

# **An Evaluation of the Moana House Residential Therapeutic Community**

Alcohol Advisory Council of New Zealand

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*Ruia taitea kia tu ko taikaka anake  
Cast off the sap, leave only the heart*

# **ACRONYMS**

AA.....	Alcoholic Anonymous
ACC .....	Accident Compensation Corporation
AOD .....	Alcohol and Other Drugs
CADS .....	Community Alcohol and Drug Service
CYF.....	Child Youth and Family (a service of MSD)
DARP .....	Drug Abuse Reporting Programme
DATOS .....	Drug Abuse Treatment Outcome Study
DHB .....	District Health Board
DTORS.....	Drug Treatment Outcomes Research Study
DTU .....	Drug Treatment Unit
GP.....	General Practitioner
HDANZ.....	Health and Disability Auditing New Zealand
MATCH .....	(Project) Matching Alcoholism Treatments to Client Heterogeneity
MIS.....	Management Information System
MoH .....	Ministry of Health
MSD .....	Ministry of Social Development
NA.....	Narcotics Anonymous
NGO .....	Non-Government Organisation
NTORS.....	National Treatment Outcome Study
PHO.....	Primary Health Organisation
TC.....	Therapeutic Community
TOPS .....	Treatment Outcomes Prospective Study
WINZ .....	Work and Income New Zealand

# GLOSSARY

- ahuatanga** ..... aspects, elements, dimension, the shape of things  
**aroha** ..... love  
**atua** ..... ancestor with continuing influence, god, supernatural being  
**awhi** ..... embrace, aid, help  
**hui** ..... meeting, meeting together  
**kai** ..... food, eat, dine  
**kaimahi** ..... worker, employee  
**kapa haka** ..... 'Māori Performing Arts', it is an avenue to express heritage and cultural identity.  
**karakia** ..... incantation, prayer, ritual chant. The means of clearing spiritual pathways  
**kaumātua** ..... elder (male or female)  
**kaupapa** ..... strategy, theme, philosophy  
**kōrero** ..... speech, narrative, account, discussion, conversation, discourse  
**koroua** ..... old man  
**kuia** ..... old woman  
**mana** ..... integrity, charisma, prestige, jurisdiction  
**mana whenua** ..... those who have trusteeship of local land  
**mokopuna** ..... grandchildren, young generation  
**noa** ..... free from *tapu*  
**pōwhiri** ..... formal welcome  
**rangatahi** ..... youth  
**rongoā** ..... remedy, medicine, drug, cure, medication, treatment, solution (to a problem), tonic  
**rūnanga** ..... a traditional Māori assembly or tribal gathering; the governing council or administrative group of a Hapū or Iwi  
**tamariki** ..... children  
**tangata** ..... people, human beings  
**tangata whaiora** ..... clients, service users  
**tangata whenua** ..... people of the land, the indigenous people  
**tangi** ..... funeral  
**tapu** ..... sacred, forbidden, confidential, taboo  
**te ao Māori** ..... a Māori world view, 'the Māori world'  
**te reo Māori** ..... the Māori language  
**tika** ..... correct, accurate, valid, reliable  
**tikanga** ..... meaning, custom, criterion  
**tinana** ..... body, oneself  
**tino rangatiratanga** ..... self-determination  
**tupuna** ..... ancestors  
**waiata** ..... song, sing  
**wairua** ..... attitude, mood, spirit, soul  
**wānanga** ..... learning, seminar, series of discussions  
**whakapakari whānau** ..... to strengthen, mature (whānau)  
**whakapapa** ..... genealogy  
**whakapiripiri** ..... a time of coming together  
**whakatauaki** ..... proverb, saying, aphorism - particularly those urging a type of behaviour  
**whakawhānaungatanga** ..... relating well to others, making and maintaining relationships

- whānaungatanga** .....relationship, kinship, sense of family connection
- whānau** .....family - *kuia, koroua, rangatahi, tamariki*. Kaupapa whānau are related by common interest rather than whakapapa.
- whānau hui** .....at Moana House, following directly from whakapiripiri, allowing residents to call house meetings
- whānau ora** .....potential for health and wellbeing of family / extended family
- whānau whānui** .....wider whānau
- whare** .....house

# **EXECUTIVE SUMMARY**

## **Background**

The main purpose of the current summative evaluation was to assess the impact of participation in the Downie Stewart Foundation programme, Moana House, on the functioning and changes of its residents. It was also an opportunity to identify possible areas of enhancement for the Moana House programme as well as to identify critical success factors that need to be taken into consideration in the development of any other therapeutic community (TC) of a similar nature.

There is a diversity of programmes resulting from the therapeutic community's adaptation to contemporary treatment requirements. However, maintaining the integrity of the TC model is critical, requiring demonstration of the essential elements pertaining to the model and method.

The role of the therapeutic community can be viewed as an important facilitator of a broader healing and recovery process. The therapeutic community provides a structured programme to assist those individuals with the most severe and complex addiction-related issues to achieve significant internal and behavioural change. The stages of treatment typically include an induction or early treatment phase, a primary treatment phase and a re-entry phase to assist individuals with integration into the wider community.

Taking into account methodological issues, therapeutic community outcome evaluations, in general, demonstrate marked reductions in substance use and offending and significant improvements in health and functioning. However, sufficient retention in treatment (a minimum of three or more months) coupled with adequate provision of services, client participation and active engagement in the programme and treatment progress is required for positive outcomes.

The limited New Zealand data on therapeutic communities supports the overseas literature in respect to the complex profile of individuals with serious addiction related problems entering therapeutic community programmes.

There is a small but developing literature on addiction treatment for Māori, and increasing agreement on key requirements for effective services for Māori based on holistic and integrative Māori perspectives. Given the high proportion of Māori with offending and substance-related issues in Aotearoa New Zealand there are significant challenges faced by treatment providers in providing Māori-responsive treatment.

In respect to conducting therapeutic community outcome evaluations, the approach taken needs to be carefully considered. Key considerations include: cultural considerations, the scope of the evaluation and resources available, including duration of the evaluation period, defining outcomes to be evaluated, the values and composition of the evaluation team, the programme context and key stakeholders, relationships between the programme staff and residents and the evaluation team, methodology, process and sources of data, data collection and interpretation.

## **Method**

The evaluation was undertaken using three primary modalities:

1. A set of standardised questionnaires were administered to intending, current and former residents and were repeated at four monthly intervals where possible.
2. A series of in-depth open interviews were conducted with residents, staff, family/whānau and a range of key stakeholders. These were then transcribed and underwent a thematic analysis.
3. Archival material was accessed from within the programme to identify the profile of past admissions.

## **Findings**

The standarised questionnaires were completed on one occasion by 18 men, a second time by nine of these men, and a third time by four of these men. The small sample size rendered statistical analysis inappropriate and therefore only cautious observations were made as to what the data might represent.

There was some indication from the treatment sample of good motivation to engage in treatment, and of residents exhibiting high levels of responsibility. There was strong endorsement for the programme having a positive impact on the four cornerstones of health as operationalised by Hua Oranga – wairua, hinengaro, tinana, and whānau, and these positive changes appeared to be more strongly endorsed as residents progressed through the programme.

Improvements were apparent in mental health functioning for the men interviewed more than once and, congruent with the treatment literature, it is likely that given the relatively high scores for mental health, significant improvements may have already occurred before the first interview, which was conducted an average of seven months after treatment initiation.

There was no apparent shift in TC dimensions of change (DCI) between the first and second interview, but it is notable that for eight of the nine scales scores are higher for the Moana House sample than for a US Phoenix House sample.

Qualitative data indicated a range of in-treatment and early post-treatment impacts for residents and their whānau, as well as longer-term outcomes for the programme, the Dunedin community, and local and national stakeholders. These include:

- Residents' identification and acknowledgement of, and commitment to, the need to change specific personal core beliefs and behaviours (substance misuse, criminality, anti-social behaviour) if they are to successfully complete the programme.
- The achievement and maintenance by Moana House of a physically, psychologically, culturally and spiritually safe and supportive environment within which to achieve the above personal work.

- The programme's successful harnessing of residents' motivation to change, resulting in increased retention and length of stay (e.g. through the development and deployment of its whānau ora programme).
- Acknowledgement by residents and their whānau that the programme structure and content (stages, monitored goal setting, therapy groups, one-on-one personal work, fellowship, cultural work, education/vocational training, whānau ora, after-care) produces change in core beliefs and behaviours.
- Evidence of core beliefs/behaviour change is seen in senior residents'/graduates' reduction of substance misuse and offending (and e.g. relapse prevention planning), increase in pro-social behaviours (e.g. uptake of personal and whānau responsibilities) and uptake of education and employment.
- Programme flexibility (e.g. responding to residents' needs by change of programme structure).
- External validation of the programme's value (e.g. awarding of new national contract; successful grant applications; on-going positive relations with neighbours and community; healthy relationships with stakeholders and funders).

Archival data showed some fluctuation with variable mean length of stay. The 2008 retention rate was the best of the years examined, and the 2009 entry cohort (i.e. during the evaluation period) was marked by higher than expected retention, suggesting that 2008 was not an aberration. More specifically, when examined as the proportion staying for a minimum of one and three months, retention rates have been good historically (77% beyond one month, 45% beyond three months) and were even better for the most recent cohort (89% and 67% respectively).

## **Recommendations specific to the Moana House Programme**

1. We would recommend expanding the Moana House programme to enable it to benefit from economies of scale, although certain caveats are noted in the Discussion.
2. The programme should be supported in reviewing its staff training, succession planning, workloads, and management structure, particularly in light of the recent expansion in the programme size and the possibility of further expansion.
3. The programme would benefit from the development of a computerised management information system (MIS) that would include core resident and waiting-list information.
4. Moana House achieves good outcomes by delivering beyond contractual requirements. However, funding constraints potentially act as a brake on further development. This situation should be reviewed.
5. The Moana House Training Institute warrants wider recognition and support.

## **General Recommendations**

Many of the above points should be borne in mind when considering establishing similar programmes.

6. We would like to call for a strong national commitment to TC treatment as a viable and effective alternative to prison for individuals with significant substance use and offending issues.
7. The achievements of the Moana House programme can be replicated elsewhere in New Zealand. Any new programme should accommodate the needs of different regions, ensuring it is meeting a treatment demand for that region and should do so on the basis of strong links with the local community.
8. Caution should be exercised in providing funding for the establishment of new TC programmes until adequate funding of current TCs is assured. Relatedly, the development of new programmes may be best achieved by working with existing TC providers.
9. The distinctive identity of TC programmes should be maintained by ensuring fidelity of the TC model, such as that proposed by De Leon (2000). Adaptations or modifications should reflect clinical rationales not a reaction to cost containment.
10. Duration of TC programmes should be matched to the needs of sub-groups of individuals.
11. Continuing care/aftercare must be seen as an essential element of effective TC treatment delivery.
12. The time has come for the establishment of a national network or body of New Zealand TC programmes, along the lines of the National Association of Opioid Treatment Providers.
13. The workforce implications of any expansion in TC provision should be considered, as well as the extent to which the current TC workforce is adequately supported and trained.
14. A cost effectiveness study to identify the actual costs and benefits associated with New Zealand TC programmes for individuals with high and complex treatment needs would allow for quantification of their benefit and has the potential to assist in setting funding priorities.
15. A nationally agreed suite of measures pertinent to the TC model of treatment and the New Zealand cultural setting should be identified.
16. Risk of Conviction Risk of Imprisonment (RoC RoI) index scores could provide a particularly powerful tool for demonstrating change and so should be routinely collected when available.
17. Research is required in respect to differences amongst sub-groups, treatment setting and TC modifications.

# **1. INTRODUCTION**

## **Background and purpose**

The Downie Stewart Foundation was established in Dunedin in 1983 in response to a desire to offer an alternative to imprisonment and other judicial processes for those appearing in the Criminal Justice System. The programme was initially designed for men who had major alcohol and other drug problems and since 1987 has operated as a therapeutic community. It currently receives funding from the Department of Corrections and Vote Health to run this residential treatment programme. The main purpose of the present summative evaluation was to assess the impact of participation in the Downie Stewart Foundation programme, Moana House, on:

- short- and medium term client functioning, and
- longer-term change

Thus the evaluation was concerned with programme fidelity (does the Moana House programme do what it is designed to do?) and effectiveness. It was also a means of identifying any areas for enhancement. This was to be done by identifying:

- critical processes, success factors and obstacles to positive outcomes
- core criteria for achieving positive outcomes
- core programme components unique to Moana House or more generic and transferable components

A third expected outcome of the evaluation was the identification of critical success factors and obstacles to implementation and ongoing sustainability of similar initiatives i.e. what would be necessary to develop an intensive bicultural therapeutic community-based AOD treatment programme (for serious offenders) elsewhere.

The current project was the first comprehensive outcome-focused evaluation of the Moana House programme. It should also be said that it is the first independent outcome evaluation of any of the therapeutic communities operating in the addiction treatment sector or within the criminal justice context in New Zealand.

This evaluation had its origins in the Government's Effective Interventions programme of work which initiated a project to investigate an intensive bicultural residential AOD treatment programme (Moana House) and an intensive residential AOD treatment programme (Odyssey House, Auckland). The subsequent report to the Ministry of Health (Katene, Gilgen, Pere, & Williment, 2007) had a primary aim to identify success factors to effectively support an intensive AOD residential programme. Because it was outside of the evaluation scope, a literature review was not undertaken and thus no evaluation of the programme was carried out in relation to the literature pertaining to therapeutic communities or outcome. While the review identified some factors that would contribute to a successful programme and potentially positive outcomes, it did not evaluate programme effectiveness.

Given the desire by potential funders for an outcome evaluation to build a business case for investing in a new service and the opportunity to commission such work under the Effective Interventions programme, the Alcohol Advisory Council of New Zealand (ALAC) put out a tender for the current summative evaluation of the Moana House programme.

## Evaluation team

The composition of the evaluation team drew on existing relationships with members of the Trust Board as well as with Moana House. It brought together skills and experience of both qualitative and quantitative methodologies as well as Māori evaluation and treatment paradigms. These elements allowed for ease of process in negotiating with the Board and programme staff as well as acknowledgement of mana whenua interest.

## Methodology

Evaluation of a small-scale programme such as Moana House poses challenges, given a low volume of participants in any given year. The evaluation used a mixed method approach, gathering quantitative and qualitative data.

The objective of the qualitative evaluation was to provide some indication of how participants and other stakeholders assessed the programme's impacts (intended and unintended). The key objectives of this dimension of the evaluation were to explore:

- the extent to which residents display positive gains in terms of increased motivation, pro-social behaviour, improved cultural knowledge and identity;
- the extent to which residents lead positive and constructive lifestyles in the community, and are motivated to avoid further substance misuse and re-offending; and,
- identify any unintended impacts of Moana House participation.

In relation to programme design and context, the objectives were to:

- investigate the specific role of the therapeutic community method in promoting positive gains for residents;
- investigate the role and impacts of the Māori beliefs, values and experiences of the programme in promoting positive gains for residents;
- identify factors that contribute to, or are barriers to, successful recruitment into and retention in the Moana House programme; and,
- identify ways in which the programme might be enhanced.

The open-ended interviews focused on residents' and others' experiences of the programme and what they considered gains had or had not been as a result of participation. Non-staff and non-residents were able to provide additional information on observed programme impacts and processes. First-hand *observations of programme activity* occurred via house visits by the interviewers and available *programme documentation* was also reviewed.

The interviews followed guidelines developed after two initial focus groups. Open-ended questions were augmented by prompts where interviewers considered more detail was required on particular issues. The interviews were recorded and transcribed.

The purpose of the quantitative evaluation was to provide some objective indication of change. The key objectives of this dimension of the evaluation were to explore:

- resident substance use, gambling, offending and demographical profile
- change in health and wellbeing
- changes in motivation

- changes in self efficacy
- treatment impact and satisfaction.

## **Ethical approval**

Ethical approval was sought and gained from the Lower South Island Regional Ethics Committee. Approval was granted on 18 November 2008, approval number LRS/08/10/048. The team also made particular efforts to ensure the local Runanga were involved to provide another level of team accountability.

Confidentiality was assured by the evaluators, and all participants were given an information sheet and signed a written consent form prior to the commencement of the interviews (see Appendix IV for these forms). In the case of interviews undertaken by phone, the consent form was read and verbal consent was obtained and recorded.



## **2. LITERATURE REVIEW**

### **2.1 THE THERAPEUTIC COMMUNITY MOVEMENT**

#### **2.1.1 A brief history of the therapeutic community**

The origins of the contemporary Therapeutic Community (TC) Movement are found in developments in mid-twentieth century England and Western Europe, and the United States (Meyers 2008, Broekaert 2006, Gowing et al. 2002, Glasner 1981). However, the notion of the therapeutic community is much older. Glaser (2006) suggests it may be further traced back through Alcoholics Anonymous to the so-called Oxford Group Movement and thence via its founder, Frank Buchman, to early Christian practices described in the Dead Sea Scrolls. Quoting Philo Judaeus (ca 25BC - 45AD) Glasner (1981) references a therapeutic community of Egyptian physicians, practicing over 2000 years ago, who were concerned not only with their patients' physical ills but also their "innumerable multitude of other passions and vices".

Though also acknowledging this ancient history, Gowing et al. (2002) emphasise the more contemporary distinction between the residential treatment of psychiatric patients developed in England, and the United States' non-psychiatrically oriented self-help residential treatment of those with substance-use problems. Similarly, Bale et al. (1984) distinguish between the American and European/British models. They note the latter's use of therapeutic community treatment of character disorder by employing professional staff in contrast to the American use of 'para-professional' peers. Thus, as Maxwell Jones (1979) comments, the evolution of UK therapeutic communities was influenced by a psychiatric base, and those in the US by Alcoholics Anonymous and Synanon (see below). Jones (1984) refers to the psychiatric model as 'democratic' and the AA/Synanon model as 'programmatic', although the latter is more commonly known as the 'Concept' model (Meyers 2008).

As with Glaser (1981), Gowing et al. (2002) observe that a common feature of both involves patients, in collaboration with staff, becoming active participants in their own therapy, as well as in that of other patients, and in the entire community's general conduct. These elements are likewise cited by Mattick and Hall (1993) who describe the therapeutic community as one treating residents with behavioural disorders within a 'community' where residents and staff participate in a structured residential environment. Nonetheless, despite these elements being common to both European/British and American therapeutic communities, differences between the two remain.

##### **2.1.1.1 Therapeutic communities in Western Europe: The democratic model**

Pines (1999) proposes that May 1946 marks the birth of the therapeutic community as developed in hospital psychiatry in the United Kingdom, and suggests the antecedents to this approach are found in pedagogy, therapeutic education, social medicine and in the changing human relations occurring between the two world wars. Earlier influences include the Moral Treatment of the eighteenth century and the fundamental ideals of the Enlightenment (Meyers 2008).

Of particular significance in the mid-twentieth century were two experiments in psychiatry at Northfield Hospital during 1942 and 1948 respectively. The first of these, led by Wilfred

Bion, lasted only six weeks. However, others such as Harold Bridger, Tom Main, Sigmund Foulkes and John Rickman developed Bion's principles further (Meyers 2008).

With army psychiatric services expected to heal hundreds of traumatised soldiers and return them to the front lines, the Northfield psychiatrists decided to focus on group rather than individual problems. Wards were structured as communities, with mutual support and cooperation encouraged, and non-directive group discussions conducted. The community was viewed both as patient and instrument of treatment. The aim was to train the community in problems of neurotic defenses and interpersonal relationships. Psychiatrist Tom Main, credited with coining the term 'therapeutic community', subsequently directed Cassel Hospital, which he developed into a therapeutic community based on psychoanalytical theory (Meyers 2008). Citing Shorter (1997) Meyers (2008:15) describes Main's 'Second Northfield Experiment' as "a therapeutic setting with a spontaneous and emotionally structured (rather than medically dictated) organisation in which all staff and patients engage". In this setting 'sincerity' was the 'basis for management'.

In the 1940s Maxwell Jones' unit at Mill Hill in London developed along similar lines. His lectures concerning the physiological basis for the condition of soldiers suffering from 'effort syndrome' led to more open discussions. Newer patients were educated by more experienced ones, and the demarcation between doctors, nurses and patients became less rigid, a form of treatment Jones referred to as 'democratic therapy' (Meyers 2008). Jones subsequently directed a unit at Belmont Hospital in Surrey to address the problems of 'unemployed drifters'. Shephard (2002, cited in Meyers 2008) notes this became known as an 'Industrial Neurosis Unit' for treating patients diagnosed with long-standing neuroses and character disorders, and employment difficulties.

This movement from a strict medical hierarchy run by doctors in the interests of technical efficiency to a community focusing on 'real tasks' allowed the opportunity to identify and analyse interpersonal barriers to full participation in community life. Jones (2004) suggests physicians' movement from a traditional paternalistic role to one of reflective commentator and participant in daily circumstances marks a radical shift in treating mental illness. This transformation in the status of patients was one of the most significant psychiatric effects of the Second World War.

Building on these developments, the 1960s saw the emergence of a 'social psychiatry' movement in Britain and France. Meyers (2008) notes the impact of Ronald D. Laing (1960, 1967, 1969, 1971) and David Cooper (1971, 1974). These authors examined the impact of families and other social forces on individual pathology, and how patterns of behaviour were replicated, particularly in group settings. The family-like culture of the therapeutic community was considered a remedy to dealing with problems with roots in family relationships.

### **2.1.1.2 American therapeutic communities: The concept-based model**

Meyers (2008) observes that in the United States the Therapeutic Community Movement derives principally from Synanon, an organisation started by Charles Dederich in Santa Monica, California, in 1958 as an offshoot of Alcoholics Anonymous. Dederich, a former alcoholic, was familiar with AA and its self-help concept. According to Lewis Yablonski (1994), a sociologist having a long association with Synanon, the name itself derived from an attempt by a recovering alcoholic to say 'seminar' and 'symposium' at the same time, resulting in his slurring the words into 'Synanon'.

While AA, established in 1935, contained a strong God-centred moralistic element, this religiosity was less evident at Synanon. The self-supporting anti-materialist community expected life-long commitment, with everyone working in its various businesses. Residents had few personal resources and ‘graduates’ remaining with the programme received a small stipend. Voluntary participants lacking addiction problems often worked outside the community but would donate their income (Meyers 2008).

In contrast to the European/British ‘democratic’ model, life at Synanon was highly regimented, disciplined and hierarchical. The group provided the main treatment modality, with the central activity being ‘The Game’, a verbally aggressive encounter group. This emphasised the articulation of feelings and confrontation, with fear, anger and joy expressed without mediation of self-control or inhibition. Yablonsky (1994) describes these experiences as metaphorical ‘haircuts’ with community members knowing the activity by that name and enthusiastically participating. Meyers (2008) observes that during Synanon’s early years, residents were given actual haircuts and made to carry signs identifying their ‘crimes’ (see also Yablonsky 1965). Unlike the European/British TCs, during the formative years of the US TCs, no trained professionals were present.

The success of Synanon was highlighted by the relatively poorer outcomes of other treatment modalities in early 1960s America. This was apparent to a 1962 team headed by a Supreme Court Probation Department official who visited the TC while touring the US in search of solutions to problematic drug use. One team member electing to stay on at Synanon, psychiatrist Daniel Casriel, subsequently founded another programme in New York (Daytop Lodge—Drug Addicts Treated on Probation), later named Daytop Village (see Kooyman 2001). With the growing awareness that TCs were effective in treating issues around criminality, thereby providing an alternative to prison, Daytop became the first therapeutic community to formally connect with the justice system (Meyers 2008).

### **2.1.1.3 Evolution beyond the two models: a TC diaspora**

While Synanon collapsed as a therapeutic community, ex-residents and staff contributed to the establishment of a number of subsequent programmes in the United States. Among these were the Delancey Street Foundation, the Habitat community, Phoenix House, the Gateway community and Odyssey House. The 1970s also saw communities set up in Canada, the Philippines, Malaysia and Europe. Although retaining Synanon’s methodology, the aim of creating a discrete utopian society was exchanged for returning addicts to a drug-free life beyond the TC. Thus reintegration replaced isolation. Similarly, the extreme methods characterising Synanon, such as ‘The Game’, were replaced by elements including self-help and responsible concern (Meyers 2008).

Though TCs in Europe incorporated elements of the American model, in the wake of the Nazi experience authoritarian structures were resisted (see Raimo 2001), an approach some (e.g. Broekaert 2006) have suggested held back their development. In this regard Meyers (2008) cites the example of the Emiliehoeve community in the Netherlands, based on the UK ‘democratic’ model. Here it was found that chaotic addicts lacked the level of maturity required for democratic functioning. This led to regression, avoidance, acting out and violent outbursts, in response to which the implementation of a more structured, authoritarian regime increased success. Generally, however, between the late Sixties and Eighties, European TCs eschewed the US models’ harsh behaviourism in favour of dialogue and understanding. Thus during the initial phase of TCs in Europe, professionals occupied more pivotal roles than ex-addicts, as was the case with the American model (Broekaert et al. 2006).

The 1970s also saw the diversification of TCs gather momentum with the burgeoning use of drugs and its associated problems. Health budgets were strained by increasing numbers of clients with substance use problems. Cost cutting saw briefer interventions, the introduction of outpatient methadone treatment for opioid dependence and, in the mid-1980's, as a response to the threat of the spread of AIDS (Acquired Immunodeficiency Syndrome) (Strang & Farrell 1989), the introduction of public health objectives reflected in a harm reduction approach needle and syringe exchange programmes and other harm reduction initiatives. This led to difficult financial times for the potentially more expensive therapeutic communities (Broekaert & Vanderplasschen 2003, Yates & Wilson 2001). Methadone treatment, for example, was seen as more cost effective (Gerstein & Harwood 1990, Smith & Luce 1969) and leading to lower intravenous use of heroin, particularly significant due to the increasing prevalence of AIDS (Hartel et al. 1995). Other factors promoting a shift in TCs' focus included the growing recognition of the role of mental health problems in substance use issues, changing patterns of substance use and profiles in users, and pressures to rationalise resources. The influence of social, historical, cultural and political factors within the context of the TCs' operation impacted differently across the globe (Meyers 2008).

This diversification in treating substance use issues has seen adaptation by TCs in their approaches to engaging with various populations with specific needs but also concerns within the TC movement over the impact on core TC values. Broekaert & Vanderplasschen (2003) note a significant decrease in TC numbers in some European countries. An exception to this trend is the increase in TCs located in prisons (Turnbull & Webster 1998). Some see a potential for the 'drug-free' approach to be overshadowed by the incorporation of harm reduction principles reflecting a public health approach. The European Federation of Therapeutic Communities has voiced concern about the "adulteration of its value-based and abstinence-oriented approach due to the decline of the recovery principle and the establishment of a new harm reduction paradigm in which drug use is considered acceptable" (Broekaert & Vanderplasschen 2003:238; also Inciardi 1999).

Diversification and cost containment has also led to treatment services relying on multiple sources of funding that includes justice as well as other public and private sources, with the most important source influencing treatment provision and what services are offered (Arfken & Kubiak 2009).

## **2.1.2 Traditional and modified therapeutic communities**

Despite the above concerns, today the term *therapeutic community* describes a variety of programmes; short and long-term residential, and those involving day treatment and ambulatory care for a diverse range of populations. Clients include drug dependent people, those with mental illnesses, personality disorders, co-existing disorders, the homeless, prisoners, adolescents, women and children (Meyers 2008, Broekaert 2006, Melnick & De Leon 1999). These developments have led to the TC modality being divided into a variety of types, though generally described as 'traditional' and 'modified'. As Gowing et al. (2002) note, this has occasioned considerable discussion, particularly in the United States. De Leon (2000) comments that even in traditional TCs the previously common programme durations of two to three years have contracted to stays of 12-18 months. In modified TCs even shorter durations are common (e.g. 3, 6 and 12 months) as well as TC-oriented outpatient and day treatment programmes.

For the purposes of categorising TCs, the large US study of treatment programmes, the Drug Abuse Reporting Program (DARP) (Simpson & Sells 1983), divides TCs into three sub-categories:

- **traditional TCs**, having the goal of total resocialisation, one to three years duration, treatment includes high demands, confrontation and sanctions;
- **modified TCs**, where the goal is developing practical skills, six to eight months duration, moderate treatment demands and sanctions;
- **short-term TCs**, with the goal of providing survival skills to clients and facilitating re-establishment of family relationships, three to six months duration with treatment demands being moderate to high.

In considering traditional and modified TCs in the US Drug Abuse Treatment Outcome Study (DATOS), Melnick et al. (2000) observed that the two types differed in adherence to elements of TC treatment, on operational characteristics and in client mix. They suggested modified programmes showed:

- greater emphasis on professional staff rather than recovering paraprofessionals
- a decreased reliance on community as method
- a reduction in group therapy

Other client groups elicit further modifications in TCs, for example for adolescents, where the emphasis is less on work than being a student and obtaining educational qualifications. Thus differences include:

- shortened recommended lengths of stay
- family participation
- limited use of peer pressure
- more emphasis on hierarchy, with less adolescent input than adults on community management (Jainchill et al. 2000)

Within prisons Hiller et al. (1999) note that, as with their community counterparts, prison TCs are separated from the general prison population. In the US there is differing adherence to traditional TC processes with the role of peer leaders limited and greater use of professional staff. In New Zealand this is also the case with the Care NZ facilities' employment of prison officers as well as TC professionals (see below). In US facilities treatment durations are shorter than for traditional TCs (e.g. 6-12 months) with an emphasis on 12-step, self-help recovery and relapse prevention.

For clients in TCs who have co-existing substance use and mental health problems, there is less participation in group sessions and fewer requirements around job functions. Pharmacological and psychological therapies are used to manage symptoms and, to avoid confrontation and promote support, groups are facilitated by staff members (Taylor et al. 1997).

### 2.1.3 Defining the contemporary therapeutic community

Given the diversity of programmes resulting from TCs' adaptations to contemporary treatment needs and changing health care environments, it should be unsurprising that a single definition of the therapeutic community is hard to find. Gowing et al. (2002:47-9) recognise this in their review of literature, with descriptions of diverse TC definitions.

As Gowing et al. (2002) note, this lack of a clear definition for TCs risks uncertainty when the term is discussed. Therefore, the present review will be in accordance with Meyers' position (2008:21-2) based on De Leon's (2000) view of the essential elements of the TC. In broad terms these elements are inherent in the "community as method" approach underpinned by a perspective consisting of interrelated views of: substance use problems, the individuals who experience such problems, goals of treatment in respect to required changes in identity and lifestyle, and beliefs and values essential to the broader recovery process. Key components include:

1. The promotion of socially responsible roles by participating in a community.
2. Concerned, responsible feedback on the member's behaviour from peers.
3. Clients as role models: each member's task is to become a positive role model for others.
4. Relationships in the community are used as learning tools: the tragic dramas which are acted out in life are reflected in these relationships. Self-destructive patterns of feeling, thinking, and behaviour can be studied and modified as they emerge in the community.
5. Collective learning formats: education, working together, meetings, and recreation.
6. Culture and language of change: there is a positive focus on what life can be. This culture is also expressed in celebrations of achievements, traditions, and rituals to enhance community cohesiveness as well as in a belief system, values and philosophy that guide socially responsible living.
7. Structure and systems: daily living in the community is prescribed by job descriptions, chores, sanctions, privileges, rules, routines and procedures, which might be found in any environment that produces socially responsible adults. These are balanced by concern, affectional bonds, the involvement of others outside the community, and transparent operations to avoid a counter-productive authoritarian culture. The process of feedback within the community is reflected in a similar process between the community and the surrounding society, from neighbours to funding and auditing agencies.
8. Open communication: personal information is openly shared in the community. This is an antidote to the manipulation and secrecy characteristic of drug abusing and criminal populations.
9. Individual and community balance: the community exists to serve the individual, but the relationship is reciprocal. The community must have a similar attitude of self-criticism as is expected of the individual. Neither is allowed to become a threat to the other. External auditing and transparency are essential to the health of the community, and it may expel a member who becomes a threat to its integrity and the safety of others.

### **2.1.3.1 Programme structure and stages of treatment**

As the foregoing discussion implies, a central component of treatment in therapeutic communities is the structured delivery of programme components. This structure moves

community members away from their negative behaviours, through the programme and ultimately towards the goal of integration into the wider community. To facilitate this process TC programmes are divided into stages (NIDA 2003, Nielsen & Scarpetti 1997, Yablonski 1994). Commonly there are three, although this may vary, as in the case of Moana House which has four (see below).

A three-stage programme typically comprises induction or early treatment, primary treatment and re-entry stages:

1. *Induction/early treatment.* This occurs during approximately the first 30 days, during which the individual is assimilated into the TC. They learn TC policies, procedures, norms and TC philosophy, and establish trust with staff and other residents. An assisted personal assessment of the self (including circumstances and needs) is initiated; the resident begins to understand the nature of addiction and should begin to commit to recovery.
2. *Primary treatment.* This stage provides the therapeutic foundation for the programme, with the resident becoming immersed in the life of the TC and working on their issues and needs (e.g. social, educational, vocational, familial, psychological). There is often a structured progression through increasing levels of pro-social attitudes, behaviours and responsibilities (NIDA 2003).
3. *Re-entry.* In this stage the individual's separation from the TC is facilitated, leading to a successful transition back into general society. In the case of community programmes, graduates will leave drug-free and employed or in school. For those in prison TCs, the stage may comprise a work-release phase lasting perhaps three months. Employment may be a major focus though as Nielsen and Scarpetti (1997) note, the individual may continue with a modified version of primary treatment. Self-help groups such as AA or NA may be part of this, with residents and graduates being encouraged to participate.

In general, in respect to retention and factors that influence positive outcomes (see 2.2.2 below), specific time spent in each stage is of less significance than remaining in treatment for a significant proportion of the programme (e.g. at least a third or a half of planned treatment—Gerstein & Harwood, 1990) and progress through stages. These latter criteria underscore engagement with the programme. However, as has been noted above, with increasing financial and other resourcing pressure, where TCs have traditionally allowed for 18-24 month stays, more recently the trend for many programmes is to reduce stays to 12 months or less (NIDA 2003).

## **2.2 EFFICACY AND EFFECTIVENESS OF THE THERAPEUTIC COMMUNITY: EVALUATING TREATMENT**

This section draws heavily on Gowing et al.'s (2002:219-255) summary of research evidence on the effectiveness of therapeutic communities. Their review considers both data relevant to within-TC analysis and those comparing TCs with other modalities. These authors note that there have been very few controlled studies of TCs, and almost none having randomly allocated participants to a TC or other mainstream treatment approach. The principal reason for this being randomisation is generally not well accepted by staff or potential clients (Bale

et al. 1980). Gowing et al. (2002:219) offer a critical appraisal of several studies attempting (but in their assessment failing) a randomised approach. The remainder of the first section of their review (pp 219-233) details a range of studies, noting treatment modality, drug use types and patterns, numbers of participants etc. which, though not discussed in the present document, provides a useful backdrop to the information below.

Other methodological limitations discussed in earlier literature (e.g. Bale et al. 1980) include most studies being retrospective, very little pre-treatment information being available and no advance planning for follow-up made. This had the effect of yielding, with few exceptions (e.g. Mandell et al. 1974, Sells et al. 1976), location rates between 30%-60%. Earlier studies also focused primarily on graduates, a select group, many of whom were still associated with the programme. The single variable of drug use was assessed but frequently in an ill-defined manner, e.g. reports used phrases such as ‘stayed clean’, ‘tend to become drug free’, ‘abstinent’, ‘relapsed to drug use’. Thus, the specific drugs being used were unclear, as were sampling procedures and levels of clients’ previous dependence. Further, non-treatment control groups were rarely utilised and typically only one post-treatment contact was reported, with varying lengths of post-treatment contact. In some studies all clients were evaluated at the same time, with no differentiation between period of post-treatment (Bale et al. 1980).

### **2.2.1 Complexity of client profile**

Therapeutic communities are largely designed to treat individuals with the most severe and complex addiction related issues, many of whom require habilitation as opposed to rehabilitation (Gerstein & Harwood 1990). Such individuals have frequently experienced significant adversity and social disadvantage in their lives and are less connected with their families and other support networks (Anonymous 1990). Overseas studies highlight client profiles that incorporate a complex range of substance use and co-existing mental and physical health and social issues (e.g. DATOS, Melnick et al. 2000; NTORS, Gossop et al. 1998; and the Woolshed evaluation, Mattick et al. 1998). As is discussed below (section 2.3.1), there is a dearth of New Zealand literature in this area.

### **2.2.2 Retention in treatment**

Retention in treatment is a major concern for therapeutic communities. For example, De Leon and Schwartz (1984) surveyed admissions to seven long-term therapeutic communities in the US during 1979. They noted a dropout rate of 40% by the end of the first month. An Australian study of five TCs (Latukefu 1987) indicated rates of between 39%-64% in the first thirty-five days.

Results from three large quasi-experimental studies conducted in the US (Drug Abuse Reporting Programme (DARP) (Simpson & Sells 1983); Treatment Outcome Prospective Study (TOPS) (Hubbard et al. 1989); Drug Abuse Treatment Outcome Study (DATOS) (Hubbard et al. 1997) highlighted the relationship between duration in treatment (retention) and post-treatment outcomes. For example, favourable post-treatment outcomes were associated with remaining in residential treatment for at least three months (Simpson & Sells 1983). This finding of an association between greater duration in treatment and positive outcomes was replicated in the UK National Treatment Outcome Study (NTORS) (Gossop et al. 1999) and more recent UK Drug Treatment Outcomes Research Study (DTORS) (Jones et al. 2009) as well as in a recent review of continuing care research of 20 studies over 20 years

(McKay 2009). Where comparable, the positive DTORS outcomes were equivalent or better than those observed in the previous decade in NTORS.

These findings highlight that for individuals with a complex range of frequently intertwined substance use, health, vocational and social problems, change takes time and requires a holistic approach, together with a focus on a continuing process of change subsequent to early improvements. More broadly, this approach is similar to a continuing care approach for other chronic conditions such as diabetes (McLellan et al. 2000).

However, while longer duration in treatment predicts greater success, as Gossop et al. (1999) emphasise, the best outcomes relate to completed planned duration of treatment. Furthermore, that identifying a critical time in treatment does not necessarily relate to clinical improvement, although as the authoritative Institute of Medicine Report on Treating Drug Problems concluded, based on available evidence, "...those clients who stay in therapeutic communities for at least a third or half of the planned course of treatment, a threshold that seems to vary greatly from programme to programme – that is, those that stay in treatment for at least 2-12 months, varying from programme to programme for reasons that are not yet clear- are much closer to achieving the treatment's goals at follow-up than those who drop out earlier" (Gerstein & Harwood 1990, p.166) ...and further "... The outcomes from the earlier dropouts basically cannot be distinguished from those of individuals who did not enter any treatment modality" (Gerstein & Harwood 1990, p.167).

In the last decade or so there has been an emphasis on examining more specifically the factors that may contribute to time in treatment such as motivation, engagement and participation in programmes (De Leon 1996), how rigid and confrontational the approach is (De Leon 2000) and client-staff rapport (Melnick et al. 2000). A large UK study conducted by Simpson et al. (2009) examined client functioning and engagement in relation to staff attributes and organisational climate across diverse treatment agencies and outreach programmes and compared the results with US data. The key findings were that high client scores on treatment participation and counselling rapport were directly associated with higher levels of motivation and psychosocial functioning as well as with ratings of staff (professional) attributes and programme atmosphere.

Two other studies of interest highlight how relatively low cost, low effort activities can positively impact on engagement and retention (McKay 2009). Firstly, a study trial which showed that Mindfulness-Based Stress Reduction adapted for TC treatment, compared to treatment as usual, was associated with decreased drop out amongst 459 participants entering a residential facility (Marcus et al. 2009). Secondly, a qualitative study (Wilkinson et al. 2008) explored client and staff views on what is most and least useful in residential rehabilitation and concluded that:

- Taking a holistic approach, arrangements for care need to be considered before admission not just prior to discharge, e.g. childcare, housing, training and education, employment, family and relationship concerns.
- Skilled key workers, effective interagency collaboration and the clear setting of quality standards are required.
- Diversification of substance use amongst client populations requires the need for a flexible and adaptive approach.

Regarding study findings on predictors of retention, results are mixed with the most reported association being between better social support and retention (Westreich et al. 1997; Dobkin et al. 2002; Soyez et al. 2006). Of note, is that Soyez and colleagues (2006) found that, of all

the client-related characteristics examined, only social support and motivation contributed to a model predicting retention.

Lastly, retention success may be linked to an individual having multiple admissions, suggesting a cumulative effect; for example De Leon (2000) observed that about a third of dropouts seek readmission to either the same or another TC. The fact that a proportion of those who leave treatment early are likely to re-present, signals the importance of effort put into increasing motivation for treatment amongst all individuals referred, engaging all individuals who enter the TC door and welcoming back those who re-present.

### **2.2.3 Treatment effects on drug use**

Gowing et al. (2002) note the consistent findings across all studies that treatment produces significant reductions in the subsequent use of drugs. Although most obvious during and just after treatment, the rate of drug use is reduced for at least one or two years. Some examples of the 32 studies cited by Gowing et al. (2002) include:

- the Drug Abuse Reporting Program (DARP) (Simpson & Sells 1983), where daily use (mostly heroin) dropped from 70% of residents two months prior to entry, to 35% at one year follow-up and then 17% in the year before the final follow-up interview (on average, four years after treatment);
- Hubbard et al. (1984) reported 20% of clients in treatment for 13 weeks or less, and 33% of those in treatment for more than 13 weeks reported no weekly use of drugs a year after treatment;
- Hughes et al. (1995) noted that at follow-up (2-6 months after treatment) 56% of a modified TC cohort of women was not using drugs and 50% in the traditional TC cohort.

#### **2.2.3.1 Cross-modality effects**

Gowing et al. (2002) note the limited studies comparing drug-use outcomes between TCs and other modalities. In general, clients staying in TCs two months or more have good outcomes in reduction of drug use relative to other modalities or to no treatment. For example, Simpson and Sells (1983) observed similarities in post-treatment outcomes between methadone maintenance, TCs and non-residential drug-free treatment, with these three modalities being more successful than detoxification and intake-only groups.

In the TOPS project (Hubbard et al. 1984), 95% of residential clients reported a large reduction in the use of their primary drug in the first three months of treatment compared with 90% of methadone clients and 45% of non-residential drug-free clients. Bale et al. (1980), reporting on the 12-month follow-up of proportions reporting heroin use in the month prior to interview, observed that 52% of TC clients had used compared with 47% of methadone clients and 65% of detoxification clients.

Drawing on the DATOS project Hser et al. (1998) noted that clients in TCs reduced heroin use by 72% and cocaine by 70% from admission to one-year follow-up. For short-term residential programmes the figures were 55% and 70% respectively, for outpatient methadone 73% and 54%, and for non-residential drug-free 50% and 61% respectively.

## **2.2.4 Treatment effects on health status**

As with reduction in subsequent drug use, studies also consistently show a correlation between TC treatment and the improvement of health status. Hubbard et al. (1984) report that following three months of treatment 50% of TC residents reported recovery from depression compared with 39% of methadone and 35% of non-residential drug-free clients. Suicidality fell from 40% to 20% over the same period for TC residents. In a study of 36 participants completing a year of inpatient treatment, Ravndal and Vaglum (1994) reported that 19% met criteria for ‘depressive’ at one year, compared with 69% of the overall sample on entry to the programme. This is consistent with other studies, indicating that early improvement in depression symptoms is associated with entering substance use treatment and a decrease in the level of distress experienced (Rounsville et al. 1982). Other areas of reported health-related improvement associated with TC residency include a decrease in sexual risk-taking behaviours (Martin et al. 1995, Department of Human Services Victoria 2000) and general health assessed using the SF-36 health survey (Mattick et al. 1998).

## **2.2.5 Treatment effects on criminal behaviour**

Although there are fewer data on criminal behaviour than for drug use and health status, Gowing et al. (2002) observe that as with the latter, there appears to be a significant reduction in criminal behaviour, associated with TC treatment. This is, in general, supported by the findings of the large-scale outcome studies that have included residential TCs (TOPS, Hubbard et al. 1984; DARP, Simpson & Sells 1983; DATOS, Simpson et al. 2002; and NTORS, Gossop et al. 2003, Gossop 2005b; see also Gossop 2005a for an overview of all programmes). This is particularly the case for clients staying in programmes for two months or more, with good outcomes relative to other modalities or no treatment.

De Leon et al. (1982) report that their pre-treatment index of criminal activity for combining two cohorts was 97.4 for dropouts and 94.4 for graduates. The 1-year post-treatment indices were 40.9 and 4.2 respectively, indicating substantial decreases, even for those not completing the programme.

An early study that followed up the first 61 people (mixed gender) entering a UK mixed gender TC divided them into three durations of stay; long (more than six months), medium (one to six months) and short-term (less than one month). The short and long-term follow-up (two and 10 years), provides interesting data. The long-stay group (n=20) had a pre-admission conviction rate of 60%, dropping to 10% at 2-year follow-up and rising slightly to 15% at 10-year follow-up (from searches of criminal records). The medium-stay group (n=20) had figures of 70%, 45% and 70% respectively, and the short-stay group (n=21) reported 57%, 57% and 85% (Wilson & Mandelbrote 1978, 1985). The authors suggested that periods of *more* than six months are effective in reducing subsequent criminality. Additionally, four of the short-stay group had died as a result of drugs (19%), one medium stay person from natural causes and one long-stay person as a result of suicide. However, the non-random assignment of clients to groups warrants caution when interpreting these results.

Post-treatment reductions in offending are also apparent in prison TCs. Hiller et al. (1999) report that 30% of parolees completing in-prison TC and aftercare TC treatment were rearrested for a new offence at 13-33 months. This compares to 36% of parolees completing only the in-prison TC treatment and 42% of a group of untreated matched parolees. Gowing et al. (2002:245-6) note a number of other studies reporting similar findings.

However, while evidence of effectiveness may be the case for male prisoners there are more equivocal findings for women. In a review article considering the appropriateness of prison TCs for women, Eliason (2006) suggests a range of issues mitigate against the clear-cut usefulness of TCs for female prisoners. With women offenders having higher levels of abuse (particularly sexual) than men, issues related to abuse and trauma are significant factors in their treatment, with trauma being proposed as a trigger for drug and criminal recidivism. Eliason (2006) cites a range of studies providing equivocal evidence for TC success rates for female offenders (e.g. Wexler et al. 1990, Jarman 1993, Inciardi 1996, Rhodes et al. 2001). She suggests the US style of TCs with their emphasis on confrontation is more suited to males exhibiting antisocial personality disorder than to females more commonly diagnosed with mood and anxiety disorders, and borderline personality disorder. Consequently, she suggests TCs may potentially be toxic environments for female offenders. This perspective receives support even in studies indicating predictors of outcomes from TCs were similar for men and women. For example, while Messina et al. (2000) found similar outcomes for men and women following 12-month treatment programmes and that longer residential programmes had a particularly beneficial effect on women, they also noted the greater risk of relapse for women with more pre-admission arrests.

Though the above studies provide some useful data, a matter less discussed concerns the difficulties of measuring criminality. These include the relatively low base rate of arrest/conviction in a given time period with factors other than offending per se impacting apprehension rates, or when using self-reported offending (independent of apprehension). Thus the validity of such studies will, for example, face issues of accuracy of self-report, at least at intake (see Blumstein 1986).

### **2.2.5.1 TCs in prisons**

Traditionally, the correctional system does not include service provision as a primary goal, even though individuals in prison and on probation/parole have large unmet substance abuse needs (Taxman et al. 2009). Nevertheless, treatment of AOD offender populations in prisons began in the 1950s, particularly in the United States. The two models previously discussed ('Democratic' and 'Concept-based') were each represented, with the Democratic model first making inroads into the US prison system in the 1960s. These developments followed a growing awareness during the 1950s of the need for a more humanistic approach to prisoners, which led to the implementation of transitional therapeutic communities. Subsequently, Maxwell Jones, having been invited to the US by the California Department of Corrections, consulted on pilot projects using therapeutic community principles in prisons (Vandevelde et al. 2004). Hence, in the US, the initial deployment of prison-based TCs involved the Democratic model.

The Concept-based TC model was established in the US at Nevada State Prison in 1962, following an earlier attempt in California, which met with hostility from prison system authorities (Gates & Bourdette 1975). The original model (named Asklepion, after the Greek god of healing) operated until the 1970s and remained an influence for other concept-based TCs operating in prisons. Outcome studies assessing TCs such as the Stay 'n Out programme (e.g. Wexler et al. 1991) indicated their success.

In the 1990s further success of prison-based TCs was acknowledged with positive reviews of the approach both in the US (e.g. Martin et al. 1995; Martin & Butzin 1999) and in the European Union (Turnbull & Webster 1998).

In their review of these two models of TCs for prisons Vandevelde et al. (2004:73-75) observe that, despite differences, the models have a number of common linkages:

- *Social learning and behavioural modification.* Both models have elements of a behaviourally oriented approach, though the hierarchical TC is more inclined towards this. The prison's strict and authoritarian regime facilitates this (Genders & Player 1995).
- *Permissiveness and modelling.* The democratic prison-based TC, with its greater permissiveness, allows prisoners greater freedom to act out, without constant disciplinary action. In the hierarchic concept-based TCs, behavioural modelling by more experienced prisoners in TCs encourages 'right living' (De Leon 2000).
- *Democracy and hierarchy.* In both models these components are facilitated by the isolating of prison TCs from the prevailing anti-social prison culture. Thus the hierarchy of the TC in the concept-based model represents an alternative to that of prison culture, as does the freedom to withdraw from the programme, which is contrasted against the non-freedom represented by imprisonment (Rawlings 1999).
- *Communalism and community as method.* This refers to the use of the community as a therapeutic force. Though relevant to both models, the mutual support offered whereby appropriate behaviour is rewarded by privileges can be problematic in a prison situation where security regulations can impede community-driven action. Thus boundaries between security issues and community decisions must be set.
- *Reality testing and acting as if.* These address the inherent confrontation/contradiction between self-image and peer perception (Rapoport 1960). Each resident is given the freedom to be themselves, but is simultaneously the subject of commentary and responsible concern.

In considering TCs more generally, a review of AOD offender treatment in the US (Center for Substance Abuse Treatment 2005) noted that the unique characteristics of prisons have important implications for developing and implementing treatment programmes. These include the potential for in-prison programmes to maintain individuals in treatment for 9-12 months and follow this up with community after-care. In prison, a comparatively stable treatment group can receive a full range of services, including comprehensive assessment; treatment planning; placement; group, individual, family, and specialty group counselling; self-help groups; educational and vocational training; and planning for transition to the community. The high level of TC structure, hierarchy and intense interventions, lasting a minimum of six months facilitates successful treatment. The efficacy of TCs in UK prisons also receives support from a review article by McMurran (2007) who notes that the most promising interventions around substance use in prisons are associated with therapeutic communities and cognitive behavioural therapies.

Further, there is research considering the impact of intensity of treatment (i.e. TC vs outpatient) on offenders with differing levels of AOD problems. Burdon et al. (2007) followed up 4,165 male and female parolees who had received prison-based TC treatment and who subsequently participated in *either* outpatient only or residential only aftercare. The study examined 12-month recidivism rates, finding participants benefited equally from outpatient and residential aftercare, irrespective of the severity of their AOD problem.

The issue of aftercare has been signalled elsewhere as extremely important, particularly in the context of AOD offender populations. A recent UK review (McSweeney et al. 2008) noted both the success of in-prison TC treatment and the need for adequate aftercare and innovative strategies such as contingency management to promote engagement and behaviour change in offenders following their release. The lack of these undermines the effectiveness of interventions aimed at treating and supervising drug-dependent offenders. Relatedly, Lehman et al. (2009) identified the lack of empirical data describing existing practices between correctional and other treatment services and highlighted the variations in linkages from informal networking to more formal arrangements.

### **2.2.5.2 Co-existing problems and criminality**

Along with an established literature on the efficacy and effectiveness of TCs in treating AOD and offender populations, there are more recent but limited studies considering the impact of TCs on clients with co-existing substance use and mental health problems and criminal histories. In a study of 183 sequential admissions to a modified drug-free TC, Taylor et al. (1997) noted that 48% were found to have had one or more convictions. No differences were observed between convicted and non-convicted admissions regarding differences in length of stay, social adjustment on admission and change in social adjustment during the first two months of treatment. The authors suggest this indicates a history of criminality does not undermine the engagement of these clients with successful treatment in a TC.

More generally, it is recognised that many offenders with AOD issues also suffer from co-existing mental disorders (Center for Substance Abuse Treatment 2005). These issues require assessment with the prospect that they may resolve over time in the absence of substance use. A 1998 study of US offenders estimated 283,800 inmates and a further 547,800 probationers reported suffering a mental disorder and/or had stayed overnight in a mental institution (Ditton 1999). She reported that rates varied across setting, with 16% of State prison and probationers, and 7% of Federal prisoners reporting a mental disorder or a stay in a mental institution. Rates were higher for women than men and for whites than African-Americans or Hispanics/Latinos. Further, those suffering mental disorders were more likely to have been under the influence of a substance at the time of their offending and substantially more likely to report a history of substance abuse (Ditton 1999). Other US data indicate significant substance use issues for inmates identified as having a mental illness, with 64% reporting alcohol or other drug use at the time of their offending (Peters & Hills 1997). These authors propose that all offenders under community supervision should be assessed on first contact with the justice system, although for those not yet having attained sobriety, assessment should be delayed four to six weeks. They also note the successful deployment of prison TC programmes, some of which are modified to cater for the specific needs of this sub-population.

### **2.2.6 Dimensions of social functioning**

Gowing et al. (2002) note that assessing the effects of TCs on social functioning is more difficult than with other measures due in part to variability of outcome measures between studies, but also because aspects such as employment are influenced by factors beyond control such as social and economic conditions. These difficulties aside, TC treatment does correlate with trends to increased employment, education and other indices of social functioning. The limited comparisons with other modalities make comment on the relative effectiveness of TCs unviable.

De Leon et al. (1982) report that in a combined two-cohort study, at pre-treatment 66% of graduates and 55% of dropouts were employed for less than a quarter of their employable time. At 1-year post-treatment substantial improvements in employment rates were found with the proportions in this low employment category decreasing to 3% and 28% respectively. Other studies report similar trends. Coombs (1981) notes that 20% of the study's total cohort was employed in the year prior to admission, compared to 54% at follow-up. In comparing long and short-term programme graduates at follow-up, the former were 86% employed and the latter 56%. Similarly, Hubbard et al. (1984) report that for clients remaining in treatment for three or more months, those in full-time work increased from 12% to 25% from pre- to post-treatment.

In a study where all participants were homeless at intake, follow-up indicated 70% were housed at 3 months and 89% at 6-12 months (Burling et al. 1994). A number of other studies reporting similar trends to these and related measures are noted by Gowing et al. (2002:246-8).

## 2.2.7 Factors affecting outcomes

Gowing et al. (2002:248-51) note the association of improved treatment outcomes with a number of factors, including:

- being drug-free on entry into a TC;
- longer treatment duration coupled with participation, engagement and treatment progress (e.g. Nemes et al. 1998, Burling et al. 1994, Toumbourou & Hamilton 1993, Wilson & Mandelbrote 1985, Simpson & Sells 1983, Bale et al. 1980);
- completion of scheduled treatment programmes (e.g. Keen et al. 2001);
- family involvement, including children living with treatment-attending mothers;
- provision of allied services, particularly where these meet special needs, e.g. those associated with comorbidity and cultural dimensions.

Additionally, these authors (2002:252-253) reference a number of other factors that impact on treatment effectiveness. These include:

- time in treatment may be significantly strengthened by the involvement of family in treatment (Broekart et al. (1998));
- treatment success or failure is not associated with gender, age at admission, length of time addicted, age at first addiction, mode of drug administration or being in receipt of a methadone prescription (Keen et al. 2001);
- vocational training and the number of service units (i.e. inpatient group treatment, vocational training, self-help group work etc.) received by clients correlate with post-treatment success in arrest-reductions (Messina et al. 2001);
- Hawke et al. (2000) found adolescent amphetamine-using TC clients were less likely to stay in treatment than those using alcohol or other drugs;
- the significance of cultural components included in treatment was demonstrated by Fisher et al. (1996) with the inclusion of indigenous staff and indigenous Alaskan cultural components. Elements included spirit groups, cultural awareness activities, urban orientation and individual counselling. Although still less than for other clients, retention of indigenous clients increased.

According to Broome et al. (1999), positive outcomes in addiction treatment are the result of a linked series of recovery-related events. Whether a client stays in treatment depends on factors such as early commitment to and engagement with programmes. Client behaviours

provide indices of engagement, such as attendance at counselling sessions and rapport with staff. Factors considered by Broome et al. (1999) included patient involvement criteria, treatment experience, background and programme environment measures for a subset of participants in DATOS. Findings included greater expression of confidence and commitment by clients after three months of treatment where this was aligned with higher motivation at intake. They noted variation across programmes, with greater average involvement by clients in programmes where more social and public health services were used, where consistent attendance in treatment sessions was maintained, and where clients with similar needs were served by the same programme.

These authors also noted that intra-programme variation was greater than variation between programmes, suggesting client attributes and experience significantly influence confidence and commitment to treatment, with the most notable and consistent factor being that of treatment readiness, a component of motivation. This suggests both client and programme factors are important.

A decade later, Simpson et al. (2009) reported on the results of a large UK study that examined client functioning and engagement in relation to staff attributes and organisational climate across diverse treatment agencies and outreach programmes and compared the results with US data. The key findings were that high client scores on treatment participation and counselling rapport were directly associated with higher levels of motivation and psychosocial functioning as well as to staff ratings of professional attributes and programme atmosphere.

## **2.2.8 Assessing costs within and between modalities**

In their review, Gowing et al. (2002) suggest that despite some assessment of TC treatment costs there have been no full cost-effectiveness studies. What data that are available derive from the US. These indicate TC treatment results in significant savings arising from reduced costs of crime and use of health services.

Existing evaluations of TCs suggest that TC treatment is cost effective, cost efficient, or both. Anonymous (1990) carried out a study using the DARP database, reporting greater gains in respect to legitimate income and employment status from pre- to post-treatment for TCs in comparison to methadone or outpatient non-methadone treatment. However, in general, methadone is decidedly more cost effective because it is cheaper. In addition, while the restrictive nature of residential treatment programmes results in greater initial reductions in substance use and criminal activities, methadone treatment is better able to retain opioid-using clients over time (Ward & Sutton 1998).

Flynn et al. (1999) used the DATOS database to assess treatment costs for 502 cocaine-dependent patients, comparing long-term residential and non-residential drug-free treatments. Long-term clients had the greatest pre-treatment costs, the greatest cost reductions in the year following treatment and yielded the greatest net benefits.

Finally, McGeary et al. (2000) looked at costs in the context of a modified medium-intensity TC, a modified low-intensity TC and mainstream treatment. They further divided TC clients into ‘completers’ (retained in treatment for one year) and ‘separators’ (left treatment earlier and often against staff recommendations). Their aim was to assess use of other services, e.g. emergency room visits, detoxification, other types of drug treatment and psychiatric services.

Findings indicated better outcomes for both types of TC relative to mainstream treatment, with cost savings (per client) particularly for the low-intensity programme on a client basis.

It is important, however, to be mindful that there are a number of limiting factors to more fully understanding the cost effectiveness of one treatment modality relative to other interventions. These include a consistent and robust methodology that takes into account agreed upon items to be costed in service delivery and their measurement standardised, as well as greater consensus on what are the appropriate treatment outcomes and how these should be valued and measured (Ward & Sutton 1998).

Finally, it can be argued that given the chronic and relapsing nature of addiction, similar to other medical conditions (McLellan et al. 2000), cost effectiveness and outcomes should be considered from a continuing care perspective. In a review article (Mckay 2009) based on 20 studies over 20 years of treatment, a number of key points emerged. These include:

- a long-term continuing care approach, e.g. from detox through to extended recovery (versus specifying limits on time in treatment) generally leads to better outcomes;
- emphasising collaborations and linkages between specialist care and other services;
- flexible and adaptive strategies in response to individuals' needs;
- regular monitoring of individuals progress and adapting interventions accordingly, i.e. implementing routine outcomes monitoring during treatment.

These key components of a continuing care approach are consistent more broadly with two key themes that arose from a New Zealand review of the literature on residential care pertaining to children and youth (Murdoch & Tyler 2009). Firstly, that the future of therapeutic residential treatment services lies along a continuum within an integrated system of care, and secondly, that maintaining linkages with family and the local community, and ensuring continuing care via follow-up and aftercare, are crucial for long-term successful outcomes.

## **2.2.9 Summary**

The review by Gowing et al. (2002), together with other research considered in the above sections suggest there are few comparative studies of TC treatment with good control of bias and confounding factors. Further, existing data often combines data from TCs with other residential programmes. However, general conclusions can be drawn based on the consistency of outcomes across multiple follow-up studies undertaken in different contexts and in varying time periods. These include:

- it is likely that three or more months treatment is a necessary minimum for internalised changes in patterns of thinking and core beliefs and enduring behavioural change;
- the issue of retention in that 30%-50% of clients remain in treatment around the three month mark, thus a majority of clients leave before effective treatment is embedded;
- a number of possible strategies may be employed to decrease this attrition, including preparatory interventions prior to entry and additional services to meet specific needs (e.g. cultural components);
- TCs do not suit all people and individuals vary in receptiveness as a consequence of their stage of substance use and recovery and other factors; therefore there is a need to link TCs to other programmes to provide alternatives;

- as with other approaches, relapse is common following treatment, in keeping with the chronic relapsing nature of addiction;
- overall, however, levels of substance use are reduced with TC treatment, measurable at two years post-discharge;
- there is a degree of recovery at least similar to and possibly exceeding methadone treatment;
- there are similar findings to those for substance use in relation to physical and mental health, criminality, and social integration;
- while time in treatment (retention) is highly significant it must be coupled with engagement, participation and progress in treatment, thus time is a proxy for other factors;
- it is important to take a holistic approach inclusive of family involvement, childcare, co-existing problems (particularly psychiatric conditions), education, employment and cultural issues;
- there is a need to take a continuing care approach when considering the cost effectiveness of residential therapeutic programmes;
- data on the cost effectiveness of TCs is lacking.

## **2.3 LITERATURE CONCERNING AOTEAROA NEW ZEALAND**

This section discusses New Zealand AOD, mental health and offender populations, and their treatment, where possible focusing on TCs. Related relevant international literature concerning criminality, AOD and mental health has been discussed above (section 2.2). There is a particular emphasis on these populations in relation to Māori given their over-representation regarding AOD use and the justice system. The broader implications of culture in respect to TCs are also discussed. It should be noted that the published work relating to New Zealand is limited.

### **2.3.1 AOD, mental health and offender populations in Aotearoa New Zealand**

As is the case internationally, there is clear evidence of AOD and related mental health issues associated with the New Zealand offender population. Huriwai (2002a) notes estimates of substance misuse in Australasian inmates to be typically between 60%-80%. These levels of substance misuse and mental illness mesh with the correlation between criminogenic needs and recidivism, with the former reflecting aspects of personality, lifestyle, social and situational circumstances. Thus AOD use is one of the key identified criminogenic needs (Huriwai 2002a).

Similarly, lifetime rates of New Zealand inmate psychiatric morbidity have been estimated at over 80%, with evidence of a significant proportion of those suffering mental illness being undiagnosed (Simpson et al. 1999). This is particularly the case for Māori at 14.6% of the population (Statistics New Zealand 2006) who are over-represented in the prison system and also have a higher rate of prisoner suicide (Simpson et al. 2003). Although less so for Pacific Peoples at 6.9% of the population (Statistics New Zealand 2006), taken collectively they are also over-represented on these indicators.

Māori are over-represented in each component of the prison population, being 49.8% and 46.2% of remand and sentenced males respectively. They are also 52.4% of female prisoners. For Pacific Peoples, the pattern varies, with 10.2% and 8.5% of remand and sentenced males respectively being Pacific, while only 2.9% of female prisoners are Pacific (Simpson et al. 2003).<sup>1</sup> Māori prisoners are also significantly younger than others, and Māori and Pacific Island prisoners are significantly less well educated. In respect to mental health, Māori and Pacific Peoples are less likely than other groups to suffer major depression. Simpson et al. (2003) report this as the only difference between self-reported ethnicities in mental health. Non-Māori are more likely to have been convicted of drug offences.

Of further concern was the high level of comorbidity with substance misuse disorders. While 80% of inmates diagnosed with bipolar disorder were receiving psychiatric treatment in the prison, only 46% of depressed inmates and 37% of those suffering from psychosis were receiving treatment (Brinded et al. 2001).

### **2.3.2 AOD, mental health and offender populations in TCs**

These data notwithstanding, there is very limited published research describing the profile of individuals (including offenders) entering therapeutic communities in New Zealand. However, a recent New Zealand study (Mulder et al. 2009) that examined the three-month retention rate in Odyssey House, Christchurch, provided a profile of residents on entry, which was consistent with overseas findings. Of the 187 men (range 17 years to 50 years, mean  $\pm$  sd =  $29.3 \pm 8.1$  years), the majority (65%) had more than 20 convictions and most (71%) were in treatment under a Court Order. Lifetime substance use disorders included alcohol (87%), sedatives/hypnotics (67%), opioids (59%), stimulants (55%), hallucinogens 34% and cocaine (10%). At entry, multi-drug use was common with 31% dependent on opioids, 31% cannabis, 25% alcohol, 19% stimulants, and 16% on sedatives/hypnotics. Lifetime psychiatric conditions amongst these residents were also common: depression (44%), bipolar disorder (24%), social phobia (31%), post-traumatic stress disorder, generalised anxiety disorder (20%), pathological gambling (17%) and anti-social personality disorder (91%). Depression was the most common diagnosis on entry (28%).

### **2.3.3 Retention and other outcomes**

Mulder et al. (2009) found the three month retention rate amongst the Christchurch Odyssey male residents to be 57% (107/187), which is moderate to high in comparison with other studies. No significant association was found between ethnicity (Māori versus non-Māori), legal status (court order versus voluntary admission), spiritual identification or the importance of cultural identity. Consistent with the literature on social support and retention (e.g. Soyez et al. 2006), although not statistically significant, 69% per cent of those who were retained at three months reported family support compared with 52% of those who left treatment. Those who remained in treatment for longer than three months were more likely to have lifetime depression but overall better mental health on admission as measured by the SF-36 (Ware et al. 1993). They were also more likely to have current sedative/hypnotic dependence but less likely to have lifetime stimulant dependence. The findings from this study support improving mental health and social support at admission and specifically focusing on those with lifetime stimulant dependence, as well as attending to the factors known to support engagement more generally with all entrants.

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<sup>1</sup> Simpson et al's (2003) paper used data from the 1999 Census. Māori and Pacific Peoples' populations had increased by 0.5% each by the 2006 Census (Statistics New Zealand 2006).

An unpublished report of a summer studentship at Higher Ground Rehabilitation Trust (Gordon 2005) identified nine intermediate outcomes resulting from successive intervention episodes. These included:

1. understanding the realities of addiction;
2. accepting the need to ask for help;
3. understanding more about themselves and accepting self responsibility;
4. learning strategies to avoid drug use and understanding relapse prevention;
5. learning how to relate to others;
6. rebuilding family relationships;
7. gaining spiritual values;
8. increased feelings of self-worth and looking to the future;
9. desire to help others and contribute to society.

Conclusions reached were that individuals with drug dependence tend to have multiple and successive treatment episodes, and that each episode is associated with significant changes in attitudes, beliefs and behaviours with the identified intermediate outcomes reflecting steps in the recovery process. These conclusions are consistent with the broad definition of retention incorporating multiple episodes of treatment suggesting a cumulative treatment effect (De Leon 2000).

### **2.3.4    Kaupapa Māori approaches to treating AOD, mental health and offender populations.**

The articulation of indigenous models of treatment and care challenge notions that assimilation is the only solution to providing better futures for indigenous peoples. The ‘development’ of these models has been given particular potency by perceived shortcomings of Western-based treatment models to deliver responsive and effective outcomes. What indigenous peoples agree is vital for indigenous programmes of recovery is the provision of a framework which, when applied around a treatment model or programme, can reconstruct cultural reference points that support participants to reclaim the healing mechanisms of their cultural worlds and offers a better understanding of the process which allowed whānau, hapu and iwi losses to occur.

Coyhis and White (2002) identify among indigenous peoples of North America, five movements that link an individual’s health and sobriety to the survival and health of the tribe. Each movement operates on a multidimensional level, with each containing a unique combination of spiritual/religious rebirth, cultural revitalisation, personal healing, and, in some cases, political advocacy.

In Aotearoa New Zealand, there is still a dearth of indigenous literature related to specifically treating tangata whaiora with addiction (a generic term to denote alcohol and other drug as well as problem gambling) or mental health issues or, to a lesser degree, for treating Māori offender populations. What literature there is appears to concur in placing wellness and treatment in the context of holistic reintegration and the reclamation of 'tikanga' constructs. Such Māori-centred approaches are characterised by Māori experience, Māori values, and Māori aspirations being central to treatment delivery.

In a broader sense, efforts to reclaim tribal health and wellbeing for whānau and hapu members may be seen as located in a circular history where rangatiratanga - colonisation - decolonisation - rangatiratanga are made to evolve in response to each other. Approaches that

respond to whānau, hapu and iwi losses as a result of the colonisation process are the drivers for decolonisation efforts to re-order, re-centre and re-prioritise whānau, hapu and iwi members in their societies.

Many Māori commentators have come out in support of decolonisation as the pathway forward including Ngāti Raukawa ki te Tonga scholar Hayley Susan Bell (2008) who compares colonisation to the coercive and illusory reality created in the popular series of Matrix movies, and argues that the whakawātea process of decolonisation is about "exiting the Matrix". Thus where the Matrix movies saw humans trying to disconnect their minds from a controlling programme, decolonisation works at disconnecting the mind from the colonisation programme.

Similarly, Ngāti Porou/Ngāti Awa scholar Linda Tuhiwai Mead (1996) suggests that decolonisation is still considered a major task for the world's colonised people such as iwi Māori of New Zealand and that there is never a point when decolonisation will not be important even if rangatiratanga is attained.

Andrew Eruera Vercoe (1998) notes that tino rangatiratanga is a total transformation of society that requires a programme of decolonisation which effectively educates people about the history of this country. His belief is that the dark age has interrupted the normal course of societal evolution, ultimately crippling the capacity of iwi to develop and that dependency can only be overcome by enabling Māori to go through a lengthy period of decolonisation.

The role of educating those trapped in the colonisation matrix is a significant feature of any decolonisation programme that attempts to decolonise minds through re-education. This can take the shape of overt decolonisation agendas like Treaty of Waitangi workshops that have specific agendas to decolonise at one end to the more subtle presentation of "Kaupapa Māori" models at the other which often do not make obvious the relationship to colonisation impact.

Ruwhiu (1995), Turia (2000) and Walsh-Tapiata (2000) are also amongst Māori writers who have explored the link between colonisation and whānau, their works being immersed in the stories of whānau who are yet to live authentic Māori lives where they are proud to be Māori, celebrate being Māori and practise the skills, traditions, and beliefs of their tupuna in the modern world. In this authentic Māori life whānau provide support for many, intermarriage ensures that their wairua remains connected to tupuna as well as ancestors from other lands. They stand strong in Aotearoa and in many other lands, comfortable in the many paths that they follow and able to pursue their dreams.

Royal (1999) explains this authenticity in terms of knowledge of truth that sets people free. He speaks of the search for authenticity through the seeking out of a collective or individual identity and links it to one's own humanity.

In her work Bell (2008) argues that colonisation has had a major impact on the lives of Māori and the racism associated with the colonisation has had major effects on wellbeing. She questions the attention that is paid to whānau who are not enjoying this reality, who are still suffering and unwell. Whānau members evident in AOD, mental health and offender populations are examples of these whānau.

Durie (2003) describes those who have become trapped inside intergenerational lifestyles of abuse, addiction, poverty, poor mental health and offending histories as not participating in the positive development of te ao Māori in the 21st century.

Bell's (2008) study is based on the belief that all Māori have not had the opportunity to learn about themselves—therefore their true selves are not set free.

Moana Jackson (2004:102) argues that colonisation has been an attack on the Māori soul:

The attack on their soul was so terrible that it would lead to a weakening of faith in all things that had nourished it. The demeaning of the values that cherished it, the language that gave meaning to its soul, the law that gave it order and the religion that was its strength were ultimately to affect the belief of Māori in themselves.

Alongside this indigenous literature that sets out colonisation cause and decolonisation solutions, other literature has appeared for treating Māori individuals with AOD or mental health issues or, to a lesser degree, for treating Māori offender populations. This approach to creating cultural treatment models can be described as Kaupapa Māori and is used across spheres and sectors like AOD, mental health and offending. The growing body of literature regarding kaupapa Māori theories and practices asserts a need for Māori to develop initiatives for change that are located within distinctly Māori frameworks.

Durie describes the approach as a holistic phenomenon that values the interconnection between spirituality, nature, ceremonialism and kinship. Durie (1994:72) states:

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.

Smith and Cram (1997) go further to suggest that Kaupapa Māori is also about thinking critically, including developing a critique of Pakeha constructions and definitions of Māori and affirming the importance of Māori self-definition. Similarly, both the global indigenous and the Aotearoa New Zealand approaches seem driven by notions of holistic reintegration and the reclamation of tikanga constructs. Such Māori-centred approaches are characterised by Māori experience, Māori values, and Māori aspirations being central to treatment delivery.

Māori health perspectives characteristically emphasise balance and integration across a number of personal, environmental, cultural and spiritual dimensions. In contrast, reductionist Western models historically have separated these areas and concepts of identity and health, which have instead tended to be based on individual autonomy while traditional approaches saw the whānau as the basic social unit in a hapu context with wellbeing as a collective responsibility for all members.

Huriwai and colleagues (Huriwai et al: 2001), in their exploration of what works for Māori in AOD treatment, describe Māori wellness as usually including a sense of identity and self esteem as Māori; confidence and pride; spiritual awareness; personal responsibility; knowledge of Te Reo and tikanga Māori and whānau support.

While Kaupapa Māori approaches can be applied across a range of sectors, it is germane to the present discussion to examine endeavours to apply them specifically to a treatment paradigm (i.e. concerning the addictions).

### **2.3.4.1 Addiction**

A number of Māori health conceptual frameworks, within which treatment is provided, have been adapted to address AOD problems. These include, Te Whare Tapa Wha, Te Wheke, and Poutama o te Powhiri (Durie, 1999). A number of process models have also been developed to guide practice e.g. powhiri poutama, dynamics of whānaungatanga and the Rangi Matrix (Huriwai et. al, 2001). Information has also been presented on the preferences of Māori clients (Huriwai et al., 1998; 2000) and potentially important constructs in treatment (Huriwai et al, 2001; 2002b [i.e. the Optimal Treatment Study]). Additionally, data have been published in relation to the perceived specific needs of Māori undertaking alcohol and other drug treatment (Huriwai et al, 2001). However, to date there has been little systematic documentation of treatment practices, and limited operationalisation of Māori health frameworks and practice models.

The evaluation of the outcomes of indigenous AOD treatments is an area in which there is a paucity of information, in terms of methods and frameworks for evaluation, and actual data. One of the earliest reviews of Māori outcome was undertaken by Faisandier and Bunn (1997) who examined the outcomes for Māori who had completed the treatment programme at Queen Mary Hospital. The former of these authors (Faisandier & Bunn, 1997) deployed a basket weave metaphor to describe the parallel tracks of the Queen Mary Hospital programme—Hanmer and Taha Māori—during their evaluation of it. Bunn writes that a cautionary note needs to be considered when evaluating or developing a programme with 'cultural and clinical elements' and cites Dr Mark Schuckit:

...it should be clear from the start that the aim of the programme is patient care—not social reform. Confusion here can lead to feelings of frustration and betrayal with resultant destructive in-fighting" (Schuckitt & Cahalan, 1970, cited in Faisandier & Bunn, 1997).

In mid-1999 work began on reviewing data covering the period of August 1997 through August 1999 on 128 Tauira (patients) admitted to the Taha Māori Unit at Queen Mary Hospital. This review is one of the earliest attempts to look at outcome for Māori. The review found the tauira were experiencing alcohol and/or other drug related problems earlier in life (average = 12 years old). A large percentage with at least one member of their whānau with a serious alcohol/drug problem. Ninety percent of tauira had had some kind of treatment prior to entering Queen Mary Hospital. The extent of medical problems experienced by the group of people exceeded what one would expect in the normal Māori population in the age range. "Almost two-thirds of Hanmer Programme clients (63%) have had a conviction at some time in their lives, as compared with 82.4% of the Māori clients" (cited in Thomas, 2002).

Comparisons between entry and exit questionnaires (indicators being maturity and coping) were positive, indicating that over a period of eight weeks, the majority of tauira reported positive and significant changes in the following areas: quality of life, including major improvements in mood; anxiety; anger and violence; shame, guilt and low self-esteem. The insights many tauira gained regarding what is "normal" are the first they had experienced in their lives. It frequently activated a sense of "things could be different".

Strength of identity issues, including improved strength of Māori identity, more positive feelings about the experiences of being Māori, and more positive about their non-Māori side too, were experienced. This change probably is the most pronounced that tauira experience, especially those who are admitted with little, or no, appreciation or understanding of their heritage. None are more dramatic than those who enter Queen Mary Hospital on the Hanmer Programme and then request a shift to Taha Māori after a few weeks in treatment.

Faisandier and Bunn's (1997) review did not look in any depth at the components or processes of the programme and their relation to outcome.

It is notable that in a review of evaluation approaches for indigenous programmes in Australia and Canada, there were no suitable generic models identified (Gray et al, 2002:123). However, these authors observed that subsequent reviews and experience in working with Aboriginal community organisations suggest a number of general principles pertinent to undertaking evaluations of any health and substance abuse programmes for indigenous peoples. Of critical importance is realising that evaluation is not politically or ideologically neutral and acknowledging differences in agendas between those of indigenous peoples and those who seek to evaluate indigenous programmes. In New Zealand, the development of Hua Oranga (Kingi & Durie, 2000) is beginning to address the lack of frameworks. Nonetheless, further work is needed, especially with a specific focus on alcohol and other drugs.

As well as the work generated by the Optimal Treatment Study (Huriwai et al, 2000), the then National Centre for Treatment Development (NCTD [renamed the National Addiction Centre—NAC]) also took the opportunity to examine clinician beliefs and practices in their inaugural and subsequent telephone surveys. Robertson et al. (2001) found that there was strong support by workers for consideration of the specific needs of Māori and adjustment of clinical practice when working with this client group. The survey indicated that a broad range of people in the AOD sector were making efforts to be more responsive to the needs of Māori clients. Workers were more likely to intervene in a culturally appropriate way, rather than refer a Māori client on to someone else for this, if they were themselves Māori or Pacific, worked in outpatient settings and were based in North Island rural/provincial settings.

In arguing that attention to ethno-cultural factors contributes positively to the process and outcomes of treatment of alcohol and drug-use related problems for indigenous people, Huriwai and colleagues (2001) described cultural linkage as a form of cultural entitlement and cultural enhancement as the reconnecting of Māori with aspects of their heritage and affirmation of aspects of their identity in the process of treatment. They discussed the importance of cultural connectiveness –pride in being Māori and a sense of belonging to an iwi, to retention and satisfaction in AOD-user treatment. However, they agreed that both cultural linkage and cultural connectiveness are simplistic descriptions as they ultimately fail to account for the complexity of contemporary whānaungatanga and re-enculturation processes.

Huriwai et al. (2001, 2002b) support the proposal of whānau being a key component of Māori identity and the healing process and a core feature of Kaupapa Māori theories of social change. Values and practices derived from whānau can be used to facilitate teaching, learning and change. However, of importance is that advocates of whānau and whānaungatanga models recognise that an overly reductionist examination of the process will be fruitless as the cultural and spiritual context is unlikely to be taken into consideration, given the process that reductionism is. Whilst reconnection with whānau is likely to be important for some it is only a part of the process of healing. Development of greater understanding of healing processes relevant to Māori is needed if clinical and cultural based processes are to be successfully integrated.

### **2.3.4.2 Māori offender populations**

In Aotearoa New Zealand the Department of Corrections is charged with the management of Māori offenders (likewise for non-Māori offenders) from assessment to intervention. The Department's approach is primarily based on ensuring the safety of the public. They also have

goals relating to targeting rehabilitative efforts likely to result in a reduction of re-offending. Some of the Department's motivational, rehabilitative and reintegrative programmes have incorporated tikanga Māori such as:

- Motivational tikanga Māori programmes to develop offenders' awareness and responsibility for behaviour and its impact on themselves, their whānau, hapū and iwi.
- Māori therapeutic programmes at five Māori Focus Units that integrate cognitive behavioural therapy and tikanga Māori concepts.
- Māori Focus Units functioning as therapeutic environments where staff and prisoners work together to promote learning and application of the principles of tikanga to thoughts, beliefs and actions.
- Bicultural Therapy Model that offers Māori offenders options to work with a psychologist or a Māori service provider or both.

These initiatives endeavour to not only engage Māori offenders in a pro-social process of change but also build the capability of the Department's workforce. The Department of Corrections has undertaken a number of reviews and evaluations of its rehabilitative programmes, including those with a Māori focus or utilising Māori values and practices. Ultimately these evaluations are looking at reductions of offending; however a range of other outcomes are noted.

Te Ihi Tu - is a Community Residential Centre based in the Taranaki—a specifically tailored Kaupapa Māori intervention that provides a structured environment for high-risk offenders to undertake rehabilitation programmes and reintegrative services for safe repatriation into the community. The 13-week programme implements a range of interventions within a tikanga Māori framework. It does not cater for any sex offenders, including child sex offenders. The evaluation by the Department of Corrections (2008) found that the tikanga Māori basis to the programme was a key reason noted by clients in choosing Te Ihi Tu over other available programme or service options. Many clients stated that they would not have applied for entry had it been a mainstream programme; this was especially the case for those who were from outside Taranaki. Factors inherent to the tikanga base that were of particular value to participants included the following: Te reo Māori, tikanga, tika and pono and a focus on whānau. Unfortunately, the analysis of reconviction and reimprisonment data did not reveal positive programme effects. Rates of reconviction and reimprisonment amongst participants in the years 1997–2006 were substantial, and slightly higher than might have been expected in light of their risk profile. Further, the Rehabilitation Quotient matched control methodology (“RQ”) found no differences in rates of reconviction and reimprisonment between treated and untreated offenders.

Nathan and colleagues (2003) reviewed the Te Piriti Special Treatment Unit at Auckland Prison - a programme for male sex offenders to reduce sexual re-offending against children. Te Piriti blends a cognitive-behavioural therapeutic environment within a tikanga Māori framework promoting precepts, such as mana, tautoko, whakawhānaungatanga and tika to ground participants within the therapy programme. The review found that tikanga used in combination with CBT appears to be an effective treatment programme for Māori men, with significant change from pre- to post therapy in a number of key cultural variables, including knowledge of whakapapa, mate Māori (sickness)/makutu, Māori traditional values and beliefs, knowledge of marae protocols and cultural skills. In terms of reducing sexual reconviction for Māori and non-Māori men, it had a 5.5% recidivism rate compared to an untreated group who had a sexual recidivism rate of 21%.

The most recent evaluation by the Department of Corrections (2009) examined the Māori Focus Units and the Māori therapeutic programmes. Evidence was found that the MFUs are offering the full range of tikanga based courses and activities, regular involvement of local iwi groups, and functioning prisoner-staff forums for decision-making. There was also a large amount of information supporting a positive and pro-social environment in these units, which is conducive of learning and change. With respect to learning, the evaluation also found MFUs' participants acquiring new knowledge in relation to tikanga Māori. In terms of those participating in the Māori therapeutic programmes, the evaluation found participants displayed positive change in terms of attitudes and beliefs related to criminal lifestyles. Finally, relatively small but positive changes were found in terms of reduced reconvictions and re-imprisonments for both MFU and MTPs.

The evaluations being undertaken by the Department of Corrections appear to be highlighting the use of Māori processes and values as a means of engagement (both with Māori and non-Māori) and therapeutic value. Additional findings include:

- Potential incompatibility in using North American psychometric instruments with Māori and awareness of the need for more research into the validity and reliability of such measurements for use with populations in Aotearoa New Zealand.
- Te Piriti model considered a robust and rigorous cultural assessment tool needing to be piloted in other cultural initiatives within Corrections to demonstrate the impact of tikanga principles across programmes.

#### **2.3.4.3 Mental health**

Mental health services in Aotearoa New Zealand have undergone a transformation over the past 30 years through the introduction of Māori health perspectives into treatment and care.

With the establishment of Māori models of health and intervention, Māori workforce development is now being targeted as a key driver for increasing Māori health gains. In building on these significant achievements and in drawing discussion and debate threads together, the Mental Health Commission (2001) produced a checklist for mainstream mental health providers in developing models on how best to deliver mental health services to Māori. In meeting the requirements of the blueprint in Aotearoa New Zealand the checklist identifies:

##### *1. By Māori, for Māori*

Mainstream services as the Crown partner to the Treaty of Waitangi, must acknowledge the right of Māori to ownership and delivery of services for Māori within mainstream services. Mainstream services need to promote this right by practising the protection, partnership and participation principles of the Treaty through forging a formal relationship with Māori in their area. A Māori mental health workforce, with knowledge and experience to meet the clinical and cultural needs of tangata whaiora is the key to achieving effective mainstream services for Māori.

##### *2. Linking with local iwi*

A relationship needs to be created and developed with local iwi to assist the service in its development.

##### *3. Māori models of practice*

Mainstream services must acknowledge Māori tino rangatiratanga in Aotearoa by working with local Māori models of health.

#### *4. Tangata whaiora-centred clinical and cultural pathways*

Tangata whaiora must have access to a choice of the best clinical and Māori treatment interventions delivered in a way that they choose: by whom, where and when.

#### *5. Whānau involvement*

Whānaungatanga is the inclusion of whānau in the decision making process from assessment through to discharge planning. The whānau, whose membership is defined by the person using the service, is one of the cornerstones of a person's health. With guidance from the person using the service, the whānau needs to be an integral part of the person's programme towards recovery.

#### *6. Tangata whaiora participation in service development*

Services need to have a formally negotiated partnership and collaboration with tangata whaiora in the planning, development, delivery, monitoring and review of the service. This is the foundation for providing services that Māori will choose to use.

#### *7. Linking with people outside mental health services*

With the person's consent, other people involved in their life should be included in their overall recovery plan.

#### *8. Measuring results*

There should be a formal process for evaluating changes in a person's health, as perceived by tangata whaiora, whānau, clinicians and other people closely involved in the person's life. Māori should carry out assessment of mainstream service for Māori.

While these eight points are not entirely incongruent with the development of Kaupapa Māori services, specific Māori drivers for development would ensure the inclusion of other mechanisms inherent in the literature to date to give effect to successful delivery including:

- Kaumātua influence and guidance in service development and delivery.
- Recruitment and retention of skilled practitioners who can competently work across whānau, hapū, iwi and other configurations of Māori communities.
- Development of identity for both kaimahi and tangata whaiora encompassing Te Reo (Māori language), tikanga (values and beliefs) and Māori models of practice.
- Specific workforce development opportunities for kaimahi.
- Provision of training/education/information about kaupapa Māori approaches to external organisations within the mental health sector.
- Ability for kaimahi, tangata whaiora and whānau to participate at all levels of mental health service and Māori mental health service development.
- Research that supports further development for tangata whaiora and their whānau.
- Clear accountability externally to mana whenua.
- A physical environment that is supportive of belief systems (i.e. marae based).
- Working responsively with whānau, hapū and iwi.

#### **2.3.4.4 Broader cultural considerations in treating the above populations**

The last 20 years has seen indigenous addiction issues increasingly become a global matter as indigenous peoples who, in experiencing the uncompromising process of colonisation, have become alienated from their cultural points of reference. In describing the impact of colonisation on tangata whenua of Aotearoa New Zealand, Marsden (1986) focused on the effects of having one people's philosophy imposed on another and how this oppression can lead to serious mental and spiritual disorders.

This period of indigenous self-critique has coincided with the Māori development agenda of the last 25 years—an agenda that has endeavoured to create more potent socio-economic futures for whānau, hapū and iwi and other Māori communities in moving toward autonomy and self-determination—the rangatiratanga guaranteed protection in the Treaty of Waitangi. It has seen cultural treatment models challenge long-held notions that the adoption of Western-based constructs is the best solution to providing recovery for indigenous peoples. In helping to introduce the dialogue, Mason Durie asked that if the methodologies and the rationales used were not linked to Māori realities, they were not going to have much impact or be of much use to anyone later on. Without discounting Western methodologies, he asserted that the approach needed to take account of the values of the people being researched (Wood, 2002).

Meyer (2008) supported this thinking in noting that there is a growing body of research, especially in Canada and the US, and to a lesser extent in Australia and New Zealand, which indicates that indigenous populations derive greater benefit from the use of their own traditional healing methods, applied in their own unique settings, than they do from the treatment methods of Western culture alone. Brady (1995) too comments on the innovative interventions of indigenous people in Australia and Northern America who are incorporating traditional healing methods and cultural values into otherwise Western treatment modalities.

A list of therapeutic benefits identified by Brady (1995) and Marsden (1986) includes:

- commitment: rationales for abstinence are culturally framed for the benefit of the community;
- purification, both physically and spiritually;
- substitution, replacing alcohol with sacred substances;
- the affirmation of personal and cultural identity;
- reconciliation, the mending of family and social relationships.
- a reconstruction of values and daily lifestyles;
- re-connection to a community, which supports recovery in an appropriate cultural context;
- celebration and participation in rituals that confirm pro-recovery values and relationships;
- using the ancient oral tradition of storytelling to communicate life-changing events. (A familiar method for those who attend AA, NA, or similar meetings); and,
- meaning: communicating a worldview of oneself and one's sobriety within the context of one's culture.

These are in keeping with the individual and collective range of indigenous approaches to wellness, health and being which stem from a mutually common world view that values balance, continuity, unity and purpose and responds to the physical, mental, spiritual and community dimensions that describe the whole. The reclamation of these traditional dimensions of healing with their abundance of techniques has seen an early 1990s emergence of an international healing movement—Healing our Spirits Worldwide—in which Canada, Australia and Aotearoa New Zealand have played leading roles.

In relation to kaupapa Māori in research, Moana Jackson (cited in Cram et al, 2006:16) states:

We have to accept that the Treaty did not submit us to the research methodologies and ethics of somebody else. The Treaty affirmed our right to develop the processes of research which are appropriate for our people, and to do that, the only people we have to seek permission from are our own.

Furthermore, this Kaupapa Māori approach has necessitated developing a critical mass of researchers, teachers, practitioners and evaluators who contribute to the development of robust tikanga-based response frameworks to address the multiple colonisation outcomes impacted on whānau members.

In Aotearoa New Zealand pre-European health systems valued tapu and noa as underpinning a system of "public health" which saw spiritual and social health linked with elements of physical health (Durie, 2006). Between 1800 and 1900, the balance between the dimensions of mana atua (the power of the spiritual realm), mana tangata, mana whenua, and mana Māori (Māori control over their own matters, the Māori political dimension) was overturned. Mason Durie (1995) also gives an equal place to the effects of the loss of mana atua.

Introducing Whaiora Durie (1995:1) said: "Māori health development is essentially about Māori defining their own priorities for health and then weaving a course to realise their collective aspirations". Durie envisages development as not just a goal, but a way of approaching Māori health, in which Māori have control over the strategies used, manage and deliver their own services taking a preventive and integrated approach, and work in partnership with the State. Durie further asserts that enough is known about health to justify an integrated approach to cultural, social and economic development and to recognise the futility of designing highly sophisticated treatment procedures while blatantly ignoring educational failure or inadequate housing (Durie 1995:1-2).

## 2.4 THERAPEUTIC COMMUNITIES IN AOTEAROA NEW ZEALAND

There are at present a number and variety of therapeutic communities operating in Aotearoa New Zealand. Some of these are independent or private while others are associated with the Australasian Therapeutic Association (ATCA). The latter include:

- **Care NZ** is New Zealand's largest residential TC operation. In partnership with the Department of Corrections, Care NZ has established Drug Treatment Units within women and men's prisons in both the North and South Islands.
- **Higher Ground Drug Rehabilitation Trust**. Established in Auckland in 1984 to provide treatment for people with severe dependence. This TC provides a 18 week residential programme modeled on 12 Step recovery principles.
- **Odyssey House Trust Inc.** (Auckland). Odyssey House, Auckland, opened its first TC facility in 1981, employing graduate and non-graduate staff seeded from an Australian Odyssey House. It now operates a number of diverse programmes and facilities across multiple sites, employing approximately 100 people. These include an adult and young adult residential programme, a family residential programme (inclusive of children aged less than 12 years), a youth residential programme, a programme for people with co-existing mental health problems, transitional houses and a mobile community programme that provides assistance to people who have had previous contact with Odyssey House.
- **Odyssey House Trust Inc.** (Christchurch). Odyssey House Trust Christchurch was formed in 1985, seeded from Australian and Auckland Odyssey Houses. Similar to

Odyssey Auckland, Odyssey Christchurch employs both professional and graduate staff. The TC programmes comprise mixed gender youth residential and day programmes and a residential programme for adult men. This programme caters for up to 22 men and is of up to 15 months duration. A transitional house is available to men transitioning from the residential programme to independent living.

- **Moana House**, the subject of the present evaluation, is an 11 bed TC for recidivist offenders in Dunedin. It is run under the auspices of a charitable trust, the Downie Stewart Foundation. The trust was set up in 1984 and in its current form was opened in October 1987. Moana House was initially set up along the European ‘Democratic’ lines. Following limited success with this approach it adopted a more ‘Concept-based’ hierachic and group-based model, which improved the programme’s performance (Meyers 2008). Presently those residents completing treatment live at Moana House for approximately 18-24 months. With a strong tikanga Māori emphasis, Moana House has developed a unique bicultural programme (though also acknowledging the significance of Pacific Peoples) of four stages, each more difficult than the previous and with no set time spent in each.

## 2.5 MODELS OF PROGRAMME EVALUATION

Evaluations must do more than objectively looking at a programme, they must explore the needs of the community and the individuals affected by the programme and its outcome measurement. Having noted this, most evaluations are constrained by resources, particularly time and cost (Health Canada 1998).

Organisations choosing to be evaluated must accept this process openly to facilitate potential transformation. Evaluations are, however, likely to have their roots elsewhere, which may be a source of resistance. Particularly in this case the programme’s ‘spirit’ will be of central concern to the programme, along with the operations and outcomes of their service (Jorgenson 1987). If possible, therefore, the evaluation should be integrated into the programme so it becomes a part of the organisation and the staff (and clients) are not merely passive recipients of the process.

A number of limitations to Western evaluation models and approaches used in a first nations or indigenous context may exist (the example noted above involved a Canadian Aboriginal project, The Four Winds Development Project; see Health Canada 1998). While the limitations in that case were directed at educational evaluations, it is proposed there is a two-fold relationship to substance misuse. Firstly, the implications of education as a healing mechanism for the consequences of substance misuse and secondly, that the medical model of substance abuse treatment uses similar values to education. Thus, programme efforts are focused on individuals judged to be deficient in certain areas. Therefore, although the example above describes an evaluation project developed in the mid 1980s, its perspectives remain relevant when developing contemporary evaluations, and the following limitations pertaining to models of evaluation are worthy of reiteration:

- the focusing on an individual in which a standard or normal person is defined and each person is then compared to this standard. (In the Four Winds holistic view, screening and testing instruments were proposed to arise from an interrelation of physical, mental, emotional and spiritual aspects of the individual);

- the evaluation usually focuses on a single aspect of a system—the client, with remedial action being required if standards are not met. Thus the system itself is not tested or evaluated;
- remedial actions isolate behaviours from their context or environment rather than transforming the context. This is contrary to a community-focused approach (see also Health and Welfare Canada, undated).

## 2.5.1 Indicators of programme effectiveness

Section 2 above has outlined the literature on programme effectiveness. While the customary indicators in a general sense include the rates of success in achieving abstinence and programme completion, it was also noted (e.g. Bale et al. 1980) that there are many difficulties with obtaining some of these data, both from a client and a systems perspective.

A brief summary of measurable outcomes/indicators from an Indigenous Canadian context follows (Health Canada 1998:14):

1. *Factors outside of the programme's control*
  - i. Demographic variables: age, ethnicity
  - ii. Abuse history (onset, severity, primary substance)
  - iii. Criminal history
  - iv. Psychiatric history
  - v. Education and dropout
2. *Factors related to the programme*
  - i. Residential treatment length
  - ii. Outpatient treatment length
  - iii. Client perceptions and attitudes towards treatment
  - iv. Experience of programme staff
  - v. Application of pragmatic problem solving by staff
  - vi. Provision of special services (e.g. recreational, educational)
3. *Post-treatment factors*
  - i. Drug cravings
  - ii. Lack of involvement in productive activities
  - iii. Lack of involvement in leisure activities

## 2.5.2 Types of evaluation

While organisations should anticipate on-going evaluation of their functions with links to planning and operations, evaluations should depend on established objectives from which progress can be measured. Three broad types of evaluation are (after Health Canada 1998):

- *Needs assessments.* Conducted at the planning stage of a programme, aimed at addressing the community's needs and its goals
- *Process evaluation.* In other words, operational review or formative evaluation. Although a common type of evaluation, a frequent problem with it concerns the frequent lack of engagement with a programme's outcome results

- *Outcome evaluation.* As in the present case, this evaluation measures the impact of the programme on the target population. Consequently it is usually completed once the programme has been in operation for some time. It is expected that in this type of evaluation, residents and their wider community, along with staff, are engaged with. In outcome evaluations there are three types of effectiveness that can be measured (Correctional Service of Canada 1992):
  - i. Immediate outcomes—did the programme change attitudes and behaviours?
  - ii. Ultimate outcomes—does the programme actually reduce substance misuse/offending? What is the impact on the community?
  - iii. Differential effectiveness—is the programme more effective with some clients than with others?

### **2.5.3 Sources of information**

There are a variety of data sources available, both qualitative and quantitative. The latter provides the ‘hard proof’ of the impact of a programme, such as lowering substance misuse rates or criminal recidivism. The former allows a dynamic approach to obtain information from various stakeholders by giving them a ‘voice’.

#### **2.5.3.1 Client data**

This is essentially a quantitative component, systematically collecting demographic, life history and substance use information. Examples previously noted include large data bases associated with studies such as TOPS (Hubbard et al. 1984), DARP (Simpson & Sells 1983), DATOS (Simpson et al. 2002) and NTORS (Gossop et al. 2003).

#### **2.5.3.2 Organisational information**

The programme itself is an actual repository of information for evaluation. Included here should be the programme’s philosophy, its mission, goals and objectives. Also systems management (including annual reports), service delivery standards, staff qualifications, staff moral, environment, measures of client and staff satisfaction with the programme, cost of the programme (either per participant or by some other measure) along with observations about how the programme functions (Health Canada 1998).

#### **2.5.3.3 Community information**

Health Canada (1998) proposes that in the context of Aboriginal substance misuse prevention and treatment, community surveys and forums should become an integral component of evaluations. The authors note, however, that this methodology is rarely deployed. However, the concern of the community regarding substance misuse and offending, and the impact of programmes on the community suggest that this approach could potentially generate improvements to meet community needs. A more readily applied approach in this regard is to include community members among key informant interviews.

#### **2.5.3.4 Focus groups**

Focus groups (Krueger 1997) typically number 8-12 individuals, with the topic of interest being discussed under the direction of a facilitator. While the facilitator may direct the conversation to engage with issues of interest for the evaluation (Health Canada 1998), focus groups allow those present to draw to the attention of the facilitator issues that might

otherwise have not been considered. Primary data from focus groups are the transcripts of the group discussion. Focus groups may aid evaluation by:

- Obtaining general background information about programmes
- Isolating problem areas
- Gathering information about clients' perceptions of programmes

Groups may be comprised of programme clients and family of clients, stakeholders (board members, officials allied with the programme, funders etc.), staff, and community members (for example neighbours of the treatment facility). By narrowing the discussion's focus to include the interests of the clients they may develop a sense of ownership of the evaluation and feed further information into the evaluation (Race et al. 1994).

#### **2.5.4 Evaluation team**

Health Canada (1998) notes the complexity of assembling teams for the evaluation of TCs and related treatment programmes. While there is a need for objectivity and therefore external observers, nominated external personnel should most appropriately hold similar values to the community or programme being reviewed. Thus evaluators may be peers from similar programmes or professionals specialising in such evaluations.

While there is an expectation of objectivity, and therefore externality of personnel in evaluations, the option of a partnership between evaluators and the programme being evaluated is a further option. Stevens and Morral (2003) note this regarding an evaluation by the Center for Substance Abuse Treatment (RAND Drug Policy Research Center, Los Angeles) and Phoenix House. This allows the programme under evaluation to take on an active role in the process.

Health Canada (1998) also observes that while there may be a periodic need for external evaluations, there also exists the option of on-going internal evaluations for programme development. The latter allows staff and clients to feed into their own programme, while offering a further advantage of providing a complementary evaluative model for periodic external evaluation processes.

#### **2.5.5 Evaluation models**

This final section of the literature review examines a number of types of evaluation. In its 1998 review of evaluations in indigenous Canadian programmes Health Canada described five specific types:

- Naturalistic Model
- Best Advice Model
- Outcomes Analysis
- Community Evaluation
- Accreditation

For the purposes of the present review, attention will be focused on the first three of the above as these, particularly the latter two, are considered to be most relevant to the Moana House Outcomes Evaluation.

Community evaluation has been incorporated into the discussion on Outcomes Analysis and to a lesser extent the Best Advice Model (sections 2.5.5.3 and 2.5.5.2 respectively).

The final evaluative category, Accreditation, is described by Health Canada (1998:23) as “a client-focused process by which facilities are evaluated against standards of care and service delivery”, noting data collection at all levels of management, staff, clients and their families (ibid: 24). This form of evaluation is comparative, typically against national standards, where external evaluators review documentation and interview a range of stakeholders during relatively brief site visits. Health Canada (1998) notes that in Canada a set of national treatment programme standards was formulated by the National Native Alcohol and Drug Abuse Program (NNADAP) in 1992. However, at the time of their review these had not been implemented.

In New Zealand, before the advent of the mental health standards and Health and Disability Standards, accreditation in this field was driven by the New Zealand Alcohol and Drug Accreditation Board working to the New Zealand Standard Alcohol and Other Drug Treatment Sector Standards Paerewa Rangai mote Maimoatanga Waipiro me te Taru Kino (NZS 8157:2003). In the case of Moana House, the most relevant standard involves certification by the Ministry of Health under the Health and Disability Services (Safety) Act 2001. Accreditation success is expressed by awarding organisations varying lengths of certification, i.e. up to five years. Moana House was audited in June 2009, with the final report (HADNZ, 2009) completed in September 2009.

### **2.5.5.1 Naturalistic Model**

In a First Nations context the Nechi Institute (Jorgenson, 1987) describes the deploying of a naturalistic evaluation model comprising four stages:

1. *Awareness*: Programme participants and community members held significant roles within the evaluation, thereby facilitating learning from it, as well as mediation, negotiation and discussion. In this example, the organisation’s Board developed a paper on the evaluation and the evaluation team was visible in the First Nations community. Openness, value orientation, skills and credibility were emphasised.
2. *Need Identification*: To bring about positive change, the evaluation process was internalised through workshops, curriculum evaluation and personal evaluation.
3. *Skills and knowledge about evaluation*: Through the above process, i.e. relationships between evaluators and participants, the evaluating organisation increased its skills. Thus the relationship between parties incorporated mutual teaching and learning through negotiation and discussion.
4. *Integration of evaluation*: By incorporating the evaluation into the strategic plan, annual report and operationally in staff and activity reviews, the evaluation in this example engaged with an institutional structure. The evaluation team comprised a native evaluator sensitive to First Nations community relations with the programme; a former evaluator familiar with the programme and therefore able to note changes; a ‘fresh’ evaluator, i.e. one able to bring a new perspective; and the programme administrator in order to motivate the organisation’s acceptance of change, including evaluation recommendations.

The success of the above evaluation relied on eschewing preconceived systems of evaluation. Behaviours, systems and patterns were allowed to emerge during the process. These were discussed with the organisations' personnel, leading to a mutual understanding of observations and recommendations. Staff considered this empowering and providing a sense of ownership in the evaluation (Health Canada, 1998:20).

Further, the overall relationship between the evaluators (Nechi Institute) and the treatment organisation had previously been nurtured through a prior initial evaluation, enabling a longer period of engagement. This two-stage process facilitated the development of relationships and trust in the actual process itself (Health Canada, 1998:20).

### **2.5.5.2 Best Advice Model**

Citing a 1989 review of Canada's National Native Alcohol and Drug Abuse Program (NNADAP), Health Canada (1998:21) proposes that the 'best advice model' considers what should ideally be achieved "in the areas of treatment, prevention and training". These areas are used as templates for evaluating programmes, with an emphasis on process. In the above example case studies of 37 NNADAP projects were evaluated with information gathered from staff, case records being reviewed and stakeholders consulted.

Despite the extensive nature of this review, however, cost constraints disallowed the undertaking of independent evaluation and required the selective evaluation of projects. The authors noted other limitations of the review:

- selection bias, i.e. non-random selection of programmes for evaluation;
- the evaluation represented a 'snapshot' view rather than providing data on development over time;
- consequences potentially resulting from data provided meant respondents might have been reluctant to relay negative information;
- clients of programmes were not interviewed;
- the evaluation team had no input into programme selection;
- inappropriate design and content of aspects of the questionnaire.

In general, with the emphasis on process over outcomes, principal foci were limited to employee statistics (e.g. staff numbers, time on job, time involved with programme activities), fit of programme with service provision agreements and alignment with the best advice model.

- Concerning treatment, programme criteria evaluated included: ease of access to detox services and services in general, level of comprehensive assessment, extent of clients' involvement with referral system; extent of treatment options to meet individual client needs; extent/scope of aftercare and; comprehensive record keeping (management of information systems—MIS).

This emphasis on a rigorous evidence base is noted by others, for example, Korhonen (2004), who argues its necessity. She claims effective services "can only be provided when identification of needs, treatment planning and effectiveness of strategies have been assessed through valid evaluation" (2004:27). Evaluations are undermined where programmes' statements of success are overly reliant on the personal experience/opinions of staff, management and clients. Citing Miller and Willoughby (1997:14) Korhonen (*ibid.*) notes the subjective and 'notoriously inaccurate' impressions of providers and clients concerning treatment outcomes. Thus she emphasises the importance of outcome studies and,

significantly for the present evaluation, notes the utility of developing valid criteria for success. Consequently, rather than measuring effectiveness solely by achievement of abstinence, success may also be indicated by the disappearance or reduction of substance misuse and other behaviours targeted by interventions. Additionally, there is value in understanding that what works for one individual may not work with others. Therefore mere *assumptions* of effectiveness are not adequate in themselves.

### 2.5.5.3 Outcome analysis

While historically outcome analysis has been characterised as relying on quantitative methods for generating data (e.g. Health Canada, 1998; Leukefelde & Tims, 1992), as the preceding section suggests, a range of data sources may be exploited, several of which offer possibilities for a qualitative approach. Therefore the defining feature of outcome analysis is its focus on programme outcomes *per se* rather than other aspects of programmes; for example, the processes associated with achieving treatment goals. To this extent outcome analysis is most usefully aligned with the needs of mature programmes.

In a sense research reporting on the client outcomes of programmes generally might be considered to have an evaluative component, i.e. in as much as such research monitors the efficacy of programmes (see Section 2). However, outcome analysis should also consider programmes' effects on all stakeholders: clients, staff, family, community and funders (see e.g. Brooke & Berends, 1999). Or, as the title to Chen's (2005) text states, it should assess and improve planning, implementation and effectiveness. In a useful précis Chen, (cited in Coryn 2005) notes the distinguishing features between programme monitoring and its evaluative counterpart are scientific rigor and credibility.

For Chen (2005), two types of outcome evaluation—those aligned with *efficacy* and *efficiency*—are described as assessments of programme goal achievement. Of these the former is conducted to determine outcomes under ideal conditions, with its central tenet being internal validity. However, this approach requires the tight controlling of potential confounding conditions (e.g. by using randomised controlled experiments), which Coryn (2005:407) criticises as unlikely to be feasible, ethical or practical. He sees greater utility in efficiency outcome evaluations, which accommodate real-world conditions for assessing programme effects.

In countries with First Nation populations and a context of relatively recent colonialisation (e.g. Canada, the United States, Australia, New Zealand), evaluations of treatment programmes engaging with AOD issues and offending populations are further complicated by the need for sensitivity to indigeneity and related cultural issues. In this regard the complexities involved are increasingly recognised, for example by guidelines of the Australasian Evaluation Society (AES, 1998) and the American Evaluation Association (AEA, 2008). In the case of the AES three areas are focused on: commissioning and preparing for an evaluation; conducting an evaluation; and reporting results (AES, 1998). While these, and criteria expanded from them, may provide guidance in an Australian context, it is useful also to compare individual evaluations against criteria developed elsewhere. This was the case in a Victorian (Australia) project (Berends & Roberts, 2004), where the authors compared their evaluation protocols against the AEA standards to ensure a 'fit' with the needs of all stakeholders. Seven items designating needs to be met are noted:

- i. *Stakeholder identification:* Persons involved in or affected by the evaluation should be identified in order to address their needs.

- ii. *Evaluator credibility*: Competence and trustworthiness are necessary qualities of the evaluators, thus leading to maximum credibility and acceptance of findings.
- iii. *Information scope and selection*: A broad selection of pertinent information is required, with this being responsive to stakeholders' needs and interests.
- iv. *Values identification*: The bases of value judgments are clarified through careful description of perspectives, procedures and rationales (an important component here is acknowledging that more than one value system may be in operation).
- v. *Report clarity*: All aspects of the evaluation and programme require clear description (the need for site visits is highlighted here).
- vi. *Report timeliness and dissemination*: Interim findings/evaluation reports require dissemination in a timely manner to facilitate their use by stakeholders.
- vii. *Evaluation impact*: To increase uptake of evaluation findings/suggestions, evaluation planning, implementation and reporting should aim to encourage follow-through by stakeholders.

These authors (Berends & Roberts, 2004) are not alone in signalling the importance of attending specifically to the needs of indigenous programmes. In a review of research into this area, Thomas (2002) references the increasing sensitivity to the cultural appropriateness of evaluations, emphasising both the suitability of research methods' design and conduct of the research team, and also assessing the extent to which programmes and services operate in culturally appropriate ways. Concerning the latter, he describes a number of strategies by which culturally appropriate service delivery may be achieved. These include appropriate management practices and policies, staff training and orientation, using cultural advisors, networking with local communities, monitoring programme effectiveness, and liaising with specialist service advisors. These strategies may be deployed to produce a framework of specific indicators for assessing culturally appropriate services.

In his review Thomas (2002) notes the relative underdevelopment of research and practice in Australasia, though he suggests there is an increasing body of New Zealand literature focusing on this area and particularly on outcomes assessment (see also Faisandier & Bunn, 1997; and Yeboah, 2000, for evaluation in the criminal justice sector). He cites the work of Durie (1994; 2001b), Durie and Kingi (1997) and Te Puni Kokiri (1999) in linking Treaty of Waitangi obligations to services and evaluations involving Māori. The latter notes the development of guidelines for culturally appropriate evaluations and for determining the extent to which mainstream services might be able to meet the needs of multiple cultural groups. Guidelines (after Te Puni Kokiri, 1999:20-21) include:

- Identifying the target Māori population; is the programme reaching this group; if not, why not?
- How well is the service delivered; how do we know; how is it perceived by Māori?
- What are the overall outcomes for Māori?
- Do different Māori groups experience different outcomes; if so, why?
- Māori/non-Māori differences; if these exist, why; implications; do Māori require different programme/policy/service design or delivery?
- Positive outcomes for Māori are ensured by which programme/service components?

More recently Mihi Ratima (2000) has proposed strategies relevant to ensuring the cultural appropriateness of programmes for Māori, including:

- Links to Māori development
- Utilising Māori community resources
- Cultural affirmation
- Iwi endorsement
- Programme meeting high technical and cultural standards
- Operation within Māori domains
- Whānau-focused service
- Inter-generational transfer of knowledge

Thomas (2002) notes several examples of data gathering methods relevant to the indicators outlined above that have recently been deployed in New Zealand. These include Māori mental health outcome indicators, qualitative client data from self-completion questionnaires, the development of an environment questionnaire, and experience of discrimination questions. In concluding his review, Thomas (2002) suggests that the reporting by evaluators of how they assess cultural appropriateness, would facilitate the development of an analytical framework. This could be extended, for example, by recording culturally appropriate and inappropriate styles of interpersonal communication for clients of services and programmes.

## **2.6 SUMMARY**

The preceding sections have provided a summary of the pertinent overseas and New Zealand literature on TCs, AOD and offender populations in Aotearoa New Zealand, indigenous and Māori perspectives of health and wellness and approaches to treatment, and models of evaluation.

The background to the development of the contemporary TC was outlined together with the influences leading to the diversity of programmes which now exist under the TC umbrella. While TCs clearly must adapt in order serve their target sub-populations and in response to the cultural environment and funding constraints, the importance of maintaining the integrity of the TC model of treatment is emphasised.

The complex profile of individuals who enter the doors of TC programmes has been highlighted as well as the benefits that can be expected from an effective TC programme, given sufficient time over one or multiple treatment episodes to allow for internalised changes in patterns of thinking, attitudes and core beliefs, and behavioural changes. Such changes will occur differentially depending on multiple client and programme factors.

There is very limited published data on New Zealand TCs; however, what data are available are generally consistent with the overseas literature e.g. characteristics of individuals entering TC programmes. With regard to Māori, there has been an increasing call for cultural models of treatment as well as broadening agreement about critical treatment components based on holistic and integrative Māori perspectives of health and wellbeing. Given the high proportion of Māori with offending and substance related issues in Aotearoa New Zealand, there are significant challenges for treatment providers and outcome evaluators in providing culturally responsive treatment and employing appropriate evaluation approaches.

As well as Moana House there are a small number of TCs in New Zealand, each providing varying programmes. These include Care NZ which provides DTUs in prison settings, Odyssey House Trust Auckland and Christchurch, and Higher Ground in Auckland.

Finally, the international literature on models of programme evaluation highlighted important considerations concerning outcome evaluation models and approaches and appropriateness to indigenous peoples. Key considerations include cultural considerations and the values and composition of evaluation teams, and linkages with the programme to be evaluated, methodology, sources of data, data collection, analysis and interpretation.



### **3. METHODS**

The summative evaluation sought to examine the experience and impact of treatment from the perspective of residents, families and whānau, key stakeholders (including referrers) and staff. Thus the evaluation concerned itself with efficacy (the ability of the Moana House to do what it is designed to do) and identifying any areas for enhancement. This was undertaken as a combination of focus groups and individual interviews. For residents the interviewers were supplemented by administering a set of standardised questionnaires. In addition, archival programme data were explored to provide a wider profile of people attending the programme.

In evaluating a small therapeutic community programme such as Moana House, there are several significant methodological challenges to be faced:

- the size of the programme means that, in the absence of a very long evaluation period, the size of the sample will be small, making statistical analysis difficult due to limitations of precision and power;
- the length of the programme (potentially two years or more) severely limits the ability to follow residents from the start of the programme through to completion and post-treatment functioning, unless the data collection phase is able to be carried out over a similar timeframe;
- the characteristics of the residents makes post-treatment follow-up potentially challenging. For those men who return to serious offending or substance misuse, attempts to locate them could be difficult and if located the chances of them being willing to be interviewed may not be high.

The present evaluation was designed to recognise the above considerations and produce valid and informative findings within these inherent limitations. Specifically, the following design features are highlighted:

- the dominant methodology is qualitative, with flexible interviews and thematic analysis that allows for the exploration of treatment experience, impact and outcome with a comparatively smaller number of participants;
- attempts to recruit a large sample of post-treatment participants have not been made as this would have produced a highly biased sample, disproportionately populated by former residents who achieved good outcomes;
- a distinction is made between treatment outcome (after completing/exiting the programme) and treatment impact (initial changes within the treatment programme that can be considered a mediator of later outcome). These “change indicators” can be identified as occurring during the early treatment phase (from referral through to the end of Stage I of the Moana House programme, see section 4.1.3.1 for a description of the programme stages) and late treatment (Stages II, III of the programme and aftercare);
- where possible and appropriate archival data were explored as a means of widening the total sample of men who have engaged in the programme.

## **3.1 PROGRAMME DESCRIPTION**

A description of the Moana House programme was sourced from programme documents, discussion with House staff and was further informed by the direct observation of evaluation team members (see logic model, Appendix I).

## **3.2 DATA COLLECTION**

### **3.2.1 Cultural competence**

As noted in the literature review, both internationally and in New Zealand there is increasing awareness of the significance of culturally appropriate practice in evaluation (see Durie, 2001a; Thomas, 2002; Berends & Roberts, 2004). Johnson et al. (2008) state, culturally appropriate processes are not an end in themselves but a means to an end. They encourage evaluation to be “conducted in a way that supports credibility, that data reported accurately represent the phenomena of interest, and that interpretations are trustworthy” (Johnson et al. 2008:201).

In planning the evaluation, the team took into account the literature on evaluation strategies appropriate to the cultural context of the Moana House TC Programme (Health Canada 1998). For example, in respect to the assembling of the evaluation team the values of the team members were congruent with the values of the Moana House TC. The methodology incorporated both qualitative and quantitative methods in order to gather “objective programme data” as well as to provide a voice for the multiple stakeholders and to give them a voice.

Given seventy percent of Moana House residents are Māori and the programme has a ‘culturally’ blended programme the evaluation team drew on the leadership and experience of its two Māori members (Ms Moana-O-Hinerangi [Ngāi Tahu, Ngāti Mamoe, Waitaha, Rapuwai, Rongomaiwhahine] and Mr Terry Huriwai [Te Arawa and Ngāti Porou]). They not only ensured appropriate practice in terms of engagement with stakeholders and participants but were able to bring to the analytical process perspectives relating to Māori and Māori health in the context of colonisation and journeys of rangatiratanga.

### **3.2.2 Mixed methods**

A formal mixed method analysis was employed whereby qualitative and quantitative data were integrated, thus facilitating data triangulation and integrity (Tashakkori & Teddlie, 2003). This method captures the strengths of both data types and meshes well with current best practice models of evaluation, as recognised internationally and in New Zealand (e.g. HDANZ, 2009; and generally section 2.5 above). Where participants contributed qualitative (interview) and quantitative (questionnaire) data, interviews preceded questionnaires to avoid ‘cueing’ participants (Davies, 1997). Thus the specific mixed methods design may be described as a **QUAL→quant** sequential study, where the uppercase **QUAL** signifies the predominating qualitative data source/collection preceding subordinate quantitative data collection.

Interviews were analysed thematically with the assistance of a computer software discourse analysis package (NUD\*IST™). Using content analysis (e.g. Miles & Huberman, 1994), the

two interviewers worked separately to generate initial thematic taxonomies before combining these in the final analysis (see Appendix II).

Both data types were collected in ‘blocks’ (e.g. in three stages at 3-4 monthly intervals). As only residents (intending/current/former) completed questionnaires, the analysis of quantitative data commenced at the conclusion of data collection due to the small numbers of participants. However, for qualitative data, analysis proceeded in stages. This allowed the building of a more complex picture as the analysis progressed and made more manageable the larger blocks of qualitative data. This staged process for qualitative analysis also facilitated the emergence of themes to guide subsequent interviews and for the final analysis.

### **3.2.3 Quantitative method: prospective questionnaire**

An evaluation questionnaire was completed by all consenting residents following the qualitative interview. Subsequently follow-up questionnaires were administered a minimum of three months later. If the resident had left the programme by this time a modified post-discharge version of the questionnaire was utilised. Attempts were also made to contact ex-residents to complete the post-discharge questionnaire and potential residents on the waiting list were contacted and invited to complete a pre-entry version. Thus there were four versions of the assessment questionnaires administered. There were:

- Pre-entry assessment
- First assessment, current residents
- Follow-up assessment, (second and third assessments were undertaken, usually while the respondent was a current resident)
- Post-discharge assessment

Data collected covered the following areas:

- Demographic and treatment history
- Health and wellbeing
- Motivation
- Addictive behaviours
- Self efficacy
- Treatment impact and satisfaction

Health and wellbeing were measured using the Medical Outcomes Trust Short Form health survey, the SF-36 (Ware, Snow, Kosinski, & Gandek, 1993). The SF-36 questionnaire comprises 36 items, measuring physical and mental health limitations in social and personal role functioning, wellbeing and overall health status, grouped into eight scales. Scale scores are coded, summed and transformed on to a scale of 0 – 100, higher scores indicating better self-assessed health and wellbeing. For five of the scales (PF, RP, BP, SF and RE), a score of 100 indicates the absence of limitations or disability. On the remaining three scales (GH, VT and MH), a score of 100 indicates a positive state of wellbeing, with mid-range scores indicating no reported limitations or disabilities. As a guide, a five-point difference between group scores defines differences that are clinically and socially relevant. The 8 scales of the SF-36 are shown below. In addition, two summary component scores can be generated, a Physical Component Score (PCS) and Mental Component Score (MCS), incorporating scores from across the individual scales. The population mean for PCS and MCS is 50, with higher scores denoting better functioning. The SF-36 was administered as part of all four assessments.

**Table 1: A summary of SF-36 scales**

Scale	Label	No. of items
Physical functioning (limitations in physical activities including self-care due to health)	PF	10
Role – physical (limitations in work/daily activity due to physical health problems)	RP	4
Bodily pain	BP	2
General health (self-assessed health status)	GH	5
Vitality (energy/fatigue)	VT	4
Social-functioning (interference with social functioning due to physical health or emotional problems)	SF	2
Role – emotional (limitations in work/daily activity due to emotional problems)	RE	3
Mental health (psychological distress and psychological wellbeing)	MH	5

Motivation was measured by the Circumstances, Motivation and Readiness (CMR) questionnaire (De Leon, Melnick, Thomas, Kressel, & Wexler, 2000) is an 18 item instrument designed to measure motivation and readiness for treatment and to predict retention in treatment among substance users. The CMR consists of four factor derived scales as outlined in Table 2. The CMR was administered at all assessments except post-discharge.

**Table 2: A summary of CMR scales**

Scale	No. of items	Possible range
Circumstances 1 (external influences to enter or remain in treatment)	3	3-15 (high score = strong influences)
Circumstances 2 (external influences to leave treatment)	3	3-15 (high score = weak influences)
Motivation (internal recognition of the need to change)	5	5-25 (high score = high motivation)
Readiness (perceived need for treatment)	7	7-35 (high score = high readiness)

The Degree of Drug Use Index (DDI) was developed in New Zealand and measures use of a range of substances and injecting behaviour over the preceding four weeks (Deering, Sellman, Adamson, Horn, & Frampton, 2008). For this evaluation the DDI was modified to also record cigarette use. Because of the small sample size and the diversity of substances used, DDI responses are summarised so as to show the proportion using substances from each category and the range of use frequency for each. For men in prison or in the House, the time-period enquired about was the last four weeks prior to entering a residential setting. The DDI was not administered at follow-up assessment points for men who were still resident in the programme.

The Eight Gambling Screen (Sullivan, 2007) was developed as a brief eight-item measure to identify problem gambling. The eight questions are all yes/no and a score of four or more is indicative of problem gambling. For men in prison or in the House, the time-period enquired about was the last 12 weeks prior to entering a residential setting. The Eight Gambling Screen was administered at all assessments except follow-up assessments for men who were still resident in the programme.

Self efficacy was measured using the Brief Situation Confidence Questionnaire (BSCQ) (Breslin et al. 2000), an 8-item abbreviated form of the 100 and 39-item Situational Confidence Questionnaire (Annis, 1982; Annis & Graham, 1988). These scales are designed to assess to what extent the respondent feels confident they can resist the urge to drink/use

drugs in a range of settings, with each item rated on a visual analogue scale between 0% and 100% for how confident they would be if they were faced with that situation right now. Each item can be examined individually in order to identify which situations are the greatest risk for which patient; however as the BSCQ was employed as an evaluative and descriptive measure we have limited analysis to examining the mean confidence score across all eight items. The BSCQ was administered as part of all four assessments.

Hua Oranga (Kingi & Durie, 2000) measures health outcome in four domains consistent with Māori concepts of health and wellness, in line with the Te Whare Tapa Wha model. The four domains of this model operationalised by Hua Oranga are:

- Te Taha Wairua (spiritual dimension)
- Te Taha Hinengaro (mental dimension)
- Te Taha Tinana (physical dimension)
- Te Taha Whānau (family dimension)

Each domain contains four questions where the respondent is asked to rate how they see their functioning “as a result of the intervention”, for example “more valued as a person” (item 1a, wairua) with each item coded on a five point scale (much more, more, no change, less, much less). Scores for individual items range from -2 (much less) to 2 (much more) and each domain score represents an average of the four items and therefore also has a possible range of -2 to 2. Hua Oranga was administered as part of all assessments except pre-entry.

The therapeutic community Client Assessment Inventory (CAI) (Kressel et al. 2000) was developed by George De Leon and colleagues from a theoretically-informed TC basis. It aims to measure a range of behaviours relevant to functioning within a TC. The CAI comprises 98 items spread across 14 subscales. For the purpose of this evaluation we chose to focus on three of these scales: Responsibility, Values, and Drug/Criminal Lifestyle. Responses to each individual item can range from strongly disagree (1) to strongly agree (5), with many of the items reversed scored so that higher scores reflect more pro-social behaviour.

The CAI was administered at all assessments where the respondent was still attending the programme (first assessment and follow-up assessments), but not pre-entry or post-discharge.

**Table 3: A summary of CAI scales**

Scale	Meaning	Number of items	Possible range
Responsibility	Meeting obligations to self and others as well as taking responsibility for behaviours and attitudes. Responsibility includes concern for the welfare of self, peers, and the community.	8	8-40 (high score = more pro-social)
Values	Strong personal beliefs that define characters and guide behaviour and life choices. Treatment promotes honesty, integrity, and self-reliance coupled with genuine concern for others.	7	7-35 (high score = more pro-social)
Drug/Criminal Lifestyle	Behaviours and attitudes that accompany the drug and criminal lifestyle. Examples: physical violence, stealing, manipulation, deceiving, intimidating, and joining gangs.	6	6-30 (high score = more pro-social)

The Dimensions of Change Instrument (DCI) is a measure of treatment process, designed for use in therapeutic communities (Orlando et al., 2006). The DCI contains 54 items, each of which is answered and scored on a five point scale from not at all (0), to completely (5). Eight subscales can be derived, with scores representing the mean of the items constituting the subscale, so that the possible range for subscale scores is also zero to five. The eight factors are:

- Community Responsibility
- Clarity and Safety
- Group Process
- Resident Sharing, Support and Enthusiasm
- Introspection and Self-management
- Positive Self-attitude and Commitment to Abstinence
- Problem Recognition
- Social Network

The DCI was administered at all assessments where the respondent was still attending the programme (first assessment and follow-up assessments), but not pre-entry or post-discharge.

Treatment Perceptions Questionnaire (TPQ) is a measure of consumer satisfaction designed specifically for use with alcohol and drug treatment clients (Marsden et al., 2000). Of the 10 TPQ items, five are concerned with perceptions of staff and five with programme perceptions. Items are scored on a five point Likert scale (strongly disagree–strongly agree scored 0-4). The TPQ was administered post-discharge only.

Because of the small sample size analyses of statistical significance are not conducted. Rather the data is presented and summary comments are made about apparent change over time and, where possible, ratings in comparison to equivalent samples in published data. We have been cautious to not over-interpret these data. Instead they should be read as a companion to the qualitative interview findings.

### **3.2.4 Qualitative method**

Qualitative interviews were carried out with two general groups of participants:

- residents (intending/current/former) and their whānau, and
- non-residents (Rūnanga, funders, referrers, staff, Moana House Board members).

Resident interviews were preceded by two focus group interviews with staff and former residents to establish a basic thematic structure to inform the formal interview process.

The subsequent interviews were open-ended and face-to-face, with residents remaining within the programme being interviewed at repeat intervals as above. The duration of initial interviews ranged from sixty to ninety minutes, with subsequent interviews lasting between thirty to sixty minutes.

Several site visits by the evaluation team and more frequently by the two interviewers established a level of rapport with resident and other programme participants.

### **3.2.4.1 Participant numbers**

Prior to project commencement, the proposed total number of interviews based on past Moana House admission and turn-over data was calculated on a projected average occupancy per month of nine residents, with twenty-four new admissions per year, ten of whom would remain in treatment beyond one month. It was intended to conduct follow-up interviews at three monthly intervals for all participants throughout the data collection period.

Additionally, it was planned to interview five people leaving within the first month (early exiters), five people waiting to enter the programme, five graduates, six staff, 16 whānau or family members, eight members of the community (Rūnanga and marae connections) and three funders/organisational service users (e.g. Parole Board, Community Probation Service).

### **3.2.4.2 Interviews**

It was proposed to divide interviews between two interviewers (Māori and non-Māori). Residents and staff would be interviewed on site, with other interviews being carried out at locations/venues agreed upon by participants. It was anticipated that some would occur outside of Dunedin.

## **3.3 QUANTITATIVE METHOD: ARCHIVAL DATA**

A range of administrative documents was provided in digital form by Moana House which were examined to determine if any usable client-level data was present. In addition, permission was gained to look through archival paper documents when these could be located. Staff were approached for advice on what data were available and how any of the gaps in the data might be satisfactorily filled.

Amongst the materials examined were two sets of data that proved to be sufficiently complete to yield a picture of the programme in previous years. These were a 1993 report of the past 13 months referrals and admissions, and 2003-2009 Department of Corrections reports, which are produced monthly as a requirement of service provision for Corrections and which track resident progress.

## **3.4 ETHICAL APPROVAL**

Ethical approval was sought from the Lower South Island Regional Ethics Committee. Approval was granted on 18 November 2008, approval number LRS/08/10/048.



## **4. FINDINGS**

### **4.1 PROGRAMME DESCRIPTION**

#### **4.1.1 Kaupapa**

The Downie Stewart Foundation was established in 1983 in response to a desire to offer an alternative to imprisonment and other judicial processes for those appearing in the Criminal Justice System. The impetus came from Mike Martin who had been a consumer of different services at that time and who had developed a friendship with one of his Sentencing Judges, Judge J.D. Murray and his wife Ngita.

The programme was initially designed for men who had major alcohol and other drug problems as well as other problems, which would now be called co-existing problems (i.e. co-existing substance use and mental health problems). From that grew the Foundation, with many of the original trustees still remaining as part of the organisation. It grew therefore from a strong community, and what would now be called “service user” focus.

The mission statement of “Giving you a real chance” emerged later as the programme developed at 401 High Street, Dunedin. They began operating from this address in 1987. The programme was established and continues to run as a therapeutic community (TC).

The kaupapa, or philosophy, incorporates the mission statement and the framework of practice is referred to as “Heke Tikanga”. This is based on the belief that change is possible and that everyone has the capacity for wellness and wellbeing, which can be achieved by providing a comprehensive programme able to address all issues presenting at any given time.

The inclusion of families, however they are constructed, expands on an already dynamic process for residents and their affiliates. Thus there has always been the recognition that due in part to the offending histories of the men referring themselves to Moana House, the programme needs to be flexible enough to manage a range of behaviours and histories. Therefore, staff look to how the programme can include those who refer or are referred to it.

#### **4.1.2 Referral**

Residents can refer themselves, be referred by their families, or by anyone else at any time. The programme receives referrals from all over Aotearoa. Many self-referrals to Moana House are generated by ‘word of mouth’.

In responding to referrals, 85% of assessments are done by phone, with these lasting from 1-2 hours depending on where prospective residents are, how much prior information Moana House (the Whare) has, whether the referrals are straightforward or very complex. Whānau or family involvement at this early stage includes the provision of information regarding the programme and parole process or, if permission has been given by prospective residents, interactions may involve providing relevant history. If the whānau is local they may visit to gain a sense of the Whare and to experience the programme and environment first hand.

## **4.1.3 Programme stages, structure and content**

### **4.1.3.1 Stages of treatment**

As noted above (section 4.1.1) Moana House has developed a unique programme of treatment and habilitation. In its broadest sense, this comprises three formal stages and a pre-stage assessment period:

*Whakaohooho* (the awakening). This is an assessment stage by staff and a time of orientation for the resident, who must take responsibility for his behaviour and begin to understand its effect on others.

- I. *Ahuatanga* (the ‘shape’ of recovery). A stage of contemplation, where social skills and self-care are attended-to. Relationships are examined and victim empathy developed. A sense of ownership of problems is worked towards, i.e. ‘the problem is me’ rather than ‘my family’, ‘the police’, ‘the law’ etc.
- II. *Mohiotanga* (understanding). A knowledge of the self on the journey is developed; it is the most difficult and challenging stage. By now there must be firm commitment to change, with the resident being a role model to others, sticking to rules and taking responsibility. The resident will have future and education plans, and will have set his own personal goals. He will have supportive contact with the wider community.
- III. *Mana Motuhake* (autonomy and self-determination). This is the stage of transition, with the resident moving from the therapeutic community into the larger community. Work and full-time study is possible. He still needs and receives support of the Moana House community and is expected to report regularly for guidance rather than for being told what to do. Though his routine is still tightly controlled, it is his responsibility. At this stage he may also choose to graduate in a formal ceremony.

### **4.1.3.2 Structure**

- The day begins and ends with **Whakapiri**, which is a time of coming together, energising and reflection.
- This is followed by **whānau hui**, where the issues of the day are attended to.
- The first three days of the week are taken up with therapeutic and focus groups.
- The second three days of the week focus on community activities usually in the form of workplace activities.
- Sunday is a day where the programme’s focus turns to whānau, with whānau activities usually scheduled for this time.
- Elements of the programme structure are subsequently discussed in greater detail and in relation to outcomes below (see section 4.3.6.2).

### **4.1.3.3 Content**

A wide range of issues and topics are covered in groups in keeping with the programme’s overall objectives. Residents are encouraged and challenged to bring issues themselves rather than an agenda being set for every session.

- **Process group**—Allowing residents to clarify their thinking and feelings.

- **Goals group**—Setting weekly SMART goals.
- **Culture group**—Exploring the dynamics of culture.
- **Education**—Ensuring that residents can continue their learning.
- **Steps group**—Recovery and 12-step fellowship.
- **Waiata/haka**—The power of music and self-expression.
- **Ara tika**—Exploring roles, responsibilities and relationships.
- **Criminogenics**—Addressing offending lifestyles.
- **Psychotherapy**—Focusing on deep personal issues.
- **Occupational therapy**—Creative and artistic expression.
- **Awhi Whānau**—In-house fellowship group.
- **Tinana kori**—Personal fitness programmes.

There are also block sessions of special interest spread throughout the year, for example:

- **Victim empathy**—Understanding the impact of offending on others.
- **Wānanga**—Marae noho such as mau rakau, wairuatanga.

Underpinning all of these activities are the common threads of alcohol and other drug misuse, violence and shattered relationships. These are seen to have arisen from disrupted identity development and poor attachment, so that relationship building, including community membership, is a major factor in producing change (Manning, 2007).

As with aspects of the programme’s structure, a number of these programme elements are discussed in greater detail in section 4.3.6.2.8.

#### **4.1.4 Possible programme developments**

As a consequence of the programme undertaking a new Ministry of Health contract, there are potentially a number of future options, including:

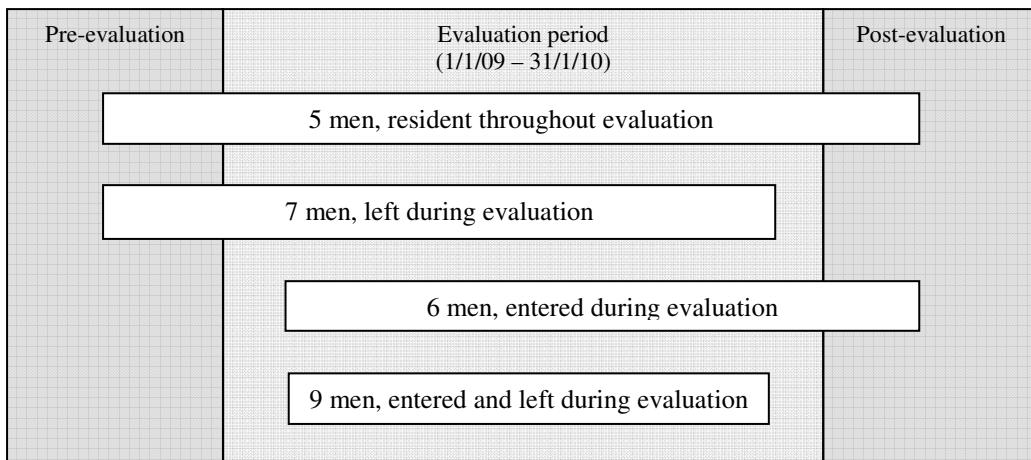
- Developing a continuing care programme to include whānau ora, aftercare and parenting.
- Increasing the programme’s interaction in the community to build stronger support networks.
- Piloting an internship programme, which initially will focus on psychotherapy and alcohol and other drugs (AOD).
- Presenting more training outside of Dunedin.
- Building a network of peer support workers, mentors and supervisors.

## 4.2 QUANTITATIVE ANALYSIS

During the course of data collection (1/1/09 to 31/1/10) 27 men were resident in the house or aftercare (one man only) at one time or another. This comprised 11 men who were resident at the start of data collection (1/1/09), one who was in aftercare, and 15 who subsequently entered the programme. At the completion of data gathering 11 men remained in the programme, including five men who had been resident throughout the 13 months of the evaluation.

Of the 16 men leaving the programme, three left within the first month (1-5 days), three left between 1 and 3 months (61-72 days), six left between 3 and 9 months (92-173 days) and three left after more than nine months (357 to 844 days). The sixteenth man had re-engaged with the programme after a term of imprisonment (which followed four months as a Moana House resident), but did not, in fact, re-entered the house as a resident but rather had an informal “aftercare” status, with the House providing support.

**Figure 1: Moana House residents throughout outcome evaluation period**



Of the 11 men still resident at Moana House at the end of data completion, two had been resident for less than 3 months (61 and 82 days), four had been resident for between 3 and 9 months (92-195) and five had been resident for more than 9 months (520-655 days). In total, for the 15 men entering the programme in 2009 the three month retention rate is 67%. See Table 13, section 4.4, for more detail on retention rates for this cohort and a comparison with previous years.

In total 32 self-report assessments were conducted with 19 residents/prospective residents as follows:

- 3 pre-admission assessments (while in prison)
- 15 current resident first assessment
- 11 follow-up assessments (seven were second assessments and four were third assessments)
- 3 post-discharge discharge assessments (one new, two as repeat assessments)

## **4.2.1     The sample**

The 19 men completing assessment questionnaires had a mean age of 28.8 years (range 21–39). Sixty-eight percent identified as Māori, 37% as New Zealand European and 5% as Tongan. These figures include two residents identifying multiple ethnicities. At the time of first assessment 53% were in de facto relationships or married, 42% were single and 5% were separated. Of the 15 men first interviewed while resident in the house, 12 were on sickness benefits, two on unemployment benefits and one on an invalid's benefit. The three pre-admission assessments were with men currently serving prison sentences, two of whom identified themselves as being employed in that context, while the one respondent first interviewed as an ex-resident was in paid employment. Fifty-five percent had been employed in the two year preceding assessment, with the remainder having last been employed between three and 11 years prior to interview. Employment was primarily in unskilled and labouring roles.

Respondents reported a mean 9.1 years education (range 6-13), with a third completing eight years or fewer, equivalent to completing primary school but no secondary education. Twenty-two percent had completed 11 or more years of education.

Amongst the 15 residents and three men on the programme waiting list, 83% had dependent aged children (under 16 years), two thirds of whom reported regular contact with at least some of these children.

At the time of first assessment the men had averaged 6.8 months in Moana House (range 1-22 months), with 62% having been in the house for three or more months. When referred to the programme two had been flatting while the remainder were in custody, two on remand and the remainder serving prison sentences. Referral was often self-referral (eight of 18 known referral sources), with four referred by family members or friends, two by drug counsellors, one by another health professional, two from prison staff, and one by another resident of Moana House. Six came from with the Otago region, and 13 from further a field, including 8 from the North Island. All respondents had criminal convictions (mean 72, median 50, range 1-300), with 78% reporting 20 or more convictions, and all had spent time in prison.

Thirty-three percent had attended outpatient or inpatient mental health services in the past. Only 22% reported ever attending outpatient alcohol and other drug (AOD) services and 28% AOD day programmes in the past, while 50% had attended self-help meetings. 22% had been admitted to detoxification units or a hospital for the purpose of detoxification and 57% had been admitted to a residential AOD treatment programme. In total 78% reported previous contact with some form of AOD intervention.

## **4.2.2     Health and wellbeing**

A guide to interpreting the SF-36 is that differences between groups, or over time within groups of 5 or more points, can be considered clinically meaningful. Scores obtained for residents on the SF-36 show a group who when first interviewed had good physical functioning, but some degree of bodily pain, and difficulties with social functioning and mental health when compared to the general population.

**Table 4: SF-36 scores across three assessments, with NZ population norms**

SF-36 Scale	NZ population mean score	Respondents, 1 <sup>st</sup> assessment n=18	Respondents, 2 <sup>nd</sup> assessment n=9	Respondents, 3 <sup>rd</sup> assessment n=4
Physical functioning	86.0	86.9 (21.1)	78.9 (30.6)	67.5 (16.6)
Role-physical	80.7	77.8 (39.2)	75.0 (43.3)	31.3 (31.5)
Bodily pain	77.9	70.6 (29.3)	66.9 (22.8)	46.3 (13.3)
General health	73.8	76.7 (16.3)	77.3 (14.4)	62.0 (7.1)
Vitality	65.6	61.4 (19.8)	72.8 (12.3)	60.0 (8.2)
Social functioning	86.6	75.7 (25.2)	79.2 (17.7)	65.6 (12.0)
Role – emotional	85.0	88.9 (22.9)	92.6 (22.2)	58.3 (50.0)
Mental health	78.0	67.3 (16.3)	73.8 (12.5)	62.0 (10.1)
Physical component	50.0	50.5 (10.2)	47.4 (12.0)	39.4 (8.7)
Mental component	50.0	48.1 (10.5)	53.1 (6.4)	46.1 (5.4)

At first glance the table would suggest some slight fluctuation between the first assessment and the second, which occurred on average four months later, with some slight improvements (Vitality, Mental Health) and some slight deterioration (Physical Functioning). Caution needs to be exercised in drawing such conclusions, not only because of the small overall sample size but also because only half of the first wave respondents were re-assessed. However, when baseline scores for the nine men assessed a second time are examined they continue to support these observations, with their initial scores very similar to the larger group mean represented in the table. For this sample of nine the relevant baseline mean (SD) scores are Physical Functioning 88.9 (18.5), Vitality 59.4 (10.7), Mental Health 68.0 (11.1), Mental Component 50.0 (6.0). In addition limiting the first assessment scores to the nine men followed up suggests that an improvement also occurred for Role Physical (baseline mean 66.7, SD 43.3).

The scores presented for the third wave of assessments are for an even smaller group of four men. All scores are lower for the third wave than the second, and sometimes dramatically so. The change from first/second assessment to the third assessment is less dramatic when limiting the earlier figures to these four men only but the apparent reductions continue to prevail.

#### 4.2.3 Motivation

**Table 5: Circumstances, Motivation and Readiness Scale (CMR) scores across three assessments, with a TC comparison sample**

Scale	Comparison sample (n=658) <sup>1</sup>	All responses n=29	Respondents, 1 <sup>st</sup> assessment n=18	Respondents, 2 <sup>nd</sup> assessment n=7	Respondents, 3 <sup>rd</sup> assessment n=4
Circumstances 1	8.0 (2.8)	10.3 (3.4) <sup>2</sup>	9.8 (3.1)	12.0 (2.3) <sup>4</sup>	10.4 (5.5)
Circumstances 2	11.8 (2.2)	12.9 (2.9)	12.8 (2.3)	14.0 (1.8)	11.3 (5.7)
Motivation	19.8 (4.1)	21.3 (4.7)	22.0 (3.7)	22.7 (2.0)	15.9 (8.4)
Readiness	27.5 (5.1)	30.0 (5.0) <sup>2</sup>	29.1 (5.3) <sup>3</sup>	32.1 (2.9)	30.3 (7.2) <sup>5</sup>

<sup>1</sup> Prospective residents, Amity Prison TC, San Diego California (De Leon et al. 2000)<sup>2</sup> n=27, <sup>3</sup>n=17, <sup>4</sup>n=5, <sup>5</sup>n=3

The Moana House sample was compared to a group of US inmates found suitable for entry into a prison-based TC (half were then randomised to the TC and half to a no treatment control group). Although Moana House is not a prison-based TC all but two residents were in prison at the time of entry and so this was deemed the most suitable comparison group. The Moana House sample shows somewhat higher pressure to enter treatment (Circumstances 1)

but comparable pressure to leave treatment (Circumstances 2). Perceived need for change (Motivation) is somewhat higher as is perceived necessity for treatment in order to bring about that change (Readiness). The drop in mean Motivation score amongst the four residents assessed a third time was due to a single outlier who scored 5, the lowest score of 29 CMR completions, with the second lowest score being 14.

The motivational profile revealed by these scores is compatible with the motivation theme (section 4.3.6.2.5) which revealed motivation to enter and remain in the programme to be a mix of external pressures and desire from within.

#### **4.2.4 Addictive behaviours**

The DDI and 8 screen were completed by all 19 respondents. Respondents in jail (n=3) or currently resident in Moana House (n=15) were asked to complete the questionnaires with reference to the last time they were in the community. The questionnaires were also completed by the three post-discharge respondents.

**Table 6: Substance use, four weeks preceding incarceration/entry to Moana House, n=18**

Substance	% used	Range
Alcohol	44%	1-21 to 42+ standard drinks per week
Tranquillisers/sedatives/hypnotics	39%	Once a week or less to 4+ per day
Cannabis	78%	More than once a week to 4+ per day
Other non-injected substances	61%	Once a week or less to 4+ per day
Amphetamines/stimulants	50%	Once a week or less to 4+ per day
Hallucinogens	17%	Once a week or less to more than once per week
Opioids	28%	Once a week or less to 4+ per day
Nicotine	82%	6-10 to more than 20
Injecting drug use	22%	Daily to 4+ per day

The four respondents who identified injecting drug use all injected both opioids and stimulants during the four weeks covered by the DDI, and three of the four reported that they had shared injecting equipment during that time.

Four respondents scored zero on the DDI, with no substance use in the four weeks preceding incarceration/entry to the programme, with the remainder scoring between 6 and 19 (mean 13.5).

For gambling, seven respondents reported no gambling in the four weeks preceding incarceration/entry to the programme. Of the remainder, four scored in the probable problem gambling range (scoring four or more) and six scored in the sub-threshold problem range. All of the respondents who did gamble endorsed at least one of the gambling screening questions, most commonly an urge to return to gambling to win back losses, being criticised for gambling, and acknowledging that gambling has caused problems.

Of the three former residents assessed post-discharge from Moana House, none reported use of any substances in the four weeks preceding interview (except for nicotine in one case), while one reported gambling in the sub-threshold problem range.

## 4.2.5 Self efficacy

Brief Situation Confidence Questionnaire (BSCQ) total scores averaged 78.9% (SD 22.6%), with the mean score for individual items ranging little, from 74.2% to 82.3%, and standard deviations ranging from 26.2% to 32.9%, while individual respondents' ratings ranged from 0% to 100% for all items except one ("pleasant times with others", range 10%-100%).

**Table 7: Brief Situational Confidence Questionnaire scores across three assessments**

	Respondents, 1 <sup>st</sup> assessment n=18	Respondents, 2 <sup>nd</sup> assessment n=9	Respondents, 3 <sup>rd</sup> assessment n=4
All responses	78.2% (24.6)	81.5% (14.0)	71.0% (32.7)
Assessed twice or more	87.6% (11.6), n=9	81.5% (14.0)	
Assessed three times	92.2 (8.4), n=4	83.1% (14.3), n=4	71.0% (32.7)

Table 7 shows mean scores across the three assessment periods. When the sample is limited to those responding more than once the apparent reduction in mean scores over time becomes more apparent. The three men assessed while still in Otago Correctional Facility were amongst the lowest scorers on the BSCQ, with a mean confidence score of 47.7%. In contrast, the three men assessed after discharge from Moana House had high BSCQ scores (mean 96.1%).

## 4.2.6 Treatment impact and satisfaction

Respondents' self-rating on Hua Oranga is outlined below. As can be seen ratings were almost universal in identifying positive impact of treatment across the four domains. Possible score ranged from 2 (much more) to -2 (much less).

**Table 8: Hua Oranga impact direction for all responses, n=29**

Hua Oranga scale	Mean (SD)	% positive impact	% no change	% negative impact
Wairua	1.36 (0.57)	96.6%	3.4%	0%
Hinengaro	1.44 (0.61)	96.6%	3.4%	0%
Tinana	1.21 (0.61)	93.1%	3.4%	3.4%
Whānau (n=28)	1.45 (0.61)	92.9%	7.1%	0%

For Wairua the strongest endorsements were for items 1b "As a result of the intervention I feel healthier from a spiritual point of view" (mean 1.48, SD 0.63) and 1a "As a result of the intervention I feel more valued as a person" (mean 1.45, SD 0.78). For Hinengaro the strongest endorsement was for item 2b "As a result of the intervention I feel more able to think, feel and act in a positive manner" (mean 1.52, SD 0.69). For Tinana the strongest endorsement was for item 3c "As a result of the intervention I feel more able to understand how physical health improves mental wellbeing" (mean 1.38, SD 0.68). For Whānau the strongest endorsement was for item 4a "As a result of the intervention I feel more able to communicate with whānau". Overall the two least strongly endorsed items were both in the Tinana scale, 3a "As a result of the intervention I feel more able to move about without pain or distress" (mean 1.07, SD 0.81) and 3d "As a result of the intervention I feel physically healthier" (mean 1.07, SD 0.96). Of the 17 men who attended the programme three identified that as a result of the programme they felt less physically healthy, the only item with more

than a single individual identifying a negative impact. Closer examination of these three responses, however, revealed that all were during a first interview, with the one resident interviewed a second time rating the programme has having improved his health. Furthermore, on the other three Tinana items these three residents were largely positive about the programme's impact.

An examination of change over time (Table 9) identifies an increase in ratings from first to second assessment, with the greatest increase being for Wairua, a trend that remains when the first assessment responses are limited to the nine residents completing the second assessment (mean 1.39, SD 0.52).

**Table 9: Hua Oranga mean scores across three assessments**

Hua Oranga scale	Respondents, 1 <sup>st</sup> assessment n=15	Respondents, 2 <sup>nd</sup> assessment n=9	Respondents, 3 <sup>rd</sup> assessment n=4
Wairua	1.23 (0.64)	1.66 (0.43)	1.06 (0.31)
Hinengaro	1.37 (0.63)	1.47 (0.64)	1.50 (0.61)
Tinana	1.15 (0.65)	1.47 (0.44)	0.69 (0.47)
Whānau (n=28)	1.38 (0.68)	1.47 (0.65)	1.50 (0.35)

The therapeutic community Client Assessment Inventory (CAI) scales for Responsibility, Values, and Drug/Criminal Lifestyle are summarised in Table 10.

**Table 10: Client Assessment Inventory mean (SD) scale scores across three assessments, with a TC comparison sample**

Scale	Comparison sample, n=980 <sup>1</sup>	All responses n=26	Respondents, first assessment n=15	Respondents, 2 <sup>nd</sup> assessment n=7	Respondents, 3 <sup>rd</sup> assessment n=4
Responsibility	25.7 (6.3)	30.8 (4.7)	30.4 (5.3)	32.7 (4.2)	29.0 (1.8)
Values	23.5 (4.4)	25.0 (6.1)	24.9 (5.6)	25.1 (7.3)	25.1 (7.6)
Drug/Criminal Lifestyle	21.7 (4.1)	21.6 (6.3)	21.3 (6.2)	22.6 (7.7)	21.1 (5.5)

<sup>1</sup> 980 attending one of 18 US correctional drug treatment TCs. Administered a mean 121 days in to treatment (Sacks, McKendrick, & Kressel, 2007)

Scores on the three CAI scales remained fairly static across the three assessments, although there is some indication of an improvement in Responsibility scores between the first and second assessments, with a lower score of the small sample assessed a third time. Examining change over time when limiting the sample to those residents assessed multiple times does not change this overall impression. Moana House scores were higher for Responsibility and slightly higher for Values, while scoring about the same for Drug/Criminal Lifestyle when compared to the US correctional comparison sample. Similar figures to Sacks et al. (Sacks et al. 2007) were also found in a Phoenix House sample (Kressel et al. 2000).

DCI scores (see Table 11) are largely stable from assessment one to assessment two, but show a decline (with the exception of Social Network) at assessment three. Examining change over time when limiting the sample to those residents assessed multiple times does not change this overall impression.

**Table 11 Dimensions of Change Instrument mean (SD) scale scores across three assessments, with a TC comparison sample**

Scale	Comparison sample, n=390 <sup>1</sup>	All responses n=26	Respondents, 1 <sup>st</sup> assessment n=15	Respondents, 2 <sup>nd</sup> assessment n=7	Respondents, 3 <sup>rd</sup> assessment n=4
Community Responsibility	4.46 (0.56)	4.33 (0.50)	4.43 (0.48)	4.39 (0.48)	3.81 (0.43)
Clarity and Safety	3.89 (0.74)	4.61 (0.40)	4.62 (0.41)	4.71 (0.31)	4.35 (0.45)
Group Process	3.82 (0.68)	4.23 (0.66)	4.16 (0.78)	4.50 (0.37)	4.04 (0.57)
Resident Sharing, Support and Enthusiasm	3.59 (0.67)	4.14 (0.55)	4.21 (0.64)	4.23 (0.34)	3.73 (0.40)
Introspection and Self-management	3.92 (0.62)	4.19 (0.48)	4.20 (0.57)	4.22 (0.40)	4.09 (0.27)
Positive Self-attitude & Commitment to Abstinence	4.27 (0.57)	4.45 (0.49)	4.52 (0.55)	4.46 (0.46)	4.18 (0.20)
Problem Recognition	4.05 (0.83)	4.20 (0.51)	4.28 (0.55)	4.27 (0.39)	3.78 (0.37)
Social Network	4.02 (0.91)	4.23 (0.84)	4.36 (0.87)	3.81 (0.84)	4.50 (0.58)

<sup>1</sup> 390 patients attending one of 9 Phoenix House programmes, USA. DCI administered at 30 days.(Orlando et al., 2006)

DCI scores for the Moana House sample are consistently higher than is the case for the 30 day scores of the Phoenix House comparison sample, with the sole exception of Community Responsibility. Many of the differences are large, with effect sizes (mean difference divided by mean standard deviation) ranging from 0.33 (Problem Recognition) to 1.27 (Clarity and Safety) when Phoenix House scores are compared to first assessment scores.

The Treatment Perceptions Questionnaire (TPQ) was completed after treatment exit by the three men undertaking the post-discharge assessment. Responses are summarised below.

**Table 12: Treatment Perceptions Questionnaire (TPQ) responses, n=3**

TPQ Question	Strongly Disagree	Midway	Strongly Agree
<i>Staff perceptions</i>			
The staff did not always understand the kind of help I wanted	1	2	
The staff and I had different ideas about my treatment objectives	1	2	
There has always been a member of staff available when I have wanted to talk	1	2	
The staff helped to motivate me to sort out my problems	1	2	
I think the staff were good at their jobs	1	1	1
<i>Programme perceptions</i>			
I was well informed about decisions made about my treatment	2	1	
I have received the help that I was looking for	1	2	
I did not like all of the treatment sessions I attended	1	1	1
I did not have enough time to sort out my problems		1	2
I did not like some of the treatment rules or regulations	2	1	

The number of responses for the TPQ (three) were very small, but in general can be summarised as showing that these ex-residents were positive about the treatment and staff, but did express some concerns about not having enough time to sort out their problems, not always being understood and having differing ideas about treatment objectives.

## **4.3      QUALITATIVE ANALYSIS**

### **4.3.1    Participant numbers**

As noted above, resident participant numbers were calculated on a projected average occupancy per month of nine residents, with 24 new admissions per year, 10 of whom would remain in treatment beyond one month.

During the thirteen months of data collection (1.1.09 – 31.1.10) there were fewer new admissions (15) than the projected 24, due to a trend to increased average length of stay compared with previous years. Contrarily, the proportion of those remaining in treatment beyond a month (12 of the 15 new admissions) was greater than projected, as was average monthly occupancy (12 per month).

Nonetheless there was a degree of difficulty in accessing a proportion of residents and their affiliates. Four residents declined to be involved in the evaluation. Some exiting the programme (i.e. completing (1), absconding (3) or returning to prison (1)) proved difficult to access or even contact.

Finally, there were difficulties associated with accessing residents' families and whānau, e.g. some residents were extremely wary of whānau being involved.

As might be anticipated, non-resident participants were more readily accessed. Overall, therefore, the 69 'category interviews' noted below (table 4.1) represent interviews with 49 individuals, 20 of whom were residents at various stages of the programme, or intending residents.

**Table 13: Categories and numbers of face-to-face interviews (n=60\*)**

<b>Interview category</b>	<b>Interviews</b>
Residents	
1st round interview	15
2nd round interview	10
3rd round interview	4
Early exiters	4*
Intending	3
<b>Total (actual) resident interviews</b>	<b>32</b>
Graduate/completed programme	4*
Whānau	8
Staff/former staff	10
Board members	3
Community	3*
Funder stakeholders	4
Sector stakeholders	3
<b>Total (actual) non-resident interviews</b>	<b>28</b>

\* 'Actual' interview totals are less than the sum of individual interviews due to double counting. E.g. two Early Exiters (1 returning to prison, and 1 leaving the programme and then returning to it) are counted as 2<sup>nd</sup> round interviews. Of the three Board Members, two were also 'Community' members while one also counted as a 'Graduate' interview. A second Graduate interview also counted as a 2<sup>nd</sup> round resident interview.

### **4.3.2 Interviews**

Interviews were divided between two interviewers (Māori and non-Māori) with the exception of one stakeholder interview, where a third team member also participated. For residents and staff (with two exceptions), all interviews were conducted on site at Moana House. Conversations were recorded directly onto laptops, burned to disc and transcribed by a professional transcriber whose contract included a non-disclosure clause.

Non-resident whānau and stakeholder interviews took place in a variety of locations (Dunedin, Christchurch, Wellington). Most were face-to-face, with the exception of four whānau interviews, two ‘community’ interviews and one former staff interview, which were done by phone.

One early exiter interview and three intending resident interviews were carried out during a site visit to the Otago Correctional Facility ('OCF'; north of Milton, South Otago).

### **4.3.3 Outcomes**

#### **4.3.4 Defining outcomes**

In its broadest sense, Moana House sets out to contribute to a reduction in substance use; reduction in offending; and increasing health and wellbeing of those who undertake its programme.

As indicated in the *outcomes matrix* below (Figure 2) the evaluation revealed not only a number of outcomes but also that these range across a variety of categories.<sup>2</sup> Most simplistically, outcomes occur along a continuum. Thus, in the Moana House programme, combining lengthy treatment, goal setting and staged progression, outcomes are not solely observed at the end of treatment, whether completed or not. Rather, there are numerous points throughout treatment where significant transformation in residents' behaviour and attitudes occurs, as well as outcomes at the end of a resident's time in the programme; this view is very much congruent with that held by senior Moana House staff:

I guess the interest around research is in outcomes after people leave the programme and that's what they base it on. But not enough attention is paid to *achieving* outcomes because it's a whole journey. You're not going to get an outcome at the end, a good outcome presumably, unless you also get outcomes all the way through. You don't just “magic” and suddenly get one. You know they have to be achieving things all the way along.

—Moana House Staff Member#1

Māori residents of Moana House also present as historical outcomes in the context of New Zealand history. Many residents come to the Moana House programme as mokopuna of ingenious and inspired tupuna, and often in a Treaty of Waitangi vacuum—as members of whānau, hapu and iwi disconnected from the potency of Te Ao Māori. Being able to glimpse the world of tupuna was framed as a revelation by one resident:

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<sup>2</sup> The matrix represents a distillation of key categories and concepts from the evaluation's more detailed Logic Model. See Appendix I.

[The programme] gives me more of an understanding of who I am. Like what my tupuna are about and what my culture is and how that plays a part in my life and also what we did in the old days...it gives me a bearing...appreciation for tools...there are a lot of tools that our ancestors used that I can still use today. The life that I was brought up with wasn't what I thought it was expecting that that was my culture, the drugs the alcohol, the whatever, violence. But you know looking into the other side of things it's nowhere near it and it's a part that I've never learnt. So learning about that gives me a bearing in my life but also identity which makes me feel good.

— Resident[R8], (at Stage II)

'In-treatment outcomes' occurring *during* a resident's stay in the programme are referred to as 'change indicators', thereby drawing a distinction between these and what occurs for residents following their time in the programme. Thus, for residents the term 'outcomes' refers solely to changes having occurred at the conclusion of residency, whether residents have completed or not. Hence there are outcomes for those returning to prison, leaving the programme once their sentence is completed, remaining in aftercare or graduating.

In sequencing both resident and non-resident outcomes for this evaluation three periods are delineated. These are described in Figure 2 as 'early-treatment' (occurring early on during a resident's stay), 'late-treatment' (occurring during a resident's time in stages II and III) and 'early post-treatment' (occurring once the resident has left the programme).

The matrix (Figure 2) also suggests that there is a range of outcomes impacting on other actors, for example staff, residents' whānau and community members, and on institutions varying from funding bodies and other health sector providers, to community entities such as Rūnanga and iwi. As with residents' outcomes, those in other categories may also be described sequentially or chronologically.

**Figure 2: Outcomes matrix indicating sequences and categories of programme outcomes**

	Characteristics	Residents	Whänau	Stakeholders	Community	Staff	Programme
		Age Ethnicity Education Children Motivation	Partners Children Hapu	Corrections DHB Ministry of Health	Community Rünanga		Treatment Administrative
<u>Data sources/Evidence</u> <ul style="list-style-type: none"><li>• Interview transcripts</li><li>• Questionnaires</li><li>• Archival data</li><li>• Observations</li><li>• Monitored self-change data</li><li>• On-site observation</li></ul>	Outcomes						
	Early-treatment (change indicators)	Integration into programme Retention Stage transition	Whakapakari Whänau	Whakawhan-aungatanga	Whakawhan-aungatanga		Stages Groups
	Late-treatment Stages II and III	Engage with programme Behaviour change Learning / skills development Retention	Whakapakari Whänau	Whakawhan-aungatanga	Whakawhan-aungatanga	Morale Professional development	Stages Groups Data collection MIS
	Early post-treatment After-care beyond, and leaving the programme	Reduction in offending, substance use Increased pro-social attitudes	Whakapakari Whänau	Whakawhan-aungatanga	Whakawhan-aungatanga	Morale Professional development	Aftercare

### **4.3.5 Themes, change indicators and outcomes**

This section draws on the outcomes matrix structure in reporting change indicators, outcomes and themes resulting from a content analysis of the 60 face-to-face interviews with 49 individuals, 20 of whom were residents at Moana House between January 2009 and January 2010.

### **4.3.6 Change indicators and outcomes**

#### **4.3.6.1 Pre-entry**

Some of the earliest changes experienced by men who subsequently become residents in the Moana House programme occur as a result of relationships the programme has nurtured with institutional partners such as the Department of Corrections. In this context prison Drug Treatment Units (DTUs) are increasingly part of New Zealand's AOD treatment landscape with, at the time of writing, the most recent being a 60-bed unit in the Otago Correctional Facility (OCF), opened in March 2010.<sup>3</sup> However, as there are differing views on their utility in TC treatment, consideration of their significance, along with the relationships Moana House has nurtured with stakeholders such as the Department of Corrections, will be taken up in the discussion.

Moana House does, however, maintain an active engagement with individuals (most of whom are in prison) prior to their entry into the programme. Relationships with these men are strengthened through regular staff visits to the nearby OCF to assess prospective residents and advise them about the programme. Intending residents have frequently learned about the programme through the experiences of ex-residents. Interestingly, while the latter may have had unsuccessful tenures at Moana House they are nonetheless prepared to acknowledge its value to intending residents:

Just like a few mentioned that they've gone there. They'll bring up stuff that they didn't like about it...if you're not willing to succeed, to change, you might not get where you want to go. But if you're willing to change then it will work for you.

—Intending Resident[R19]

Evidence that this strategy of relationship building with prospective residents produces positive outcomes for the programme is seen in referral sources, with these trending towards self-referral. This is taken up in the Discussion (section 5.2.1).

#### **4.3.6.2 Programme characteristics, content and structure**

##### **4.3.6.2.1 Safety<sup>4</sup>**

Perceptions of safety can contribute to programme engagement and increasing motivation to change. For example, prominent early on is residents' experience of Moana House as a safe environment; one producing a change in how residents interact with those around them:

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<sup>3</sup> The OCF unit offers a three-month drug treatment programme, run by Care NZ who is contracted to the Department of Corrections in seven prisons around New Zealand. The other six are all six-month programmes. The first fifteen OCF prisoners commenced an assessment phase in March 2010, with the programme proper starting at the end of that month (Personal Communication between the authors and Jack Harrison, Prison Manager, OCF, 18 March 2010).

<sup>4</sup> See Appendix II for an explanation of the derivation of themes and their graphic representation.

When I was in Whare Moana it was like a safe zone. You know, like one hundred percent. It was sort of like being sheltered basically.

—Former Resident[R7], (in After-care)

There's a line that can't be crossed, that won't be tolerated: any physical or harmful or threatening behaviour. So this is a safe place to come.

—Resident[R2], (at Stage I)

This sense of safety and respite is noted also by others, for example residents' whānau:

And we actually feel it as soon as we walk in. You feel—I don't know—the welcome and the calmness.

—Whānau of Resident[1]

This notion of the Whare as a safe environment has a powerful impact on the consciousnesses of men who may seldom have experienced safety in their lives (see also Table 11 for quantitative support of perceptions of safety), facilitating the openness necessary for the personal exploration and growth at the core of the programme:

Knowing that I'm in a safe environment where I can have a voice to put out my concerns, whether they be valid or not is a fucking real relief and a bonus you know. Because to cut my voice off here leaves only one option and so I'm so lucky that I'm in an environment that doesn't cut my voice off. Providing I use [it] respectfully.

—Resident[R1], (at Stage II)

Implicit in the final statement of this quote is the awareness that there is an appropriate way to think, behave and speak and that one has a responsibility to act on this knowledge. This awareness signifies an important change in an individual, one resulting from the programme and consistent with its core aims or outcomes as defined above (section 4.3.4) which, collectively, represents the creation of a new identity.

#### **4.3.6.2.2 Identity**

In the analysis of residents' narratives, *identity* emerged as a major theme. Men entered the programme with a particular perception of themselves, typically negative, with low self-esteem and lack of positive self-image. Substance use was common (see Table 6), as was a significant history of criminal offending (e.g. mean 72 convictions, median 50, range 1-300), signifying an identity orientated around anti-social behaviours and lifestyle. Residents came to understand that the programme would facilitate a dismantling of this negative identity through a combination of group and individual work, goal setting, routine and community activities (see section 4.1.3):

It's just what this place does. It rips everything out of you, puts it on the table and goes: there it is, now what are you going to do about that? That's what it does. There's just no other way.

—Resident[R2], (at Stage I)

And I think that's been a strength of Moana House, you know recognising that these guys will never be fixed if they can't understand their identity.

—Community member/Stakeholder

#### **4.3.6.2.3     Stages**

While the programme comprises a number and variety of activities designed to bring about this reconfiguring of identity, it is also a staged process, with residents having to make identifiable progress or changes in order to move from one stage to the next. Thus, movement through stages ostensibly replicates stages of personal development. Reflecting the earlier comments concerning the continuum of change, however, a senior clinical staff member observes that this staged progression is to some extent artificial, given residents' developmental status:

You know [progress] occurs more or less continuously because we're not dealing with children whose brains are still developing, we're dealing with adults and so there's no point at which you can say that this stage is complete and now we're moving on.

—*Moana House Staff Member#2*

Nonetheless, implicit in residents' movement through stages is the notion that some change must have occurred; that indicators of change are evident. This suggestion is supported by data from residents' responses to the self-report Hua Oranga (Tables 8 and 9).

The groundwork for such change is laid when first commencing the programme, with residents entering an assessment phase or 'pre-stage' known as *Whakaohooho* [the awakening] (section 4.1.3.1) . This initial phase allows staff to carry out a thorough assessment of prospective residents and for both parties to decide whether residency is viable or desirable.

In assessing and subsequently meeting a new resident's needs, impacts will occur in individuals that make possible yet further changes. These include GP and dental visits producing improved physical health, and organising WINZ support. More directly associated with residents meeting programme requirements are actions such as beginning to call house meetings, where issues requiring to be addressed by the therapeutic community are discussed. Even at this stage residents are expected to develop some personal goals around their presence in the Whare and what they hope to achieve during their stay. They will also complete an introductory self-directed learning package around AOD and gambling, and other health issues. Therefore, the assessment stage is about helping people settle in, an individual process that could take one resident three weeks or another resident nine weeks.

So for example someone is clean from cannabis for the first time in 20 years—clearly they're going to have lots of issues around craving. So then they move into *Ahuatanga* [Stage I—the 'shape' of recovery] and they then develop longer term personal goals: So what are the personal issues that you bring here, that you're needing to make progress with?

—*Moana House Staff Member#1*

#### **4.3.6.2.4     Stage transition**

Change indicators explicit in the preceding quote include that an individual has ceased to use a drug, and that in terms of the programme, they have achieved a goal through their movement from assessment to the first stage. Perhaps less obvious, through changing a substance use behaviour and thereby achieving transition into the programme's next stage, residents are redefining their identity away from 'drug user' and also contributing to their own treatment plan incorporating more detailed personal goals. These actions reinforce their new identity and an awareness of the difference between this and the old one:

[M]y personal goals were deviousness and manipulation, drama-queen role, relationships with others (which was around [how] I treat women, and anger), my core beliefs. And I've spent 5 months really pulling all that apart now. So I sort of know why I've done a lot of things in my life.

—Resident[R2], (at Stage I)

Thus a process involving identifiable changes has occurred. The preceding passage shows how individual needs are catered to and that residents begin to achieve insight into their previous behaviours and negative identities, and how their programme work has given them new tools to create a new future:

I'm not in control of what's happened in the past but I am in control of what I do from here and now. That's basically my philosophy now.

—Resident[R2], (at Stage I)

It must be acknowledged, however, that not all residents achieve equally in reaching the goals necessary for transition through stages and thereby successful outcomes in the programme.

I just don't like the fact that they think they know me better than what I know myself...they think that they can just change [my criminal thinking] just like that and I disagree fully. And just because I disagree to them they think I'm resisting or I'm not here to change. It's just bullshit.

—Resident[R11] (at Stage I)

This quote is from a resident who had multiple admissions and at the time of writing was back in prison negotiating possible re-admission. Even when residents fail to complete the programme, for example finding themselves returned to jail, data from the present evaluation suggest that their time at Moana House may result in solidly embedded changes to thinking and behaviour. This is evident in the comments from a former resident (reached Stage I) who returned to jail prior to interview, having informally joined the After-care programme upon release:

I didn't have any fights this time [in jail]...I had one where this guy punched me—I was going to wipe him out but I just stopped and thought about it for some reason, ay?

Interviewer: I'd imagine that would put you in a difficult situation in a way because people would say: Oh he's not stepping up.

Well my bro (he's a mobster from up north) was just looking at me, like: What are you up to? If that sort of thing happens you can turn around and walk away...that's what they teach you [at Moana House]. If I had of retaliated then ultimately he would have been controlling my life and dictating my future, and so that wasn't something that I was prepared to do.

—Former Resident[R7], (in After-care)

#### 4.3.6.2.5 *Motivation*

The fact that the above resident (and others) made the decision to return to prison rather than continue with the programme indicates its intensity and the hard work those remaining are prepared to undertake. The significance of the degree of commitment necessary for success in treatment is discussed in the literature around motivation, this being both a key indicator of success in such programmes (e.g. Broome et al., 1999) and a meta-theme in the narratives examined in the present analysis. Further, while motivation (particularly treatment readiness, its most notable and consistent factor [*Ibid*]) is more of a 'mediator of outcome' than an outcome *per se*, harnessing motivation will *produce* outcomes.

In the present analysis residents' most-emphasised motivational factors included treatment readiness, indicated by a professed 'need for change'; the presence of children; and the often noted, though likely more transitory, desire to get out of jail:

Let's be honest, ay? I just wanted to get out of jail. Go to Moana House because I was on remand and then I just thought; No, fuck it, I'll just go...because I was trying to get an alternative to my sentence.

—*Resident(R14), (at Stage I)*

The above quote, while illustrative of a view commonly expressed by residents (at least at the early stage of residencies), should not be taken as evidence of ambivalence concerning motivation. On the contrary, as quantitative data in Table 5 indicate, Moana House residents were generally highly motivated, particularly in respect of pressure to enter treatment, perceived need for change and perceived necessity for treatment. As the following quote indicates, and as discussed above, the initial reason for entry into treatment may shift and is of less significance for treatment outcome than factors including engagement with the programme and time in treatment:

I wanted to be [in Moana House] for myself and when it got too tough, for my kids as well. So I had my kids coming to Moana House twice a week and yeh it just made it a lot harder [to leave]. I couldn't be so selfish...I had my kids and so I couldn't just dismiss them.

—*Programme Graduate/Stakeholder*

#### **4.3.6.2.6 Time in treatment**

Once in the programme for whatever reason, it is possible for residents to gain traction in their recovery, as the longer they stay the more exposure they have to the programme's influence. As is the case for motivation, the literature on retention is clear; the longer a person stays in a programme, the closer they are to achieving treatment goals at follow-up (Gerstein & Harwood, 1990). In this sense the capacity of the Moana House programme to *retain* an individual in treatment is, as with motivation, a mediator of change for that individual. See section 4.4 (Archival Data) for a description of retention rates.

#### **4.3.6.2.7 Whānau ora**

Senior staff at Moana House acknowledged that recent changes in criminal justice legislation (e.g. the Parole Act, 2002; Sentencing Act, 2002; Parole Amendment Act 2007), resulting in increased imprisonment rates, lengthier sentences and greater difficulty in exiting prisons before sentence completion, have contributed to the likelihood that men paroled to Moana House are less inclined to leave early. However, other factors specifically related to the programme also impact on increased retention. Of particular significance is a recently funded *whānau ora* programme, which sees children, partners, parents and other family members reconnected with residents. While at the time of writing there was only a year's data to draw on, trends indicated that higher levels of commitment to the programme and greater retention were associated with residents' whānau connections being encouraged by Moana House, e.g. through paying for whānau to visit, stay in the Whare and receive other support. This draws residents more proactively into the programme. Such support is expensive, especially for a chronically under-funded programme, and so residents are made aware that evidence of commitment to the programme must be forthcoming:

You know we've just gone away from pulling in family immediately. Once we're seeing commitment then we'll actively bring the family in, whether it's children, partners, parents, to reconnect.

—*Moana House Staff Member#3*

This quote underscores how the relationships Moana House develops with residents' whānau result in impacts on residents and their families. This proactive approach to whānau ora has the potential to set a solid foundation for long-term outcomes for families, i.e. *whakapakari whānau* (Figure 2). Quantitative data supported the perceived value of this process and its actual impacts on residents' thinking, with both a majority of residents (93%) reporting better communication with whānau (section 4.2.6) and a consistent improvement in perceived whānau relationships over time (Table 9).

Strengthening whānau relationships is, however, not without its risks. For example, residents may achieve considerable success in the programme, dealing with deep personal issues, making changes to their thoughts, attitudes and behaviours, developing life skills, furthering their education and gaining employment. Nevertheless, through reconnecting with whānau who may have not necessarily developed such competencies, residents put themselves in situations of great stress, which may ultimately threaten all they have achieved. While some may have the resilience to accommodate these situations others will struggle:

I met my sister. When I got to her house there was alcohol and drugs all around. I know that for me it's not my stuff. I'm okay myself, I'm straight, I stay sober. I'm [drug] free and I know that it's not tika.

—*Resident[R3], (at Stage III)*

They've got to have some internal strength these guys to survive, you know? Having come through the programme, [to] get back out there and be placed in tough situations, to be consistent and to continue. But I know that one or two of them come unstuck because of the situation in the whānau.

—*Community member/Stakeholder*

#### **4.3.6.2.8 Groups**

As noted previously (sections 4.3.1.3.2-3), along with discussing impacts and outcomes in the context of structure (e.g. stages), changes undergone by residents may also be linked to the programme's content. In particular, there are a variety of groups in which residents undertake specific types of learning and development, aimed at addressing discrete aspects of their thoughts and behaviour.

#### **4.3.6.2.9 Psychotherapy**

Run weekly by a senior clinical staff member, and three-monthly over intensive three-day blocks during a week, this long-standing group is aimed at addressing deep personal issues. One graduate of the programme suggested that for many, this potentially presents too much of a challenge, especially for newly arrived residents:

Well, that's when the majority of the residents would leave, after his group! Leave the House that night or the next day. I noticed over the year period they'd be more inclined if you were doing statistics-wise...that was the most challenging group of the week. [T]hey just didn't do things on the surface, they got right under your skin. And there was no subject that wasn't like out of bounds.

—*Graduate /Stakeholder*

However, many residents experience significant impacts on their identities, how they formulate core beliefs and, as a consequence, how they behave:

He [therapist] sort of spits it back at you; as if you role-play, your violence issue is where it comes from; if I was in that predicament, what would I do? Just swapping that around, you know just putting yourself in your victim's shoes. I never thought about that shit, ay? Because I didn't really care about myself at this stage because they asked me what happens if that was you? I don't think I'd put myself in that predicament and then he turned it around and said: What happens if it were your daughters? And that's what made it sort of click, you know?

—*Resident[R13], (at Stage I)*

#### **4.3.6.2.10    Victim empathy**

The psychodrama group Victim Empathy shares a ‘deep therapy’ focus with the weekly psychotherapy group. It is held over three-day blocks approximately every three months, when its Christchurch-based facilitator visits Dunedin. The therapist notes similar disengagement, as in the quote above, by residents when they initially discuss their perceptions concerning victims:

And so we talk about the feelings of the victim: Well I didn't know them, can't see them, don't know anything about them, they can't possibly have feelings.

—*Moana House Staff Member#5*

However, while some residents may deny empathy with their victims, even not being able to exhibit it at all, over time others will acknowledge a growing understanding of their role in creating victims and the need to take personal responsibility:

Well my understanding back then before I last seen you [at Stage I] was that okay you put yourself in the shoes of victims. That's all I really knew. But my thinking now is that I've created victims in my life by reliving experiences that have happened to me through my life... You know using things that have happened to me in my past and victimising people that are close to me or anyone really to make myself feel better and you know it hasn't really worked.

—*Resident[R2], (at Stage II)*

As residents continue to move through the programme, undertaking work in this group, they build on their knowledge and skills. Staff recognise when senior residents have achieved the level of understanding and empathy allowing them to move beyond the group:

It was really clear for these three that in terms of themselves and their lives and the victims they'd created that their understanding was such that they wouldn't necessarily create a victim again in a way they had in the past. They might in terms of being shitty with someone and saying something unkind but in terms of re-offending it would be most unlikely. Claire and the other staff could create a list of when the man has achieved these things then he could probably graduate but for me ,who tends not to make lists in that way, instinctively I knew that these men would not need another intense group.

—*Moana House Staff Member#5*

#### **4.3.6.2.11    Criminogenics**

Criminogenics is a relatively new group, commenced in 2009, and run principally by the programme’s Director. Its primary focus is on criminal thinking and behaviour, with its facilitator using a thematic approach incorporating residents’ individual stories. Residents are

required to contribute and work out how their criminal thinking manifests in their behaviour; for many, a confronting experience:

In a way I like it because it's bringing up [his criminal actions] and working it out but the thing I don't like about it is visiting my past. And all those kinds of feelings come...and they visit the past, telling people why I did this.

—Resident[R12], (at Stage I)

For others, engaging with the process of Criminogenics offers the possibility of insight into long-standing negative behaviours and the prospect of change:

I have a favourite group in the programme and it's called Criminogenics...the biggest thing I get out of that is being able to connect my alcohol and drug use and offending, and how it's related to the way I think and my behaviours and distorted thinking: you go from a situation to thinking, to feelings, to behaviour.

—Resident[R2], (at Stage I)

#### **4.3.6.2.12 Ara tika**

This weekly group exploring roles, responsibilities and relationships offers residents the opportunity to change abusive behaviour and thinking patterns, particularly with regard to their partners and family, and the use of violence:

So you can think about women differently, about partners differently, about children, about the impact of your behaviour on them...you don't have to go down that abusive lifestyle that you have been involved in.

—Moana House Staff Member#4

During interviews residents expressed a variety of opinions about Ara tika, some negative, for example due to its facilitator and its timing on a Monday evening:

Come 6 o'clock your body is winding down. My body would wind down and I'd walk in to this fucking group with a person I believe she's initially against men, it's a boring group...It's like, people will nod off.

—Former Resident[R9], (left at Stage III)

Others, however, gained therapeutic traction in Ara tika. In the quote below the group's korero resonated with the speaker's current situation, which included the arrival of a new child:

Ara tika has been really great too; it's been a real eye-opener. I'm in a relationship and I've been in a lot of crazy relationships and it just resonates and is relevant for a lot of things I've been through, that I'm going through now that I can see would help me in the future. [I]t's helped me appreciate that the centre of the universe is not me, it doesn't revolve around me. I think that's one of the biggest things that I had to come to, is getting over myself, that it wasn't all about me.

*Interviewer:* Right. And you feel that you've got to that step?

No, I just think that I've been made aware of it. Yeah, put it that way. I have a sense of being able to pull myself up.

—Resident[R4], (at Stage II)

Also of interest in this last quote is the speaker's recognition that, while he has gained insight into his previous behaviour, he is yet to master it. Nonetheless he is developing strategies to achieve this.

#### **4.3.6.2.13    Process group**

Occurring at the beginning of the week, this group aims to allow residents to clarify their thinking and feelings around issues of the moment:

[I]t's almost like a mini psychotherapy group. Where are people in their thinking? What's their learning? What have you learnt about yourself over the weekend? What's the issues? How are you going? Where are you to begin the week? You know, where have you moved from last week?

—*Moana House Staff Member#4*

Monday morning we have Process Group—that's how you're processing your thinking, how you're travelling, pretty much how I'm talking to you now, as a process...you would be given goals. Right? So your goals would come out of Process Group around your thinking.

—*Resident[R1], (at Stage II)*

While the 'process' alluded to above describes a group method or practice in the programme, of greater relevance to the present evaluation is that this 'process' depicts a method of progression in residents' thinking. Further, an outcome of this method is the combining of various programme aspects, including other groups, into the programme's therapeutic practice. This is explicit in the second quote's final statement regarding the outcome of weekly goals from the Process Group.

#### **4.3.6.2.14    Goals group**

This Monday group sets weekly SMART goals (Specific, Measurable, Activity-related, Realistic, and Time-specified) (Siegert & Taylor, 2004), which are noted for each resident. Goals are orientated around the personal (i.e. therapy issues), the practical (e.g. whether a resident needs to sort their WINZ entitlements or commits to cutting more wood for the Whare) and work/education (i.e. building a plan towards achieving employment or furthering education upon leaving the programme). Residents' individual progress with these is plotted and adjustments made where necessary (i.e. if goals are too hard or irrelevant). While a specific group facilitates goal development, these have relevance to other groups and to the programme's therapeutic practise in general:

So you would be given goals for the week to complete over five days and those goals you would...present them to the whānau [Moana House residents and staff] and they would give you feedback and whether in a positive or a negative fashion. Then on Tuesday...you then have Criminogenics, then from Criminogenics you go straight into your Process Group and also your house meeting goals because the goals that you're given for Process group are generally linked to criminal thinking; Why are you thinking like this? Can you see the pattern? Can you see how that pattern is criminal, is connected to your criminal behaviour and you actions?

—*Resident[R1], (at Stage II)*

### **4.3.6.3 Resident characteristics as change indicators**

#### **4.3.6.3.1 Residents as role models**

As noted in the literature review (section 2.1.3) and also in the description of the Moana House programme content (section 4.1.3.1), there is an expectation in therapeutic communities that all residents act as role models for their fellows. This expectation increases as an individual moves through the programme, gaining seniority and taking on more responsibilities, as their ability allows:

If you're close to stage three you have to move to the senior residents' group. Senior residents need to take...responsibilities...well I look after the garden. Maybe also I support [staff] a little bit. I step up especially at handover by staff.

—Resident[R3], (at Stage III)

While the above reflects added personal responsibility in pragmatic matters, of clearer therapeutic significance is the role senior residents take in their interactions with other residents concerning personal behaviour and the support of the House kaupapa:

[T]he senior residents...not only are they role models but they also act as conduits for good behaviour in terms of maintaining the stability of the House. They don't need to come and tell me for example that so-and-so is not making his bed. I'm not interested. Nor...that so-and-so is feeling out of sorts with so-and-so. Go and do something about it!

—Programme Consultant/Moana House Staff Member

Nonetheless, there are moments in a resident's treatment and recovery when the changes, knowledge and skills they have achieved in the programme are put to the test, sometimes requiring augmentation within the Whare's supportive community:

The example yesterday was me and my partner had a disagreement and it was the first time in two years that we've disagreed on something to that extent, and I lapsed in my thinking and went: Stuff this! The only thing I know how to do in these situations is go and run and never to be seen. I ended up walking down past the House and I knew group therapy was happening here and in that moment I weighed up [where] that road would lead me to and where was this road going to lead me to? So I come down here halfway through group and said; Look, I need some time here. And I shared everything that was going on for me and got told that I'm a role model, that I role model exactly to these men that have just started in the programme that have been there a little while; that it's not all a fairy picture, that men that are where I am in the programme actually do struggle from time to time and that it's okay to come down and talk about it.

—Resident[R2], (at Stage III)

This is an important passage as it demonstrates a range of in-treatment outcomes, albeit anecdotally, for both the individual and the programme. These include: recognition of problematic behaviour; ability to empathise; use of tools/strategies to engage with the problem (i.e. seeking help, knowing where to find it, use of a safety plan); willingness to communicate honestly; appropriate response in the context of the programme (i.e. as a senior resident, offering something to junior members of the community); and, further, recognition that there will be times of difficulty but that these can be overcome by commitment and appropriate strategising.

Finally, as with the junior resident quoted earlier (R11, in Stage Transition), it is necessary to recognise that reaching senior residency in the programme does not guarantee the successful achievement or maintenance of the desired in-treatment outcomes:

From what I've experienced in the whare so far with senior residents, like [Stage III resident] does help a hell of a lot. In terms of [second Stage III resident], he can give a lot of information but through his actions his information is hard to believe. Like he has lapsed a few times. –

—Resident[R15], (at Stage I)

This quote provides an interesting contrast between outcomes for two specific residents and, through its accuracy in depicting their behaviour and its subsequent consequences, substantiates the validity of the narrative data reported in this section.

One of the senior residents referred to in the quote by R15 above is, despite two decades of gang involvement, serious offending and substance misuse, a highly motivated individual, recently released from prison when he joined the programme of his own volition 22 months previously (at the time of writing). Currently he is in Stage III, beginning independent living, studying full-time and preparing to graduate the programme in July 2010. His newly forged identity is evident, both to those within the programme and beyond it:

[H]e's so proudly Irish and I don't know what he was like prior to [treatment] but I just see this real Celtic pride in this man and I know they'll [the House] continue to explore that stuff for himself because in a sense when you are open, cracked open and exposed for what you are and all that you aren't, you hold onto anything that will keep you afloat in the chaos of; Oh my God! I've got to change! And everything is just so new. A new environment, a new way of thinking, a new way about talking to people, a new way about everything about being a human being.

— Stakeholder, Kaitiaki Prisoner Caseworker, Corrections

In contrast, the other senior resident referred to by R15 provides an example of an individual to whom every possible avenue for treatment and recovery has been offered. Over the years he has attended numerous programmes and this most recent stay in Moana House is his third. Despite this, and reaching Stage III, his inability to achieve meaningful and lasting change is evident to many, including residents as well as staff:

Addiction is a chronic relapsing condition sadly. We are at least [the] 4th programme [he] has been in, more if you count adolescent counseling, and he has been here 3 times—he does not want to grow up!

—Moana House Staff Member#1

#### 4.3.6.4 Relapse prevention and after-care

Moving beyond the programme itself towards early post-treatment for successful residents offers an alternative means by which to assess treatment outcomes. While negative identity was a strong theme in the early-treatment phase of data collection, its disestablishment and reconfiguration as *positive identity*, expressed through pro-social attitudes, and eliminated/reduced criminogenic and substance using behaviour, provides evidence of early post-treatment outcomes.

As with the newly deployed *Whānau ora* programme, Moana House's *After-care* component embodies a growing branch of activity. In this sense it is an outcome of the programme's ongoing efforts to nurture a vital continuum of care for former residents. It also hones a skill-set for those moving away from the House:

What's going to be happening when you leave; what do you need to get yourself healthy, and have you got all the life skills you need, and if you haven't got them what are they, what can

be built on, what can we establish? So their relapse prevention plan is absolutely specific to them, and it's home situations: what's going to cause relapse, what are the support systems to try to prevent relapse or to minimise it?

—*Moana House Staff Member#4*

For Stage III residents and those moving into After-care however, while the world beyond the House provides opportunities to use and display newly acquired skills and knowledge, it also harbours hazards to negotiate:

Going to [names a city]—that was pretty tough, just running into people and people putting situations in my face like trying to get me back into dealing and that. Oh fuck, I could have made some serious coin and I was broke at the time. Like I could have gone up there and just done a couple of deals and got [\$100,000] and no one would have known.

Interviewer: And would it be fair to say that the programme here has prepared you for resisting that?

Yeah, definitely. A lot of things I learnt here. But at the end of the day I mean it's down to me, isn't it? Be honest and be straight up and not be doing anything dodgy. It's pretty easy to walk over that line if you wanted to, you know? But I've just said to myself I'd never go back to it, you know? Well if I got busted, it's not only going back to jail but it's ruining everything that I worked for, you know? It's like I might as well throw everything in the bin.

—*Resident[R6], (at Stage III)*

This quote exemplifies both the potential risks that newly completed residents face when leaving the programme as well as the possibilities for change that Moana House offers.

After-care itself is a vital component of TC treatment, something recognised internationally. Likewise, Moana House acknowledges this critical area and consequently has dedicated a staff member working with after-care, this being closely aligned with education and employment. Accordingly in 2008 the programme produced a report for the Ministry of Health, in part based on resident interviews, detailing this component of the programme's service delivery. In this regard residents mentioned the following: being encouraged to attend a number of support groups; connection to support services meeting individual and whānau needs, and advocacy by people within these groups; receiving help applying for educational courses and scholarships and liaison with associated institutions; and, having kai, phone contact or short visits to Moana House which reinforced connections to maintain new lifestyle changes.

Nonetheless, despite Moana House's strong commitment to provide after-care services, something for which it is not fully funded but has provided since inception, this area remains under-developed. There was also awareness amongst stakeholders that the lack of post-treatment care is a national problem and that expecting those completing a programme like Moana House to completely avoid relapse is unreasonable:

We're conscious of the fact that most of the people we see have had terrible lives and it is stupid to think that they will suddenly fix that [having] lived for years in very difficult circumstances. They go into a programme for 6 months and then they come out different human beings...Well you know that's not going to necessarily happen. Sometimes it does miraculously but mostly people will relapse, they will fall back in their old ways. It's a journey, not an end. This is absolutely to be expected. The climate in New Zealand doesn't allow for it and should we judge Moana House for that? I think that's unrealistic.

—*Stakeholder, Corrections*

#### **4.3.6.5 Recognition of change indicators and outcomes**

##### **4.3.6.5.1 Whānau perceptions**

The transformation of residents' lives is also noted by their affiliates, particularly whānau, both those with family members in the midst of treatment and nearing completion:

How he has blossomed into something that we're both really proud of, and proud of Moana House because without them I don't think [R1] would have gone anywhere.

—Whānau of Resident[R1]

[H]e's already done his three year safety plan. You know? It's oh my Gosh! It blowed me away, you know? It's like from a guy that wouldn't even think about tomorrow.

—Whānau of Resident[R2]

He doesn't want to do crime. His thoughts have changed hard out. [And]...his negative thoughts and stuff, his anger... he used to be angry all the time, now he's happy as. And just like scheming to get money...like he just wants to work for his money instead of trying to steal his money and stuff. It's the big change. Like crime and his anger.

—Whānau of Resident[R16]

##### **4.3.6.5.2 Education**

While whānau members have the possibility of noticing changes in familiar partners, parents or children, when meeting former residents, others in the community will gauge them by what skills they present with. Consequently the programme places a strong emphasis on furthering education which, as discussed in the quote below, is commonly under-developed for many residents. This is corroborated by data from the present sample (see section 4.2.1 The Sample):

[W]hen [residents] come into the programme they've been through the prison system or they've been through the court system for so long that education hasn't been something that's important to them and in the current environment what employers are looking for is either a piece of paper or some long-term job history experience that someone can offer...What Moana House does is break through those barriers around literacy and numeracy that someone might have.

—Stakeholder#3, Department of Corrections

Thus a dedicated staff member assists residents in developing an educational plan and achieving the resulting goals:

I can't get a higher paying job to be able to support my family because I know I lack education...I've got no qualifications whatsoever, whatsoever, and like for myself it's good to learn how to set myself a plan for what I want to do to gain education and to employment that I'd like to see myself doing and the steps that I take to be able to achieve that.

—Resident[R11], (at Stage I)

During the thirteen months of the evaluation, of 17 residents who stayed longer than one month (i.e. who were either already in the programme or joined it in this time), one graduated and five reached Stage III. Of these six, at the time of writing two were studying and working, two were in fulltime study, and one had enrolled in fulltime study but had relapsed (recommenced misusing alcohol). All study was being undertaken at the Dunedin Polytechnic, with which Moana House has developed a close relationship.

#### **4.3.6.5.3      *Employment***

As with education, employment is considered an important goal for residents entering the programme. Of the 17 residents noted above, during the evaluation period nine either left the programme upon completing their sentence, reached Stage III or graduated; two left the programme and returned to jail but then re-entered the programme in After-care. Of these 11, four are (at the time of writing) in fulltime employment.

However, as with all outcomes, residents leaving the Whare and taking up employment, either upon programme completion or at the conclusion of their sentences, experience varying degrees of accomplishment. There are major success stories, for example the former resident who subsequently became CEO of New Zealand's third largest corporation. Despite acknowledging that others of his peers also enjoyed success, he nevertheless comments that achieving sustained recovery is difficult:

You were terribly successful because you weren't putting a needle in your arm every day and fucking living in a cell. But it wasn't really like that. You know? And lots of them ended up going down quite badly before they've come back up. Some of them have not ever come back up to where they were.

—*Graduate/Community member*

Despite these concerns he also comments:

When we were doing the research fifteen odd years ago you know 80% of the people that went into Moana House were coming out and not necessarily never re-offending, but 80% of them were never offending to the point that they were when they went [back] into Moana House.

—*Graduate/Community member*

#### **4.3.6.6    Programme characteristics**

Three final outcome areas bear comment. These concern indicators of programme success, including delivering outcomes in response to Treaty of Waitangi understandings, programme flexibility, and the sustainability of the programme in relation to resourcing, which includes, but is not limited to, staffing and funding.

##### **4.3.6.6.1    *Response to Treaty of Waitangi: the colonisation/decolonisation debate***

Māori residents of Moana House (approximately 70% of residents) present as mokopuna drifting both inside and outside of seriously damaged whānau, hapū and iwi constructs struggling to survive through a colonisation process.

The Treaty of Waitangi, with its many dimensions of impact on Te Ao Māori and its people, does not appear to be clearly deployed in the programme as a liberatory education tool in itself. In recognising this one resident/mokopuna commented that residents should question this:

Like finding out more about who they really are. What does the independence kind of thing, the Treaty of Waitangi kind of stuff...[mean]? Because half these people that come through this whare don't even know, but they know when they go to a hui once in awhile just for the purpose of the staff here, or something like that, when they're running the group, but that's about it. And that only lasts for like two days. I just don't think that kind of stuff is enough.

—*Resident [R11], (at Stage I)*

That affected mokopuna are not receiving decolonising material is an issue that concerns not only the descendants of whānau, hapū and iwi who most felt the impact of colonisation but also non-Māori New Zealanders. A programme of decolonisation could present historical truths to help explain the context in which we currently operate and inform non-Māori potentially in a powerful position to effect meaningful change in the awareness of a nation. The programme serves to increase independence of the residents. For some that sense of rangatiratanga will be enhanced by having an understanding of matters that have shaped and continue to shape their world.

Others interviewed felt a sense that Moana House and its programme was Treaty responsive, and that a potential outcome of the programme would be a decolonising not only of Māori, but also of non-Māori:

I was quite comfortable it being called bicultural. It was not kaupapa Māori...because half of it is Western modalities and ideas and techniques. And in a wider context it makes really really good sense for New Zealand [because I] think Treaty! And I think the more it's spread, not just in treatment programs, but in general, the more harmonious a country we're going to live in.

—Former Staff Member#2

#### **4.3.6.6.2      Programme flexibility**

Following Wilkinson et al. (2008) (see Section 2.2), there is recognition that programme flexibility (i.e. adaptability to the needs of those in treatment) is an important success factor for treatment programmes such as Moana House. As with motivation (see above) while not a direct outcome in itself, evidence of flexibility in programme structure provides an indication of the increased likelihood of success.

In the present case the implementation of the *criminogenics* therapy group during the period of the current evaluation has already been noted. Further evidence of the programme's responsiveness to residents' needs occurred during the evaluation as a result of House staff and senior residents attending workshops presented by world-renowned therapeutic community figure George De Leon, who visited New Zealand in 2009. In discussing the value of communities' initial early morning meetings, De Leon observed that their principal purpose is to 'set the tone' of the coming day through taking a celebratory approach to this first vital gathering. Moana House staff and senior residents present at his workshop commented that the Whare's *whakapiripiri* typically also included house meetings and other challenges to unsatisfactory behaviour by residents. De Leon responded that this was inappropriate. Upon returning from the workshops discussions were held, and as a result the morning meetings were altered in line with De Leon's proposal, and a second and subsequent meeting *whānau hui* (where challenges and house meetings could be implemented) was introduced:

[W]e changed it. So it was a reminder about having times and places for various things. So the *whakapiripiri* went back to being karakia, readings, sharing of thoughts, waiata and then as soon as we've finished we go into *whānau hui*. And that's where those issues come up.

—Moana House Staff Member#1

This responsiveness by the programme typifies a flexibility that has seen it evolve over the more than twenty years of its existence:

[L]ong term residential programmes that get very stuck and continue doing the same things usually self-destruct or kind of believe that that's the only way of doing things. We have to

be open to continual evolution with research, with expectations, with changes in the wider community, about new discoveries, new medications. We discover that something works well and that didn't...You know we have to be open to developing what we're doing all the time.

—*Moana House Staff Member#1*

#### **4.3.6.6.3      *Resourcing—staff***

Aside from Moana House's external relationships with stakeholder partners, there are also important non-resident relationships within the House, notably those involving staff, which may have a profound impact on outcomes. A therapeutic community's intense environment requires that staff be reliable, experienced and committed. These qualities, necessary for all staff, are exemplified by the programme's Director, who has been a driving force behind the programme since 1988:

Claire is a very experienced mental health practitioner and has a huge energy and there is something about her mana around the place that when she's not here she's missed.

—*Moana House Staff Member#7*

The long-term involvement of a highly competent individual in a key area of operations confers the advantage of organisational continuity. Nonetheless it potentially also exposes the programme to negative outcomes; for example, a crisis in management should that person suddenly become unavailable, i.e. through illness or other unforeseen circumstances. Further concerns include limited input by other staff into programme development, and an undermining of the necessary separation between management and governance, something vital in not-for-profit organisations such as Moana House:

Claire is the programme. The programme is Claire...That's a strength and a weakness...Well she's the one that holds it together...at DeLancey Street [a US TC visited by Moana House staff in 1987] was a philosophy that was held by a collective of people...a shared philosophy that's been ingrained over 20 years through hundreds of people. At Moana House it's Claire's philosophy...You know she's the touchstone, she's the person that can change the rules, she can set the rules, people can sit down and negotiate these things until they're blue in the face and feel like they're part of the process and nine times out of ten they are, but the buck stops with her...the programme, what's happening, who gets the money, what shifts philosophically, what shifts therapeutically, all of those things are determined by her.

—*Graduate/Former Staff Member/Community Member*

The impact on staff morale of both a demanding programme and an exacting manager/Director can lead to staff tensions and the possibility of burnout:

Jesus Christ every staff member there just about left. You know there's been all sorts of bloody scraps, people leave and they never want to speak to [staff member] again, and they come back...it's like a big bloody dysfunctional family!

—*Graduate/Former Staff Member/Community Member*

Nonetheless, others recognised the support provided by the programme:

Staff were very much looked after. As long as staff put out what went on for them they were fully supported.

—*Former Staff Member*

In explanation of these varying staff experiences at Moana House, one current worker proposed that staffing issues are also a function of the type of person attracted to this particular field:

People don't come and work in a programme like this because they've led perfect lives. People are attracted to working with criminals for a reason. So all of us have vulnerabilities. As a group of people we probably have less stable personal relationships, we probably have some colourful history; we probably have a greater tendency towards anxiety and depressive disorders than the general population.

—*Moana House Staff Member#2*

Furthermore, there is the recognition, even from beyond the programme, that there will be times when difficult decisions about colleagues must be made to protect the programme's integrity:

I so admire the Director that she has had staff over the years that might do one sort of thing wrong...Well she can cut them just like that...she goes: It's a risk. So I'm going to cut that out. As much as it hurts her to do it she'll do it. But she will stick by her principles and these are rules...But I can see that she would have thought: If these men see me give on this what else am I going to give on? And I can't do it. As much as I may regret it I'm going to let this person go. Even though they've been my right-hand person for 6 years. And she'll make those tough decisions for the benefit of the programme, which is what I admire about her.

—*Stakeholder, Māori Health Sector*

Consequently there are a variety of outcomes, positive and negative, associated with staffing. Rather than being 'merely' employees, staff exhibit a passion and commitment to the programme and residents, potentially providing strong therapeutic traction. In clinical parlance this is known as the 'therapeutic alliance', a vital relationship between staff and residents and, in its most positive expression, one recognised as integral to successful programme outcomes (Simpson et al., 2009):

When I think back to the MATCH project [e.g. Connors et al., 1997], the modalities didn't seem to make much of a difference; the strength of the therapeutic alliance is pretty much an indicator of how far client and therapist will journey together.

—*Former Staff Member*

Along with dedicated staff and the positive outcomes they generate, the programme itself (through management and Board) is committed to succession planning, with likely candidates identified through their passion for work in this area and relevant experience. Individuals are made aware of the programme's interest in them, but also that there will be an appropriate time for them to take up a role, even as important a one as future Director:

Interviewer: at the end of the day [Claire's] not going to last forever!

No, but the shoes that she fills are very big shoes to fill...[and] the question for me is; Can I do justice to what she already does? And that's just a personal thing for me. Can I fulfil those needs? Because Claire is a very special person.

—*Stakeholder#3, Department of Corrections*

While negative staffing outcomes include the risk of burnout and potential disaffection by some former staff, the programme is also proactive—through its training institute Te Take Take—in developing a future workforce, some of whom have already taken up positions as Moana House staff. Thus further outcomes of the programme include not only it providing for

its own needs in future workers, but also its furnishing the wider New Zealand AOD sector with well trained and culturally competent workers:

The added benefit is that other services in the community and around the country get the benefit of providing their own staff into this programme to get the benefits of that training as well.

—Stakeholder#3, Department of Corrections

#### **4.3.6.6.4 Resourcing—funding**

For Moana House achieving outcomes is set against a backdrop of limited and convoluted resourcing. The programme has multiple part-funding sources, holding three contracts: an integrated contract between the Otago DHB and the Department of Corrections to fund eleven/eight beds respectively; a short-term contract (ending June 30<sup>th</sup>, 2010) with the Ministry of Health to fund infrastructure development; and, a recently secured Ministry of Health contract to fund six beds dedicated to the needs of methamphetamine users.<sup>5</sup> This creates its own difficulties due to each contract having unique output requirements and reporting criteria. However, the greater problem remains chronic underfunding, something some stakeholders with a knowledge of the programme are acutely aware of:

What I mean is that every year they have to sell Christmas trees—I don't know any programme that does that! It just annoys me that they have to do that and I know other programmes can hire statisticians and...pretty much full-time RFP writers to apply for new things...Odyssey House in Christchurch is huge...[they] got another new residential contract because they basically have the space and they had other options...They can save a lot of money and I know that was a big part of the decision..[Moana House has] three options and two of them involve building new buildings to do it.

—Stakeholder, Health Sector

While perhaps more sanguine regarding the constant need to search out and secure funds, the programme's Director acknowledges that a single national price per bed would facilitate the programme's further development. She noted that the recently secured contract for six 'methamphetamine beds' was funded two thirds better than the current eleven beds combined:

Interviewer: So what's a per bed price that you that would be viable for you?

\$102,000 a year. [W]e would immediately want to develop ourselves further. We're not interested in earning money and putting large amounts in the bank. Our philosophy is that yes of course you have to have some money in the bank because they might stop funding you suddenly and you need to have three months in backup, but you get money to actually spend on residents and their families and provide a service...And I think the really important thing is if you do earn some money you have the opportunity to be innovative and you can do things outside the square...and I think that's vital.

—Moana House Staff Member#1

As with the discussion of motivation above, resourcing per se is not an outcome, rather it mediates outcomes. In this instance, limited resourcing equates to a brake on programme development and thereby reduced potential for positive treatment outcomes. These issues notwithstanding, through its own initiative the programme gains a level of funding and related resourcing support independent of its longstanding contracts. As examples, recent positive outcomes in this regard include the securing of the new contract for the above mentioned six methamphetamine beds and a recent substantial grant for premises redevelopment from the

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<sup>5</sup> See Section 8.7 in Katene et al. 2007:32, for further detail on funding as at 2007.

Otago Community Trust with whom, as with many other community organisations, the programme has nurtured a longstanding and productive relationship. Senior staff will also take up *ad hoc* teaching and presentation opportunities, which generate occasional and modest income.

One final point deserves to be made concerning on-going self-funding activities which include occasional paid speaking engagements by senior staff, House workdays, where staff and residents operate a gardening/property clearing business, and the annual Christmas tree sales noted above. While these generate a useful proportion of the programme's annual budget (approximately 25%) they also serve two other important functions, each with clear outcomes. They act as an interface between the House and the Dunedin community, thereby breaking down barriers with neighbours and the townsfolk. That Moana House has operated successfully in a suburban environment for over twenty years is testament to this:

No one's bitching about it being a neighbour not like up in Taumaranui. And the relationship that Moana House has with all the neighbours around here is a very good one. Can you come and trim my hedge? Yeah, sure. Can you come and move my piano? Yeah, no trouble. We'll come and do that, you know. We need some men to come and do this... Yeah, no trouble. You know the neighbour next door, Mr. [X]; he gave us that TV that's in the lounge because he's upgraded. And I suppose in terms of the community spirit around here, locally, you will see it at Christmas time when the old folks from across the road, they come over and bring scones and sit down and have a scone and watch us selling Christmas trees, and comment.

—Graduate / Moana House Staff Member

Perhaps of greater significance for the programme itself is that, as with every activity undertaken in the House, the communal work carried out by the residents is always done with therapeutic intent. This was illustrated to one of the present report's authors who, whilst accompanying residents on their annual Christmas tree harvest early on during the evaluation, experienced a 'house meeting' when a resident was challenged over his perceptions resulting from a recently attended Victim Empathy intensive. The skill of the facilitating staff member, himself a former resident, and the firm and honest, yet supportive, guidance of the other residents as they drew their erring 'brother' to engage critically with his perceptions of his behaviour left a lasting impression on the observer: residents' therapeutic work towards recovery is not something that ceases at the door of the Whare. It is for life.

#### 4.3.6.7 Summary of change indicators and outcomes

In the preceding section narrative data were presented relating to programme pre-entry, the early and late in-treatment programme phases (change indicators), and in early post-treatment (outcomes). These data are summarised with reference to the following areas:

- **programme characteristics, content and structure**—where the following themes and/or programme components signified or elicited change in residents:
  - *safety*—the acknowledgement, by residents, that Moana House creates a safe environment, thereby offering traction for recovery;
  - *identity*—residents' acknowledgement of their negative identity (i.e. criminogenic and substance misuse behaviour, and anti-social orientation) and the need to change;
  - *programme stages and stage transition*—movement by residents through a staged programme, with transition predicated on measurable change;
  - *motivation*—a 'mediator of change', harnessed by the programme, thereby facilitating residents' gaining of traction in recovery;

- *retention*—‘time in treatment’ is a significant indicator of change; in the Moana House programme the harnessing of motivational factors has led to increased retention;
- *whānau ora*—a programme adjunct linked to increased motivation and retention, and to strengthened whānau relationships (*whakapakari whānau*);
- *groups*—residents offered examples of personal change mediated by and specific to therapeutic work in various groups: psychotherapy, victim empathy, criminogenics, ara tika, process group, goals group;
- **resident characteristics as change indicators—**
  - *residents as role models*—evidence of residents taking on pragmatic and therapeutic responsibilities as they progress in the programme;
  - *relapse prevention*—residents develop individual plans; evidence of their efficacy in resident narratives;
- **external recognition of change indicators and outcomes—**whānau perception/acknowledgement of changes in residents’ behaviour and attitudes.
- **programme characteristics—**
  - *Treaty of Waitangi understandings*—was not strongly signaled by residents;
  - *programme flexibility*—responsiveness of the programme to the needs of residents; continual adaptation of the programme;
  - *resourcing*—
    - negative and positive outcomes around staffing, with the potential for burnout; the retention of highly experienced staff providing programme continuity; succession planning developed through the growth of the Training Institute which, as a further outcome, generates a pool of well qualified AOD workers for the national treatment sector;
    - funding outcomes, both negative and positive: under-funding acting as a brake on programme development; independent funding initiatives increasing capacity, building community relationships, and providing further therapeutic traction.

## 4.4 ARCHIVAL DATA

In 1993 a report was prepared summarising all referrals and admissions to the programme in the 13 months to 30 June 1993 (Aitken, 1993). In total 59 men and 2 women were accepted to the programme of whom 44 had been admitted, or were currently resident, during the period of data collection. This group of 44 were 57% Pakeha, 39% Māori, 2% Pacific, 2% other, with a mean age of 25.6 years (range 17 – 40). Of the 44 programme attendees, 70% were from Otago, 25% were from elsewhere in the South Island, and 5% were from the North Island. Excluding the five men still in the programme, 54% stayed for less than one month, 36% for 1-3 months, 8% for 3-9 months and 3% for greater than nine months. The five men still in the programme included three who had been resident for four months or more. All but five of the residents were engaged with the justice system in one form or another.

The evaluation team were able to source archival data on all admissions from 1 January 2003. From 2003 to 2009 (inclusive) the number of programme entries varied from 12 (2004) to 21

(2007), with a mean of 17 admissions. Excluding the 27 men entering, or already resident within the programme as of 1/1/09, there were 101 men included within this database. This group was 63% Māori, 31% Pakeha, 5% Pacific, and 1% Asian, with a mean age of 30.8 years (range 17-48). All but one of the residents were engaged with the justice system in one form or another. This cohort is contrasted with the evaluation sample and the cohort summarised by Aitken (1993), as shown in Table 14.

**Table 14: Characteristics of three Moana House resident cohorts**

	(Aitken, 1993) cohort 1/6/92-30/6/93	Archival cohort 1/1/03-31/12/08 <sup>1</sup>	Evaluation cohort 1/1/09 – 1/3/10
Sample size	44	101	27
Age (mean, SD)	25.6 (5.4) years	30.8 (7.8) years	30.0 (6.7)
% Māori	39%	63%	81%
Duration of stay			
0-30 days	54%	23%	11% (+0%) <sup>2</sup>
31-90 days	36%	32%	14% (+4%)
91-270 days	8%	28%	21% (+18%)
270+ days	3%	18%	14% (+18%)
Stage on exit			
Assessment		36%	11% (+0%)
Stage I		41%	36% (+18%)
Stage II		15%	7% (+4%)
Stage III		4%	4% (+18%)
Graduate		4%	4%

<sup>1</sup> Excludes men entering during this time who were still resident as of 1/1/09, who are instead included in the evaluation cohort.

<sup>2</sup> Figures in brackets are for current residents as at 1/3/10

An examination of resident profile across the years 2003 to 2009 shows no change in average age at entry, or ethnicity, although it is worth noting that 2009 was an unusual year with only one Pakeha admission out of 17 men, when following past trends approximately five Pakeha would be expected to be represented within this group.

Data was also obtained on sentencing status upon entry to and exit from the programme. From 2003 to 2009 a number of changes were noted for these variables, with new sentencing and parole options becoming available over that time. The most common legal status on entry across these years was parole, typically in the region of 60-80% of admissions per year. However, from 2008 the prison release option of parole with residential restrictions was introduced. By 2009 82% of admissions were thus designated (with the remaining 18% on standard parole). Supervision has been a minority legal status, accounting for 9% of admissions, while community detention with intensive supervision was briefly a significant designation, accounting for a third of the 18 admissions in 2008, with none the year before or the year after. Home detention accounted for a quarter of 2003-2004 admissions, but none since. A small number have entered the programme on life parole (2%), with special conditions (1%), with standard conditions (i.e. under no obligation to stay in the programme, 1%), and with no legal status (1%).

In contrast, on leaving the programme 18% have been under no continuing legal status, but this has significantly reduced over time, accounting for 25% of 2003-2006 residents but only 9% of 2007-2009 residents. On leaving the programme, parole (with or without residential restrictions) remains the most common legal status, accounting for two-thirds of all men leaving the programme.

When excluding 2008 and 2009 admissions, there was significant reduction in the mean length of stay and the obtained treatment stage at time of exit. 2008 and 2009 admissions were excluded because in many cases treatment was not yet completed so that including those entering in these years would have produced a biased result. Specifically, there was a negative correlation between year of entry and stage obtained (Spearman's rho = -0.300, p=.004, n=90) and year of entry and time in the programme (Spearman's rho=-0.280, p=.008, n=90). It should be noted that length of stay and stage at time of exit are very highly correlated (Spearman's rho=0.920), as would be expected within a TC.

On closer examination, it is notable that while mean length of stay varied from 155 days to 221 days in the four years 2003-2006, there was a sudden drop in 2007, when the mean length of stay for those who entered in that year was 64 days. This figure had rebounded for the cohort entering in the programme in 2008, with those having since left having been in the programme for a mean of 139 days. Because five of the men entering the programme in 2008 were still residents as at 1/3/10 this mean represents a substantial underestimate however; inclusion of these additional five men would produce a mean stay of 284 days (and rising), making 2008 the best year for length of stay to date.

The data obtained on residents for the period 2003-2009 also contained a designation for the reason for leaving the programme, with categories provided by the Department of Corrections. These were, in order of prevalence: absconded (37%), (lack of) motivation (23%), imprisonment (14%), employment (13%), transfer (11%), and segregation (1%).

## **5. DISCUSSION**

The men attending Moana House are characterised by poly substance use and high rates of criminal offending, with all except two of those entering the programme during the period of evaluation doing so while serving a sentence of one sort or another. Although employment rates in the two years preceding evaluation were low, all had at least some employment history, primarily in unskilled and labouring roles. Around half were in relationships. Past educational attainment levels were low, but there was evidence of several men taking the opportunity whilst in the House to pursue formal qualifications as part of their recovery process. The men were predominantly Māori, a feature which has become progressively more characteristic of the programme, although we note that the non-Māori attending the programme also spoke positively of their experience, with the bicultural nature of the programme very much including exploration of, and respect for, a range of cultures.

We also found the residents willing to engage in an evaluative process that called on them to reveal information about themselves and reflect on their experiences within the programme.

The characteristics of residents attending therapeutic communities will vary as a function of a range of factors, such as their geographic location, typical referral sources, and special characteristics. Moana House has a substantially higher proportion of Māori clients than either Odyssey Christchurch (Schroder et al. 2005) or Odyssey Auckland (Davidson, 2008). Age is similar to that found in Odyssey Christchurch. The Moana House sample were found to have better mental health and equivalent physical health functioning to Odyssey House Christchurch (Mulder et al. 2009), as measured by the SF-36. It should be noted, however, that the Odyssey sample completed the SF-36 at intake to the programme, while our sample was completing it after an average of nearly seven months in the Moana House programme. Moana House residents came from a much wider geographic spread, and were much more likely to be admitted while under sentence than was the case for Odyssey Auckland (Davidson, 2008).

### **5.1 IS MOANA HOUSE AN EFFECTIVE PROGRAMME?**

Firstly, it is important to view the Moana House as a facilitator of the continuing process of change and healing (recovery) from a criminal and substance misusing lifestyle towards abstinence/moderation, wellbeing and participation in the broader community.

In considering the effectiveness of the MH programme the present evaluation utilised qualitative and quantitative methods to attempt to elicit treatment processes, impacts and outcomes. Owing to the time frame of the evaluation period (13 months) relative to the length of programme involvement (up to two years), it is necessary to place an emphasis on in-treatment impacts observed. However, this is not out of keeping with the current trend from retrospective follow-up evaluations toward measuring in-treatment client outcomes as indicators of effectiveness in keeping with other chronic disorders (McLellan et al. 2005).

Motivation is a strong predictor of retention and outcome in both TC (De Leon et al. 2000) and non-TC populations (Adamson et al. 2009; Broome et al., 1999). Good levels of motivation (perceived need for change and necessity for treatment to bring about that change)

were found in the evaluation sample when compared to another TC sample (De Leon et al. 2000). Residents also spoke of the dynamic nature of their motivation to remain within the programme, with an initial desire to get out of jail and avoid negative consequences evolving over the course of treatment into a desire to bring about change for the sake of themselves and their whānau.

From stage two on residents are expected to act as role models for others within the programme, while more generally programme transition is marked by increasing levels of responsibility. Increased responsibility was something residents were very aware of the need to accept, and in many cases there was real pride in achieving this. The Responsibility scale of the CAI (see Table 10) was found to be higher than for a comparable TC sample from the US, and showed some evidence of having increased between interviews one and two, although this was not found to be the case for the Community Responsibility scale of the DCI (Table 11).

Although stage transition is highly correlated with time in the programme, there were nevertheless some residents who, despite substantial time in the programme during their current admission, or cumulative programme time over multiple admissions, were not able to achieve the changes in responsibility exhibited by many of their peers. However, given the longevity, complexity and severity of the problems faced by many of the men entering Moana House, having realistic goals is critical, including viewing small steps as progress. The literature makes this point (see sections 2.2.1 and 2.2.2), emphasising that the complex problems faced by this group mean many require habilitation rather than rehabilitation (Gerstein & Harwood, 1990), and multiple treatment experiences. This view received support from non-resident participants. For example, a senior Corrections stakeholder, although strongly favouring the programme, cautioned against unrealistic expectations given the difficult population being engaged with (see section 4.3.6.4).

A number of changes in patterns of thinking, attitudes and beliefs were reported by residents, and some of these internalised changes had led to changes in behaviour. Internalised change is a key outcome indicator for TCs (De Leon 2000). This was most pronounced when discussing the victim empathy and criminogenics groups. The psychotherapy and ara tika groups were identified by residents as being challenging but leading to significant positive changes, and the process and goals groups were recognised by residents as having a clear purpose and achieving positive results.

Self efficacy scores, a measure of confidence to resist the temptation to use drugs, were quite high even at initial assessment. It is not possible to know from the data collected what self efficacy scores would have been like at the time of intake, although it was noted that the three men assessed in custody while on the Moana House waiting list had particularly low scores. For those engaged in treatment there was a trend for confidence scores to reduce somewhat. In the alcohol treatment literature there is consistent evidence that higher self efficacy at treatment intake predicts better outcome (Adamson et al. 2009). For drug treatment, however, research findings are more mixed, with evidence that over-confidence can inhibit active treatment participation (Burling et al. 1989), while self efficacy has been shown to initially improve and then diminish again as treatment is withdrawn (Reilly et al., 1995). It is possible that reductions in self efficacy may be a sign of increased awareness of risk, an important component of the relapse prevention model (Marlatt & George, 1984).

There was strong endorsement for the programme having a positive impact on the four cornerstones of health as operationalised by Hua Oranga – wairua, hinengaro, tinana and whānau. Furthermore, these positive changes appeared to be more strongly endorsed as

residents progressed through the programme. While there was some variation across the four domains, all can be said to have been identified as areas of positive change.

Three residents reported becoming less physically well as a result of the programme on one tinana item of the Hua Oranga scale, but this was in the context of overall positive endorsement of the Tinana domain. There were mixed findings for physical health as measured by the SF-36 (see Table 4) with a possible reduction in Physical Functioning scores, and possible improvements in Vitality and Role Physical scores. A number of the men may come to the programme with compromised physical health, with high rates of smoking and histories of assault and accident-related injuries. Additionally, through the programme the residents develop a greater commitment to wellbeing and thereby may become more aware of some aspects of their physical health impacted on by lifestyle related factors. It was noted that physical health was a particular focus in the early stages of treatment, with significant support present throughout the course of the programme.

Improvements were apparent in mental health functioning for the men interviewed more than once and it is likely that given the relatively high scores for mental health, significant improvements may have already occurred before the first interview, which was conducted an average of seven months after treatment initiation. Early positive changes (e.g. after three months) in key outcome indicators, including mental health, are demonstrated for TCs in the large international outcome studies such as the TOPS project (Hubbard et al. 1984). Improvements in mental health may be the result of a wide range of programme factors, including abstinence from drug use, the safety experienced within the programme, and specific therapeutic elements such as the psychotherapy groups. None of the men reported a negative impact of the programme on their mental health/Hinengaro (see Table 8) and all but one reported positive changes.

In preparation for their futures post-treatment, the residents are not only exposed to a good work ethic through the routines of the House, they are also actively encouraged and assisted to undertake further education and vocational training. Evidence was found of a high rate of participation in such activities, and an appreciation of their importance by both residents and stakeholders within the community.

In the absence of longer follow up with a larger sample, TC fidelity and retention are important proxies of change. There was no apparent shift in TC dimensions of change (as measured by the DCI, see Table 11) between the first and second interview, but it is notable that for eight of the nine scales, scores are higher for the Moana House sample than for a Phoenix House sample, and ranged between 4.1 and 4.6 on a scale from 0 to 5. There was an apparent decline in DCI scores for the four men interviewed a third time, but this finding is difficult to interpret given such small numbers.

High retention rates were achieved. Archival data showed some fluctuation with variable mean length of stay, but with 2008 appearing to be the best year to date, while the 2009 entry cohort (i.e. during the evaluation period) was marked by higher than expected retention, suggesting that 2008 was not an aberration. Retention rates when examined as proportion staying for a minimum of one and three months have been good historically (77% beyond one month, 45% beyond three months) and were even better for the most recent cohort (89% and 67% respectively). These figures compare favourably with other TCs (De Leon & Schwartz, 1984; Latukefu, 1987; Mulder et al. 2009). As has been noted previously (see section 2.2.2), retention in treatment is a significant challenge for TCs, but when better retention can be achieved it is a strong predictor of good outcomes. Furthermore, successful transition to higher stages of treatment is a key success indicator. A comparison between the evaluation

cohort and the preceding six years residence data shows the percentage achieving stage two or better increasing from 23% for 2003-2008 to 37% plus an additional 18% still in treatment and currently at stage one for the 2009 cohort.

As noted, in the absence of a much longer time frame, or the evaluation of a programme with a substantially higher bed number, it is not possible to have post-treatment outcome data on a sufficiently large sample to provide relatable data. Three men were followed up post-treatment, and clearly their circumstances can be treated as anecdotal only. Outcomes observed for all three men were positive, with no significant substance use, no legal issues and the presence of pro-social factors such as employment and positive goals.

## **5.2 CRITICAL FACTORS IN ACHIEVING THESE IMPACTS AND OUTCOMES**

### **5.2.1 Success factors**

Moana House effectively manages relationships with funders and referrers. In the case of the Department of Corrections, these two institutional relationships combine as historically the programme has received a significant proportion of its residents either as self-referrals from men in prison (the bulk of residents) or formally from Corrections. Archival data suggest a trend towards increased self-referrals, although the recent development of AOD clinicians providing Court assessments has seen a number of referrals from this source in the last twelve months. Irrespective of the actual source of referrals, the relationship with Corrections is vital for Moana House as, leaving aside the recently funded six methamphetamine beds, the programme is only funded to work with offenders.

The advent of the Otago Correctional Facility (OCF) in Milton has also increased opportunities for Moana House to interact more directly with Corrections staff and bureaucracy. This process is facilitated by related linkages with other stakeholders in this area, particularly local Māori, through well established relations with Otakou Marae, where periodic Moana House events and their annual Christmas hui occur. The hui is particularly important as it provides an opportunity for Moana House to invite stakeholders to an annual event showcasing its achievements. Along with manawhenua, attendees include funder representatives (Department of Corrections, Ministry of Health, Otago DHB, grant providers), local and visiting politicians, AOD sector providers and workers, whānau of residents and former residents, and others with an interest in the programme.

Adding to the relational nexus with the Marae is the Otakou Executive's supervision, through a contracting company, of staff employed at OCF, for example the Kiatiki prisoner caseworker. Collectively these relationships have the effect of raising awareness around AOD issues, the needs of prisoners in this regard and the work that Moana House does in this area. This raised awareness goes some way to ameliorating historical problems of access to prisoners as potential residents for Moana House.

A clear success factor for Moana House concerns the programme's achievement of a safe environment within which residents are able to engage with their recovery. Evidence of residents' perception of Moana House as safe, not just physically but also psychologically, comes from both qualitative sources and quantitative data. Regarding the latter, high clarity and safety DCI scores (see Table 11) suggested a level of perceived safety greater than that of

a comparable US sample (Orlando et al. 2006). These data were supported by the narratives of residents and others, with common themes involving not only personal safety but the safety facilitating the free and open expression of ideas and sharing of personal information, i.e. therapeutic safety. The significance of the achievement of feelings and perceptions of safety is evident in that it was frequently one of the first ideas explored by residents in their interviews and was mentioned in 46 of the 51 interview transcripts.

As discussed in the analysis of qualitative data, the creation of a safe environment allows recovery work to gain traction. This in turn gives residents a sense of personal achievement which, along with feeling safe, is something many have had little experience of prior to entering the programme. That whānau of residents, many from beyond Dunedin and some unfamiliar with an environment strongly validating Māori cultural values, also experienced Moana House as a safe environment adds further legitimacy to claims of the programme's success in this regard.

Moana House embraces its role as a Treaty partner. To this end they have made significant linkages with local hapū and offer a TC programme infused with Māori values, beliefs and processes that contributes to the overall therapeutic milieu, although residents were not always aware of the Treaty underpinnings of these programme features. This blend appears to provide feelings of safety for the residents and staff and the specific Māori approaches resonate for both Māori and non-Māori, especially in terms of exploring new notions of self-identity.

High retention rates have been identified in the preceding section, with this highlighted as an important predictor of good outcome. The ability demonstrated by Moana House to achieve these retention rates for individuals with such extensive criminal offending and substance abuse histories is noteworthy, and is likely to be a product of several of the factors discussed in this section, including safety, cultural factors, and TC treatment fidelity. The potential for cumulative benefit was also evidenced by the number of residents who had left and returned to Moana House, with this being observed both within the evaluation period and the archival data.

The findings of the evaluation show clear evidence of fidelity to the TC model of treatment and the associated essential elements (De Leon 2000; Gowing 2002). The mission statement of "*Giving you a real chance*" based on the assumption that change is possible and that everyone has the capacity for wellness and wellbeing is in keeping with the holistic nature of the goals of a TC (De Leon 2000). The community as method approach is clearly demonstrated and there are explicitly articulated linkages and feedback loops between the programme components and activities. The programme has a clear differentiation between the stages in terms of resident expectations and the aims of treatment. Stage progression is correlated with time in programme but is not contingent upon time alone, rather transition from one stage to the next requires individuals being able to develop and meet SMART goals. Frequent reference to senior residents as role models was a further demonstration of the programme working well as a TC.

Related to the importance of TC process and structure within the programme is the duration of treatment available to residents. For men with substantial offending histories, major substance use problems and dysfunctional family relationships, change can be a slow process, with more than simple education or skill development required for recovery to occur. Residents can stay within the programme for up to two years and may engage with aftercare beyond this. The programme attempts to retain and support men even when funding is no longer provided. Although it is a minority who stay for an extensive duration, we found a

significant number still present after nine months. The ability of the programme to provide treatment of this duration is, we believe, a critical factor in the success achieved by the programme.

Residents spoke about the various active therapy components of the programme, such as groups, as being variously challenging and as engines of real learning and change. The groups fall in to two overlapping categories: TC-specific process groups (e.g. whakapiri, whānau hui) and targeted therapeutic/education groups (e.g. criminogenics, psychotherapy, steps group). Groups are run by qualified and highly skilled clinicians who have the respect of their peers well beyond the programme itself. These groups have been carefully thought out and are subject to regular reflection and review by staff.

*Whānau ora* is a recently funded programme for Moana House, although whānau engagement has been an important element of the programme for many years. This represents a challenging undertaking, as highlighted in section 4.3.6.2.7. Our own efforts to interview whānau or family as part of the evaluation process highlights the complexity of whānau engagement for this population, with difficulties encountered both due to many residents being very guarded about allowing access to their whānau and the difficulty often of identifying a whānau member who had been in sufficient recent contact with the resident and who was sufficiently stable to be reliably located and interviewed. Indeed, family/whānau have been identified elsewhere as both leading promoters of positive change and leading barriers to achieving change (Adamson et al. 2009). With this caution in mind, carefully managed family involvement is a factor associated with improved treatment outcomes (Gowing et al. 2002) and has the potential to set a solid foundation for long-term outcomes for families and whānau. Moana House staff are careful to seek an understanding of the nature and quality of family and whānau relationships and to individualise the extent and timing of their involvement, and have a dedicated staff member in place for this.

The wide geographic spread of residents' places of origin means that whānau involvement can represent a significant expense. It is a strain on the Moana House budget but the programme has prioritised this new development, with the aforementioned dedicated position and funding for travel when required. Moana House expect a level of engagement in the programme by residents prior to significant investment in their whānau. Rather than being solely a prudent use of limited programme funds, this approach also harnesses residents' motivation and increases engagement and retention.

As well as whānau and family engagement, the programme works hard to make connections with the local community and to make full use of available resources, so that residents receive dental care and GP visits. They also have a good relationship with WINZ and local educational providers.

Moana House is the beneficiary of strong leadership from its very hard working Director, while the staff as a whole were described as being highly dedicated. Working in a residential TC with a bicultural programme for substance using offenders is a demanding task, placing high expectations on staff both in terms of the skills required and their own attitudes and behaviour. The Director was described as being central to the programme, having been in the position since 1987, and being the person through whom all major decisions were required to go. Some expressed the view that the programme would not be possible without her. Whilst acknowledging her exceptional contribution, we believe this view does a disservice to the skills of other staff, past and present, within the programme and potential staff within the wider treatment community. In particular, we note that the programme represents the work of the current senior staff triumvirate of the director, psychotherapist and cultural advisor, and

continues to embody the kaupapa nurtured by the past cultural advisor, the late Takarangi Metekingi.

Supporting Moana House and its staff is a dedicated board of trustees who have a reputation for providing strong governance. The Board shares the programme's commitment to "Giving (residents) a real chance" and benefits from its strong links to the judiciary and the wider community, including mana whenua.

A feature of the management and governance of Moana House is flexibility. The programme is in a continuous process of reflection and improvement while opportunities to expand and contribute to helping those with serious addiction-related problems are taken on. This ability to innovate has led to Moana House having a strong reputation both as a treatment provider and, through the Moana House Training Institute, as a training provider. This ability to innovate is borne partly of a strong desire to achieve good outcomes and partly due to the need to survive, delivering an intensive service on a very tight budget.

## **5.2.2 Barriers**

Clearly the greatest threat to the Moana House programme is funding which is tight, with a core contract that may be inadequate for the actual service delivered. Significant time is diverted in to work to develop new funding streams and to secure the continuance of existing funding streams. The three contracts each have their own delivery expectations and reporting requirements. Whilst this may not be unusual or unreasonable for an NGO, the evaluation team was aware that Moana House does not have a robust administrative system in place to ensure efficient and consistent reporting. This contributed directly to the difficulty encountered by the evaluation team in identifying consistent archival data for all residents for a meaningful time-span.

Although not strictly a barrier, the increasing deployment of Drug Treatment Units (DTUs) in prisons has potential implications for intending residents and referral pathways. While the DTU programmes are meant to be stand alone, some individuals, both Moana House and Corrections staff, see advantages in preparing prisoners for release into post-imprisonment treatment by initially involving them in DTUs.

For Corrections staff involvement in the DTU could be seen as evidence of a prisoner's commitment and determination to address AOD issues. Agreement to participate in DTU treatment might then result in a more favourable parole hearing. Contrarily, a prisoner declining to be involved in a DTU might run the risk of being denied parole into Moana House.

The DTUs are promoted as operating within the principles of a TC but are different in their treatment style to the Moana House programme. The recently commenced OCF programme is only three months duration and has the potential to be 'contaminated' by general population prisoners entering it should there be a shortage of beds in the prison. It seems desirable, therefore, that specific dialog around the implications of DTUs for post-imprisonment treatment occur between Moana House and the Department of Corrections. It should also be noted that there are clear references in the recent literature to the need for aftercare subsequent to DTU TC involvement. For example, in the recent UK review, McSweeney et al. 2008 argued that treatment effectiveness for drug-dependent offenders is undermined by the lack of adequate aftercare and innovative strategies to promote aftercare engagement and continuing behaviour change after release. Relatedly, as Lehman et al. (2009) observed, there

was a lack of empirical data describing the practices and linkages between correctional and other treatment services.

A significant number of men return to the programme for repeat admissions. It is likely that this reflects only a fraction of those who would be interested in re-engaging, or being otherwise supported, if they were engaged more proactively. Programme resources, the geographic spread of ex-residents and their personal characteristics make continued engagement post-discharge a formidable task, one no doubt shared by other TCs in New Zealand. Moana House does well in engaging men at the beginning of the continuum of care, partly due to its strong working relationship with DTUs and the OCF, but it is possible that men are not so well served once leaving the programme. The worrying lack of more developed post-release aftercare options in Aotearoa New Zealand was also commented upon by stakeholders interviewed for the present evaluation. This is a concern given that addiction is a chronic disorder with a high rate of relapse as for other chronic medical disorders (McLellan et al. 2000).

Whilst the good relationships with referrers have been acknowledged, a barrier to treatment entry will be experienced by those men who find themselves in correctional facilities not so well linked to Moana House. In the absence of a formalised relationship treatment access is therefore likely to be variable.

Moana House is a small TC by international and New Zealand standards. As a result the organisation does not enjoy the benefits brought by economies of scale, such as the ability to employ specialist management and administrative staff and also the flexibility to offer a range of programme types to clients and the capacity to provide aftercare services. Small programmes are also more vulnerable to fluctuations in bed occupancy and changing mix of residents, e.g. early versus late stage. This is particularly relevant for a TC where the presence and role of senior residents is an integral part of the therapeutic milieu. A smaller programme is vulnerable to critical incidents amongst residents which may lead to a number of discharges, or to the moving on of key staff. While such events can also occur in larger programmes the disruptive impact may tend to be smaller. On the other hand, a small TC such as Moana House has the advantage of developing a strong cohesive culture, and allows for better engagement with the wider community (i.e. being part of the community rather than being a large community in its own right which others are occasionally invited into). Both of these strengths are evident within the Moana House programme and should not be underestimated.

The substantial variation between the number staying beyond a month (12 of 15 admissions) and what was projected based on past MH experience (10 of 24) highlights the fact that external factors can have a significant impact on programme delivery, in this case believed to be due to a combination of increasing risk of reimprisonment for early exiters and the benefits of whānau involvement via the newly developed and funded whānau ora process .

Lastly, the programme's heavy reliance on the current Director leaves it vulnerable. This is particularly so for a small programme with a smaller range of staff to fall back on. Succession planning is also more difficult in a smaller organisation. Senior staff within the programme and the board of trustees acknowledge this vulnerability and that it remains a critical area for development. This perspective was also voiced by members of the community. An identified Moana House strategy is to establish a succession plan over the next five years.

### **5.3      IMPLICATIONS FOR DEVELOPMENT AND DELIVERY OF OTHER THERAPEUTIC COMMUNITIES IN NEW ZEALAND**

The foregoing sections have identified Moana House as a TC producing good outcomes for male serious offenders with addiction-related problems. There are specific characteristics of the programme that have contributed to this success, as outlined above. Nevertheless, we do not believe there is anything about the programme that would be impossible to replicate elsewhere. This does not mean that establishment of a new programme would be a simple matter however. As well as an awareness of the above strengths and barriers, the following should be considered:

The Moana House programme has developed over two decades with particular complementary attributes and skill sets amongst senior staff. Moana House is only one TC in New Zealand however. Closer connection between TC programmes could foster knowledge exchange, strengthen TC treatment and help maintain standards. While different TCs will have variations in respect to the nature of their programmes, the sub-groups who are the target population, the context in which treatment is delivered and associated treatment duration, the essential elements and core stages of treatment should be common to all.

Core components of the Moana House programme reflect the essential elements of a TC programme (De Leon, 2000; Gowing, 2002) and are therefore transferable. However, the sub-group of individuals who are the target population of Moana House represent those with the highest needs in respect to habilitation. More socialised individuals may require a shorter duration of residential treatment linked with stepped down TC care such as day programmes and aftercare, in order to produce the required degree of internalised changes in patterns of thinking, attitudes and beliefs leading to enduring behaviour change.

TC programmes are one significant facilitator of recovery and wellbeing along a continuum of care. This has implications not only for the consideration of the need to provide different levels of care depending on problem severity, but also, as noted above, for the establishment of aftercare/continuing care arrangements that support the ongoing recovery process and achievement of wellbeing and integration into community life.

Leadership and staff are the key resources of a programme. Adequate and sustainable funding is required to attract and support leadership and mentoring of new leaders, the employment of trained staff and the ongoing provision of scholarships and internships to support staff gaining the required qualifications and experience. Closer TC linkages as suggested above could also assist in these areas.

Adequate funding is an important contributor to ensuring programme fidelity. Specifically, there is a danger of reducing treatment duration and residential treatment options in times of recession without consideration of matching clients' level of need to treatment settings and duration based on treatment stages and time required to achieve stage transitions and the required degree of internalised change.

When considering transferability of a programme such as Moana House, it is important to recognise the ways in which local features contribute to a programme's characteristics. Moana House has developed in the way it has partly as a result of its environment. Establishing a successful programme requires developing a good relationship with the local community. Who the key stakeholders are, how they are best approached, and the opportunities that may grow from establishing key linkages and relationships require careful

consideration, and will all be locally determined. Local elements to consider also extend to considering what local resources are available in areas such as education, vocational training, therapeutic input, opportunities to collaborate with other service providers and fund raising.

Moana House prides itself on a commitment to meeting or exceeding contractual obligations, as outlined in their strategic plan, and articulated during interviews with staff members. There is an attitude of getting on with the job of providing service and support even in the absence of funding. While the dedication to deliver good care to as many as possible is to be applauded this is clearly not a sustainable model. Setting up similar programmes must recognise the actual cost of delivery with appropriate funding. Similarly the workload sustained by the director over a long period of time exceeds what would normally be expected, with this workload mentioned in several stakeholder interviews and acknowledged by the Downie Stewart Foundation board. Developing a new programme to deliver similar services on the current Moana House budget would be very unwise, setting the new programme up for failure.

## **5.4 LIMITATIONS OF THE PRESENT EVALUATION**

The primary limitations of the current programme outcome evaluation, as highlighted in section 3, are the small number of men going through Moana House at any given time, and the long duration of treatment relative to the time available for this evaluation. We believe that the methodology, developed with these challenges in mind, has been able to produce meaningful findings. Although we achieved a high participation rate by residents, the lower number of admissions during the evaluation period, due to higher retention rates and therefore fewer vacancies for new admissions, meant the sample size was lower than had been anticipated.

The evaluation team experienced difficulty in tracking residents' progress and general problems with the House's 'Management of Information System' [MIS], due to how they were presented in various reports, such as being anonymously presented and residents double counted if being present in the House over two consecutive reporting periods. This has limited the amount and detail of archival data that could be accessed and analysed as part of this evaluation.

Difficulties of studying offender populations were noted in a review of the literature (section 2.2). Whilst greater numbers of ex-residents could have been sought, we avoided over-reliance on graduates which are noted to be a biased sample.

We did not seek interviews with men within their first month in the programme. This decision was made in consultation with programme staff on the basis that this is a critical settling in phase. At the same time we experienced difficulty obtaining access to men in custody awaiting treatment entry. We did interview three such men, none of whom had yet entered the programme by the end of the evaluation period. As a result of these factors, and the lower number of new admissions than was anticipated, residents taking part in the evaluation had been in the programme for an average of seven months at the time of first interview. This reduced our ability to measure and witness the early stages of change, although there were some early stage residents included within our sample.

## **6. RECOMMENDATIONS**

### **6.1 RECOMMENDATIONS SPECIFIC TO THE MOANA HOUSE PROGRAMME**

1. The Moana House programme presents as having high fidelity to the TC model and many of the factors associated with successful outcome were observed. Within the programme changes were observed for both Māori and non- Māori residents. With the caveats identified above, we would recommend expanding the Moana House programme. As noted in the Discussion, larger programmes benefit from economies of scale in terms of infrastructure possibilities and more stable residents' profile (i.e. ratio of senior to junior residents).
2. The programme should be supported in reviewing its staff training, succession planning, workloads, and management structure, particularly in light of the recent expansion in the programme size and the possibility of further expansion. We note that concrete steps are underway in this regard, with a recently developed strategic plan considering these issues (Moana House, 2009). Such a process may include developing an annual operational planning and evaluation cycle that links to the strategic goals.
3. The programme would benefit from the development of a computerised management information system (MIS) that would include core resident and waiting-list information.
4. Moana House achieves good outcomes by delivering beyond contractual requirements. However funding constraints potentially act as a brake on further development. This situation should be reviewed.
5. We note that the Moana House Training Institute has become an increasingly significant part of the organisation's activities. Not only could it be a potential revenue source, if adequately supported, but it also provides an opportunity for identifying new staff and contributing to workforce development nationally. The Training Institute warrants wider recognition and support.

### **6.2 GENERAL RECOMMENDATIONS**

Many of the above points should be borne in mind when considering establishing similar programmes.

6. We would like to call for a strong national commitment to TC treatment as a viable and effective alternative to prison for individuals with significant substance use and offending issues.
7. As stated in section 5.3 we believe the achievements of the Moana House programme can be replicated elsewhere in New Zealand. Any new programme should accommodate the needs of different regions, ensuring it is meeting a treatment demand for that region and should do so on the basis of strong links with the local community. A specific advantage

of considering regionality is the prospect of access to, and harnessing of, supportive family and whānau relationships, which we have argued potentially provides an important lever for motivation and programme engagement, the complexities around unhealthy family and whānau notwithstanding. This is a particularly significant option for Māori, given their predominance in offender statistics and the importance of region, i.e. opportunities for linkages also at hapū and iwi level.

8. Caution should be exercised in providing funding for the establishment of new TC programmes until adequate funding of current TCs is assured. Relatedly, the development of new programmes may be best achieved by working with existing TC providers
9. The distinctive identity of TC programmes should be maintained by ensuring fidelity of the TC model. That is, retention of the essential elements of the model which have demonstrated effectiveness guided by a theoretical framework such as that proposed by De Leon (2000). Adaptations or modifications should reflect clinical rationales not a reaction to cost containment.

Duration of TC programmes should be matched to the needs of sub-groups of individuals. TC programmes represent an intensive treatment programme for high needs individuals. The treatment process and stage transition should reflect observed change processes, i.e. behavioural and internalised changes in accordance with identified goals and a TC framework.

10. Addressing continuing care/aftercare along a care continuum as for other chronic conditions is essential in order to: 1) make best use of available resources; 2) to support building on achievements attained by residents in TCs and; 3) to intervene early to prevent/limit periods of relapse, which is a feature of addiction for the majority of people. Strategies will include strengthening the linkage between DTUs and other TCs, developing a national system of supported accommodation/aftercare facilities to provide *bridges* back to the community and family and whānau; developing stepped down day and outpatient components following residential TC treatment as well as strengthening linkages with probation officers, primary health care providers; peer support/self-support groups; whānau recovery groups.
11. The time has come for the establishment of a national network or body of New Zealand TC programmes. This would include, but may not be limited to, Moana House, Odyssey Trust Auckland, Odyssey Trust Christchurch, Higher Ground, and Care NZ. The National Association of Opioid Treatment Providers is a model that has worked well to establish collegial linkages for the benefit of opioid substitution treatment in New Zealand.

One important goal of such a national network would be to engage with those State agencies particularly associated with TC clients, e.g. Corrections and Justice, in order to negotiate the most appropriate interface with TCs in terms of service provision and outcome. For example, the present evaluation has drawn attention to the potentially differing client groups and modes of treatment deployed by TCs and DTUs, and the possible negative consequences of assuming these separate entities serve the same populations and ends.

12. The workforce implications of any expansion in TC provision should be considered, as well as the extent to which the current TC workforce is adequately supported and trained. TCs are a highly specialised treatment environment. Currently there are no TC-specific formal training opportunities within New Zealand. The establishment of a relevant

qualification should be considered. The Moana House Training Institute, or senior Moana House staff, may be in a position to contribute to this, although the input of other TC programmes would also be desirable and expected.

13. A cost effectiveness study to identify the actual costs and benefits associated with New Zealand TC programmes for individuals with high and complex treatment needs would allow for quantification of their benefit and has the potential to assist in setting funding priorities. Any such analysis would benefit from a longer evaluation period than was the case for the current evaluation, given the length of treatment and relatively small numbers entering TCs per annum.
14. The development of a national network of TCs and better understanding of their impact on offenders would be greatly aided by identification of a national agreed suite of measures pertinent to the TC model of treatment and the New Zealand cultural setting. Measures to consider include Hua Oranga (Kingi & Durie, 2000), the Alcohol and Drug Outcome Measure, or ADOM (Pulford et al., under-review), Circumstances, Motivation and Readiness (CMR) questionnaire (De Leon et al. 2000), Client Assessment Inventory (CAI) (Kressel et al. 2000), and Dimensions of Change Instrument (DCI) (Orlando et al., 2006). The use of consistent measures across programmes would also provide the opportunity to consider a national reporting system, and tracking of individuals who undergo multiple TC admissions. The administrative burden of standardised measurement and reporting should be reflected in programme funding.
15. We would also strongly encourage TC programmes treating offender populations to routinely include on their client files RoC RoI data, where this was available, for all offenders referred to and entering treatment. The Risk of Conviction Risk of Imprisonment (RoC RoI) index (Bakker, O'Malley, & Riley, 1999) provides a clear prediction of future re-offending against which TC attendees could be measured, thus quantifying programme impact. Although it will not be available for all offenders entering TCs, it provides a particularly powerful tool for demonstrating change.
16. Research is required in respect to differences amongst sub-groups, treatment setting and TC modifications. The use of standardised measures and a possible national reporting system, as identified in recommendation 14 above, may assist in research, although this would not be their primary purpose.



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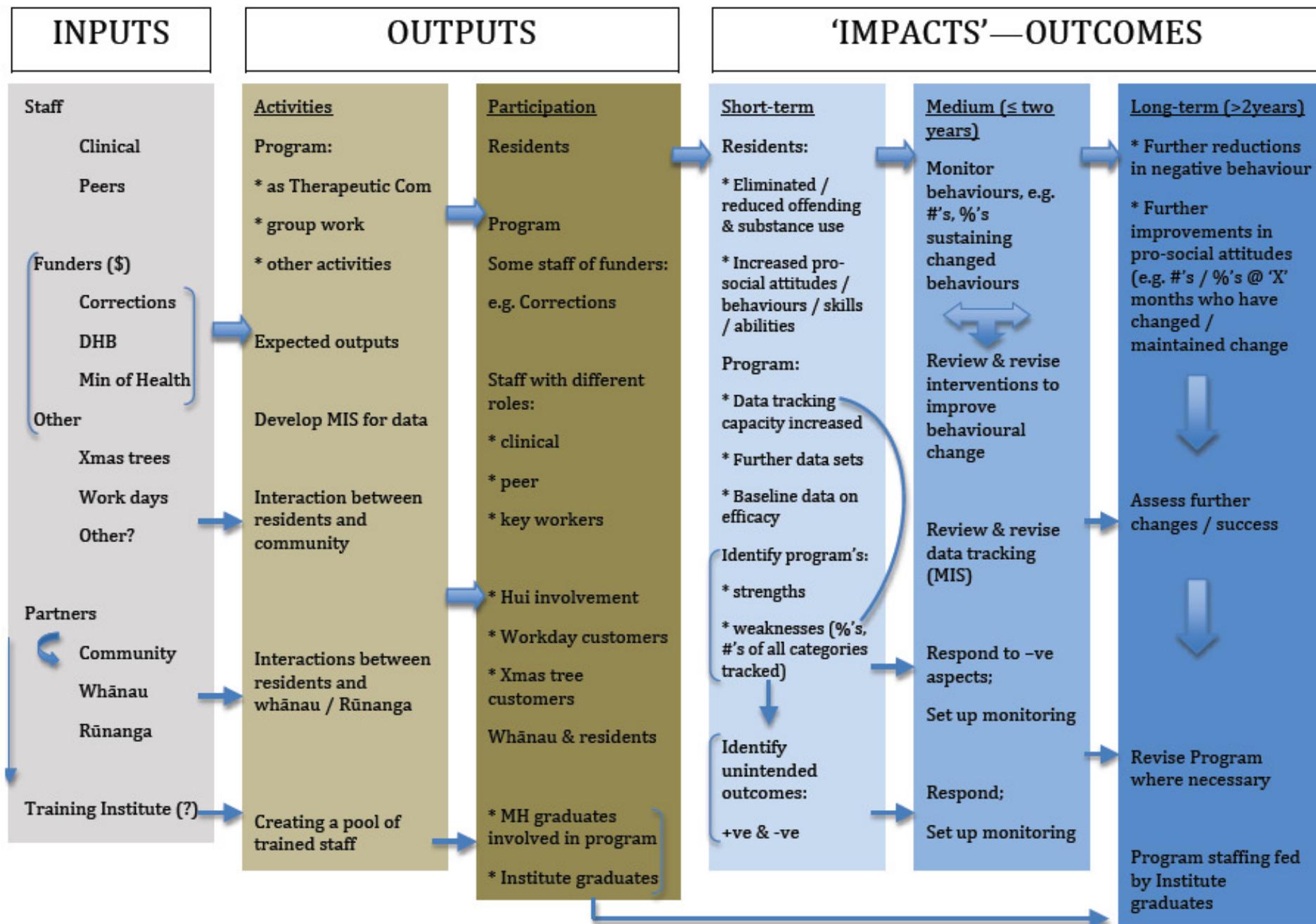
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## **APPENDIX I: EVALUATION LOGIC MODEL**

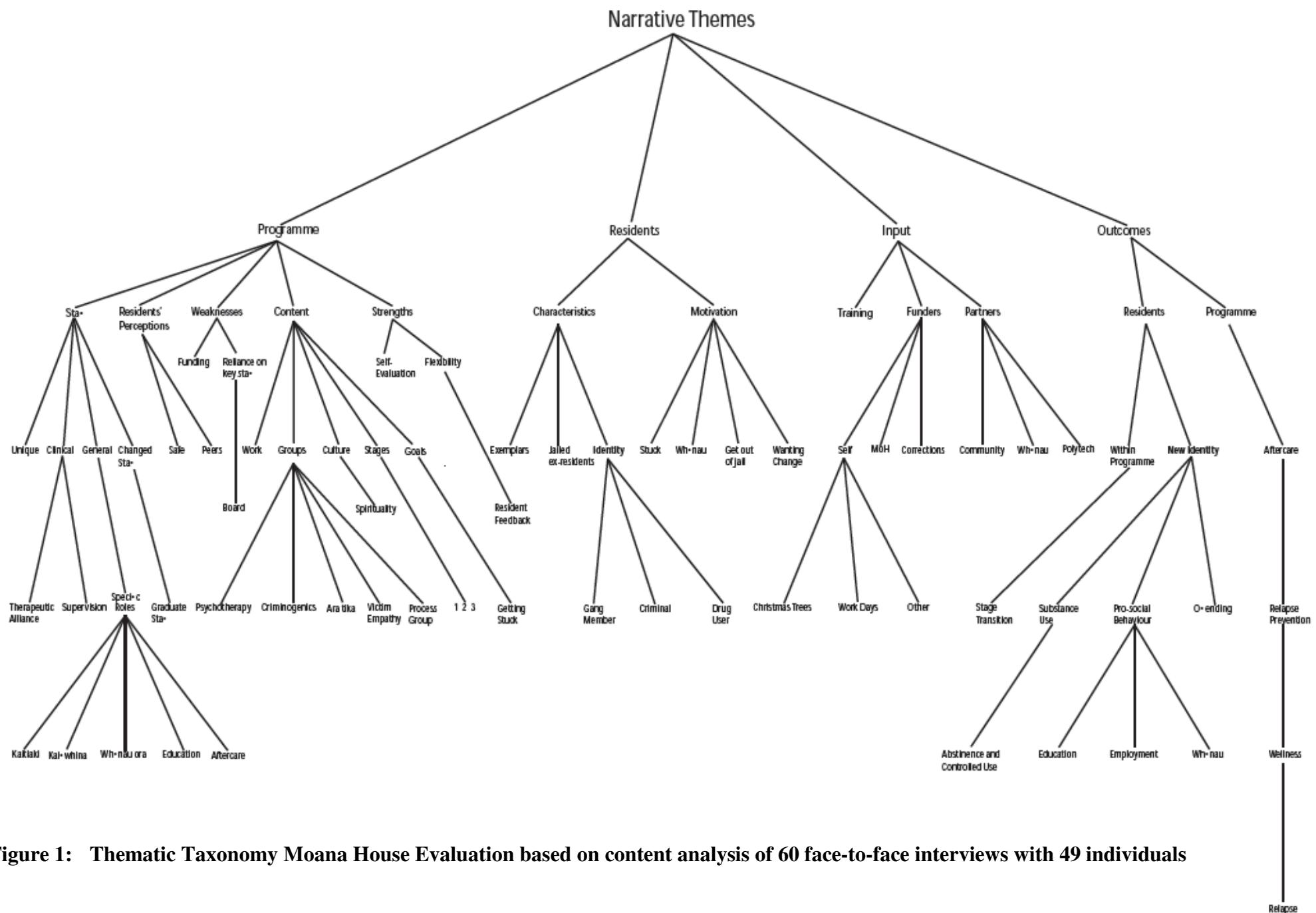


## **APPENDIX II: THEMATIC TAXONOMY**

The *thematic taxonomy* represents the mutual relationships of themes, concerning the programme, inputs, residents and non-residents, organisations and groups, and outcomes. These were derived from a content analysis of 60 face-to-face open-ended ‘category’ interviews (i.e. ‘residents’, ‘whānau’, ‘stakeholders’) with 49 individual participants. The figure included here is the result of an iterative process, whereby mind-maps of themes and earlier versions of the taxonomy were revised, culminating in the present taxonomy.

Two interviewers (Māori and pakeha) developed thematic structures separately before combining their analyses. A discourse analysis package—NUD\*IST™—was used to process transcripts, manage data and structure the analysis.

A detailed discussion of every theme noted in Figure 2 is beyond the scope of the present evaluation. Furthermore, not all of the themes identified by the interviewers carried equal weight in the analysis as some held greater explanatory power. For example, in the discussion of qualitative findings three major themes—*safety*, *identity*, *new identity*—were discussed, with subsequent analysis of these supported by quotes from interviews. These three themes were chosen due to their weighting by participants and their relevance to the discussion, and thereby the importance that interviewers believed they held for the analysis. Weightings for the themes were determined by the number of participants referring to each theme, i.e. this includes utterances that relate to a theme such as *identity*; for example seeing oneself as a ‘criminal’ links with one’s identity, and the frequency to which each theme was referred. In the case of the three themes noted above, the number of transcripts citing them were 51 of 56 (*safety*), 50 /56 (*identity*) and 27 / 56 (*new identity*).



**Figure 1:** Thematic Taxonomy Moana House Evaluation based on content analysis of 60 face-to-face interviews with 49 individuals

# **APPENDIX III: FORMALISED MEASURES USED IN QUANTITATIVE QUESTIONNAIRES**

## **SF-36**

### **General Health**

**1** In general, would you say your health is:

- |   |                          |           |
|---|--------------------------|-----------|
| 1 | <input type="checkbox"/> | Excellent |
| 2 | <input type="checkbox"/> | Very good |
| 3 | <input type="checkbox"/> | Good      |
| 4 | <input type="checkbox"/> | Fair      |
| 5 | <input type="checkbox"/> | Poor      |

### **Health and Daily Activities**

**2** Compared to one year ago, how would you rate your health in general now?

- |   |                          |                                       |
|---|--------------------------|---------------------------------------|
| 1 | <input type="checkbox"/> | Much better now than one year ago     |
| 2 | <input type="checkbox"/> | Somewhat better now than one year ago |
| 3 | <input type="checkbox"/> | About the same as one year ago        |
| 4 | <input type="checkbox"/> | Somewhat worse than one year ago      |
| 5 | <input type="checkbox"/> | Much worse than one year ago          |

**3** The following questions are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

**a) Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports

- |   |                          |                        |
|---|--------------------------|------------------------|
| 1 | <input type="checkbox"/> | Yes, limited a lot     |
| 2 | <input type="checkbox"/> | Yes, limited a little  |
| 3 | <input type="checkbox"/> | No, not limited at all |

**b) Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf

- |   |                          |                        |
|---|--------------------------|------------------------|
| 1 | <input type="checkbox"/> | Yes, limited a lot     |
| 2 | <input type="checkbox"/> | Yes, limited a little  |
| 3 | <input type="checkbox"/> | No, not limited at all |

**c) Lifting or carrying groceries**

- |   |                          |                        |
|---|--------------------------|------------------------|
| 1 | <input type="checkbox"/> | Yes, limited a lot     |
| 2 | <input type="checkbox"/> | Yes, limited a little  |
| 3 | <input type="checkbox"/> | No, not limited at all |

**d) Climbing several flights of stairs**

- |   |                          |                        |
|---|--------------------------|------------------------|
| 1 | <input type="checkbox"/> | Yes, limited a lot     |
| 2 | <input type="checkbox"/> | Yes, limited a little  |
| 3 | <input type="checkbox"/> | No, not limited at all |

**e) Climbing one flight of stairs**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**f) Bending, kneeling or stooping**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**g) Walking more than one kilometre**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**h) Walking half a kilometre**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**i) Walking 100 metres**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**j) Bathing or dressing yourself**

- 1  Yes, limited a lot  
 2  Yes, limited a little  
 3  No, not limited at all

**4** During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities, **as a result of your physical health**?

**a) Cut down on the amount of time you spent on work or other activities?**

- 1  Yes  
 2  No

**b) Accomplished less than you would like**

- 1  Yes  
 2  No

**c) Were limited in the kind of work or other activities**

- 1  Yes  
 2  No

**d) Had difficulty performing the work or other activities (for example, it took extra effort)**

- 1  Yes  
 2  No

**5** During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

**a) Cut down the **amount of time** you spent on work or other activities**

- 1  Yes  
 2  No

**b) Accomplished less than you would like**

- 1  Yes  
 2  No

**c) Didn't work or other activities as **carefully** as usual**

- 1  Yes  
 2  No

**6** During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

- |   |                          |             |
|---|--------------------------|-------------|
| 1 | <input type="checkbox"/> | Not at all  |
| 2 | <input type="checkbox"/> | Slightly    |
| 3 | <input type="checkbox"/> | Moderately  |
| 4 | <input type="checkbox"/> | Quite a bit |
| 5 | <input type="checkbox"/> | Extremely   |

**7** How much **bodily** pain have you had during the **past 4 weeks**?

- |   |                          |                |
|---|--------------------------|----------------|
| 1 | <input type="checkbox"/> | No bodily pain |
| 2 | <input type="checkbox"/> | Very mild      |
| 3 | <input type="checkbox"/> | Mild           |
| 4 | <input type="checkbox"/> | Moderate       |
| 5 | <input type="checkbox"/> | Severe         |
| 6 | <input type="checkbox"/> | Very Severe    |

**8** During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- |   |                          |              |
|---|--------------------------|--------------|
| 1 | <input type="checkbox"/> | Not at all   |
| 2 | <input type="checkbox"/> | A little bit |
| 3 | <input type="checkbox"/> | Moderately   |
| 4 | <input type="checkbox"/> | Quite a bit  |
| 5 | <input type="checkbox"/> | Extremely    |

## Your Feelings

**9** These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**:

a) Did you feel full of life?

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

b) Have you been a very nervous person

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

c) Have you felt so down in the dumps that nothing could cheer you up?

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

d) Have you felt calm and peaceful?

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**e) Did you have a lot of energy?**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**f) Have you felt down?**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**g) Did you feel worn out?**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**h) Have you been a happy person**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**i) Did you feel tired?**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | A good bit of the time   |
| 4 | <input type="checkbox"/> | Some of the time         |
| 5 | <input type="checkbox"/> | A little bit of the time |
| 6 | <input type="checkbox"/> | None of the time         |

**10** During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives etc)?

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1 | <input type="checkbox"/> | All of the time          |
| 2 | <input type="checkbox"/> | Most of the time         |
| 3 | <input type="checkbox"/> | Some of the time         |
| 4 | <input type="checkbox"/> | A little bit of the time |
| 5 | <input type="checkbox"/> | None of the time         |

## Your Health in General

**11** How TRUE or FALSE is **each** of the following statements for you?

**a) I seem to get sick a little easier than other people**    **b) I am as healthy as anybody I know**

- |   |                          |                  |
|---|--------------------------|------------------|
| 1 | <input type="checkbox"/> | Definitely true  |
| 2 | <input type="checkbox"/> | Mostly true      |
| 3 | <input type="checkbox"/> | Don't know       |
| 4 | <input type="checkbox"/> | Mostly false     |
| 5 | <input type="checkbox"/> | Definitely false |

- |   |                          |                  |
|---|--------------------------|------------------|
| 1 | <input type="checkbox"/> | Definitely true  |
| 2 | <input type="checkbox"/> | Mostly true      |
| 3 | <input type="checkbox"/> | Don't know       |
| 4 | <input type="checkbox"/> | Mostly false     |
| 5 | <input type="checkbox"/> | Definitely false |

c) I expect my health to get worse

- |   |                          |                  |
|---|--------------------------|------------------|
| 1 | <input type="checkbox"/> | Definitely true  |
| 2 | <input type="checkbox"/> | Mostly true      |
| 3 | <input type="checkbox"/> | Don't know       |
| 4 | <input type="checkbox"/> | Mostly false     |
| 5 | <input type="checkbox"/> | Definitely false |

d) My health is excellent

- |   |                          |                  |
|---|--------------------------|------------------|
| 1 | <input type="checkbox"/> | Definitely true  |
| 2 | <input type="checkbox"/> | Mostly true      |
| 3 | <input type="checkbox"/> | Don't know       |
| 4 | <input type="checkbox"/> | Mostly false     |
| 5 | <input type="checkbox"/> | Definitely false |

**CIRCUMSTANCES, MOTIVATION, and READINESS**

**SCALES for SUBSTANCE ABUSE TREATMENT**

**CMR FACTOR SCALES**

**Intake Version**

How you feel can have a powerful effect on treatment. These feelings include your circumstances, the problems in your life, your feelings about yourself, and your feelings about treatment. Carefully consider each of the questions below and indicate how closely they describe your own thoughts and feelings.

Circle the number that best describes your response.

<b>1</b> <b>Strongly Disagree</b>	<b>2</b> <b>Disagree</b>	<b>3</b> <b>Neither Agree nor Disagree</b>	<b>4</b> <b>Agree</b>	<b>5</b> <b>Strongly Agree</b>	<b>9</b> <b>Not Applicable</b>
--	-----------------------------	---	--------------------------	---------------------------------------	---------------------------------------

**CIRCUMSTANCES**

1. I am sure that I would go to jail if I didn't enter treatment. 1----2----3----4----5----9
2. I am sure that I would have come to treatment without the pressure of my legal involvement. 1----2----3----4----5----9
3. I am sure that my family will not let me live at home if I did not come to treatment. 1----2----3----4----5----9
4. I believe that my family/relationship will try to make me leave treatment after a few months. 1----2----3----4----5----9
5. I am worried that I will have serious money problems if I stay in treatment. 1----2----3----4----5----9
6. Basically, I feel I have too many outside problems that will prevent me from completing treatment (parents, spouse/relationship, children, loss of job, loss of income, loss of education, family problems, loss of home/place to live, etc.). 1----2----3----4----5----9

1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree	9 Not Applicable
---------------------------	---------------	---------------------------------------	------------	------------------------	------------------------

## MOTIVATION

7. Basically, I feel that my drug use is a very serious problem in my life. 1---2---3---4---5---9
8. Often I don't like myself because of my drug use. 1---2---3---4---5---9
9. Lately, I feel if I don't change, my life will keep getting worse. 1---2---3---4---5---9
10. I really feel bad that my drug use and the way I've been living has hurt a lot of people. 1---2---3---4---5---9
11. It is more important to me than anything else that I stop using drugs. 1---2---3---4---5---9

## READINESS

12. I don't really believe that I have to be in treatment to stop using drugs, I can stop any time I want. 1---2---3---4---5---9
13. I came to this program because I really feel that I'm ready to deal with myself in treatment. 1---2---3---4---5---9
14. I'll do whatever I have to do to get my life straightened out. 1---2---3---4---5---9
15. Basically, I don't see any other choice for help at this time except some kind of treatment. 1---2---3---4---5---9
16. I don't really think I can stop my drug use with the help of friends, family or religion, I really need some kind of treatment. 1---2---3---4---5---9
17. I am really tired of using drugs and want to change, but I know I can't do it on my own. 1---2---3---4---5---9
18. I'm willing to enter treatment as soon as possible. 1---2---3---4---5---9

## DEGREE OF DRUG USE INDEX (DDI)

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.* These questions are about your substance use in this four week period and ask you to think about how frequently, on average, you used substances during this time. Take your time to think about this period and what you were doing/events happening to assist you with responding.

### NON-INJECTING SUBSTANCE USE

#### 1. ALCOHOL (circle number of standard drinks consumed per week)

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

- How much alcohol per week did you drink on average during this 4 week period?

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Female</b>	Nil	1-14	15-21	22-28	29-35	36+
<b>Male</b>	Nil	1-21	22-28	29-35	36-42	43+
SUBTOTAL						

#### 2. Tranquillisers / Sedatives / Hypnotics

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

- Did you use any tranquillisers / sedatives / hypnotics in this 4 week period?  
(e.g. benzodiazepines such as valium, halcion, ativan, clonazepam, imovane, etc)

Yes                          No

If Yes circle whether:                          Prescribed                          Non-prescribed                  Both

- How frequently on average?

<b>0</b> Nil Use	<b>1</b> Once per week or less	<b>2</b> More than once per week	<b>3</b> Daily	<b>4</b> 2-3 times daily	<b>5</b> 4 or more times daily
SUBTOTAL					

### 3. Cannabis

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

1. Did you use cannabis in this 4 week period? Yes No
2. How frequently (on average)?

0 Nil Use	1 Once per week or less	2 More than once per week	3 Daily	4 2-3 times daily	5 4 or more times daily
SUBTOTAL					

### 4. Other non-injecting substance use

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

1. Did you use any other drugs (not-injected) in this 4 week period ie other than tranquilisers/sedatives/ hypnotics, cannabis and alcohol? (exclude any medications prescribed for psychiatric/medical disorders)
- Yes No
2. How frequently (on average)?

0 Nil Use	1 Once per week or less	2 More than once per week	3 Daily	4 2-3 times daily	5 4 or more times daily
SUBTOTAL					

**If you used any other non-injected drugs what did you use and how often (tick columns below)**

*NB not scored – ie for additional information/discussion*

	Nil Use	Once per week	More often than once a week	Daily	2-3 times daily	4 or more times daily
i) Amphetamine like stimulants including BZP specify:						
ii) hallucinogens- specify						
iii) Inhalants specify						
iv) Other specify						

## **5. Nicotine**

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

How many cigarettes did you smoke on average per day in this 4 week period?

**NB. 50gms tobacco = 100 retail cigarettes**

<b>0</b> None	<b>1</b> 5 or less	<b>2</b> 6-10	<b>3</b> 11-15	<b>4</b> 16-20	<b>5</b> More than 20
------------------	-----------------------	------------------	-------------------	-------------------	--------------------------

## **INJECTING DRUG USE**

*Please reflect back to the four weeks before you entered the Moana House Programme/prior to entering a residential setting including prison.*

1. Did you inject any drugs in this 4 week period? Yes No  
(if No: score zero and move to Eight Screen)

2. How frequently (on average)?

<b>0</b> Nil Use	<b>1</b> Once per week or less	<b>2</b> More than once per week	<b>3</b> Daily	<b>4</b> 2-3 times daily	<b>5</b> 4 or more times daily
SUBTOTAL					

**If you injected what specific drugs did you use & how often? (tick columns below - NB not scored – but for additional information/discussion)**

	Nil Use	Once per week	More often than once a week	Daily	2-3 times daily	4 or more times daily
i) opioids						
i) amphetamine-like stimulants. Including BZP Specify						
ii) tranquillisers/sedatives Specify:						

- 3 How often did you share injecting equipment? (injecting equipment includes needles, syringes, filters, spoons, tourniquets, “dregs” and water)

<b>0</b> Never	<b>1</b> Hardly ever	<b>2</b> Sometimes	<b>3</b> Frequently
-------------------	-------------------------	-----------------------	------------------------

- 3.a With how many different people did you share injecting equipment with?

Number of people:

## **“EIGHT” GAMBLING SCREEN**

***12 Week Version***

Early Intervention Gambling Health Test

**Did you gamble with any money **in the 12 weeks before you entered the Moana House Programme/prior to entering a residential setting including prison?****

Yes

No

If Yes: Please think about your gambling in this 12 week period when answering these questions

1. Sometimes I've felt depressed or anxious after a session of gambling.

Yes, that's true

No, I haven't

2. Sometimes I've felt guilty about the way I gamble.

Yes, that's true

No, I haven't

3. When I think about it, gambling has sometimes caused me problems.

Yes, that's true

No, I haven't

4. Sometimes I've found it better not to tell others, especially my family, about the amount of time or money I spend gambling.

Yes, that's true

No, I haven't

5. I often find that when I stop gambling I've run out of money.

Yes, that's true

No, I haven't

6. Often I get the urge to return to gambling to win back losses from a past session.

Yes, that's true

No, I haven't

7. Yes, I have received criticism about my gambling in the past.

Yes, that's true

No, I haven't

8. Yes, I have tried to win money to pay debts.

Yes, that's true

No, I haven't

This is a 12 week version of the “Eight” Gambling Screen developed by  
Sean Sullivan – Goodfellow Unit – Auckland Medical School

## **Brief Situational Confidence Questionnaire (BSCQ)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Listed below are eight types of situations in which some people experience an alcohol or drug problem. Imagine yourself as you are right now in each of the following types of situations. Indicate on the scale provided how confident you are right now that you will be able to resist drinking heavily or resist the urge to use your primary drug in each situation by placing an "X" along the line, from 0% "Not at all confident" to 100% "Totally confident" as in the example below.

**I feel...**

X

---

<b>0%</b> Not at all confident	<b>100%</b> Totally confident
-----------------------------------	----------------------------------

**Right now I would be able to resist the urge to drink heavily or use my primary drug in situations involving...**

1. **UNPLEASANT EMOTIONS** (e.g., If I were depressed about things in general; if everything were going badly for me).

**I feel...**

---

<b>0%</b> Not at all confident	<b>100%</b> Totally confident
-----------------------------------	----------------------------------

2. **PHYSICAL DISCOMFORT** (e.g., If I were to have trouble sleeping; if I felt jumpy and physically tense).

**I feel...**

---

<b>0%</b> Not at all confident	<b>100%</b> Totally confident
-----------------------------------	----------------------------------

3. **PLEASANT EMOTIONS** (e.g., If something good happened and I felt like celebrating; if everything were going well).

**I feel...**

---

<b>0%</b> Not at all confident	<b>100%</b> Totally confident
-----------------------------------	----------------------------------

**Right now I would be able to resist the urge to drink heavily or use my primary drug in situations involving...**

**4. TESTING CONTROL OVER MY USE OF ALCOHOL OR DRUGS** (e.g., If I were to start to believe that alcohol or drugs were no longer a problem for me; if I felt confident that I could handle drugs or several drinks).

**I feel...**



**5. URGES AND TEMPTATIONS** (e.g., If I suddenly had an urge to drink or use drugs; if I were in a situation where I had often used drugs or drank heavily).

**I feel...**



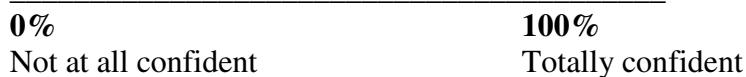
**6. CONFLICT WITH OTHERS** (e.g., If I had an argument with a friend; if I were not getting along well with others at work).

**I feel...**



**7. SOCIAL PRESSURE TO USE** (e.g., If someone were to pressure me to "be a good sport" and drink or use drugs with him; if I were invited to someone's home and he offered me a drink or drugs).

**I feel...**



**8. PLEASANT TIMES WITH OTHERS** (e.g., If I wanted to celebrate with a friend; if I were enjoying myself at a party and wanted to feel even better).

**I feel...**



# Resident Hua Oranga

**Q1 As a result of the INTERVENTION do you feel: (please circle one)**

a) More valued as a person	Much more	More	No Change	Less	Much less
b) Stronger in yourself as a Māori	Much more	More	No Change	Less	Much less
c) More content within yourself	Much more	More	No Change	Less	Much less
d) Healthier from a spiritual point of view	Much more	More	No Change	Less	Much less

**Q2 As a result of the INTERVENTION are you: (please circle one)**

a) More able to set goals for yourself	Much more	More	No Change	Less	Much less
b) More able to think, feel and act in a positive manner	Much more	More	No Change	Less	Much less
c) More able to manage unwelcome thoughts and feelings	Much more	More	No Change	Less	Much less
d) More able to understand how to deal with your health problems	Much more	More	No Change	Less	Much less

**Q3 As a result of the INTERVENTION are you: (please circle one)**

a) More able to move about without pain or distress	Much more	More	No Change	Less	Much less
b) More committed to having good physical health	Much more	More	No Change	Less	Much less
c) More able to understand how physical health improves mental well being	Much more	More	No Change	Less	Much less
d) Physically healthier	Much more	More	No Change	Less	Much less

**Q4 As a result of the INTERVENTION are you: (please circle one)**

a) More able to communicate with your Whānau	Much more	More	No Change	Less	Much less
b) More confident in your relationships with other people	Much more	More	No Change	Less	Much less
c) Clearer about the relationship with your Whānau	Much more	More	No Change	Less	Much less
d) More able to participate in your community	Much more	More	No Change	Less	Much less

## Dimensions of Change Instrument (DCI)

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

	Not at All	A Little	Somewhat	A Great Deal	Completely
1. Program meetings are helpful to the recovery of people in treatment here.	<input type="checkbox"/>				
2. It's important to have male and female friends.	<input type="checkbox"/>				
3. When people confront me in groups, it helps me understand my problems better.	<input type="checkbox"/>				
4. Encounter groups are helpful to the recovery of people in treatment here.	<input type="checkbox"/>				
5. People in treatment here take an active part in things like groups and discussions.	<input type="checkbox"/>				
6. When I need something I go through the structure.	<input type="checkbox"/>				
7. People in treatment here listen to each other when they need to talk about their feelings.	<input type="checkbox"/>				
8. Requirements for program completion are clear.	<input type="checkbox"/>				

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

	Not at All	A Little	Somewhat	A Great Deal	Completely
9. Making the program work requires everyone to do their share of work.	<input type="checkbox"/>				
10. This program is a safe place for people in treatment here.	<input type="checkbox"/>				
11. I support other people in treatment here during encounter group.	<input type="checkbox"/>				
12. Keeping my room neat is an important part of being a good community member.	<input type="checkbox"/>				
13. I feel responsible for other people in the program.	<input type="checkbox"/>				
14. People in treatment here can support one another despite conflict.	<input type="checkbox"/>				
15. I believe I should do every job I am given to the best of my ability.	<input type="checkbox"/>				
16. There are people in treatment here with whom I can share my feelings.	<input type="checkbox"/>				
17. It is safe for people in treatment here to share their innermost feelings.	<input type="checkbox"/>				
18. I share my experiences to help others.	<input type="checkbox"/>				

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

	Not at All	A Little	Somewhat	A Great Deal	Completely
19. I use the group process to talk about my personal problems.	<input type="checkbox"/>				
20. People in treatment here give advice to each other.	<input type="checkbox"/>				
21. People in treatment here enjoy their work or school.	<input type="checkbox"/>				
22. There is a clear understanding here of what this treatment program is all about.	<input type="checkbox"/>				
23. People in treatment here know what is expected of them.	<input type="checkbox"/>				
24. People in treatment here take pride in this program.	<input type="checkbox"/>				
25. This program is helpful overall to the recovery of people in treatment here.	<input type="checkbox"/>				
26. When I've broken a rule, I admit it to other people in the program.	<input type="checkbox"/>				
27. The structure and order here make me feel safe.	<input type="checkbox"/>				
28. I recognize how negative behaviors affect the community.	<input type="checkbox"/>				

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

	Not at All	A Little	Somewhat	A Great Deal	Completely
29. What happens to me today depends on me.	<input type="checkbox"/>				
30. I think of myself as a person who can live without any alcohol or drugs.	<input type="checkbox"/>				
31. I can do just about anything I really set my mind to today.	<input type="checkbox"/>				
32. There are people outside the program to help me understand a problem.	<input type="checkbox"/>				
33. I feel it is good to look inside myself.	<input type="checkbox"/>				
34. I can distinguish between right and wrong behaviors in myself.	<input type="checkbox"/>				
35. My attitudes, feelings, or behaviors can cause problems with my relations with other people in treatment here.	<input type="checkbox"/>				
36. I feel more able to change my behaviors now.	<input type="checkbox"/>				
37. I feel that I have a number of good qualities.	<input type="checkbox"/>				
38. I can change many of the important things in my life by working on them today.	<input type="checkbox"/>				

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

	Not at All	A Little	Somewhat	A Great Deal	Completely
39. I am committed to right living.	<input type="checkbox"/>				
40. There are people outside the program to love and make me feel wanted.	<input type="checkbox"/>				
41. I try to understand myself.	<input type="checkbox"/>				
42. I pay attention to what I am feeling.	<input type="checkbox"/>				
43. My attitudes, feelings, or behaviors can cause problems with my physical health.	<input type="checkbox"/>				
44. Today, when I feel like using alcohol or drugs I choose not to.	<input type="checkbox"/>				
45. My attitudes, feelings, or behaviors can cause problems with going to school or vocational classes.	<input type="checkbox"/>				
46. I feel that I am a person of worth, at least on an equal basis with others.	<input type="checkbox"/>				
47. I spend time thinking about my feelings.	<input type="checkbox"/>				
48. My attitudes, feelings, or behaviors can cause problems with my relations with family.	<input type="checkbox"/>				

Please mark whether you agree not at all, a little, somewhat, a great deal or completely with each statement below. Mark only one box on each row.

Not at All      A Little      Somewhat      A Great Deal      Completely

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 49. When I must make a decision, I carefully think over the options and consequences.            | <input type="checkbox"/> |
| 50. I am able to control myself in situations that make me angry.                                | <input type="checkbox"/> |
| 51. I have much to be proud of.  | <input type="checkbox"/> |
| 52. My attitudes, feelings, or behaviors can cause problems with my attention and concentration. | <input type="checkbox"/> |
| 53. There are people outside the program to have a good time with.                               | <input type="checkbox"/> |
| 54. I believe that being honest with myself is very important.                                   | <input type="checkbox"/> |

## **Therapeutic Community Client Assessment Inventory For Community-Based Programs (Scales 2,3,4)**

© October 1, 1997 David Kressel, Ph.D. and George De Leon, Ph.D.  
Center for Therapeutic Community Research (CTCR) at National Development and  
Research Institutes, Inc  
71 West 23 Street - 8<sup>th</sup> floor, New York, N.Y. 10010

**DIRECTIONS:** Using the attached 5 point scale please **circle the number closest to the way you rate yourself now** on the following items: THIS RATING SHOULD REFLECT YOUR CURRENT USUAL AND CONSISTENT LEVEL OR KIND OF PERFORMANCE. Please provide a fair and honest evaluation of yourself.

Strongly Disagree	Disagree	Between Disagree/Agree	Agree	Strongly Agree
1	2	3	4	5
2.1. I correct (pull-up) peers when they break program rules.				
2.2. I am unable to meet my responsibilities when I'm under pressure.				
2.3. I do my fair share of taking responsibility for the care and functioning of the facility.				
2.4. I report violations of program rules when I see them.				
2.5. I accept pull-ups with a good attitude.				
2.6. When I have an urge to do something destructive (split, get high, act out) I let someone know.				
2.7. I participate in program activities with enthusiasm.				
2.8. I meet my responsibility to be accountable for other people's behavior.				
3.1. I lie or cover up the truth.				
3.2. I use people in a manipulative way to get what I want .				
3.3. My behavior is selfish and inconsiderate of others.				
3.4. I am trustworthy and dependable.				
3.5. I compromise my principles (honesty) for personal gain				
3.6. My behavior is sneaky and deceptive.				
3.7. I compromise my principles (honesty) in order to be accepted by people.				
4.1. If I can't get things any other way I steal them.				
4.2. I tell a lot of war stories.				
4.3. I don't tell on people; it feels like ratting.				
4.4. I hang with a "negative" group or clique in the program				
4.5. I break program rules when I think I can get away with it				
4.6. The smartest thing is to never trust anyone.				

# TREATMENT PERCEPTIONS QUESTIONNAIRE (TPQ)

Alcohol and Drug Treatment Client Satisfaction Questionnaire

These questions are about how you have found Moana House

Your comments as well as ratings are welcomed on each question – particularly specific dissatisfactions and suggestions for improvements

**1. The staff did not always understand the kind of help I wanted.**



**Comments:** \_\_\_\_\_

**2. The staff and I had different ideas about my treatment objectives.**



**Comments:** \_\_\_\_\_

**3. There was always been a member of staff available when I have wanted to talk.**



**Comments:** \_\_\_\_\_

**4. The staff helped to motivate me to sort out my problems.**



**Comments:** \_\_\_\_\_

**5. I think the staff were good at their jobs.**



**Comments:** \_\_\_\_\_

**6. I was well informed about decisions made about my treatment.**



**Comments:** \_\_\_\_\_

**7. I have received the help that I was looking for.**



**Comments:** \_\_\_\_\_

**8. I did not like all of the treatment sessions I have attended.**



**Comments:** \_\_\_\_\_

**9. I did not have enough time to sort out my problems.**



**Comments:** \_\_\_\_\_

**10. I did not like some of the treatment rules or regulations.**



**Comments:** \_\_\_\_\_

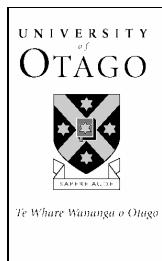
Any other comments you would like to make? (continue on back if you need more space)

**Treatment Perceptions Questionnaire (TPQ)**

**Authors: Marsden J, Stewart D, Gossop M, Rolfe A, Bacchus L, Griffiths P, Clarke K, Strang J.**

**(National Addiction Centre, Institute of Psychiatry/South London Mental Health Trust)**

## **APPENDIX IV: INFORMED CONSENT MATERIALS**



# NATIONAL ADDICTION CENTRE

## An evaluation of the Moana House therapeutic community

### Information Sheet

**Tēnā koe,**

**Tēnā koe me ngā ahuatanga o te wa, o tātou mate noho mai i roto i te ao wairua. Tātou te ao ora, kia ora mai tātou.**

Hello, this information sheet tells you about the evaluation we invite you to take part in. You may take as much time as you wish to decide if you want to participate. Please note your involvement is entirely voluntary (up to you). If you have any questions what-so-ever, please feel free to ask.

### **Who are the evaluators?**

We are:

Simon Adamson. I am the lead evaluator. I am a Senior Lecturer at the National Addiction Centre (NAC) in Christchurch. My contact numbers are:

Telephone number: 03 3640480  
Fax number: 03 3641225  
E-mail: [simon.adamson@otago.ac.nz](mailto:simon.adamson@otago.ac.nz)

*This evaluation has been approved by the Southern Regional Ethics Committee (Otago)*

Moana-O-Hinerangi (Ngāi Tahu, Ngāti Mamoe, Waitaha, Rapuwia, Rongomaiwahine, Ngāti Porou). I am a Cultural Advisor and a Christchurch-based member of the evaluation team. I will be doing some of the interviews. I am able to be contacted at:

Telephone: 03 3541362  
Mobile: 0272214290  
Fax: 03 3541369  
E-mail moana@indigemo.co.nz

Geoff Noller. I am the Dunedin-based member of the evaluation team and I will be doing some of the interviews. I am able to be contacted at:

Telephone: 03 4710340  
Mobile: 021471042  
E-mail: geoff.noller@stonebow.otago.ac.nz

Daryle Deering. I am a Christchurch-based member of the evaluation team and a Researcher at the National Addiction Centre (NAC). I am able to be contacted at the NAC on:

Telephone number: 03 3640480  
Fax number: 03 3641225  
E-mail: daryle.deering@otago.ac.nz

Terry Huriwai (Te Arawa/ Ngāti Porou). I am another Christchurch-based member of the evaluation team. I am able to be contacted at the National Addiction Centre with Simon and Daryle or at:

Email: terry.huriwai@otago.ac.nz

**The evaluation is a collaborative project involving Moana House. It has been commissioned by the Alcohol Advisory Council ALAC in association with the Ministry of Health.**

## **Background**

Therapeutic communities (TCs) are places where people with alcohol and other drug related problems live and work together to make changes in their lives. They are considered to be one of the most effective ways for treating some offenders with alcohol and other drug problems.

In Aotearoa / New Zealand there are only a few TCs and they each work in a unique way. Moana House is a well-established programme that draws on the strengths of Māori culture. A recent assessment of New Zealand TCs showed that more information is needed on how they work. Moana House sees this as an opportunity to further enhance its programme.

## **What is this evaluation trying to do?**

This evaluation is aiming to find out how and why Moana House works as well as it does, and thereby celebrate this. It also aims to identify any areas where the programme could be improved. If the evaluation can identify these factors it may be possible for more programmes like Moana House to be developed in New Zealand.

## **What will the evaluation involve?**

For Moana House residents, the evaluation involves a confidential interview with an experienced interviewer and the completion of a questionnaire. These may happen more than once, as residents progress through the programme. Non-residents will only be asked to complete one interview. In addition, with residents' permission the views of whānau and other agency personnel relevant to treatment at Moana House will be sought.

**Interviews:** These will be carried out by Moana-O-Hinerangi and **Error! Bookmark not defined..** They will involve a conversation taking about an hour. Residents will be interviewed at each stage of the Moana House programme. Interviews will be recorded onto a laptop and transcribed. Transcripts will be checked against the recordings for accuracy. When the evaluation is finished the recordings and transcripts will be kept in a locked cabinet at the National Addiction Centre in Christchurch for a maximum of ten years. Only the evaluation team and the Moana House Programme Director will have access to them.

**Questionnaires:** These will be administered by Moana House staff, along with regular questionnaires which are already part of the Moana House programme. They will cover aspects of your health and functioning and substance use as well as views of the programme. With your permission the views of whānau will also be sought. This information will also be kept securely at the National Addiction Centre in Christchurch.

### **How can I get included in this evaluation?**

All residents entering the Moana House programme will be asked to take part in the evaluation. They will be approached by Moana House staff on behalf of the evaluation team.

Along with Moana House residents, the evaluation will seek to also involve family or whānau of residents and ex-residents, graduates, staff, support staff and Moana House stakeholders.

For residents and staff, interviews and questionnaires will be administered at Moana House. For others, interviews will be conducted at a place of their choice.

The evaluation will take 2 years.

### **Can I change my mind?**

To take part is your choice. If you start the evaluation and then decide you want to withdraw, that is okay too. Your treatment now and in the future won't be affected in any way if you choose to be a part of this evaluation - or if you choose not to. However, if you choose to withdraw after November 30th 2009 your information will still be included in the evaluation.

### **Results**

If you take part, a plain-language summary of the findings will be sent to you if you want it. The results of the evaluation will be provided in a report to ALAC and the Ministry of Health and will also be relayed to all organisations and the various Rūnanga that the evaluation team has discussed the study with. The study may also be written up for publication in a journal.

Feedback will also be given to the ethics committee who reviewed the evaluation before starting. In the feedback and the reports that come from this evaluation, no names will be used and all information will continue to be anonymous so that no one who took part will be able to be identified. If you don't want your information used you can ask that it not be included.

### **Benefits, risks and safety**

Although there are no direct benefits, participants may find that reflecting on their involvement with Moana House, through being involved with the evaluation, is of benefit.

The interviews shouldn't be stressful to you, but because interviews may cover material of a personal nature you can stop the interview at any time if you should find this distressing or should you need to for any other reason.

The study is non-therapeutic and consists only of an evaluation of the Moana House programme.

Participating will not cost participants anything. Non-residents incurring transport costs will receive a travel voucher to help with this.

### **Who to get in touch with for further information?**

If you have any questions or concerns about the evaluation, or about your rights as a participant, you can ask any of the evaluation team through the NAC (03 3640480), discuss matters with the Director of Moana House or you may contact a Health and Disability Services Consumer Advocate (0800 555 050).

### **General**

This evaluation has received ethical approval from the Southern Regional Ethics Committee (Otago).

The Moana House Programme Board supports this evaluation and the evaluation team is working with the Director of the programme to carry it out.

If an interpreter is required one will be provided.

*This evaluation has been approved by the Southern Regional Ethics Committee (Otago)*

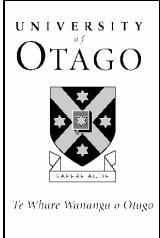
You may have a friend, family or whānau support to help you understand the risks and/or benefits of this evaluation and any other explanation you may require.

**Confidentiality:**

1. No material which could personally identify you will be used in any reports on this evaluation.
2. All data and records resulting from the evaluation will be stored in a locked filing cabinet at the National Addiction Offices in Christchurch. At the evaluation's conclusion only the evaluation team and the Director of Moana House will have access to these. They will be destroyed within 10 years of the evaluation's conclusion.

Thank you for taking the time to read this information sheet. If you still have any questions please ask.

Heoi ano, noho ora mai koe.



# NATIONAL ADDICTION CENTRE

## An evaluation of the Moana House therapeutic community

### Consent Form

English	I wish to have an interpreter.	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero.	Ae	Kao
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
Samoan	Ou te mana'o ia i ai se fa'amatala upu.	loe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	loe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
	Other languages to be added following consultation with relevant communities.		

I have read the information sheet or have had it read to me. If I want to take part in this evaluation, I know that my signature at the bottom of this consent form will show that I understand what the evaluation is all about. I also know I can keep a copy of the information sheet.

1. I have been invited to take part in this evaluation being done by the following people from the National Addiction Centre:

Simon Adamson,  
Daryle Deering,  
Terry Huriwai (Te Arawa/Ngāti Porou),  
Moana-o-Hinerangi (Ngāi Tahu, Ngāti Mamoe, Waitaha, Rapuwia, Rongomaiwahine, Ngāti Porou) and  
Geoff Noller.

*This evaluation has been approved by the Southern Regional Ethics Committee (Otago)*

2. I understand that the aim of this evaluation is to find out how the Moana House programme works and how it impacts on people. This will be done by interviewing residents, graduates, whānau and others associated with the residents and the programme.
3. I understand that the evaluation team has the support of the Moana House Board and staff. I also am aware that the evaluation team has discussed their project with local mana whenua (Ngāi Tahu) representatives.
4. I understand that my part in the evaluation will involve:
  - a) confidential interviews with either Moana-o-Hinerangi or Geoff Noller which will take about an hour. Interviews will ask me about my perspective on the Moana House programme, particularly how it works;
  - b) (if a resident) completing questionnaires which will be administered along with the other programme surveys by Moana House staff . Questionnaires will ask me about aspects of my health and functioning and substance use as well as my views of the programme. With my permission the views of whānau will also be sought.
5. I realise that the interviews will be recorded and stored anonymously and that I will not be identified in any presentations or publications about the study. The information will be stored in a locked cabinet at the National Addiction Centre, Christchurch. Access will be limited to the evaluation team and the Director of Moana House.
6. I have had the opportunity to use whānau support or a friend to help me ask questions and understand the evaluation. I am satisfied with the answers I have been given.
7. I understand that taking part in this evaluation of the Moana House programme is voluntary (my choice) and that I may withdraw from the evaluation at any time. If I do withdraw this will in no way affect my continuing or future health care. However, if I withdraw after November 30th 2009 my data will still be included.
8. I have had time to consider whether to take part.
9. I understand that my involvement in the evaluation might be stopped if it should appear harmful to me.
10. I understand that this evaluation has been approved by the Southern Regional Ethics Committee (Otago).
11. I am aware that if I have any questions or concerns about the evaluation that I can contact Simon Adamson, or any of the team (03-3640480), the Director of Moana House or I can contact the Advocacy Service (0800 555 050).

*This evaluation has been approved by the Southern Regional Ethics Committee (Otago)*

12. I know who to contact if I have any problems caused by my participation in the evaluation.
13. I am aware that the evaluation team, Moana House or ALAC may wish to publish aspects of the findings from the evaluation and I give my approval for my information to be included. I am aware that no material that will identify me will be used in any reports or papers.
14. I \_\_\_\_\_ (full name) hereby consent to take part in this evaluation.

Date

Signature

Full names of Evaluators

Contact Phone Number for Evaluators

Project explained by

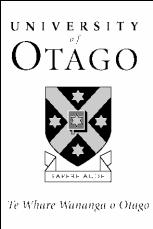
Project role

Signature

Approval for inclusion of material in publication:

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

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



# NATIONAL ADDICTION CENTRE

## EVALUATION OF THE MOANA HOUSE THERAPEUTIC COMMUNITY

### RECONTACT CONSENT

To help us contact you for follow-up interviews should you leave the Moana House Programme during the evaluation period November 2008 – December 2009 we would like you to provide the names of up to three people we could contact to help locate you. You might like to list friends, family, your doctor or others. If any of these people are contacted the only information we would give, if necessary, would be to say that we were trying to contact you for a health research study and that you had given us permission to contact the people listed below.

Name: \_\_\_\_\_ What is this person's relationship to you? \_\_\_\_\_  
Ph: (home) \_\_\_\_\_  
(work) \_\_\_\_\_  
(mobile) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ What is this person's relationship to you? \_\_\_\_\_  
Ph: (home) \_\_\_\_\_  
(work) \_\_\_\_\_  
(mobile) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ What is this person's relationship to you? \_\_\_\_\_  
Ph: (home) \_\_\_\_\_  
(work) \_\_\_\_\_  
(mobile) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

- Yes - I ..... hereby consent to allowing the researchers for this study to contact the above people if required.
- No – I ..... do not consent for the researchers to contact other people in order to locate me, should I leave Moana House.

Signature: ..... Date: .....

*This evaluation has been approved by the Lower South Regional Ethics Committee  
Version 1 - October 2008*