peers were making him feel in meetings, the following whaiora chooses to "shelter" himself from environments where he may be triggered into anger:

> I've been here [recovery] 18 months, but, one of my biggest triggers is anger…the only problem with anger, and that's what worries me, is that once it snaps and gets too far, it's, and then it's blown. So I keep myself really safe... and see at the moment I shelter myself from situations like that and try not to get triggered – *whaiora 1*

While keeping safe is a very useful strategy for this whaiora to maintain recovery, it is a 'double edged sword'. That is, although he identified his triggers and maintained his distance from potentially harmful situations, this also limited his ability to help others as much as he would have liked. Given that peers support is a big part of recovery for many whaiora, this creates the potential for further complications in recovery. However, for this whaiora, it appeared as though he was able to deal with this limitation so that it wouldn't affect his recovery:

> [Anger]… limits me to be able to help people, or moving on a lot… see, I don't do a lot of meetings coz there's a lot of people in the rooms that just irritate me…but it's just me… and I understand that… I have got the tools to deal with it – *whaiora 1*

In summary, 'understanding myself' was described in terms of whaiora realising negative personal attributes, emotions or behaviours that contributed to their addiction. Understanding addiction was described by some in terms of external influences such as Satan or a 'disease' and how they influenced their addiction. Finally, having gained understanding in these areas, whaiora described how they were able to shape their recovery journey. This included increased awareness and vigilance around addiction, a better sense of self-control, and not

taking recovery for granted. However, as noted by one whaiora, selecting strategies to avert specific emotions or behaviours may have further consequences for recovery that need to be monitored or dealt with in their own specific way.

Making Changes to the Relational Aspects of Life

This theme concerns the significance of whaiora making changes to the relational aspects of their lives and the ways in which this impacted on their recovery. These include adjustments to previous unhelpful relationships, as well as initiating and maintaining relationships that contribute to recovery success.

This theme incorporates two subthemes related to the relational aspects of whaiora lives, beginning with the boundaries whaiora put in place around previous and current relationships. A second subtheme describes the importance of making and maintaining positive, meaningful social relationships in recovery.

Putting boundaries around relationship

This subtheme concerns a common practice among many whaiora to place boundaries around relationships in recovery. The impetus to enforce boundaries stemmed from relationship experiences in treatment and broader treatment advice about relationships. In recovery, these experiences were then used to inform relationship decisions throughout recovery.

For most whaiora, an important set of relationships were those relationships with people outside the treatment and recovery context. Several whaiora described taking all necessary steps to protect against relationships that were thought to be a threat to their recovery success. For some, the threat to their recovery was such that they completely severed any ties to these relationships:

> Still being in contact with my old friends… I had to break all communications, and I have. So associating with them again would be not good – *whaiora 15*

> I've had to put boundaries up around people I can and can't associate with because of being worried about getting led astray or whatever – *whaiora 8*

In addition to ending relationships with certain people, a few whaiora also identified the importance of distancing themselves from certain locations:

> [Location] is a real trigger for me, if I go back there it would be, I wouldn't say I knew it all, but I feel that that's the danger zone for me – *whaiora 1*

While a 'cold turkey' approach was useful and necessary for several whaiora, some whaiora managed to continue previous relationships by placing boundaries around certain social gatherings and events which involved people from these relationships:

> [At a Tangi] her father turned around and said there was no drugs or alcohol to be on his property. Well they [other whānau] were still sneaking it in anyway. And they go oh cuz, why don't you come out and have a drink with us… and I was going yeah, okay but yeah, nah. And they go why not… I said because of the fact, the reason is that I'm up here and my cousin's in there, lying in a state of alcohol poisoning – *whaiora 13*

> I went to a barbecue last week, and then after that they had a party… I only stayed for about an hour and I was like oh yeah, I'm going home now. And they [whānau] all know why. Like they're cool with that… Any time I feel like just leaving I can just leave – *whaiora 15*

A few whaiora also described having to place boundaries around future flatmates due to negative experiences with other whaiora in aftercare residences. Having realised the effect of these relationships on her recovery, the following whaiora decided to move out of an aftercare residence and into a residence with whaiora who shared similar recovery expectations:

> The thing was that [my new flatmates] we all came from Higher Ground we… had our little thing in our heads that we all knew how to behave, we all knew what was expected of us in terms of cleaning your room, cleaning your house, buying your groceries – *whaiora 14*

Significant social network changes such as these can lead to equally significant consequences. On the one hand, these changes reduce the effect of negative social influences so that whaiora would not be influenced by these individuals in their recovery. Inevitably however, disassociating carries the potential to isolate whaiora and to diminish their ability to connect

socially at all. Fortunately, treatment providers such as Higher Ground realise that this is a common experience for many whaiora leaving treatment. To help buffer against this, treatment encourages whaiora to build new social connections in residence or self-help groups that whaiora attend during and after treatment. This will be covered in more detail in the following section. Here, it is worth noting many whaiora find the transition difficult. For example, having experienced a minor relapse early in recovery, the following whaiora realised the need to sever ties with his friends who continued to use substances. However, disassociating from these friends meant his social circles were smaller and his new challenge was learning to deal with boredom:

> [Since the relapse] I have learned I'm not going to pick up an old druggie mate now… I don't want all those sort of fellas. So I changed all my numbers. That's a big one in recovery… [However, since the relapse] the focus for me was the boredom and… [Disassociating from] the associates that took me up last time I relapsed – *whaiora 4*

Similar difficulties arose for the following whaiora who had decided to steer clear of his hometown. However, having made this decision, he went on to realise the further difficulty of finding employment in his new town where he was not known:

> I'm [age] now so it's like, the world's kind of closed up, you know, you could get any single job I wanted [at home] coz I was known. But this town's a lot different – *whaiora 1*

Taken together, for many whaiora, severing and enforcing boundaries around relationships that threaten recovery had overall positive consequences for recovery. However, as the whaiora describe, these decisions can present further, unexpected challenges in recovery. Having made these changes, the following subtheme presents the ways whaiora navigated through the difficulties associated with changes in their social networks. In particular, the ways in which whaiora established positive social relationships in recovery.

Making and maintaining positive, meaningful social relationships in recovery

This subtheme concerns the importance of making positive, meaningful relationships in recovery. Whaiora identified several avenues to pursue these relationships, including meeting

attendance, sponsor-sponsee relationships, and continuing relationships formed in treatment with the whānau group and facilitators.

Higher Ground encourages whaiora to engage in sponsor-sponsee (SS) relationships and to attend AA or NA meetings in recovery. For most whaiora, the SS relationships were important in recovery for remaining accountable and having support through difficult times. In addition, most whaiora who engaged in meetings described these meetings as an integral part of their recovery as they reinforced the learnings from treatment. These meetings were also described as an important way to establish or maintain positive, meaningful relationships, especially with other whaiora.

For many whaiora, positive, meaningful relationships in recovery were built on the relationships formed in treatment; especially those formed with other whānau group members and the facilitators. For these whaiora, the relationships with these people were closer and easier to continue in recovery. The depth of these relationships was often attributed to times when whaiora participated in whānau group activities in treatment, such as the Marae noho. As the following whaiora describes, the Marae noho gave him a chance to interact and build relationships with other whaiora:

> You're just so close… especially on that marae trip where yous are all there for three days, just interacting… You tend to build quite a close relationship, and you tend to just carry it on out there [in recovery] – *whaiora 2*

To capitalise on the benefits of these relationships, the facilitators encourage whaiora to stay engaged with these relationships in recovery. For example, the facilitators invite whaiora to a '90 meeting in 90 days' challenge upon graduation. This challenge is distinct to the whānau group, and many whaiora saw this as a helpful incentive in recovery. However, for a few whaiora, the '90 in 90' challenge was such a positive experience that they chose to complete an additional 90 in 90. As this whaiora explains, the 90 in 90 was helpful as it encouraged him to attend meetings where he could continue surrounding himself with positive people who shared a similar frame of mind:

> For 90 days, you know I went to a meeting if not two, every day, then I had a break, a one week break, in between and then after that I went and done another 90 meetings in 90 days, and um, that helped me because I was just

> surrounding myself with you know positive people in they are staying in a frame of mind – *whaiora 16*

A further initiative by the facilitators to keep whaiora engaged is an invite to attend ‘paua ceremony’. The paua ceremony is a treatment graduation exclusive to whānau group members and is held prior to the ‘official’ treatment graduation. Thus, in addition to celebrating treatment graduation, the paua ceremony appears to facilitate the transition from treatment to recovery for whaiora both in treatment, and whaiora in recovery. The impact of this invitation was described by the following whaiora as an important step in her recovery as it helped her to ‘keep strong’ when she left:

> Having people come back for your paua ceremony when you were leaving, when you graduated coz we couldn't come to the graduation but we could all come back for the paua ceremony… so that's a really, a really cool connection that keeps you strong and keeps you going when you leave – *whaiora 16*

Outside of these times were other times when the whaiora also acknowledged the efforts made by the facilitators to remain in contact. This was seen by many as an extension of the whānau group which was valued as an important aspect of recovery. Typically, the facilitators arranged social gatherings where hangi were being prepared, and invited whaiora to help prepare the food. At other times, whaiora were invited for less formal occasions such as bone carving or playing music:

> And sometimes she’ll just flick out a text, hey whānau, just wondering if you can support us with the hangi… and all this stuff – *whaiora 13*

> I really hung on to them [facilitators] after Higher Ground as well, even when I graduated. I used to go to their house and take part in things that they were doing and do little bits of learning – *whaiora 9*

> I’ll be round at [facilitators home] maybe once a month jamming – *whaiora 8*

In recovery, whether whaiora engaged through paua ceremony, the 90 in 90, or through more informal gatherings, most whaiora saw these relationships as a source of support, especially at

times when they were experiencing difficulty. For the following whaiora, tough times were made easier by these relationships as the other whaiora could identify with their situation and their problems in recovery:

> I think that's where the biggest thing about having the Whānau group there as support through like tough things like that. We had other guys there who had similar problems with kids and stuff, took it to the whānau group and, you know, got support – *whaiora 2*

For a few whaiora, the support provided by the whānau group and the facilitators extended to important personal occasions. As this whaiora explains, the facilitators and whānau group members made a journey to his hometown to support him when his mother died:

> [I was at the Tangi and the facilitator] brought his family up! They just turned up and a few of my mates from recovery as well… He got up and talked for me, well talked for us a few times, he talked to my mum in Australia and that and then when we got back for the feed he talked for us there as well and he taught me the recovery haka, which my mum would have loved – *whaiora 9*

The environment provided by the whānau group and the facilitators was also identified as a place for a few whaiora to remain 'safe' while in recovery:

> And you know, just do things with them [the whānau group and facilitators] cos they're not going to go and… they don't do nothing but good stuff. Go to meetings or go do some supports or… kick back and you know you're in a safe environment. Not putting myself in a high-risk situation – *whaiora 4*

A further dynamic related to the ongoing relationships with the whānau group was the opportunity for whaiora to remain accountable to their peers. Peer-group accountability is a popular process in many therapeutic community settings, often functioning to help community members maintain a minimum level of acceptable behaviour. In recovery, several whaiora describe the function of accountability in the same way, although, group

accountability also appears to help whaiora confront more personal issues impeding their progress in recovery:

> But also extremely important too… I think, you've got that group [the whānau group and facilitators] that… can pull you up when you're stuck and tell you hey, you're behaving like a dick… being open to say that to each other is quite important – *whaiora 9*

> I've been through a lot of stuff and the whānau group's actually pulled me down, hey get back on board. There's been quite a few times that I could've gone out and just gone backwards – *whaiora 13*

In a similar vein, the sponsor-sponsee relationship with the facilitators provided a further avenue for relational accountability. For example, the relationship formed between this whaiora and his sponsor empowered him to stay 'on track', encouraging him to reconnect with whānau at the Marae (coincidentally, the sponsor was the facilitator of the whānau group):

> [After that incident] I was gone [to the liquor store. However] what I learnt in here, pick up that phone and ring your sponsor and that's what I did, picked up my phone, phoned my sponsor and I was blah blah blah blah, don't know, can't remember what I was saying to him. [He said] Slow down, slow down, take a moment and here's a karakia… and his words were "you need to be a pou [support] for your whānau in this situation" and that's what I did, went back, ended up on the marae, ended up on the paepae [speaking panel] and sealed my journey in recovery – *whaiora 11*

For the following whaiora, their close-knit relationship to a facilitator was a key to receiving guidance throughout recovery for specific difficulties, and modelling important emotional processing behaviours such as "vulnerability":

> Oh yeah, I had to like, cos [facilitator] knows about, you know, my father and that and how, you know, how it is for me so, you know, I felt safest just to go straight to him and to unleash and get some feedback, I suppose – *whaiora 2*

> And like I mean [facilitator] taught me that vulnerability man, it's a strength, and you know, being honest – *whaiora 5*

Staying engaged with the whānau group was also an opportunity for whaiora to continue with the values and roles they adopted while in treatment. For example, fostering a sense of 'whānau' where whaiora can connect to other whaiora as though they were kinship whānau:

> They're [residential whānau group] are just genuinely happy to see you… that you're still going and that you're still clean and sober, and coming back and helping other people go through what you went through… and they're always supportive when I come back supporting people, and they're always really encouraging, and it's very good, you know just like whānau – *whaiora 1*

Reflecting further on this quote, there are additional positive experiences for this whaiora in relation to being involved with the whānau group in recovery. For example, he describes feeling "encouraged and supported" in recovery. In addition, he begins to describe the further role of helping others when he returns. In this context, the reciprocal relationship between current and former whaiora is often experienced as an extension of the tuakana and teina roles they learned in treatment. That is, the former whaiora were often the tuakana while the current whaiora were the teina. In relation to the tuakana role, the impartation of knowledge from experience was important for several whaiora:

> So we're always in the loop where, you know, even like some of the new ones always ask me, oh, you know, how did you deal with this? How did that go? It's great. – *whaiora 2*

> Knowing that they are where I have been helps me to, you know, to give them my experience of how to deal with whatever. You know, I've done my 12 steps and I continue to do those – *whaiora 15*

For the following whaiora, continuing these relationships in the role of a tuakana was about imparting knowledge to the younger generation in treatment when returning to the whānau group in recovery:

> I just loved giving my strength and my experience out to the rangatahi [younger generation], the young ones of our generation… because they are our future – *whaiora 13*

In the following, a particularly reflective account was given about the value of returning to help others. For this whaiora, her life experience revealed there were very few Māori women she felt she could aspire to while growing up. Knowing this, and knowing many women in recovery with difficulties similar to hers (such as those around identity) she hopes to maintain a successful recovery so she can fulfil that role for these women:

> There's not a lot of women that I know that I aspire to… that saddens me, so I want to be able to perhaps have an element of that somebody under me that is struggling with their life that I could perhaps be that for them… [so they can see] that you have done all this and you've come from that and if you've done that then there is hope for me to get there too. Yeah that would be lovely, very rewarding, yeah so I am making sure that that's the path that I stay on to get to my goal – *whaiora 18*

For the following whaiora, setting an example was also about lifting his "game" for those he helped when he returned to the whānau group. Not only did this set an example to others, he felt it really contributed to his own recovery:

> Yeah so to me it was that raising the game, was that requirement to live recovery would actually be more beneficial to my recovery and my job – *whaiora 7*

For this whaiora, helping others benefitted him by helping him to stay focused on his recovery and take his mind of his own 'stuff':

> It's a real struggle to stay focussed [in recovery], but it's doing things like that, and helping other people that take your mind off your own stuff, you know - *whaiora 1*

While reflecting on these relationships in recovery, several whaiora offered their understanding of these relationships to themselves and whaiora in general. For example, the following whaiora summarise what they learned and observed for many whaiora who continue to remain in contact with the whānau group. This included a link between the ongoing connections, helping, and a sense of belonging somewhere following treatment:

> So yeah, I think that's what it does, it gives you a foothold, you know, so that once you leave treatment you belong somewhere… yeah, every time that I go and participate in stuff that brings me in contact with the whānau, that always just feels wicked, you know, it feels awesome… because I am part of it and I get heaps of love when I'm around those people, yeah– *whaiora 8*

> Knowing that I'm not on my own… I have a place of belonging and it's helping whānau. I know I've got to set an example for the newcomer that is coming through, yeah it's all that and yeah, it's a programme of unity – *whaiora 11*

Having thought more about the value of helping others, this whaiora developed an existential understanding such that his continued place in the world is directly related to the extent to which he can help others. Moreover, having recognised this, he was able to see how it was in direct opposition to the cause of his experience of addiction:

> But I've got to keep on trying to do this, and as a result I mean there's a sense of worth and a sense of value and significance in the world really comes from being of usefulness to other people. Which goes against exactly what the cause of my problem is, which is my self-centredness – *whaiora 5*

In summary, making positive, meaningful relationships in recovery was an integral part of recovery for these whaiora. These relationships were usually established through SS relationships and meeting attendance, or continued from the relationships between whānau group members and the facilitators in treatment. Importantly, whaiora recognised these as

closer relationships and often attributed the efforts of the facilitators to continue these relationships in recovery. Within these relationships, whaiora described a range of benefits, including support and accountability from other whānau group members, the facilitators, the chance to continue values and roles they learned in treatment and a place of belonging in recovery.

Strengthening my Māori Identity

This theme concerns the recovery experiences of whaiora who experienced a growth in the strength of their Māori identity. There are several ways whaiora strengthened their Māori identity, some of which related to specific Māori processes and others to their reconnection to Māori whānau. Within these accounts are several instances when whaiora felt a sense of pride in their Māori identity to the extent that this further aided their recovery.

Discussions around Māori identity were often relayed by whaiora with very little prompting. In part, this was attributable to the way whaiora contextualised their recovery experiences in light of their former experiences in addiction. For example, many whaiora saw addiction as a reason for disconnecting from their Māori identity. In this context, Higher Ground, and the whānau group in particular, were described as both an opportunity to address underlying issues related to addiction and an opportunity to reconnect to their Māori identity. Thus, when reflecting on their recovery experiences and the role of their Māori identity, whaiora had provided a context beginning with disconnection, reconnection in treatment, followed by their recovery experiences as they related to their Māori identity.

To reflect the way whaiora described their Māori identity, this theme includes the following subthemes: my Māori identity prior to treatment, the whānau group helped me to reconnect to te ao Māori and my Māori identity, connecting to te ao Māori in recovery, reconnecting to te ao Māori helped me to be proud of my Māori identity.

My Māori identity prior to treatment

This subtheme concerns whaiora experiences of their Māori identity prior to entering Higher Ground. A common experience described by many whaiora was a feeling of disconnection brought about by circumstances outside of their control. For many whaiora this negatively affected the way they saw themselves and other Māori. For example, whaiora often characterised their Māori identity in terms of negative associations to substances, crime, violence, and abuse.

For a few whaiora, disconnection began in their parent's generation. For example, the following whaiora describes how his mother moved from whānau to whānau when her mother died. However in doing so, her upbringing was "rocky". He further explains that his mother tried to protect him and his siblings by keeping them away from her whānau, however this also kept them away from his Māori family:

> We grew up down in [location] but my mum had quite, what's the word, yeah rocky upbringing coz her mum passed away young so she'd go from whānau to whānau or her brothers and sisters and my grandparents were in [location] and so it was, she felt quite protective of us, you know, because of the environment she grew up with. So I remember being quite, feeling quite distanced from our Māori side - *whaiora 7*

A further experience for some whaiora was an upbringing with a non-Māori whānau. These whaiora grew up with some knowledge that they were Māori however they never connected to their biological Māori whānau. As the following whaiora explain, their upbringing was more of a "Pakeha" upbringing:

> I was whanga'd [adopted] out when I was 3, my mum, my biological mum passed away when I was 7, so I never really got to know my whakapapa. I was whangai'd, adopted out to this Pakeha family, a Pakeha mother Māori father, but he, doesn't really acknowledge his Māori side either. So it was more of a Pakeha upbringing – *whaiora 16*

> I'm of Māori descent, and the lack of knowledge around that cause I was adopted into a European family – *whaiora 18*

Having been adopted, a couple of whaiora describe how their attempts to reconnect were resisted at different times during their lives. For example, the following whaiora describe a sense of paternal reluctance and shame to engage the whaiora with their Māori family:

> The fact that he's still ashamed of me and doesn't want anyone to know… Otherwise his daughters [these are the whaiora's sisters] would know, and so which means that the tribe don't know, or the iwi. So it's just really

> uncomfortable that sort of, of forcing my way in, which is what it feels like – *whaiora 1*

> Yeah I wouldn't mind but I don't think my Dad is really into it, I did ask him about it, well we did talk about it, but I don't really know what's going on there – *whaiora 6*

For some whaiora, disconnection occurred later in life. For example, the following whaiora was brought up around the Marae where he would often contribute. However, as he grew older, he began using substances and eventually walked away from his Māori family and what he knew of the Māori culture:

> At a young age, yeah, I was of service at, you know, the marae kitchens and stuff. But after I started using, there was nothing in general with family, ay. Lot of cultural stuff went out the window – *whaiora 2*

Similarly, the following whaiora disconnected from her Māori whānau and identity when she began using substances. However, she experienced a lot of shame and it was this experience that led her to further disconnection:

> You no longer, well, I didn't, I no longer lived in that world. I didn't even want to think about it… because I was whakama [ashamed]. I was ashamed… that I didn't want to talk about anything Māori – *whaiora 3*

Disconnection was also described as a gradual process, to the point where the following whaiora retained some of his Māori identity but knew his connection had little "weight":

> Over the last few years I've really walked away from that side of me, but I could rattle it off, I am a Māori artist, but there would be no weight to it – *whaiora 8*

As these whaiora show, disconnection from their Māori identity occurred in a variety of ways for a variety of reasons. Inevitably, these experiences led some whaiora to develop negative views of their Māori identity, other Māori and te ao Māori. For example, the following whaiora openly identified with another identity to avoid identifying as Māori:

> You know, and I was embarrassed of that, I was ashamed of it. I was ashamed to be that, so therefore people would say are you Turkish and I'd say yeah. So I really did man, I turned my back big time on Māori – *whaiora 5*

The following whaiora describe a sense of shame and guilt about being Māori which was attributed by one whaiora to his view of other Māori being "bad buggers":

> I've quite often had that like view of Māoridom [Māori are bad buggers] from childhood… but that's on reflection… as a kid I, I don't know, you had to toughen up pretty quickly… but definitely, on reflection a lot of it was shame [about being Māori] – *whaiora 1*

> It [treatment] brought up a lot of shame and guilt on my behalf. Cause I had like disowned and left that [Māori], in that sense – *whaiora 12*

The following quotes also show negative perceptions of Māori due to their experiences with whānau or peers at school. However, their response was a sense of hurt and anger toward Māori:

> All these years you've held on to hurt and pain and all that and blamed Māori and growing up and the whānau and that, you know, all the years – *whaiora 11*

> As they [students] told me, you don't look Māori at all and you don't talk like a Māori, so you're not Māori… after I left [school], I just fucking hated Māoris completely… and I hated Pakeha just as much – *whaiora 10*

For some whaiora who experienced a level of positive connection to their Māori identity, the disconnection from their Māori identity bought about a loss in confidence to participate and contribute in te ao Māori. For example, the following whaiora lost their confidence to contribute moreover, they identify decreasing levels of confidence with their ongoing substance use:

> I kind of lost that confidence to get up and do the haka and speak in Māori and all that sort of thing and be a leader basically. So in that big gap I was using drugs, and the more I lost, the more I used, the more I lost, you know – *whaiora 4*

> But I lost all that, you know. Māori are quite confident people, you know, staunch and proud. I lost all that, and then turned to drugs and that – *whaiora 2*

For the whaiora mentioned in this section the experience of identifying as Māori was often a source of real personal difficulty. Moreover, many whaiora were unable to change their circumstances given how their circumstances led to a state of disconnection. Many whaiora experienced feelings of shame, anger and hate toward their Māori identity and other Māori and, in some instances, experiences were linked with substance use and a loss of confidence to participate in te ao Māori.

The whānau group helped me to connect to te ao Māori and my Māori identity

This subtheme concerns the experiences of whaiora with the treatment whānau group that helped them to connect to te ao Māori and their Māori identity in treatment. These experiences were significant for fostering changes in how the whaiora perceived themselves, other Māori and te ao Māori. More importantly, whaiora were able to experience the values underpinning te ao Māori and the whānau group, for example, whānau (family), kotahitanga (working as one), tautoko (support), and tuakana and teina (older sibling/younger sibling).

For most whaiora, the initial point of connection occurred with the powhiri. Several whaiora describe heightened levels of anxiety about the powhiri process given the levels of disconnection they had experienced up to that point. Yet it was during this time that whaiora also felt welcome and culturally validated. For example, the following whaiora describes feeling as though the "core" of his being had been accepted by Higher Ground:

> Yeah, it's just cool bro… to find something like that at the end of, I guess or at the beginning of a journey like Higher Ground, you know, to find in the first week that the very core of me is accepted as a Māori person, fuck man… it was like a little gift that they gave me right off the bat – *whaiora 8*

Some whaiora also spoke of powhiri as an emotional experience where they were able to reflect on their identity, realise they were Māori and feel a sense of "home":

> I hadn't been back to my Marae or anything for a long time or tangi or anything like that when I come into Higher Ground and was powhiri'd in there as a newcomer… it brought tears to my eyes and it touched me… and made me realise man, you are Māori - *whaiora 11*

> There was some sort of shift when there was the powhiri. Like even just hearing the karanga [ceremonial call], the hairs on my arms stood up and it reminded me who I was… it helped me to realise that I was home… *whaiora 5*

Positive experiences of the powhiri process such as these encouraged many whaiora to then join the whānau group for the remainder of treatment. For other whaiora, the decision to join the whānau group stemmed from different factors which led them to make a decision prior to the powhiri. For example, the chance to experience tikanga Māori was a significant draw card for this whaiora:

> It dealt with my Māori side of things, to get back into the kaupapa of my Māori heritage and… how it makes me feel inside, the tikanga and all that stuff. So when I came into Higher Ground… I went straight into whānau group – *whaiora 13*

For a few whaiora, the connection to te ao Māori occurred when they met the whānau group facilitators in the 'preadmission' meeting attendance phase. Through these meetings, whaiora were able to consider treatment attendance, and having met the whānau group facilitators, consider attending the whānau group while in treatment. Arguably, in the absence of this relationship, these whaiora may not have joined the whānau group. For example, the following whaiora emphasises how the relationship he built with the facilitator was a key to attending treatment and joining the whānau group:

> I got to know [the facilitators] prior to [Higher Ground]… just being a part of … they welcomed me into their home… I was just so grateful that they see me

> as the way they see me… not as the addict, but um yeah I'm able to just be around them… [One day facilitator] dropped me off… and just out of the blue… he put the question to me, and asked me, if I was willing to come to HG and to do the program… [I said yes] – *whaiora 17*

Several whaiora also described the opportunity to connect to te ao Māori in treatment as a "natural" decision and like "being back at home". This was also true for whaiora who had no experience of te ao Māori previously:

> For me I think because I'm of Māori descent and the lack of knowledge around that because I was adopted into an European family. [I thought] perhaps [the whānau group] could help with reconnecting to who I was… so that I could get a clearer understanding… of what is underneath Me, what makes me, … where do I come from… because it was huge for me, where I fit in the world, and I understand that that can also be a part of um, feeding the addiction, when you walk through life lost, so… I accepted it because I did want to have that understanding of who I was, where I came from, and anything to do with finding out about… Māoridom, the language, the understanding – *whaiora 18*

To emphasise the importance of reconnecting to his Māori identity, the following whaiora explains how disconnection, especially from his 'blood' connections, played a big part in his addiction. In recovery, his focus was to rebuild missing connections, and within that were the connections to his whānau and his Māori identity:

> It's that connection, its connections, and I've been missing connections to Māori… I've found connections in here… with different people, quite a few… and… I think that's what I'm lacking… especially when it's blood. Because I've never had blood either, apart from my kids, and I mean that's strong, strong so… I wonder if even my family ties are as strong… because I never had none – *whaiora 1*

Having joined the whānau group, whaiora were exposed to a number of additional experiences of te ao Māori. For example, an enduring memory for many whaiora was the

inclusion of the facilitator's whānau in the whānau group. For the following whaiora, this was important as it modelled a different way of being Māori, in a Māori family without drugs or alcohol:

> You get to spend time with [the facilitator's] family, so you get to see how a family can operate… I think that's one of the great things about those guys is that they really role model what a Māori family can be like once you take alcohol and drugs out of the picture – *whaiora 8*

> They'd bring their kids in and their kids were quite often part of whānau group, and having little kids running around. And you know, it was, that was powerful within itself – *whaiora 10*

The facilitators helped whaiora to further connect to te ao Māori by communicating the importance of additional values through activities such as the Marae noho. For several whaiora, the Marae noho was notable as it was an experience of unity, or kotahitanga. As the following whaiora explains, she was reminded of her own experience at the Marae when she was growing up and felt a "sense" of who she was in the process:

> Well, being back on the marae, just being, everyone's pitching in in the kitchen, the wharekai, you know, and then we had just kai hakari [meal], everything like just brought memories back of growing up and just getting back in touch with that and being a good sense of who I was, in that process – *whaiora 12*

The sense of unity during the Marae noho was also experienced for the first time by the following whaiora. However, his experience was important for helping him to manage his feelings of being misunderstood with a sense of belonging:

> There was a real feeling of unity there eh, and… for someone like me who felt really complicated and misunderstood, I really felt like I belonged to something eh. And that was, I haven't felt like that in a long time, so to be able

> to feel that on a marae, in that sort of environment, was pretty cool man, was pretty cool – *whaiora 5*

More broadly, a few whaiora experienced a sense of unity or kotahitanga in their general experience of the whānau group. For this whaiora, the experience of kotahitanga was such that it changed his perspective of te ao Māori:

> I guess learning through this place, what Māori's really all about… And it's about, kotahitanga as a whānau, living together as a whānau, having fun, about fun, aroha [love], about all those pretty important things – *whaiora 4*

Several whaiora also described experiences related to tuakana and teina roles. As a tuakana, whaiora described a sense of responsibility to lead the less experienced teina as they were looking up to them for guidance. As the teina, seeing peers "step up" helped them to prepare for their time as a tuakana:

> I think one of them is that they've got the tuakana teina aspect to the programme… and what that meant within the whānau group is the leadership and responsibility. So as you go on and on you're watching your senior peers step up… but knowing you're being groomed per se to step in that role at some time… and I think it was that prolonged sense of upcoming responsibility that I think helped – *whaiora 7*

> So these fellas here are looking up to you… If they want to talk about anything, they'll come and ask you. How's the haka word go…they'll come and ask you cos they're struggling. So you know, they've got phase 1, 2 and 3, so they might get to phase 2, start helping the phase 1s. Or the phase 3s will have the phase 2s – *whaiora 4*

For the following whaiora, tuakana and teina roles were most salient when he realised the facilitator was demonstrating how to live a life in recovery. Having a tuakana to role model recovery in this way then made recovery more achievable:

> I mean he'd walked the walk, he'd trudged this road ahead of me so I didn't need to come through trail blazing. I just had to follow his footsteps. And it made it achievable, it made it really achievable for me and that's all I've done in here man. Like I mean as much of a trail blazer as I'd like to think I am all I've done man, I've just followed the footsteps of people that have walked it before me – *whaiora 5*

More broadly, whaiora also recognised the way in which the whānau group created a space for tuakana beyond the residence to come and share their experience. For these whaiora, being able to see how recovery works beyond treatment was helpful to their time in treatment.

> And the cool thing is, like during that marae trip the people who are from the whānau group who are peers before that come back and support during the thing. And so you get to see how they operate in the world – *whaiora 8*

> Yeah, it helped me actually, to keep me focused on what I wanted, and I wanted to graduate. So all those other people I found inspirational – *whaiora 15*

For a few whaiora, connecting to te ao Māori wasn't without its challenges. This was particularly true for some whaiora who struggled to be led by their peers. Often, this struggle stemmed from pre-treatment experiences that negatively influenced their perspective of leadership. For example, this whaiora describes his mentality prior to treatment and how he struggled to adapt to the tuakana and teina roles during treatment:

> I was going through HG and thinking what the hell is this rubbish, you don't back down, that was my whole mentality. You back down and show weakness, you are going to get walked over. That is my world. Doesn't matter how big you are, doesn't matter if you get knocked down you stand up – whaiora 6

Similarly, the struggle with leadership was also expressed by whaiora who had low levels of confidence upon entering the residence. This whaiora became a leader during treatment

however he struggled to feel comfortable in that role as there was a sense of expectation and obligation:

> There was definitely an obligation and I felt that, yeah, it was right. If you get given the gift, then you need to share the gift… I'm more of a behind-the-scenes kind of person. I don't like being the guy upfront. And naturally I became the guy upfront… I wasn't comfortable because I knew how flawed I was and I knew what I was doing privately wasn't the healthiest as well – *whaiora 10*

For the majority of whaiora, their difficulties with leadership were described as a feeling of incompetence. To overcome this feeling, whaiora often spoke of leaving their 'comfort zone'. For this whaiora, she challenged herself in leadership by making a conscious decision to take on the karanga (call) at the marae:

> It [being the tuakana] pushed me right out of my comfort zone, because it wasn't prepared. [The facilitator said] "ok you guys, someone is going to have to do it. "[Whaiora] you're wearing the taonga [pendant], you're going to have to do it". And you know what, I'm not going to fight against what I can't do, I'm just going to do it, so it gave me that, it gave me that pride that I have not had before – *whaiora 18*

Having stepped out of their comfort zone, most whaiora were able to reflect positively on the experience. For the whaiora above, she recalled a sense of pride, whereas this whaiora described the karanga as an experience that shifted her normally shy disposition:

> I suppose because it helped me be able to get my voice out there... I didn't have to be shy and all that kind of stuff, even though that is the kind of person I am. But I guess things happen for a reason, and getting the chance to do that helped me to be more open – *whaiora 15*

Over time, a few whaiora began to adapt their views of the tuakana and teina roles when they could see it as a medium for other values in te ao Māori. For example, the tuakana role was

initially seen as a leadership role. However, this whaiora realised that tuakana, and the whānau group more generally, was about supporting others when they are struggling and getting help when they need it:

> And then I got in there and you hear like there's taonga getting passed around… that ability to lead… and sort of trying to work your way up and sort of find your feet halfway through it. But it is an opportunity to support as well and get help. That's what was probably the best about the Whānau group was actually getting support and passing that on as well – *whaiora 2*

> So some really struggle with it [waiata, haka], they still had to do it, but they'd have somebody behind them that was a bit more fluent in it that would just be whispering, you know. So that they're always supported, which is Māori anyway, so it's, you know you learn to support with the waiata and everything as well – *whaiora 1*

In summary, the whaiora mentioned in this subtheme described the whānau group as a place where they were able to experience te ao Māori in a positive way. These included experiences of kotahitanga, whānau, tuakana and teina, and a broad sense of tautoko. For some of these whaiora, the experiences in the whānau group helped to shift their thinking about themselves as Māori, about other Māori and about te ao Māori more broadly (see next subtheme).

Connecting to te ao Māori in recovery

This subtheme concerns the experiences of whaiora in recovery connecting to te ao Māori in recovery. The points of connection include times when whaiora reconnected to their whānau, hapu and iwi, participated in or included specific Māori activities in their day, and pursued opportunities to increase the use of te reo Māori in their lives.

In the aforementioned subtheme "making positive, meaningful social relationships in recovery" attention was given to the role of the whānau group in recovery. An important aspect of the whānau group yet to be emphasised was the facilitator's intention to continue these relationships in a context that reinforces the values of the whānau group. For example, values such as kotahitanga, whānau, tautoko, and tuakana and teina. However, the whaiora quotes weren't explicitly linked to their Māori identity. It can be argued that these were, in fact, expressing a reconnection to their Māori identity in recovery. In which case, the recovery

whānau group served two purposes for whaiora. Firstly, it provided positive, meaningful relationships, and secondly, the recovery whānau group provided whaiora with a connection to te ao Māori and their Māori identity. The focus of this subtheme then, is the more explicit references to Māori identity in recovery.

For a few whaiora, the whānau group was described as a platform to reconnect to their Māori identity through te reo Māori. As the following whaiora explains, having walked away from his Māori "side", the whānau group helped him to reconnect through knowledge of his whakapapa. In recovery, this reconnection prompted him to incorporate te reo Māori at home and support his granddaughter who was attending Māori immersion school:

> Over the last few years I've really walked away from that side of me, but I could rattle it off… but there would be no weight to it. Now, you know, I feel like I've reconnected to that side of me which I wouldn't have without whānau group… my granddaughter starts kura kaupapa [Māori school] today, and so me and my Dad and my daughter, we're all gearing up to speak Māori in the home again, after probably 10 years of not doing it. So you know, it's given me a good grounding from which to start doing that again… my worldview was pretty narrow by the time I got to Higher Ground… whānau group opened all that stuff up again – *whaiora 8*

For the following whaiora, te reo was not spoken when she was growing up. In recovery, she made it a priority to pursue te reo Māori through further education

> Once I left out of Higher Ground, I wanted to pick up the reo straight away, so, I entered into, into a, it's not uni, it's a free te reo classes, I entered into that, and, I wanted to get more knowledge on that – *whaiora 17*

For another whaiora, learning te reo was a priority in recovery as it enabled him to re-establish ties to his whānau. For example, he had come to see that learning te reo was a way for him exercise an important role of speaking on the paepae:

> Learning te reo would be a good start for me… [because] I only know little bits and pieces and can't just, it's probably the basic stuff that's missing… all

> those little sort of words. And the missus kind of tells me I know all these sort of words mean one thing… but she really encourages me to… go on the paepae and go to places [back home] to speak…

A few whaiora observed positive changes in their kinship whānau, and attributed these changes to the values they learned in the whānau group. Included in these were increased levels of trust with their spouse, higher levels of commitment, and more cohesion around important family goals. For the following whaiora, his experience of the whānau group taught him the importance of thinking about other people. In recovery, this led to an increased sense of accountability to his whānau as they are at the forefront of his mind if "dark thoughts" arise:

> So you know, since being in the whānau group, I think of my whānau whenever I get a dark thought, my partner, kids… If I'm in jail, she'll be in tears and broken-hearted... I think of those sort of things – *whaiora 4*

For a few whaiora, the whānau group helped them to reconnect to their Māori identity and through this, their extended Māori whānau. For example, the following whaiora also attributed her experience with whānau to her experience of the whānau group. Not only did she reconnect with her whānau, she believed in herself, and felt the courage to fully participate in the experience. This helped her to feel grounded, and more importantly, gave her a desire to "plug in" and stay reconnected:

> We had a wananga last year for our whānau, back at [location]… And I just so embraced it eh, especially at my own marae. And I was so involved it was like being back in the whānau group… I felt totally grounded there… I think that's part of recovery. Once you start to believe in yourself I think you start to… that's what drew me back anyway. You know? Getting, wanting to get reconnected again… plug myself in – *whaiora 3*

Having re-established the connection to her whānau, this whaiora went on to explain the positive reaction of her whānau when she contributed to the whānau kapa-haka. Not only had

they recognised her progress, the process of reconnecting also reminded this whaiora of the positive feelings she felt when performing with the whānau group in Higher Ground:

> But they both, they were, different ones were saying to me, God… you were good out there. And I said, yeah, I like to know what I'm doing… but that gave me a buzz, as it did at Higher Ground too… coz they were coming up to me and saying, gee cuzzie, you look awesome… I love the kōrero that you gave out there… I felt confident there… probably because it's my marae… absolutely. I felt like I was back there again… but I felt I got my strength to do what I did down there from the whānau group – *whaiora 3*

Reconnecting to extended Māori whānau was also significant for a few whaiora as it also helped them to repair relationships which were damaged while whaiora were in addiction. For example, the following whaiora explains how she was able to reconnect to her broader whānau, many of whom knew her lifestyle when she was in addiction which brought her a lot of shame. However, the whānau group experience gave her courage to reconnect with whānau and as a result she attends hui at her Marae on a regular basis:

> Well cause of the whānau group, the whānau group was a group that helped me reconnect with my family after all these years… [in the beginning] it was overwhelming just being around all the family, and just seeing a lot of them grown up with kids and I haven't seen a lot of them for years… and a lot of that shame, too, of me, cause they knew where I was in my life the lifestyle I lived… since then I go back up north on a regular basis to family hui… so when I go home for a break I go back home and spend time on the land – *whaiora 12*

Several whaiora also described reconnecting to their whānau at the Marae and having more of a leadership role. For example, the following whaiora was open about his status as an alcoholic, and by doing so he set an example which his whānau responded to:

> Being back on my marae and being open that I'm an alcoholic, and I'm a sober alcoholic, I had quite a lot of cousins going tsss, come and have a beer with us

> cuz, oh nah bro I don't drink anymore, tsss… the next day they'll come up to me and say bro what did you do, how did you do it man, I can't stop. And I say look bro, when you really want to know man come and talk to me. So like I mean, coming back to… leadership – *whaiora 5*

The following quote further emphasises a desire to help family members, through leadership, to learn from their mistakes. In this quote, the whaiora describes how he wants to demonstrate to his whānau that there is a way out of addiction. However, his strategy is to show, rather than tell, his recovery journey:

> So when you're challenging him [my son] you're helping his journey which is going to help his wider whānau… and that's how it went through that and you know. I've got many nieces, nephews, my own son, is in active use and… I want to help them but I know that putting the foot down and going rah isn't going to help them. The best way I can help them is to stay on my journey and then they can see it and hopefully in time… they'll know that there's a place to come to – *whaiora 11*

The following whaiora alluded to a broader sense of leadership, to teach waiata and haka to the younger generation within his hapu and iwi. This builds on his experience in the whānau group, but appears to have arisen in response to a decline in leadership within his iwi:

> Just basic stuff like waiata, you know, just putting it on the wall and getting the words right. They don't know the words [of waiata/haka], they can't… some of them can't pronounce it properly or there are some words missing… I guess, the leaders have sort of passed on and the next generation's here and there's a lot of young ones but there's no elders leading the way… that's what my partner tells me… You're the one who… you're going to lead them – *whaiora 4*

Several other whaiora also described times when they connected to their Māori identity by using waiata, haka or karakia. These whaiora described benefits in terms of being able to learn more about te ao Māori, as well as these being useful for managing negative emotions:

> The haka for instance, it's something that I use to keep myself grounded… like you know if I'm feeling out of sorts or anything like that. Sometimes I just go over in my head or sometimes I might even just do it on my own… whether it be hard out or even… just go through it in my head in the mornings or that's how I try and learn some of the karakia, in the shower – *whaiora 9*

While these were grounding experiences for this whaiora, the following whaiora express a meditative experience when incorporating these in their lives:

> Even now, I have stuck to that… So every time I got out toward [location] I would pray, or every time I come towards this place I pray. I run to the waterfall out there do the Haka, I pray, I do the Serenity Prayer, but my prayer out there is way different. My prayer out there is to what is provided for us in life. So I have gotten really in depth with it aye – *whaiora 6*

> Yeah, waiata, the waiata I gained from the whānau group, the karakia, um, and ‘cause, they we would sing the serenity prayer in Māori, um, and there has been a lot of times that I have had to pull out the serenity prayer and just sing it to myself… but other than that there is a whole lot of other waiata that got introduced to me in the WG… I have carried those around… still carry them around today – *whaiora 17*

A few whaiora described engaging with spirituality through understandings consistent with te ao Māori. For example, prayer to ancestors is a common practice in te ao Māori and the following whaiora prays regularly to her late grandparents as a way to receive guidance, in the same way that she received guidance during childhood:

> My higher power… are my grandparents, up the top there (points to photo). They raised [me]… so I pray to them, for guidance… every day, I don’t start without praying… because I know that when I pray… I just have this strong spiritual connection with my higher power which is my grandparents, and I know they have been with me ever since day one - *whaiora 12*

For the following whaiora, prayer, or karakia, are taonga which have been given to him by his grandparents. Therefore, regular prayer or karakia are ways of acknowledging this fact which was something the whānau group reinforced when he was in treatment:

> Yeah those are [karakia] Māori taonga and the koro [elder man] of that group helped me to connect spiritually and realise the taongas I had when I was growing up on the marae and that's, you know, I karakia morning and night, never miss and that's all started from the first meeting I went to and was stronger through the whānau group – *whaiora 11*

A few whaiora identified spirituality through their understanding of a 'higher power' or God. Referencing spirituality in this way is a popular practice amongst those who have participated in the 12 step treatment programme. For some whaiora, the Serenity Prayer was used to engage with this being, in both Māori and English. In either case these whaiora describe this practice as a way of being reflective and grateful for their current situation in recovery:

> There's one thing, it's not necessarily just from the whānau group, but saying the serenity prayer or E Te Atua in Māori to myself, that helps. Yeah, and I think that's one of the first places I learnt it in Māori. So you know, and I say it in Māori… I could be having a bad, bad day and I'll say that and I'll feel heaps better. Maybe not straight away, but you know, I will. I've got to be grateful for what I've got. If I didn't go through treatment and all that kind of stuff I could probably be, I've already been in an institution, I could be in jail which is where I was headed. Or dead. So to be grateful every day as well. I've got a whare [house], food and family really – *whaiora 15*

In summary, this subtheme described the way whaiora connected to te ao Māori and their Māori identity while in recovery. For several whaiora, the whānau group was described as platform for whaiora to pursue te ao Māori which included te reo Māori, whānau Māori and specific practices within te ao Māori such as waiata, haka and karakia. Connecting to te ao Māori in these ways helped whaiora to reinforce what they had learned in the whānau group and continue to develop their Māori identity in recovery.

Reconnecting to te ao Māori helped me to be proud of my Māori identity

This subtheme concerns whaiora's experiences of pride in their Māori identity when they connected to te ao Māori in recovery. For a few whaiora, this was the first time they had experienced pride in their Māori identity. The increase in pride was particularly noticeable for one whaiora who changed his name to a Māori name. In a similar way, the pride experienced by these whaiora allowed them to celebrate their Māori identity. For a few this was the first time they had celebrated their Māori identity:

> Like I mean the whānau group as an actual group, it helped me to re-identify with being Māori, which helped me re-identify with who I actually am. Which helped me to open up my levels of honestly as to where I came from, and it got me to ask the questions. You know, like "Dad where's our marae, whereabouts is my great grandfather"… it helped me to ask these questions which has all been part of my journey as well, big time – *whaiora 10.*

> So it got me to be, yeah, and that was definitely part of it. Like I realised that this is who I am and don't be embarrassed and don't be shy, or don't put down what you are because that's never helped me. So that was definitely, yeah it allowed me to celebrate who I was as a Māori man, you know – *whaiora 5.*

This whaiora also identifies a sense of cultural pride instigated specifically by the whānau group:

> Oh yeah, definitely, especially like being Māori, with the language, just everything about Māori, 'cause I never had that for years, since I was a child, and, it's like a strong connection to who I am today... and just being really proud to be Māori. The whānau group really brought that out of me – *whaiora 12.*

Two whaiora also identified that the process of reconnection allowed them to change their perspective of what it meant to be Māori, for example:

> Yeah, it's taught me how a Māori, being a Māori, that there's another way of life. Because you've heard it on the news about Māori this, Māori that, drugs, alcohol abuse and all that stuff, Māori families and all that stuff being abusive. Well having the whānau group actually teaching me that there's a different side to the negative side. There's an actual positive, and that's the positive that I've been taking, is that route – *whaiora 13*

Following on from this were several whaiora experiences of self-acceptance as Māori. Having made this 'concession', whaiora began to feel a sense of confidence to approach the unknown. For example, the following whaiora describes a shift toward accepting that she is disconnected from her own whānau/hapu and disconnection is "o.k.", but that hasn't inhibited her connection to the Māori world. On the contrary, it appears to have increased her confidence to engage; something she wouldn't have done prior to treatment:

> It's [the whānau group] given me the confidence to be who I am… it's ok that I don't know [my Māori identity] so I have accepted that it's ok… it [helps in recovery] because if there is an opportunity, like we have introduced a culture group at Wings as it has only just started and so I want to be part of that which I am, it's a voluntary things, it's not part of the structural side that you must attend like the other groups, so it's more of me wanting to be a part of that… and so instead of hesitating, which I would've prior to HG, because you know I didn't want to be a part of something that I had no understanding of, so yes they gave me, the WG at HG gave me the confidence that whenever things open up like that I go there now, I enjoy I am proud of the fact that I don't know who my father is and that is ok. I don't know the journey that my family took and mountain I'm from and all that, but that's ok I enjoy it – *whaiora 18*

Connecting to Spirituality in Recovery

This theme concerns the ways that almost half of the whaiora engaged spirituality in their recovery. In the previous theme, spirituality from a Māori perspective was discussed, therefore spirituality is used here to denote non-Māori ways of expressing spirituality, for

example, ‘God’ or a ‘higher power’. However, this is not to say that these whaiora used non-Māori expression of spirituality exclusively.

For several whaiora, God, or their higher power, was a being they gave thanks to on regular basis. Interacting with God in this way allowed these whaiora to be grateful, or as the following whaiora describes, change his attitude to gratitude:

> And I give thanks [through prayer], you know, grateful for all the things I’ve got these days. See, I dropped the old attitude and replaced it with gratitude, you know what I mean? And that’s another good thing I learned from this place here – *whaiora 4*

The following whaiora has a similar approach to God, however in addition to being thankful, he asks God for help in his recovery journey, especially on days when things have gone wrong:

> So what I do first is I go “God, yesterday wasn’t a good day I just need you to help me have a better day, I know I got short this time but I need you to stand alongside me so that it makes it easier for me. And I thank you for the car you gave me, the house, my job, me being me today, me having a lady that is in recovery that can understand and she is also going through problems too and we both need your help to walk alongside us both sometimes. It’s a hard road and when in recovery, but at least I am facing up to things and I thank you for another day clean”, then the Serenity Prayer – *whaiora 6*

For a few other whaiora, God was described as a source of guidance in their lives. For example, the following whaiora describes how God was leading his path by putting things in place and directing him to areas that need “fixing”:

> I believe that, that um I believe that, it’s God leading my pathway at the moment, it’s my higher power leading my pathway for me and he puts things in place that you know he is saying to me, oh look [whaiora] this is something you need to fix. Something you need to fix – *whaiora 17*

A particularly reflective account of spirituality was given by a whaiora who described the importance of spirituality in terms of uncovering a personal 'truth'. For this whaiora, truth through a relationship with God is his way of continuing in recovery, as it filled a void in his life that he had come to identify through treatment. Moreover, his development in this area grew when he left treatment such that he now has a different, more helpful perspective of his past and addiction:

> I kept trying to fill this internal void that I felt with all this external acquisition. I didn't know that all I really wanted was a calm mind and a loving God… and when I got out I felt a lot more a spiritual kind of modification, as opposed to behavioural modification… so what I learnt was when I kind of sort out spiritually and I get right spiritually, like I mean the mental and the behavioural will fall into place…I had to stop relying on this place to keep me sober when I got out… and I did, I started praying to a God that I didn't believe in until step 2 slowly came to me, and I came to believe. And I'm not a religious man at all, I call this power God, but I don't particularly believe in any sect or denomination… like ultimately it's getting that personal truth, you know, which is what I try to have spiritually and what I try to have with my background. It's like I mean finding out who I really am personally, for me, helps me to understand a lot better as to where I want to be and where I want to go. So… looking backwards helps me to see more clearly forwards if that makes any sense… and using my experience of all that stuff that happened two and a half, two years ago – *whaiora 5*

In summary, the practice of spirituality was described as a beneficial aspect of recovery for nearly half of the whaiora. Through these accounts, it was clear that spirituality took on a variety of practices, some of which included elements of te ao Māori, while others included an infusion of Māori and non-Māori practices such as those often used in the 12 step programmes. In terms of the function of spirituality, this also varied between whaiora. For some it was about creating a relationship to derive meaning and guidance. For others it was about changing personal attributes and being grateful. Moreover, for all of the whaiora who spoke about spirituality as important in their lives, it was equally important for them to maintain regular practice with spirituality in its various ways.

Chapter Four: Discussion

This research set out to explore the experiences of Māori in recovery having participated in the whānau group during residential treatment at Higher Ground. The treatment context at Higher Ground is based on a therapeutic community, and while in treatment, residents have the option to join the whānau group as an adjunct to the mainstream treatment programme. The whānau group provides residents with a context in which they can learn and explore te ao Māori, through values and practices consistent with te ao Māori. In addition, the whānau group helps to provide a context for Māori in which they have some level of cultural familiarity during the treatment process.

It was intended that research participants would be those who had abstained post-treatment. As it transpired, many of those in this study self-identified as completely abstinent but a few had experienced momentary or sustained periods of substance use relapse. For the latter group, the value of what they had learned in treatment helped them return to abstinence, and presumably would help them to manage future relapses more effectively. Moreover, this occurrence showed how relapse with substance use doesn't necessarily preclude participants from ultimately experiencing positive treatment outcomes. Perhaps a more useful way to conceive of recovery, in general and in the context of this research, is managing substance use so as to be abstinent for most of the time. There are other factors related to this, which will be discussed below.

Arising out of the interviews were five themes and nine subthemes. The themes were: 1) learning how to transition from treatment to the community; 2) understanding myself and understanding addiction (containing three subthemes); 3) making changes to the relational aspects of life (containing two subthemes); 4) strengthening my Māori identity (containing four subthemes); 5) connecting to spirituality in recovery. From these themes and subthemes it is apparent that the experiences of whaiora shared similarities and differences to the recovery experiences of those in mainstream treatment programmes. These will be discussed in turn, beginning with the experiences shared in common with mainstream treatment programmes.

Recovery Experiences in Common with Mainstream Programmes

There were a number of ways that these findings accord with recovery literature for, (mostly) non-Māori in mainstream programmes. Although the sequencing and ordering of change is still unclear, these findings highlight how recovery requires changes across multiple domains

of life in the long term, including, physical, psychological, spiritual, relational and lifestyle reconstruction (Best et al., 2010). These findings also accord with the commonly reported experience of recovery where individuals use different interventions at different times, especially when reconciling their experience in the contained treatment environment with the reality of recovery in the initial stages of the post-treatment period (Dennis, Foss, & Scott, 2007; Best et al., 2010). Similarly, as with the whaiora in this research, one way for people in recovery to manage during this initial transition is, commonly reported to be, by implementing routines or structure to their lives (Best, Gow, Taylor, Knox, & White, 2011).

Several instances of metaphor were provided by whaiora to describe aspects of their recovery journey. For example, one whaiora described their attempts to resist substance use as the resistance to steal grapes at the supermarket. According to the literature, metaphor functions as a way for individuals to make sense of complex information as they interpret changes in their emotions, thinking and behaviour. Moreover, metaphor is useful for describing untapped emotional experiences that are too difficult to interpret (Shinebourne & Smith, 2009; Lyddon, Clay, & Sparks, 2001). There are further suggestions in the literature that metaphor is useful for shifting the locus of control externally, as it can help individuals develop a sense of mastery over their affliction in order to achieve sobriety (Li, Feifer, & Strohm, 2000). For example, some participants in this study described their addiction in terms of Satan.

The most extensive overlap between the experiences of these whaiora and reports of others in mainstream programmes occurs in the social context. This includes the reconstruction of existing social networks to exclude relationships which threaten recovery (Granfield & Cloud, 2001; Klingemann, 2012) and building social networks which support recovery (Best et al., 2015; Laudet et al., 2006). Establishing new social networks with an abstinence focus is particularly predictive of successful recovery in the long term (Groh, Jason, Davis, Olson, & Farrari, 2007). As with others from mainstream treatment programmes, social networks which contribute to recovery in the long term are often established and maintained through regular group meetings such as AA and NA. Within the literature, peer support or ‘mutual help groups’ such as these have evidence for providing a range of benefits to members, including some of those mentioned by the whaiora in this research; peer accountability, living a non-addiction lifestyle and positive supportive relationships. (Kelly & Yeterian, 2008; White & Cloud, 2009).

The findings in the present study also have accord with findings from mainstream programmes that the practice of spirituality in recovery is helpful as a way to sustain abstinence and reduce substance craving (Dermatis & Galanter, 2016; Galanter, Dermatis, Post, & Sampson, 2013). Some of the positive effects of spirituality appear to be mediated by the frequency of spiritual practices, and the acceptance of certain tenets such as the belief in a higher power, or the experience of surrender (Caldwell & Cutter, 1998; Young, 2013).

Unique Recovery Experiences to Māori in this Research

This research has uncovered some aspects of recovery which may be particularly relevant for Māori, especially those who have experienced a degree of disconnection from their cultural identity prior to and/or during addiction. To the best of my knowledge, this is the first study to explore the experiences of Māori in addiction recovery following participation in a Māori-centred group rather than during treatment. This research provides insight into the recovery experiences of such Māori. The findings have elements in common with research with other indigenous populations.

Participants readily discussed the significance and importance of their ethnic identity. From the outset, I had envisioned that the ideal ethnic make-up of this study cohort would be Māori, which carried with it the assumption that they would identify as Māori. However, through the interview process, I came to question the assumptions I had made regarding ethnicity. In particular, when I reflected on what participants were saying about their upbringing and relative lack of connection to te ao Māori, I began to realise that many of those who were Māori by ethnicity struggled at some stage in their life identifying as Māori. Moreover, one participant responded and self-identified as Māori, although she was not ethnically Māori. There appeared a significant variation in the strength of Māori identity amongst individuals at the time they entered the programme, and, identity appeared for many to be an important part of the "work" they did while in the programme and in recovery.

That is, through the whānau group, whaiora are given an opportunity to make connections with their Māori identity. This was important for providing structure and context for the treatment programme, but it also validated and allowed them to reconstruct their experience of Māori identity. For some Māori who have experienced a level of disconnection from their culture the process of reconnection was challenging, and they were faced with a choice as to whether to pursue this journey or not. The whānau group facilitators appeared to navigate this sensitivity by emphasising the importance of relationships, most notably through the powhiri process. For some whaiora this was a particularly anxiety-provoking phase of

treatment. However, it helped them to feel culturally validated and safe to pursue their Māori identity further. Similar experiences of the powhiri have been recorded for Māori in other residential addiction treatment facilities, suggesting that the powhiri is a crucial part of the treatment process for Māori with addiction issues.

As discussed earlier, an insecure Māori identity has been highlighted in the literature as a possible factor in the health status and substance use behaviours of many Māori (Durie, 1994; Ebbett & Clarke, 2010; Robertson et al., 2002) prompting a call for identity and culture to be included in the treatment matrix for Māori in health-care settings (Eade, 2014; Durie, 1997; Huriwai, Sellman, Sullivan, & Potiki, 2000). Identity reconstruction holds specific importance for Māori and other indigenous cultures with a history of colonisation (Durie, 2004; Mohatt et al., 2004; Rowan et al., 2014). Specifically, it has been suggested that helping Māori to identify positively with their Māori identity may serve to buffer against negative societal stereotypes about Māori. This is particularly important where some Māori feel pressure to conform to negative stereotypes and roles in society (Gregory et al., 2011; Moewaka-Barnes, Taiapa, Borell, & McCreanor, 2013; Moewaka-Barnes et al., 2012). Recently, research has begun to substantiate these claims through quantitative measures, showing the buffering effects of cultural competence in alleviating levels of psychological distress for Māori, (Muriwai, Houkamau & Sibley, 2015; Houkamou & Sibley, 2011).

The continuation of roles, practices and learnings from treatment to recovery is important, however, opportunities for some whaiora to stay engaged with their Māori identity were limited. Some whaiora pursued opportunities to extend on their journey in treatment by incorporating personal cultural practices into their lives and developing their identity further by interaction with their own whānau, hapu and iwi. However, for most of these whaiora, the recovery of their Māori identity extended beyond the period within the treatment programme, and was largely achieved due to the unique way in which the facilitators maintained relationships with graduates, and their provision of ongoing connection to te ao Māori. This occurred across a spectrum of occasions, beginning when whaiora left treatment and as far into their recovery as they chose. The most personal accounts demonstrated how the facilitators went beyond what would be expected for people in recovery, and these efforts appeared to make a significant difference. In fact, this level of aftercare support reflects what has been called for in general in the literature (Dennis & Scott, 2007; Laudet, 2008; White, 2009) but brings further emphasis to the importance of more resources to be placed on aftercare initiatives, especially during the initial phases of recovery (Laudet & White, 2008).

However, in a health system where after care resources are inadequate, and the presence of institutional factors which impede Māori from important decisions about health care (Came, 2014; Maynard, Wright, & Brown, 2013) the burden of such provision may fall on goodwill, like the whānau group facilitators demonstrated here.

There are significant benefits of helping individuals reconnect to their Māori identity. However, this must be held alongside the reality that reconnecting is difficult (Durie, 2001) For Māori this is particularly true for those who have experienced intergenerational relational disruptions, resulting in geographical relocation away from traditional lands and important family groups (Gilchrist, 2017). In this context, supportive community relationships such as those in the whānau group are integral for helping Māori to begin the journey of reconnection.

Exploring the Relationship between these Findings and Addiction Recovery Theory

The findings of this research are consistent with current theoretical understandings of addictions and recovery. Adams's (2008) social theory of addiction argues that addiction is a social event whereby the relationship with a substance or addictive process intensifies to the detriment of other relationships. As substance use increases, intimacy, described as closeness, compassion, commitment and accord, transfers from relationships with people to the substance, mirroring the intimacy typically found between individuals in relationships. In recovery, or as Adams' prefers, "reintegration", the broad aim is to achieve a level of intimacy in relationships apart from the substance or addictive process.

While the finer detail is lacking about the course of relationships between whaiora and people in their lives, the relationships whaiora broadly described suggest levels of intimacy were increasing, especially the relationships facilitated through the whānau group. In some cases, this occurred in relationships with biological whānau members too. Adams' theory can be extended further to other aspects of whaiora identity, and what appears to be increasing levels of intimacy with more abstract objects; for example, their Māori ethnicity, and by extension, significant landmarks associated with their whakapapa. Practices such as karakia/prayer and waiata/song may help to connect whaiora to the past, future and spiritual domains. Overall, whaiora accounts demonstrate that the whānau group, in recovery, provide an environment in which intimate relational connections, to other people as well as abstract objects, can develop.

These findings can also be interpreted in light of theoretical developments around recovery capital (Best, McKitterick, Beswick, & Savic, 2015; Litt, Kadden, Kabel-Cormier, & Petry, 2009). These findings included accounts of the importance of social contexts in

recovery; which in terms of theories of recovery capital may be thought of as the development of stronger social capital to support recovery. Likewise, strengthening their Māori identity may be thought of as increasing recovery capital. Furthermore, these findings highlight how the different types of recovery capital interact with one another in recovery. The interaction between social and cultural capital is most notably facilitated by the whānau group, but maintained by some whaiora apart from the whānau group too. This was reflected at a personal level in increases in levels of pride, self-confidence and esteem, suggesting the additional importance of human capital. It may be difficult to know the exact nature and order of this interaction, although increases in self-confidence are widely understood to help recovery longevity (Buckingham, Frings & Albery, 2013; Frings & Albery, 2015; Lingdren, Neighbors, Gasser, Ramirez, & Cvencek, 2016) . For colonised groups such as Māori, there may be additional benefits of building these personal resources, given the presence of societal narratives that directly impact on levels of self-confidence (Borell, 2009; Crengle, Robinson, Ameratunga, Clark, & Raphael, 2012).

Substance abstinence was the goal of recovery for most whaiora, however, for a few, recovery included relapse or periods of non-abstinence. Despite the presence of some substance use, at the time of interview they reported substance abstinence for the previous month. These individuals still considered their progress in terms of success which included their achievement of new social connections and attainment of pride and self-confidence in their interactions. Such findings are consistent with calls to expand the definition of recovery beyond substance abstinence (White & Kurtz, 2006; White, 2007), and to incorporate a range of additional factors such as the individual's social context. This would shift the focus of treatment beyond a narrow one of abstinence, and more broadly, shift the understanding of addiction to a social perspective, as proposed by Adams (2008). The implications of this include the expansion of treatment models to involve important family members in the treatment process, and increased focus on the transition back into the community (Adams, 2015).

Fortunately, through the whānau group, some of the implications outlined by Adams (2015) have been displayed, providing a template for adapting current practices in NZ. In addition, the values underpinning the whānau group are derived, understood and applied in relationships, revealing a level of symbiosis between social and indigenous perspectives of addiction treatment and recovery. This provides further impetus to the aforementioned implications, and more importantly, validates the longstanding position that the whānau group

facilitators and many Māori have taken regarding the treatment of people with addiction issues.

Limitations

This research was not without its limitations. As with any qualitative research, the findings of this research are not generalizable to the general Māori population affected by drug and alcohol addiction for several reasons. Foremost is that the research focussed on those who had abstained (or nearly so) from further drug and alcohol use. It is deliberately a study of individuals' accounts of desistence and recovery amongst those who had attended a particular treatment programme, Higher Ground, at a particular location, Auckland. Furthermore, within this group, there was self-selection such that participants may have been to some extent a subsample of programme graduates.

In relation to the question about how they experienced the whānau programme, the potential bias from self-selection is particularly relevant. Those who chose to respond to the invitation to participate may represent those who experienced the whānau group in a positive way. This can be observed through the notable lack of criticism toward the whānau group in spite of efforts to elucidate ways in which the whānau group were not helpful. Of course, it may well be that the whānau group is universally liked. Moreover, lack of criticism could be a reflection that experiences in an adjunctive group with relatively few hours is only enough time for whaiora to have positive experiences. The lack of criticism could also reflect whaiora being unsure, despite my declaration, that I was impartial. This may have led to whaiora being reluctant to give critical feedback for fear it may affect their participation in the programme in the present and future. This is especially true for the whaiora who were still engaged with the whānau group in recovery.

Also, the group may not be representative in terms of the substances to which they were addicted. There were no screens administered to determine the type of substances they used when in addiction, and questions were not asked about this in interviews. It may be that the findings of this research were mediated, in part, by the particular substance addictions, because one or more groups were over-represented (e.g., alcohol use versus some other drug). Similarly, the absence of screening measures makes it difficult to verify self-reported abstinence. However, any non-representativeness or lack of reliability in their abstinence accounts has little impact on the validity of their experience in terms of the whānau group and progress in their Māori identity.

A limitation which may pose a greater effect on the findings is the effect of my presence as a male Māori researcher. Semi-structured interviews allow the interview to deviate from the guideline and, at least to some extent, such variation is influenced by choices the interviewer makes. What appeared to be salient may have been influenced by my background, history and knowledge. This is important, as my cultural identity and experiences in society inevitably contributed to my understanding of the identity issues in this research. Therefore, while this can contribute to the research in positive ways, it is possible that some issues only achieved their status in this research due to my influence. To balance such influence, I ensured that each step of the analysis process was performed under the guidance of my supervisor. In addition, I consulted with other Māori peers and colleagues in less formal contexts for further guidance.

Future research

This research highlighted a need for further exploration in a number of areas. Firstly, to address the paucity of research in drug and alcohol treatment programmes, more recovery research on people in NZ is needed. For Māori, this is particularly important.

One approach would be recruiting a cohort of Māori, beginning when they enter treatment within a culturally consistent programme. This would allow for a more detailed and nuanced perspective of recovery, and eliminate any issues of selection bias. For the sake of comparison, a control group of Māori could be recruited who are not participating in a culturally consistent programme. In addition, quantitative measures to assess change can be employed, including measures of Māori identity and cultural engagement (e.g., those used by Houkamou & Sibley, 2010), measures of the levels of recovery capital before and after treatment and throughout recovery (Groshkova, Best, & White, 2013), and quality of life (QOL) measures such as those endorsed by the World Health Organisation (WHO) (Skevington, Lotfy, O'Connell, & WHOQOL Group, 2004).

The links between this research and a social theory of addiction indicate future research could aim to explore the level of intimacy experienced in recovery relationships according to levels of compassion, commitment, closeness and accord. For Māori, this could include their relationships with their hapū and iwi. This may provide a valuable insight into the types of relationships which help to sustain recovery and those which bring about obstacles to recovery. At the early stages of this approach, qualitative research may be more appropriate, given the paucity of measures designed to measure the constructs describing intimacy and relationships.

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Appendix A

Higher Ground Continuing Care Plan

Higher Ground: Continuing Care Plan

Get 4 of your Peers to suggest what they feel will be best for you to do to maintain your recovery after Treatment.

Which 12 Step meetings will you attend when you leave Treatment?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Venue							
Time							
Venue							
Time							

List your Sponsor and 3 other recovering support people, who are at least 2 years clean, plus their phone numbers:

Sponsor:

How regularly will you be in contact with your Sponsor when you leave Treatment?

Where would you like to live after leaving Higher Ground?

How will you continue your Self Care after treatment?

How will you support yourself financially?_____

What plans do you have involving study, training and/or work?

_____

_____

Identify significant relationships you are looking to maintain and develop?

_____

List below your Significant Triggers and Recovery Coping Solutions

Trigger	**Recovery Coping Solution**

Resident Name:……... Date:……

Continuing Care Counsellor:……. Date:……

Appendix B

Interview Schedule

MĀORI EXPERIENCES OF ADDICTION RECOVERY

INTERVIEW GUIDE

A semi-structured interview will take place. Accordingly the interview questions below will serve as a guide for the general areas to be covered. Further (related) questions may be asked following these prompts.

Karakia, mihimihi/introductions – as appropriate

Questions:

How long have you been in recovery? (Discharged from Higher

Ground) Tell me a bit about your time in recovery.

What has been the most difficult aspect of your recovery?

What has been the least difficult aspect of your recovery?

Tell me a little bit about how much involvement you had with the Māori components of the rehabilitation programme at Higher Ground.

What was your experience of the Māori components?

Did you find any part(s) particularly helpful to you in your recovery? Tell me about these.

Did you find any part(s) particularly unhelpful? Tell me about these.

How have you managed to reduce/cease drug and alcohol use since leaving Higher Ground?

How have your experiences in the Māori components contributed to this reduction/cessation?

What would have been more helpful to you during recovery?

Is there anything else about your recovery that you would like to talk about, that I haven't asked you about?

Do you have any questions about our interview/conversation today or about this study in general, before we finish?

Thanks

Karakia/closing – as appropriate

Appendix C

Participant Information Sheet

SCHOOL OF PSYCHOLOGY
Faculty of Science

Human Sciences Building Floor 6,
10 Symonds Street Telephone 64 9 3737599 ext 88557
Facsimile 64 9 3737450

The University of Auckland

Private Bag 92019, Auckland 1142, NZ

MĀORI PERSPECTIVES OF RECOVERY PARTICIPANT INFORMATION SHEET (CLIENTS)

Tena koe

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

My name is Simon Waigth. I am a student at The University of Auckland, where I am currently studying towards a Doctorate in Clinical Psychology. I am doing this research as part of my dissertation (research report), and I am being supervised by Professor Fred Seymour and Dr Erana Cooper (Ngāpuhi, Ngāti Hine), both Clinical Psychologists and at The University of Auckland.

The aim of this research is to explore the experiences of clients who have graduated from treatment at Higher Ground and who were also involved in the Whānau group during treatment. Through this research, I am hoping to find out about your recovery and about how the Māori components of the Whānau group may have helped in your recovery. You are invited to participate in my research about this, and I would appreciate any assistance you can offer me. In order to participate, you must meet the following selection criteria:

☐Identify as Māori

☐Successfully completed treatment at Higher Ground

☐Not currently using alcohol or drugs

☐Currently a discharged client of Higher Ground (for at least 12 months)

I will be conducting confidential interviews with people who volunteer to participate. The interviews will include talking about your experiences in recovery and how you have related these to your time in the whānau group. Interviews are expected to take at least half an hour and may last for up to one and a half hours at the most. If you choose to participate, the interview will take place in one of the offices or activity rooms of Higher Ground or a place that is suitable to you. The interview will also be set at a time that is most convenient to you. You can say as much or as little as you like, and at any time of the interview you do not have to answer any questions you do not want to. You also can decide to change your mind about participating and end the interview at any time, without any questions being asked.

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

All identifiable information that is provided by you, such as your name and address, will not be seen by anyone, for any reason, other than the researchers and a University approved transcriber who has signed a confidentiality agreement. Only we will know the identity of the participants. Extracts from the information you provide may be quoted in the report for this research, and in possible publications or presentations about the research. This will always be done in a way which preserves your anonymity (no one will be able to identify you). Your interview data and consent forms will be stored securely and separately, and destroyed ten years after the research is finished.

There is a very small chance that you may become upset when talking about your experiences of the Māori components of the rehabilitation programme. If this occurs I can help access support for you from the clinical and support teams available at Higher Ground (for example, you may like to talk with a case manager) or any other person you identify. This is unexpected but important to note so that you are aware that support is available for you in relation to your involvement in this research.

Should you have any concerns about any aspect of this research, but do not wish to talk with me about this, you may contact my primary supervisor Professor Fred Seymour or Professor Will Hayward, Director of the School of Psychology or the Chair of the Ethics Committee at The University of Auckland, at the addresses supplied below.

Thank you very much for taking the time to consider being involved in this research. I am hoping that this study will contribute towards having a better understanding of what contributes to successful alcohol and drug rehabilitation for Māori men and women, and the best ways to provide Māori-focused services to men and women who are undertaking alcohol and drug rehabilitation programmes. I welcome you to take part in this research, and will contact you again soon to see if you are interested in taking part. In the meantime, if you have any queries or wish to know more, please phone me at the number provided below, or email/write to me at:

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

My primary supervisor is: **Professor Fred Seymour**

School of Psychology
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 88414

The Director of the School of Psychology is: **Professor Will Hayward**

School of Psychology
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 88516

For any queries regarding ethical concerns, please contact: The Chair
The University of Auckland Human Participants Ethics Committee
The University of Auckland
Private Bag 92019, Auckland 1142
Telephone 64 9 3737599 ext 87830

Appendix D

Participant Consent Form

SCHOOL OF PSYCHOLOGY

Human Sciences Building Floor 6
10 Symonds Street Telephone 64 9 3737599 ext 88557
Facsimile 64 9 3737450

The University of Auckland

Private Bag 92019, Auckland 1142, NZ

CONSENT TO PARTICPATE IN RESEARCH
THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF TEN YEARS

Title of Project: MĀORI PERSPECTIVES OF RECOVERY

Researcher: Simon Waigth

I agree to take part in this research

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

☐I understand that my participation in this research is entirely voluntary.
☐I understand that I cannot take part in this study if I am currently using alcohol or drugs.
☐I understand that whether I participate in this research or not, this will in no way affect my eligibility to access further services provided by the Higher Ground Drug Rehabilitation Trust.
☐I understand that I may withdraw from the interview at any point I choose, and that I am under no obligation to answer any particular questions that I may not want to.
☐I agree that my interview will be digitally recorded and transcribed, and that my data will be stored in a secure electronic location on a computer at The University of Auckland and/or a locked filing cabinet at The University of Auckland.
☐I understand that I may ask for the digital recorder to be turned off (even just temporarily and then turned back on) at any time during the interview.

☐I understand that I may review my interview transcript and suggest changes for up to two weeks after it is given to me.

☐I understand that I may withdraw any or all of the information I provide at any time up to a month after data collection, without giving reason.

☐I agree that extracts from the information I provide may be quoted in the report which will be written about this research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.

☐I understand that I will receive a summary of the findings of this research should I wish to, and I provide my contact details below so that I may receive this.

☐I understand that there is a small chance that I may become upset or uncomfortable when talking about my experiences in rehabilitation. I understand that if I feel this way that a support person is available should I need one, although I realise that it is not required.

Contact details:
……
……..

Name: Date: Signed: