Waitemata District Health Board
Te Wai Awhina

CRRC Waitemata DHB Mental Health and Regional Alcohol & Drug Services
CLINICAL RESEARCH & RESOURCE CENTRE

The Pacific Alcohol & Drug Outcomes Project

A report on:

Phase I: A study of current treatment approaches for Pacific peoples with alcohol and drug issues

Phase II: A study of the delivery of alcohol and drug services to Pacific peoples – the perceptions of clients, families and service managers

ALCOHOL ADVISORY COUNCIL OF NEW ZEALAND
Kaunihera Whakatupato Waipiro o Aotearoa
alac

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INTRODUCTION

This document presents the results and recommendations of two recent research studies on alcohol and other drug (A&D) treatment services for Pacific peoples.

The studies are part of the Pacific Alcohol & Drugs Outcomes Project (PADOPT), which was launched in 2002 with the aim of evaluating and improving the effectiveness of A&D treatment services for Pacific peoples. The studies comprise:

- **Phase I**: interviews with New Zealand-based Pacific A&D clinicians on the practices and treatment approaches they and/or their services use
- **Phase II**: building on the Phase I research, interviews with Pacific clients and families on their experiences with Pacific A&D services, as well as with service managers and team leaders within those services.

PHASE I

The Phase I study was completed in May 2003 and was the first comprehensive stocktake of A&D treatment approaches for Pacific peoples in New Zealand. It aimed to:

- document and report on current treatment interventions for Pacific clients with A&D issues across A&D services in Auckland, Hamilton, Wellington and Christchurch
- gather clinicians' opinions of the treatment models, outcome tools and processes used for Pacific peoples with A&D-related problems
- make initial recommendations on ways to improve A&D treatment for Pacific clients, with the long-term aim of reducing A&D-related problems among Pacific peoples.

The study provided a baseline of current treatment strategies from which future treatment and A&D models of care for Pacific peoples can be developed or improved. Note it did not address mechanisms to improve the information flow between and within mainstream and Pacific A&D services.

PHASE II

The Phase II study was completed in October 2004. It aimed to:

- obtain client and family perspectives on the effectiveness of treatments provided by A&D services
- gain information about service delivery from service managers and team leaders within the A&D services
- identify the extent to which these services were engaging in workforce development strategies for Pacific clients
- make recommendations for the third and final phase of PADOPT.

This work was commissioned by the Alcohol Advisory Council of New Zealand (ALAC) as part of its work to promote moderate alcohol use at community and national levels and specifically to

reduce problems associated with alcohol misuse among Pacific people. It arose in response to the lack of both quantitative and qualitative research on Pacific peoples in New Zealand – and was seen by ALAC as a mechanism for increasing the understanding of Pacific peoples' experiences with A&D treatment providers.

The research was undertaken by the Clinical Research and Resource Centre, a self-funding research centre within Waitemata District Health Board. The researchers are experienced in working within the mental health and addictions areas, as either academic or clinical researchers.

Ethical approval was sought and received from the Auckland Ethics Committee (on behalf of the Auckland, Waikato, Wellington and Canterbury Ethics Committees). Consultation was also sought with various Pacific and Maori representatives.

The project included input from two advisory boards comprising experienced leaders within the A&D field with cultural and clinical expertise, while the research team comprised Pacific researchers and clinical and/or academic investigators. As part of a commitment to developing the Pacific research workforce, Pacific researchers were employed who, with help from the advisory boards and team investigators, could blend social science and Pacific-specific research methodologies.

This document presents the study findings and recommendations, along with relevant appendices and references, in two discrete sections. A summary of their results can be found on pages 8 to 15, and a glossary of common terms used in both studies on page 106.

For more information on the studies, and on Phase III, please contact ALAC.

BACKGROUND

Before Western contact in the Pacific Islands, kava and betelnut were the only two widely used recreational substances. Little was known about alcohol production, access or trade until the 19th century, when whalers, traders and sailors introduced the Pacific population to alcohol and substances such as tobacco (Lal and Fortune 2000). Today, alcohol (and drugs) is widely available through local brewing industries and imported supplies.

In the 20th century, the desire for Western employment and educational opportunities led many Pacific peoples to migrate overseas, mainly to countries such as America, Australia and New Zealand (McCall and Connell 1993). During the 1950s and 1980s there was an influx of Pacific migrants into New Zealand looking for work, helped in part by the special relationship between New Zealand and the Pacific islands (Ministry of Justice 2000).

Today, many Pacific peoples call New Zealand home (McCall and Connell 1993; Macpherson et al 2001). In fact, more than half were born and raised here (Cook et al 1999) and many have never left New Zealand's shores.

Many Pacific migrants have formed expatriate settlements in New Zealand that replicate the practices of their island homelands, and have managed to maintain much of their traditional cultural values. However, this is more prominent for Samoan, Tongan and smaller Fijian, Tuvaluan and Tokelauan groups. Cook Islanders and Niueans have varying degrees of traditional cultural retention owing to their comparatively higher levels of assimilation into New Zealand's political, cultural and social lives.

Regardless of these differences, migration has exposed all Pacific peoples to a freedom of access to goods and services not usually allowed in their highly structured and hierarchical social systems. For example, alcohol consumption has become an accepted part of many Pacific social functions and cultural festivities – and problem drinking and drug taking has emerged. That said, cultural stigmas attached to drinking alcohol in public continue to pervade island-based drinking behaviours, especially among women, although this is less apparent among those living in metropolitan areas.

This report recognises that we need to understand the nature of these cultural stigmas and/or beliefs and the migratory experience if we are to find appropriate ways to help New Zealand-based Pacific A&D clients in their fight against problem drinking and illegal drug taking.

PACIFIC A&D RESEARCH IN NEW ZEALAND

Previous studies on Pacific peoples and alcohol consumption in New Zealand aimed to address drinking beliefs and practices (Banwell 1986; Neich and Park 1988), population patterns (Stanhope and Prior 1979; Wessen et al 1992; Statistics New Zealand and Ministry of Health 1993) and attitudes and perceptions about the importance of alcohol in their lives (ALAC 1997).

However, at the time this research was begun, detailed information on Pacific peoples and their alcohol consumption patterns was limited, and studies on Pacific peoples' drug-taking even more sparse. Similarly, there was little research on the nature and types of New Zealand-based Pacific A&D services and their delivery practices and policies – and very little anecdotal evidence about Pacific peoples' A&D problems.

More recently, a number of Pacific models that capture the essence of Pacific values and beliefs have been designed and implemented by Pacific peoples for service delivery to Pacific A&D clients and their families. These include the:

- Fonofale model (Pulotu-Endemann cited in Ministry of Health 1995), which uses the image of a traditional Samoan house, or *fale*. The house is round or oval and has a number of main posts supporting the roof. The main parts drawn on for the purposes of the model are the foundation, the posts and the roof. The model suggests that the roof symbolises 'culture'; the four posts represent the dimensions of a person's wellbeing – 'physical', 'spiritual', 'mental' and 'other'; and the foundation symbolises the 'family'. Pulotu-Endemann places this *fale* within a circle (suggestively the circle of life) containing the fundamental elements of 'time' and 'context'. In other words, an individual's cultural, physical, spiritual, mental, family and other needs have to be understood within the specific time and context
- Kakala model (Helu-Thaman cited in Pacific Models 2002), which draws on the image of a garland of *kakala* flowers. Helu-Thaman explains that a *kakala* garland has cultural significance; that not only is the flower special in Tongan culture, but when the flowers are picked, how they are woven together and how, where, when and to whom the garland is presented have deliberate and symbolic meanings. Helu-Thaman applies this as a metaphor for the research process: designing research projects requires deliberate engagement in knowing who the research is with and how, when and where it should be carried out
- Lalaga model (Mulitalo-Lauta 2000), which, like the other two models, involves the image of a Pacific artefact of significance and/or the making of it. 'Lalaga' is a Samoan term that refers to the act of making the fine mats used for ceremonial purposes at special occasions. In this model, Mulitalo-Lauta suggests the importance of the 'weaving' process as a metaphor for working appropriately with Pacific clients and/or their families. The model offers a continuum in which decisions about how fine to weave the mat depend on the 'seriousness' of the case. At one end of the continuum are very serious (complex)

cases, and at the other end those that are relatively more straightforward. The practitioner analyses the case and its needs and decides on the strands of culture, science and/or other lessons or practices they should adopt in managing the case and/or 'treating' the client.

This PADOPT study aims to further explore Pacific service delivery styles, policies and practices and their influence on the recovery and wellbeing of Pacific A&D clients. In doing so it aims to add to the existing body of knowledge and provide information and guidance for future policy and practice developments.

THE STUDIES' KEY FINDINGS

PHASE I

The key findings from Phase I are as follows.

- The current assessment and treatment tools and processes that clinicians highlighted endorse either a Pacific or a combined Pacific/Palangi (Western) approach that encompasses a holistic framework of service delivery, with assessment tools that explore the client's spiritual, mental, physical, social and wider familial contexts, rather than just their A&D problems.

- Western strength-based models, harm reduction versus abstinence strategies and client-centred approaches are, where appropriate, adapted into Pacific A&D treatment frameworks.

- Pacific services based at district health boards (DHBs) routinely use a combination of Pacific-specific and mainstream tools (such as the Leeds Dependence Questionnaire (LDQ) and Alcohol Use Disorders Identification Test (AUDIT)).[1] The genogram (Kent-Wilkinson 1999) and Fonofale models (Pulotu-Endemann in Ministry of Health 1995) are also useful for working with Pacific clients and families, as they take into account cultural and family contexts as presenting issues applicable to Pacific A&D clients.

- Clinicians recognise the need for families to be an integral part of the clinical intervention process.

- Current clinical A&D treatment models lack Pacific-specific markers and/or rapport-building techniques. Assessment forms that work well for Pacific peoples are those that use these markers and/or techniques to allow for better Pacific client engagement in the intervention process.

- New Zealand-born[2] Pacific youth clients require an approach consistent with the approach to New Zealand youth in general, rather than one appropriate for Pacific adults or their island-born counterparts. The youth group was considered to be caught between

[1] See ALAC 1996; Saunders et al 1993; Raistrick et al 1994.

[2] 'New Zealand born' refers to Pacific peoples born and/or raised mostly in New Zealand. Participants volunteered the term as part of current jargon; it is not intended to be a label. It describes a particular orientation or way of identification by some of the participants who are more aligned with local New Zealand culture. It is often used in comparison with the term 'island-born', which in this document refers to those who were born and/or raised mainly in a Pacific island and who have a more traditional orientation or identification. Any reference to the terms 'New Zealand born' and 'island born' in this report must be read in this context.

two competing worlds, the Palangi and the Pacific, with issues and experiences very different from those born in the Pacific.

- Clinicians wanting to work with both New Zealand-raised youth and their island-raised parents need to address their competing worldviews carefully.

- Clinicians need to understand the difficulties of the confidentiality principle in Pacific contexts, as families (especially parents or caregivers) often perceive it as inappropriate when dealing with Pacific children. Clinicians need to balance the legal rights of youth clients with the cultural rights of parents or caregivers.

- Communication strategies for Pacific clients and families, especially during first visits, include a wide range of interactive tools. Most clinicians find that visual and oral forms of communication, based on practical real-life examples, work best. Pacific cultures prefer oral, face-to-face communication, and education programmes adopting these strategies, media, tools or forms also seem to work well, apparently enhancing client responsiveness to interventions.

- Written documentation is used more for service monitoring and job performance purposes than as an intervention tool.

- Most Pacific A&D clinicians are not familiar with the process and thinking behind 'measuring outcomes', finding it foreign and irrelevant to their work and cultural paradigms. Many find it difficult to reconcile Pacific and Western-based definitions of 'helping' in relation to the appropriate use of time, language and workplace resources.

- Clinicians interpret 'service-based outcomes' as measuring the effectiveness of their performance with clients – and 'client-based outcomes' as measuring the client's progress or success over time. These measurements also draw on feedback from families, referrers, relevant services and any other significant people associated with clients and the service.

- Non-government organisation (NGO) Pacific A&D clinicians commented that funding based on outcome measures was unfair owing to imposed short timeframes. This also undermined the importance of rapport-building in the treatment intervention process.

- Pacific A&D clinicians often undertake multiple roles outside the scope of their work with Pacific A&D clients, such as being translators, taxi drivers and state housing and income support negotiators. For many, these roles are necessary owing to cultural expectations. These expectations, and how they can cause tensions when operating beside competing workplace requirements, need to be recognised.

- Ongoing education is important for service staff, and education programmes are important for clients and families.

- While there appear to be no differences between Pacific interventions offered by Pacific DHB-based and Pacific NGO A&D services, there are differences in resourcing and implementing their respective services. In practice at least, the Pacific DHB-based services are more systematic in their documentation systems. This suggests the need to review Pacific NGO documentation systems alongside DHB-based systems or processes.

- Treatment interventions offered by Pacific services need to reflect Pacific processes and be delivered consistently across Pacific services.

- There is a need to enhance relationships between Pacific A&D and other services.

PHASE II

The Phase II key findings relate to the three different groups involved – Pacific A&D services' clients and families and the services' team leaders and managers.

Clients

- Clients learn about the effects of A&D use and other related information through a range of media that include verbal, visual and written materials. According to clients, the information helps them to understand A&D use and its effects on them and their families.

- Clients describe current treatment interventions (mainly one-to-one counselling sessions with Pacific A&D clinicians) as positive and life-changing. They note that the goal of these sessions is to achieve zero use where possible and to help focus them on a positive future.

- Clients see treatment intervention approaches as open and directive, with rapport-building with Pacific A&D clinicians a vital part of the process. Most prefer Pacific A&D clinicians, mainly for reasons of language and cultural affinity.

- Clients believe that having a personal relationship with God is a preventive measure.

- Services that provide supportive, caring, relaxed, family-oriented and culturally aware environments help clients to feel comfortable within the services and heighten their responsiveness.

- Cultural stigma is often associated with A&D problems and can be very harmful. Dealing with it is a delicate process that involves accessing culturally sensitive services. Clients prefer services located away from public areas because of the stigma and shame associated with A&D use.

- Most participating services adopt a 'one-stop shop' approach, but some are more specialised. Clients suggest they like both.

- While services normally operate within standard business hours (i.e. 8am-5pm), those operating outside these times help to cater for clients who work 'normal' business hours. This is much appreciated by clients.

- Clients comment that workers' salaries should reflect the work they do.

- Clients offer many ideas on the best ways to inform them, families and the wider community about A&D. These include videos, community or family or church meetings, pamphlets, conferences and radio station and television advertisements. Pamphlets written in ethnic-specific languages are recommended for those whose first language is not English. Clients are willing to help in designing ethnic-specific A&D information pamphlets that meet their needs as well as the services'.

Families

- Families acknowledge their integral role in helping client family members to recover. However, familial support can take many different forms and services need to work with families to find the best support programme for client family members. Families often find they 'are in the dark' on how to help clients and need services to help 'bring them into the light'.

- Services need to be respectful and provide safe spaces for families to respond well and be fully involved in the treatment and recovery process (where appropriate).

- Family focus group participants recommend that services provide friendly staff and an inviting atmosphere that caters to working Pacific peoples, complemented by an appropriate physical environment e.g. respectable surroundings that exhibit professionalism and speak to the Pacific spirit.

- Families say that services seem understaffed and recommend more funding to help in hiring more staff. They also argue that clients need to have the 'right' A&D clinicians, that is, that work has to go into assessing and matching clients with clinicians. Clients' cultural backgrounds and personal contexts (including family contexts) need to be matched

appropriately with clinicians who can relate to those needs. Family participants also say house-calls may be appropriate in getting some families involved.

- Families expect genuine respect and appropriate treatment interventions for their client family members.

- According to family members, services can also hold and disseminate A&D information, enabling families to attend or approach them for access. Families say services should also actively engage in disseminating information to churches and other community groups.

Service Managers/Team Leaders

- Surveys of Pacific A&D services in New Zealand indicate that approximately 67% of staff are male and 33% are female. Ethnically, staff at the Pacific-specific and Pacific-inclusive services participating in the survey are predominantly Samoan (33%), followed by Tongan (17%), Palangi (17%), Maori (11%), Cook Islands (8%) and Niuean (8%), then the smaller ethnic groups (1% to 3%).

- In most services, staff positions range from administrative through to clinical and cultural. Full-time staff members are mainly team leaders/managers, Pacific support workers and Pacific A&D workers.

- Service structures have two main categories: Pacific DHB-based and Pacific NGOs, with a lot of variation between and within them. Both types have two main levels: managerial staff and frontline workers. Not all services have clinical staff in-house (especially NGO-type services) or staff with culturally defined roles, such as matua or cultural elders.

- Participating services comprise three main types: those focusing mainly on A&D issues; those focusing mainly on mental health issues (with a small A&D arm); and those focusing on both A&D and mental health. Most are outpatient services.

- According to respondents, client numbers range from 10 to 300. In those with clientele groups in the 300 range, most clients are not of Pacific ethnicity.

- Almost all services have electronic client databases or are considering installing them. Client information includes demographic data, A&D dependence and other addictions data, history of involvement with justice or mental health services, information on family, and data on completed or ongoing treatment interventions.

- Respondents recognise that a client database is valuable for service planning, to researchers and evaluators and for the appropriate compilation of a national database.

- Clients access clinical services by self-referral, through families or through the formal mental health and justice referral systems. Intersectoral referrals of Pacific clients are common, especially among Pacific NGOs.

- Services use both Pacific and mainstream screening and intervention or assessment tools. These include generic Pacific-health belief model tools (such as the Fonofale model), Pacific A&D-specific assessment tools developed by individual services in an attempt to incorporate Pacific perspectives, as well as mainstream assessment and intervention tools (such as AUDIT, the Severity of Dependence Scale (SDS), the LDQ, the CAGE Questionnaire and the Michigan Alcoholism Screening Test (MAST)). Clinical pathways for services are designed mainly by reference to clinical manuals recommended by mainstream structures. Pathways to treatment and recovery for all services involve both Pacific and mainstream treatment and recovery models and processes.

- Managers note that Pacific service delivery involves being able to cope with language constraints, meet cultural rapport-building needs and meet needs for holistic intervention approaches.

- Services negotiate cultural pathways using a range of media, mainly cultural supervision and culturally appointed staff such as matua. The importance of clients' spiritual needs is rated higher in the more rural towns, which is to be expected given the high church-going Pacific population in urban centres. Cultural pathways require appropriate funding and service delivery structures.

- Respondents are not clear on what constitutes an 'outcome measure'. Managers suggest that service delivery styles and intervention approaches provide the overall framework within which to derive outcome indicators. Respondents note that no clear indicators have yet been formulated for Pacific-specific services. They highlight substance use, spiritual wellbeing and quality of life as possible indicators, along with having case reviews, A&D screening tools, self-reporting questionnaires and client and family feedback.

- Respondents note that short-term outcomes are considerably easier to measure than long-term outcomes, especially where outcome measurements require ongoing contact with clients and families after intervention programmes are complete.

- Respondents say that the most commonly used 'methods' of 'measuring outcomes' are satisfaction surveys and/or self-assessment tools. Managers support the need for client and family feedback and note the need to have 'Pacific user-friendly' clinical measurement tools and/or assessors.

- According to survey respondents, most families attending service programmes are genuinely involved in helping their client family members to recover. They are usually clients' spouses or children and are involved in most aspects of the clients' recovery plans.

- Respondents indicate that service delivery for families should be both culturally and clinically appropriate.

- 'Family' is widely defined to include extended and immediate family members. Services use family/whanau questionnaires to help meet families' needs and acknowledge that providing a comfortable environment for families includes ensuring a safe and inviting physical environment.

- Some services have family advisors/advocates. Family members also sit on service boards of trustees or help as volunteers.

- There appears to be more intersectoral collaboration among NGO services than among DHB-based services. This may be attributable to NGOs' independent status compared with DHB-based services existing within a much wider service structure. By and large respondents feel that building intersectoral relationships is positive for client and service outcomes.

- A&D education is offered to clients, families, schools, Pacific community groups, specific youth groups, training programmes etc. A&D education and/or dual-diagnosis programmes can also be accessed through mainstream settings.

- Education programmes adopt appropriate language and delivery approaches for Pacific peoples. Services report that communities are informed of A&D education programmes within their areas mainly through networks and media advertisements. Service managers believe these programmes are effective in preventing or reducing related harm, increasing awareness and communication within the community and families and encouraging early referral for help.

- NGOs' A&D education programme resources come from various sources, for example DHBs, ALAC, the Ministry of Health, the Internet, the Foundation for Alcohol and Drug Education (FADE) and NZ Care and from within their own organisations.

- Managers encourage up-skilling among their staff. Many Pacific staff members undertake formal tertiary studies, including A&D-specific studies. All services provide in-house training for new staff.

- All services provide some form of supervision for their staff, with supervision types including professional, group or peer, administrative, clinical and cultural.

- Managers recognise the need to clarify the term ‘cultural supervision’ and the need for supervision models that are useful, appropriate, acceptable, accessible and cost effective.

- There is no comprehensive Pacific workforce strategy for Pacific services. Managers attribute this to a lack of appropriate and available funding.

Conclusion

From these three sources, the Phase II report concludes that:

- Clients and families perceive the treatment interventions provided by the participating services as, in the main, effective and culturally appropriate – largely because of clinicians' genuine concern for clients and families and the culturally appropriate mechanisms, processes and atmosphere established in Pacific services. These cover a range of Pacific peoples i.e. 'island-born' and 'New Zealand-born' clients and families

- Service treatment aims to help clients on the road to recovery and ultimately to a positive, fulfilling and A&D-independent lifestyle

- The issue of 'workforce development' needs addressing, as the extent to which services engage in workforce development strategies is influenced by funding. Important workforce development includes up-skilling staff and developing clinical and cultural competencies, while other important areas include staff supervision, database management, education programmes and outcome measures

- Staff supervision is a core requirement across all services. Clinical supervision is more accessible in DHB-based services, while cultural supervision seems more available in NGO services. While frameworks for clinical supervision draw on professional codes of conduct, cultural supervision frameworks are still being designed

- While most services are adopting electronic databases to collect and store routine client and service data, the types of information and the level of detail remain variable. The differences in electronic data collection types and processes will make it difficult to make any comparisons that contribute to informing national standards of service delivery

- Education packages for Pacific A&D clients and families need to incorporate Pacific concepts, languages and processes that are culturally appropriate and clinically relevant

- Respondents are unclear on what an outcome measure is, with definitions clinically biased. There is a need for a specific outcome measurement tool capable of addressing the cultural components of Pacific services.

PHASE I:
A STUDY OF CURRENT TREATMENT APPROACHES FOR PACIFIC CLIENTS WITH ALCOHOL AND DRUG ISSUES

ACKNOWLEDGEMENTS

'Ko e loloto ho'omou ngaahi 'ilo pea mo ho'omou fie ngaue mateaki ma'ae kakai 'o e Pasifiki, 'e 'ikai lava ia 'ehe tohi ko eni ke ne fakamatala'i kakato atu, ka 'oku ou 'amanaki pe 'oku te lava 'o puke 'a e uho ho'omou ngaahi talanoa'

'The depth of your knowledge and your passion for working with Pacific people cannot be captured fully in this written document but it is hoped that I can capture the essence of your stories'

Talofa lava, Kia orana, Malo e lelei, Fakalofa lahi atu, Bula vinaka, Taloha ni

I would like to acknowledge all the people who participated in this study for allowing me to be a visitor on their journey. Their cultural and clinical knowledge of Pacific clients affected by alcohol and drugs is valuable for informing future practices and their commitment to helping Pacific peoples makes them unique as Pacific workers.

Owing to the confidentiality of participants, specific individuals cannot be identified, but I would like to acknowledge and thank the managers and team leaders of the participants for supporting this study.

I would also like to acknowledge Amanda Wheeler for scoping and coordinating the project, my supervisors (Dr Helen Warren and Dr Gail Robinson) and other members of the Advisory Group who helped guide this study: Fuimaono Karl Pulotu-Endemann, Tina McNicholas, Jenny Wolf and Dr Francis Agnew.

Last but not least, I would like to thank and acknowledge the Alcohol Advisory Council of New Zealand (ALAC) for funding this project and for its support during all stages of the project.

Malo 'Aupito
Havila Matangi-Karsten
(Tongan Clinical Psychologist)

1.0 INTRODUCTION

The primary aim of the Phase I review was to start the process of evaluating and improving the effectiveness of alcohol and drug (A&D) treatment services for Pacific peoples. It involved documenting and reporting on current treatment interventions for Pacific clients with A&D issues in A&D services in Auckland, Hamilton, Wellington and Christchurch.

The review also aimed to:

- obtain clinicians' opinions on the treatment models, outcome tools and processes they use for Pacific peoples with A&D-related problems
- make initial recommendations on ways to improve A&D treatment for Pacific clients, with the long-term aim of reducing A&D-related problems among Pacific peoples.

The review involved face-to-face interviews with 31 Pacific staff members from 13 services based either in district health boards (DHBs) or non-government organisations (NGOs) in 2002.

MAIN FINDINGS

The review revealed a clearly identifiable 'Pacific' way of working with Pacific clients, but this was mediated to some extent by the services' funding arrangements and reporting requirements. All participants applied elements of both Pacific and Palangi (Western) understandings of A&D issues to their practice. However, the degree to which this happened depended on the workers' and clients' ages, gender, birthplaces and preferred languages.

There appeared to be no significant differences between Pacific interventions offered by NGO and DHB providers, but there were differences in resourcing and service structure. DHBs' reporting and record-keeping requirements were seen to take time away from 'Pacific processes' (in particular 'rapport-building') and the inclusion of family in treatment.

An effective A&D worker was described as someone who is of Pacific ethnicity with a sound knowledge of A&D issues and Pacific culture, and who has the skills to integrate this knowledge in the most appropriate way with the diversity of Pacific peoples accessing A&D services (wherever they are provided). It was acknowledged that it is not enough to simply be 'Pacific' to work with clients; it is also important to have formal training and skills' development. Conversely, approaching Pacific clients from a purely Palangi and/or clinical approach is also 'not enough'.

Pages 8-10 cover the key findings of Phase I, and the following pages the recommendations made as a result.

2.0 RECOMMENDATIONS

The key issues identified in the review related to clinical practice, service delivery and workforce development. While all three are interrelated, they are presented in three sections here, with recommendations for ALAC, the funder and the providers of health services, and the Pacific community in general.

2.1 CLINICAL PRACTICE

ELEMENT
Assessment recommendations • Move towards a nationwide assessment system (including assessment content) that reflects Pacific processes and ensures assessments of Pacific clients are effective. • Review assessment forms and processes to develop a simple but specific form that reflects Pacific processes and practices. This could be adapted from the A&D assessment forms currently used by some Pacific services. • Incorporate time in the assessment process: - for developing the relationship, building trust and 'connecting' with the client and family. This also needs to be recognised in contracts, service delivery models and staff performance indicators e.g. the goal of the first session is to build rapport (see Appendix 2) - for acknowledging the importance of verbal communication versus written checklists - to recognise and deal with the nuances of multilingual interactions.
Treatment recommendation • Enable diverse treatment approaches for different sectors of the Pacific A&D client group e.g. specific approaches and interventions for Pacific youth who are New Zealand born and more familiar with the Palangi and New Zealand youth culture.

Outcome recommendation

- Incorporate specific Pacific approaches in all client outcome measurement systems i.e. client progress should focus on behavioural changes such as relationship with families and productivity in the community, not just on reducing or abstaining from A&D use.

Education recommendation

- Investigate the processes and effective elements of creative A&D education programmes, delivered as an integral part of treatment interventions for Pacific clients and the community by Pacific A&D workers.

2.2 SERVICE DELIVERY

ELEMENT

Clinical pathways recommendations

- Reflect a holistic approach by Pacific A&D workers in treating Pacific clients (i.e. focus on more than A&D-related issues) in:
  - all aspects of the clinical intervention, with families and significant others recognised as integral parts of this process
  - staff resourcing and its relationship with client-based outcomes.
- Review documentation systems (electronic and paper based) to:
  - ensure they reflect Pacific interventions and processes
  - ensure consistency in Pacific service delivery
  - enhance working relationships between Pacific A&D and other services i.e. seamless care.

A&D worker competencies recommendations

- Recognise and employ Pacific peoples with relevant skills and competencies as the most appropriate A&D workers for Pacific clients.
- Recognise the unique skills that Pacific A&D workers require to work in both the Pacific and Palangi systems (evidenced by workers incorporating Pacific and Palangi concepts in treatment approaches that best fit the needs of Pacific clients and families).
- Recognise that Pacific A&D workers are 'responsible' not only to the clients and service but also indirectly to the wider Pacific community.

Service performance measurement recommendation

- Incorporate client-based outcomes into service-based output measures e.g. assessed via feedback from the client and family.

Resource recommendations

- Reinforce and enhance existing Pacific A&D networking forums specifically to review clinically related issues and new initiatives. An action group with nationwide representation could result from this network, with a key focus on identifying relevant Pacific tools e.g. assessment and outcome measures and recommendations on using these tools.
- Consider the significant implications of appropriately funding services for Pacific peoples, with respect to the clinical/cultural interventions and the services' development (i.e. funding 'what works' for Pacific peoples).

2.3 WORKFORCE DEVELOPMENT

ELEMENT
Training recommendations • Provide ongoing clinical and cultural training for Pacific A&D workers nationwide, wherever possible delivered by Pacific workers and clinicians. • Establish the credentials of Pacific skills relevant to the A&D sector and use these to develop and apply appropriate remuneration scales. • Offer training to all workers in the use of recommended tools and documentation e.g. assessment and outcome measures. • Address and enhance the cultural knowledge of non-Pacific A&D workers e.g. by incorporating Pacific modules in formal A&D training delivered by Pacific trainers. • Develop environments for mentoring and modelling exposure so that Pacific A&D workers gain supervision and training skills. • Incorporate mental health issues into formal A&D training and vice versa e.g. dual-diagnosis training. • Ensure all training considers the translation process for Pacific workers in the A&D and mental health fields.
Resources recommendation • Provide appropriate funding structures to ensure Pacific services can attract and retain skilled Pacific A&D workers, especially in the NGO sector and smaller communities.

3.0 RESEARCH METHODOLOGY

The Phase I research took a 'general inductive' approach, reflecting common patterns in qualitative data collection and analysis. This approach uses specific observations to build general patterns, enabling the important conclusions to emerge from patterns found in the cases under study without hypothesising on them in advance.

The research also applied the principles of grounded theory methods (Glaser 1992) to focus on the interests of the participants rather than those of the researcher.

The research aimed to document and interpret from the frame of reference of people living (consumers/families) and working (service providers and nominated key individuals) with A&D disorders. By theorising on what mattered to the participants, the researchers aimed to develop insights and strategies that could inform 'treatment' and policy – a kind of 'bottom-up' approach.

The data was gathered using rigorous techniques and methods, then carefully analysed with an emphasis on issues of validity, reliability and triangulation.

The review involved interviews with 31 Pacific staff members from 13 services registered with ALAC's National Directory of Alcohol and Drug Services for Pacific People (ALAC 2001a). These included services provided by DHBs and NGOs. Information from the participants was analysed and aggregated to create baseline data of assessment and intervention practices, outcome measures and service delivery among Pacific providers, and training/staff development needs.

All interviews were held either entirely in the English language or using a mix of English and Tongan. All interviews took approximately one to two hours and were either audio taped or recorded in writing.

4.0 RESEARCH FINDINGS

4.1 DEMOGRAPHIC PROFILE AND KEY PATTERNS

4.1.1 Demographics

Thirteen services from ALAC's *National Directory of Alcohol and Drug Services for Pacific People* (ALAC 2001a) were found to employ Pacific workers to work with Pacific clients with A&D related issues, either through DHB or NGO Pacific or non-Pacific services. Their core businesses were A&D services, A&D/social services or mental health services, and they were based in Auckland, Hamilton, Wellington and Christchurch.

Of the 31 Pacific 'client/clinical workers' interviewed:

- 61% were male
- 55% were Samoan, and within this group 19% were of mixed Samoan ethnicity (Samoan/Tongan, Samoan/Palangi, Samoan/Tokelauan or Samoan/Maori)
- 61% were born in their island nations; some immigrated to New Zealand as children and others as adults
- 55% were over 40 years of age
- all spoke fluent English, with 81% fluent in one other Pacific language and 12% fluent in two Pacific languages
- 77% were from NGO providers
- 65% were from Auckland-based services
- 74% were from A&D-related services. Of this sample, 39% were specifically from A&D services (16% catered for Pacific dual-diagnosis clients). Almost an equal number of participants (35%) were from A&D combined social services and 26% worked in mental health services.

The sample reflects the three main groupings of Pacific identities: those born in the islands who immigrated to New Zealand in their adult years; those born in the islands and raised in New Zealand from childhood; and those born and raised in New Zealand (Mulitalo-Lauta 2000).

Counselling and/or interventions were conducted in both Pacific and English languages.

4.1.2 Key Patterns

i. Service and Employee Characteristics

Ten services were Pacific focused, with nine managed by Samoans. Only three of the 13 services employed staff from the four main Pacific groups: Samoa, Cook Islands, Tonga and Niue.

The duration of employment in the A&D field ranged from six months to 12 years, with significantly longer work experience within the NGO services. Most workers were employed full time.

While the specifically A&D workers had varied job titles, their actual work did not differ significantly. Most referred to their roles as 'counsellor'. There was less variation in job titles among mental health workers, with the key roles mostly 'community support worker', 'team leader' or 'assistant psychologist'.

Almost half of the A&D workers had youth-specific roles, and more than 50% catered for youth clients where they often did not have to speak a Pacific language. Being fluent in a Pacific language was a requirement for working with specific ethnic groups.

ii. Relevant Qualifications and Training

Most participants had formal tertiary qualifications, and just over 50% had some type of formal A&D training. Most of the mental health participants had social work backgrounds.

iii. Current Client Caseload

The average caseload for A&D participants ranged between 12 and 25 clients at any one time. Many clients were seen with their families but this was not 'officially' documented as it was often not a requirement from the service or the funder. Workers believed that the client information required by funders did not reflect Pacific intervention processes, mainly due to their approach of working 'beyond' the requirements of their job for each individual and dealing with a variety of presenting issues other than just those related to A&D.

iv. Multiple Commitments Outside Work

Three-quarters of the participants, mostly older Pacific workers, had community commitments in addition to their A&D work. Affiliations with Pacific community groups were significantly higher for participants living in Auckland.

Many felt these roles were part of their duty (e.g. matai/chief, church and family roles) while other roles were difficult to relinquish owing to the lack of appropriate Pacific peoples to replace them.

v. Youth Approach and Confidentiality

Participants highlighted that Pacific youth needed the involvement of parents or caregivers.

Client 'confidentiality' contradicts the Pacific approach of involving significant others to support young people. Many participants acknowledged that session details were confidential and that youths often did not want their parents involved, but believed that it was beneficial for youth in the long term if they had their parents' support. The counsellor's role was to assess the home environment and family circumstances (e.g. for the youth's safety) and engage parents positively from a cultural and educational angle without revealing session details.

vi. Pacific People More Accepting of A&D than Mental Illness

Mental health service participants estimated that 30% to 70% of their current Pacific clients had addiction problems; mainly younger males under 30 years of age. Participants emphasised that formal training and knowledge of dual-diagnosis issues were crucial in both the mental health and A&D fields and that future training needed to incorporate Pacific contexts and skilled Pacific trainers.

Discussions with mental health participants revealed that while there is a stigma associated with A&D and mental illness, Pacific communities and families appear more accepting of A&D issues than mental health issues. Addiction is seen to be preventable and external, while mental illness is often attributed to the family.

vii. Traditional Healers

All participants described traditional healing practices as useful for a variety of physical and mental health issues. Many had direct or indirect experiences with traditional healers, and a few reported they practised traditional healing themselves.

Most participants said that the use of traditional methods to heal A&D issues in particular was 'uncommon' or that they were unaware of clients using healers. However, they said many A&D clients would benefit from traditional practices for a variety of health- and stress-related issues.

Most participants supported the idea of using traditional healers for mental health issues, and all mental health participants reported that some clients had either used healers in the past or were currently seeing one.

4.2 ASSESSMENT

4.2.1 Perceptions of Assessment

From a Palangi perspective, 'assessment' is broadly defined as obtaining information about the nature and severity of a problem, the reasons for the importance of the problem in the individual's life and alternatives to the problem, and identifying and agreeing on the strategies to deal with the problem (ALAC 1996).

However, many participants perceived assessment as a foreign concept, owing to its emphasis on the 'individual' and the lack of attention to the *process* of collecting this information, such as building trust or establishing a connection with clients within a Pacific context. Pacific therapists have written that the search for objective diagnoses and causes (as found in Palangi assessments) separates therapeutic problems from the social and cultural contexts in which they develop (Family Centre 1990).

4.2.2 Current Assessment Tools and Practices

Only three A&D services reported that they did not conduct any A&D initial assessments, a practice dictated by their funding structures (e.g. clients had to be referred to designated services) or the nature of the services (e.g. assessment was required before acceptance to a residential unit).

The A&D assessment practices and processes were consistent with what participants believed would be most effective with Pacific clients. Four key themes emerged, relating to:

- assessment tools and forms
- Pacific workers for Pacific clients
- establishing and maintaining relationships with Pacific clients
- working with families.

ASSESSMENT THEME	**CURRENT PRACTICES AND OPINION**
Assessment tools and forms	• All participants used specific assessment formats and processes, but there was variation between services and regions. • A&D assessment forms were not universally used. • All DHB services had specific assessment forms and structured routines. • NGOs were more flexible in their assessment processes, but their requirements appeared to mirror those of DHBs. • Participants reported dissatisfaction with 'mainstream' assessment forms owing to the lack of cultural focus, with staff conducting their own cultural assessments for Pacific clients. The forms also created a barrier to building rapport. • Other difficulties included adapting Palangi assessment concepts to Pacific clients, the time-consuming nature of completing the forms and that the forms were designed mainly for adults (and not for youth needs). • Most Pacific services adapted assessment forms for Pacific contexts.

	• Assessment forms were seen as useful for service requirements and accountability to funders. The information could be accessed later for service databases and Pacific statistics. • • Despite the negative opinion, all participants agreed that assessment forms were necessary when working with Pacific clients, particularly as a staff guideline. • Participants were unable to specify alternatives to recording information or the assessment forms
PACIFIC WORKERS FOR PACIFIC CLIENTS	• Most participants had integrated roles catering for a combination of ethnic groups, age groups (youth or adult) and genders. • Some services had ethnic-matched, gender-matched and/or age-group-matched roles. • Participants saw it as important within the Pacific context to match clients and counsellors based on gender, age group and ethnicity. This recognised that, for example, male counsellors have different experiences and understandings from women, and vice versa.
ESTABLISHING AND MAINTAINING RELATIONSHIPS WITH PACIFIC CLIENTS	• Participants believed that assessment was not just for gathering information but also for developing a sense of 'connection' (therapeutic relationship) and trust with the client, which was crucial before any meaningful work could be done. • Most participants believed that expecting assessments to be completed in the first two sessions contradicted a focus on building connection, which took an average of one to three sessions. • Some perceived that the relationship needed to be more than a 'surface' one (where the client was connected with the worker mentally and cognitively) – to be a deeper or 'spiritual' connection. Pacific writers describe spirituality among Pacific peoples as centred on the essential quality of relationships, so given that therapy is intimately tied with the quality of relationships, Pacific therapy can be acknowledged as a spiritual process (Family Centre 1990). • The ability to establish and maintain a relationship with a client is consistent with what Pacific workers considered key to being a competent A&D worker (ALAC 2002).
Working with families	• Most participants tried to involve families or significant others in the assessment stage, but usually after initial individual sessions with clients.

	• Working with families was common practice among mental health workers and older Pacific workers in NGOs. This was mainly due to the mental health services' specific expectations of community support workers and their established community roles. • Most older participants also catered for youth clients regardless of their age. • All younger participants (<30 years) acknowledged the need to work with families, but believed they were not well equipped to deal with older adults. • The Pacific culture values highly the recognition of a person's limitations owing to the intergeneration gap, and appreciates that young counsellors understand their cultures. The most culturally appropriate approach is for clients to see counsellors from the same ethnic and age groups.

Participants commented that during assessment and once clients' immediate practical needs and crises were addressed and a connection established, A&D information was disclosed for discussion (see Appendix 2 for the participants' processes of building connection) – and that through the therapeutic relationship, honest and accurate information from clients was obtained.

Participants also believed that once connection was established with clients, they were better able to influence their thinking, feelings, motivation and A&D-related behaviours. Raising clients' awareness about the effects of A&D during assessment was considered an approach to which Pacific peoples responded given their tendency to view counsellors as people who could advise them on what to do.

The most effective assessments were conducted by skilled Pacific staff with sound knowledge of A&D, Pacific cultures and processes, and the ability to integrate Palangi and Pacific knowledge in ways that helped clients.

4.2.3 Current Assessment Procedures

Participants reported that assessment procedures had a number of key characteristics.

i. Duration

A typical session took between one and one and a half hours, with an assessment completed in one to four sessions. Longer sessions were required for dealing with co-existing mental health issues (dual-diagnosis) or clients in crisis.

ii. Venue

Clients were often seen where they felt most comfortable (at their home, in the service or at schools for youth), with NGO providers offering greater flexibility. Some participants preferred seeing clients at home because this allowed them to assess clients' physical environments and family dynamics.

iii. Confidentiality and/or Consent Forms

Confidentiality and/or consent forms were available in all DHB services but not all NGOs. Almost all participants routinely discussed confidentiality issues with clients. Difficulties with confidentiality and/or consent forms mainly centred on explaining the concept of confidentiality and getting clients to sign the consent forms.

iv. Tools

DHB services were the main users of tools, the most common being the LEEDS and AUDIT tools (ALAC 1996). Some NGOs had tried adapting them to Pacific contexts but reported difficulty in explaining clearly, especially if clients spoke very little English. A timeline, genogram/family tree and the Fonofale model were reported as useful for Pacific clients as they took into account cultural and family contexts as well as presenting issues.

v. Assessment Reports

All A&D participants reported that assessment reports were only written if requested from the referrer, courts or the Department of Corrections, not simply for the file or if requested by clients. A few A&D services reported that they did not write any assessment reports even if requested, mainly because their contracts excluded report writing.

vi. A&D Assessment Contents

All participants reported that A&D issues are a small part of clients' presenting problems and that environmental and cultural factors are often given insufficient emphasis in the general A&D field. Assessment forms adapted to Pacific contexts included an emphasis on family history and background (e.g. genealogy), spirituality and general cultural issues affecting the client, such as

intercultural conflicts (New Zealand versus Pacific). Mental health issues were also raised as a requirement in the A&D assessment forms.

General mental health assessments usually included a less comprehensive A&D section. However, participants from mental health services were more satisfied with their assessment forms (combining comprehensive Pacific and Palangi clinical assessments) than A&D participants.

4.3 TREATMENT INTERVENTIONS

4.3.1 Perception of Treatment Interventions

Most participants readily understood 'treatment' from a Palangi perspective, but had difficulty translating all Palangi treatment models and practices into a Pacific context in their workplaces. The majority understood treatment intervention as another stage of 'helping' clients and their families, and all participants saw treatment with Pacific clients as needing to integrate knowledge from Palangi and Pacific interventions.

4.3.2 Models, Approaches and Styles

There are few documented treatment approaches for A&D from the Pacific, and interventions were mostly an eclectic mix of Palangi and Pacific models. Participants did not always consciously incorporate a specific treatment model, but attempted to be as 'Pacific as possible' using their knowledge of Pacific approaches and processes.

Six key themes emerged on participants' approaches to Pacific clients:

- Pacific approaches
- Palangi approaches
- spiritual approaches
- transparency and clear communication
- timing of the intervention
- 'being Pacific is not enough'.

THEME	**APPROACH**
Pacific approaches	• Many participants either were trying to develop a Pacific framework or had developed their own Pacific models for A&D, having common themes of a holistic perspective and using ethnic-specific words, concepts and processes. • The most commonly reported useful Pacific model was the Fonofale model originally developed for the mental health field, but capturing key Pacific values that could be adapted to the A&D field.

Palangi approaches	• All participants valued a specific Palangi approach when adapted to Pacific contexts. Examples included strength-based approaches, harm reduction versus abstinence, psycho-education and educational models, motivational interviewing techniques, narrative therapy, cognitive and behavioural approaches, client-centred approaches, Maslow's hierarchy of needs and a family systems approach. • Palangi models not favoured included medical and disease models and the DSM-IV diagnostic criteria, largely due to participants' perceptions that they emphasised the 'physical' rather than the preferred holistic approach.
Spiritual approaches	• Participants viewed discussing dreams, feelings, intuition and Christian principles or conducting prayers during sessions as essential to therapeutic conversation. • The spiritual approach was just as commonly used among young, New Zealand-born or Palangi/Pacific mixed participants as among older island-born participants.
Transparency and clear communication	• All participants reported the need for therapists to be transparent and clear about stages of intervention with clients – explaining their role clearly, what counselling means and why clients have to see a stranger (counsellor) for the intervention.
Timing of the intervention	• Care needs to be taken in timing the integration of Pacific and Palangi interventions. • The need to work with families and know at what stage to involve them can prolong the therapeutic process beyond the typical treatment intervention period of eight to ten A&D sessions.
'Being Pacific is not enough'	• Approaching Pacific clients from purely a Palangi and/or clinical approach is not enough. • All participants emphasised that Pacific workers are the most appropriate people for Pacific clients, but highlighted that 'being Pacific' should not be the only requirement for an A&D worker. • The more knowledge a worker has of Palangi and Pacific contexts, the more likely they are to integrate these bodies of knowledge effectively. The most common pathways to learning Palangi approaches are formal training and relevant courses.

Participants reported that a significant proportion of the community still used more traditional sources of help but, with modernisation, medical doctors were increasingly used. Roles such as 'counsellor/therapist', 'psychologist', 'social worker' and 'community support worker' were commonly perceived as Palangi roles and were often indistinguishable to many Pacific peoples.

All participants acknowledged that many of their clients were unsure what therapy was about and were often naturally suspicious. This supported their argument for developing rapport, connection and trust before any meaningful A&D work. They believed that a respectful, consistent and solution-focused personal style was effective in engaging clients in trusting therapeutic relationships.

Participants thought that all Palangi and Pacific models needed to be tested for validity and effectiveness with Pacific clients.

4.3.3 Follow-up/Continuing Care Plan

Participants referred to this stage of intervention as following counselling or therapy sessions. Both mental health and A&D services identified client follow-up as a crucial process in monitoring progress. Mental health services appeared to have more structured follow-up processes.

Only a few A&D services had formal follow-up plans, which were to contact clients at least twice within two months of the last counselling session. However, all participants described an informal process of contacting clients.

4.3.4 Current Treatment Practices

Overall, an average A&D treatment intervention lasted for three to four months (about six to ten sessions) with one or two follow-up sessions in the month after the last counselling session. This was mainly dictated by funding issues rather than participants' decisions.

Clients were normally seen once a week, reducing to fortnightly if they were showing good progress. On some occasions clients could be seen for up to six months. Clients who did not engage well tended to be those mandated by agencies such as Community Corrections.

i. Palangi Practices

Some participants said their approach to A&D was largely dictated by Palangi frameworks. Whether from an NGO or DHB service, many described feeling that they couldn't 'totally work in a Pacific way'.

Barriers within DHB services involved operational practices based on Palangi theoretical frameworks and service delivery models. NGOs were more able to operate in a 'Pacific way' but the extent of their interventions was determined by funding. Most NGO participants described

doing more interventions than those contracted by funders, mainly owing to their perception that funding did not cover 'holistic approaches', their passion for helping Pacific peoples, and their knowledge of what works with Pacific clients.

ii. Pacific Practices

There were links between what participants perceived as most effective for Pacific clients and some of their current practices. The most commonly reported practices were:

- integrating Pacific and Palangi clinical knowledge by trying to adapt written materials to Pacific contexts
- an emphasis on building connection with clients (therapeutic relationships)
- using Pacific languages and processes
- different approaches for youth and adults, men and women
- developing Pacific ethnic-specific models
- working with partners and families
- matching clients and therapists in ethnicity, gender and/or age groups (youth versus adult)
- conducting A&D psycho-education with clients and programmes within the community.

iii. Non-Pacific Individuals

Although at least 90% of clients seen by the participants were of Pacific ethnicity, almost all participants reported working with other ethnic groups, such as Maori, who wanted to engage with their services. Some clients were of mixed ethnicities, mainly Maori/Pacific or Palangi/Pacific, or had partners of non-Pacific ethnicity.

4.4 EFFECTIVE ASSESSMENT AND TREATMENT WITH PACIFIC PEOPLE

All participants emphasised that the *how* of approaching a client was crucial. They considered the following factors as important for effective assessment and treatment of Pacific clients.

4.4.1 Holistic Approach

Participants said that a holistic approach was not just a 'Pacific approach' but a human approach, as A&D-related problems were caused by multiple factors.

Many believed the approach must address physical (health issues), mental (thinking patterns) and social needs (basic needs e.g. employment, cultural and family issues) as well as spiritual needs (wanting a relationship with God, lack of hope). Influential mechanisms in reducing A&D problems included recognising the social, spiritual and cultural contexts in which A&D issues had developed, as well as teaching practical life (and particularly employment) skills.

Participants said the ideal was to provide one physical access point for addressing client issues (e.g. mental health, violence, legal or employment issues), as this would reduce the number of services involved and enable a multidisciplinary working environment.

4.4.2 Pacific Skilled Workers for Pacific Clients

All participants described an effective A&D worker as someone of Pacific ethnicity with sound knowledge of A&D issues, Pacific cultures and processes, and the ability and skills to integrate this knowledge in the most appropriate way with the diversity of Pacific peoples accessing A&D services.

While they emphasised advocacy for Pacific workers, many participants accepted that some Pacific clients may not want to access Pacific services, see Pacific workers or have the choice of seeing Pacific workers. In this case, they believed consultation by non-Pacific staff with Pacific workers was crucial.

4.4.3 Therapist-Client Match

Evidence indicates there are unspoken cultural communication barriers when men and women and younger and older men are put together within a group context (Apa 1997; Tamasese 2002).

4.4.4 Therapeutic Relationship

Participants said that trust and respect for the client needed to be practically implemented through non-judgemental understanding, being transparent and being honest but not domineering. Humour was also recognised as useful in both gaining rapport and helping clients to disclose their issues.

4.4.5 Minimal Written Material

Participants said approaches with Pacific clients needed to be interactive, visual, practical and oral to enhance client responsiveness to interventions. It was also seen as important to minimise the use of written materials and documentation, especially during the first session.

4.4.6 Involving Families

Participants described ‘families’ as not necessarily blood relatives but those whom clients perceived as ‘family’. All participants said that involving families and significant others was crucial in interventions with Pacific clients, influenced by their views that the ‘client’ is not the ‘individual’ but the ‘family’.

Participants also said that actively listening to clients’ and their families’ stories provided access to the deeper meanings and cultural implications behind their words. This was based on the belief that culture is probably the most influential determinant of meaning in Pacific peoples’ lives and Pacific families are significantly shaped by their cultural experiences.

Many participants felt that the concept of involving families was given ‘lip service’ in the A&D field and needed practical emphasis. However, many described difficulties in getting families involved,

largely owing to shame or lack of understanding of the need for their involvement. Part of the worker's role was to engage families and significant others and overcome time and other barriers.

4.4.7 Integrating Pacific and Palangi Knowledge and Skills

All participants emphasised that a sound knowledge of Pacific cultures and processes, A&D, and selective Palangi approaches is crucial to being effective with Pacific clients.

However, the skill lies in the worker's ability to integrate these knowledge bases so that clients can understand. It was seen as important to involve relevant services and Pacific community groups, especially for clients with little connection to the Pacific community (e.g. youth).

4.4.8 Transparency and Communication

Participants said it was essential to explain things clearly and simply and/or use Pacific languages when relevant, and that clients should be encouraged to ask questions and draw on Pacific examples. Transparency and honesty included acknowledging one's limitations both culturally and clinically. The Pacific A&D worker also needed to establish any service policy and expectations (if employed in a 'mainstream service') on using alternative Pacific communication strategies like incorporating biblical teachings.

4.4.9 Education Programmes

A&D education programmes (as opposed to psycho-educational approaches to individuals) were considered separate from treatment interventions.

All participants reported that education programmes were an integral part of an intervention package with Pacific clients, particularly as a prevention approach. These programmes targeted not only the clients (psycho-education) but equally importantly the families and Pacific community, with the aim of raising A&D awareness and encouraging families and communities to take responsibility for managing A&D issues.

Education programmes were most effective when provided in more 'natural' environments, such as in churches or schools, or through Pacific media like Pacific radio programmes. A significant number of participants had delivered at least one A&D programme via Pacific media or were currently running radio health programmes in their respective Pacific languages.

Research has shown that Pacific peoples are more responsive to group-oriented approaches. Participants also added that programmes needed to be ongoing rather one-off sessions. However, it became apparent that some services did not have education programme delivery as part of their contracts.

4.4.10 Translation Process

All bi/multilingual participants expressed difficulty in constantly translating concepts from English and Pacific contexts. Many said it was not only time consuming but a skill not often recognised in the Palangi clinical field.

It was widely acknowledged that many treatment-related concepts cannot be fully translated between cultures – often the essence of the meaning is lost, hence the need for ethnic-specific workers. Most participants said they felt uncomfortable when translated concepts did not 'fit'.

Typical daily translation processes included integrating Pacific and Palangi clinical knowledge, counselling and/or delivering education programmes in Pacific languages and approaching families using Pacific processes. Associated with this was the translation of Pacific counselling and approaches into English concepts and documenting the translated Pacific concepts into written English clinical language (e.g. clinical notes, reports) for non-Pacific audiences such as referrers, auditors and funders.

These challenges were also evident for participants who did not speak a Pacific language fluently. Some referred to the idea that 'speaking' in English does not imply 'understanding' things in English. Like all aspects of Pacific treatment interventions, it is in the application; speaking a Pacific language is important but the skill lies in using the language therapeutically and effectively with clients.

4.4.11 Youth Approach (New Zealand versus Island Born)

Youth were recognised as a group requiring a specific approach.

The approach to youth (especially New Zealand-born youths) was more consistent with the approach to youth in general. Speaking in English was considered appropriate, as this was normally their language of choice – however, participants reported that Pacific youths with A&D issues should be recognised as being caught between both worlds, Palangi and Pacific, and that their issues and experiences were often very different from those of youth born in the islands.

Discussions revealed that New Zealand-born Pacific youth try to adapt what they perceive to be the Pacific culture taught by their parents and grandparents – which often causes conflicts and difficulties between parents and children. The strong social control in the islands does not apply in New Zealand, and there are frequent clashes between how Pacific parents see their role and the New Zealand perspective. For example, the issue of managing parents' expectations that confidentiality does not apply to teenagers or children often results in conflict in the A&D field.

4.4.12 Supervision/Self-Monitoring

Participants said that both individual and group supervision was important for reviewing their clinical work. Although many did not have 'clinical supervisors', most reported that consulting

other staff members was the most common way of gaining help for their clinical/cultural concerns. Some services also had group supervision, where client cases were discussed as well as any clinical process issues. The lack of skilled Pacific clinical supervisors in the A&D field was commonly reported.

4.4.13 Acknowledging Limitations and Barriers

It was considered important for Pacific A&D workers to know their limitations both clinically (e.g. in specific fields such as mental health) and culturally (e.g. with certain ethnic groups or genders) – and when a participant was an inappropriate worker, for clients to be referred to other appropriate staff or services. A counsellor's community status (e.g. church minister, matai/chief) was also perceived as a barrier to communication for the client if the counsellor did not openly acknowledge this possible obstacle.

While all younger participants (<30 years) recognised the need to work with families, they also believed they were not culturally appropriate to deal with older adults (late 40s or 50+).

4.4.14 Work Flexibility

Participants valued the flexibility to cater for clients' needs if they were unable to attend sessions during regular hours because of work commitments, given that employment was portrayed as a positive influential factor in Pacific families. Some believed that disruptions should be minimised and services should acknowledge after-hours work.

Participants believed that working with youth at risk was more effective if counsellors were flexible enough to go with youths to relevant service venues.

4.5 OUTCOME MEASURES

4.5.1 Perceptions of 'Outcome'

From a Palangi perspective, 'outcome' is defined as the effect on an individual's health status that can be attributed to a treatment intervention (Teeson et al 2000).

In contrast to their reaction to assessment and treatment concepts, most participants appeared puzzled by the concept of objectively 'measuring' treatment interventions and assessing the way a worker 'helps' an 'individual'. Helping people is an important value in Pacific cultures, so participants believed the *process* was as important as the actual *outcome* of intervention. Many said that true intervention effectiveness could not be fully measured during treatment, because change is long term and a variety of factors influence it for the client, of which not all could be attributed to the treatment intervention.

Despite this, participants understood the concept of measuring a worker's performance to ensure they were effective with clients, but again it was difficult to translate the Palangi performance tools

and practices into Pacific contexts within the workplace. They said that two key areas needed to be considered simultaneously when evaluating effectiveness with clients:

- service-based outcomes, by measuring the effectiveness of the worker's performance with clients
- client-based outcomes, by measuring clients' progress or success over time through feedback from the clients, families, referrers, relevant services and any significant people associated with the clients.

4.5.2 Current Outcome Tools and Practices

While most participants described formal evaluation mechanisms for their work performance, very few reported formal processes, tangible tools or outcome measures for evaluating the effectiveness of their work with clients.

i. Service-Based Outcomes: Measuring Work Performance

Some participants in management/supervisory roles tried to adapt service mechanisms into Pacific contexts. Those available included annual staff performance reviews, clinical supervision, service use indicators and generic and 'Pacific' client satisfaction evaluation questionnaires.
However, despite their availability, most participants did not perceive client evaluation questionnaires as useful for Pacific clients and rarely used them. The reasons for this included Pacific peoples being uncomfortable with or threatened by written questionnaires because of their negative connotations, and the implication that they too (the clients) were being evaluated. Despite being advised that their responses were anonymous, clients could feel obligated and record a more favourable appraisal out of respect or shame. Most participants had difficulty finding alternatives to evaluation questionnaires.

ii. Client-Based Outcomes: Measuring Progress and Change

Despite the lack of formal outcome measures, all participants used a combination of informal processes to evaluate the effectiveness of their work with clients. The key client changes they looked for were positive behavioural changes and changes in relation to clients' treatment goals. All said it was not sufficient to simply 'measure' change by looking at a reduction in A&D use, but that other areas of clients' lives needed to be equally addressed.
Client feedback was perceived as 'not enough' given that clients often gave positive feedback out of respect. This meant their feedback needed to be double-checked with that of family members and relevant services. Clients were normally asked to involve a family member they trusted and, while some resisted at first, most eventually saw the benefits.

Verbal feedback was often obtained from staff in residential services or those working within teams because of their direct contact with clients. However, many participants said they did not always gain feedback from all these groups and often had to rely on observation and client verbal feedback in sessions.

Some participants evaluated client progress by ‘self-evaluation’, often triggered when they felt ‘something was not right’ or the client was not doing well.

4.5.3 Barriers to Measuring Outcomes

Participants noted three key barriers to implementing Pacific outcomes successfully, particularly in routine assessments of client-based outcomes:

- the outcome concept
- funding structures
- technical procedural issues.

BARRIER	CONCERNS
The outcome concept	• Difficulty in measuring outcomes because workers are unsure exactly how to measure individual parts of successful treatment. • Difficulty in measuring Pacific concepts of change that are not just a reduction in or abstinence from A&D use.
Funding structure	• Many participants said accountability to funders and to the workplace was important for maintaining professionalism. • Many NGO participants alleged an unfair funding system based on outcomes being expected within a short timeframe, contrasting with their awareness of effective interventions with Pacific clients. • There was a perception that funding dictated staff resources and should be related to client-based outcomes by taking into account Pacific A&D workers' styles of engaging with individuals and their families on A&D and related issues.
Technical procedural issues	• The capacity to record a simple outcome tool or system of documentation. • Difficulties with integrating client- and service-based outcomes. • The burden of time and costs, as well as technological applications, impacting on more comprehensive measurement capabilities. • Poor clarity on the use of outcome data collected and analysed.

4.5.4 Effective Outcome Measures with Pacific Peoples

Most participants said that some Palangi performance measures could be readily adapted to Pacific contexts. However, they all thought that only by measuring outcomes using Pacific concepts would it be possible to gain an accurate picture of the effectiveness of their interventions with Pacific clients. This was consistent with participants' approaches to assessment and treatment interventions.

i. Service-Based Outcomes: Measuring Work Performance

Measuring staff performance was seen as a useful way of improving the quality of services delivered to Pacific peoples, with client-based outcomes being the basis for identifying clinical outcomes that were best for the service.

The key processes for measuring staff performance were mainly related to workers' performance with clients through direct observation, supervision and client/family feedback (i.e. client-based outcomes).

ii. Client-Based Outcomes: Measuring Progress and Change

Participants described a number of factors as guidelines for measuring effectiveness and success. These included:

- achieving treatment goals that clients had identified, as well as reducing substance use
- regular session attendance
- clients including other significant people in therapy and disclosing their concerns despite confidentiality issues.

Other factors included improvements in family relationships, becoming more productive within their communities and reducing violent behaviour and criminal-related activities.

These behavioural changes also applied to mental health clients, but with additions that applied to dual-diagnosis clients.

4.5.5. Procedures for Measuring Outcomes with Pacific Peoples

Participants believed that the essential components for measuring outcomes were:

- observing and gaining verbal feedback from clients during individual sessions
- obtaining verbal feedback from clients' families
- obtaining verbal feedback from other staff who have contact with clients
- obtaining verbal feedback from referrers, or relevant services and community groups
- simple processes to document key changes.
- alternatives to written questionnaires for clients or families
- measuring progress at different stages based on significant behavioural changes
- a focus on key changes (positive and negative) not only related to substance use
- documenting clients' and/or families' choices to attend a Pacific service.

4.6 SERVICE DELIVERY DIFFICULTIES AND STRENGTHS

4.6.1 Current Difficulties

Many of the difficulties or barriers participants reported were specific to work-related systems and management rather than the actual work with clients. Three key themes emerged:

- documentation systems
- employment and management systems
- politics and bureaucracy.

i. Documentation Systems

Many participants believed that a number of their Pacific interventions were not captured on paper or reflected in reporting systems to funders. There was general consensus that all forms

and documentation processes needed to be reviewed by a group of 'Pacific clinical experts' from the A&D field to enable consistency in Pacific service delivery and better working relationships between Pacific A&D services. This would provide a system for Pacific peoples to test their Pacific models.

A brief review revealed that most A&D services used a set of clinical forms and processes placed within physical files. While some used more forms than others, there were few differences between the documentation processes of DHB and NGO services, with very few having centralised filing systems. However, one NGO service had developed a thorough computer-based documentation process with a step-by-step clinical manual.

Most A&D services need a well developed database system that reflects not only quantitative clinical information (e.g. demographics) but also qualitative information (e.g. Pacific processes and interventions). While there was some resistance to the amount of work that would result from more documentation, almost all participants supported the idea that their work should be recorded, contingent on the systems reflecting Pacific processes.

In some DHB mental health services, database and documentation processes were more structured and client information was accessible to workers through a computer system.

ii. Employment and Management Systems

A key issue raised was the lack of consistency and communication between management and staff. While all participants indicated good social relationships with managers, some mentioned frustrations with management skills and managers' lack of support for initiatives that would enhance A&D work. Ironically, participants in management roles mentioned similar difficulties in trying to manage staff issues and reported that many staff needs were dictated by funding, which they could not provide.

NGO and DHB participants believed that NGO staff were paid less than their DHB colleagues. This was especially so among those with tertiary qualifications, who felt their skills were not recognised and that economically they had more options outside NGO services.

There was also general consensus among both DHB and NGO participants that Pacific skills are not totally recognised in management and funding systems. Some said that adapting their Pacific and Palangi clinical knowledge for Pacific clients involved translating it into written English, and that this time-consuming process was taken for granted as a 'natural' part of being a Pacific worker.

Participants said this integrative ability was viewed as 'cultural knowledge', not 'clinical knowledge' despite their having tertiary qualifications. Ironically, deviations from Pacific contexts

were often perceived by Pacific peoples as 'Palangi or clinical knowledge'. These viewpoints left many staff frustrated or taking the 'easy way out' by doing only what they were required to for the service.

iii. Politics and Bureaucracy

Despite participants' reported difficulties, many believed that focusing on the 'politics' (especially around funding) could be a barrier to intervening with clients – that it created frustration and low morale within the workplace and affected people's capacity to commit to meeting client needs. Many suggested they needed to 'work with the Palangi systems'. Resistance to change was expected, especially when people were used to doing things a certain way. Some referred to the 'inter-Pacific politics' in Pacific groups or services.

Another difficulty emerged around the perceptions of Pacific peoples, Palangi and funders of effective interventions with clients. Participants said their more holistic Pacific approaches were often not seen as 'clinical work' by their non-Pacific colleagues.

4.6.2 Current Strengths

All participants working in Pacific teams reported that working with other Pacific staff members was what they enjoyed the most, including the family-oriented atmosphere. Their passion for and commitment to working with Pacific peoples were evident.

Other strengths that enhanced participants' work with clients included:

- having a supportive manager, particularly one who understood and responded to Pacific issues
- flexible work hours to cater for client needs
- accessibility to other Pacific ethnic groups via different staff members
- the capacity for co-therapy with other relevant staff
- networking opportunities with Pacific A&D workers through conferences and workshops.

4.7 SERVICE DELIVERY AND STRUCTURE

4.7.1 Service Providers

There were no significant differences between the overall practices of Pacific workers in DHB and NGO services.

It appears that NGOs are beginning to mirror DHBs' organisational systems where they share the same documentation and other requirements – including the clinical standards (e.g. assessment formats) and competency levels expected in the wider A&D field. Participants understood that this was largely dictated by funders' requirements.

Similarly, DHB services with Pacific teams appear to mirror NGO structures, where Pacific workers from different ethnic groups are employed to cater for Pacific clients accessing mainstream services.

Some of the key differences have already been discussed. Others included that:

- DHBs were less flexible in their specific interventions with Pacific peoples as they also catered for non-Pacific clients, and tended to be more focused on A&D issues
- DHBs were generally better resourced and had better access to the latest training, Pacific and non-Pacific supervisors, psychiatrists, nurses and psychologists
- NGOs were better able to cater for Pacific clients' holistic needs and had more access to Pacific networks and community groups. However, this placed higher demands on staff
- DHB services tended to be perceived as 'mainstream', especially by NGOs, and to be more influenced by Palangi structures and systems. This made it less likely for NGOs to refer clients to DHB services for Pacific A&D interventions, unless it was for specialised help such as dual-diagnosis.

All participants said that as the organisations became more structured and systems and paperwork dominated staff work hours, less time was spent with clients.

4.7.2 Working 'Uniquely Pacific'

There were no significant differences in the issues raised by Pacific teams in DHBs or NGOs.

When asked to describe what made their services uniquely Pacific compared with non-Pacific services, they mentioned their knowledge and understanding of Pacific cultures and processes, which many said could not be taught.

While acknowledging that integrated Palangi and Pacific knowledge can be delivered to Pacific clients in Pacific languages, participants said that as long as the organisational structure was dictated by non-Pacific systems, it would continue to be difficult to intervene fully in a Pacific way.

4.7.3 'Professionalism'

Participants often referred to Pacific peoples being 'professional' in order to be effective with Pacific clients. Descriptions of 'professional' were consistent with being a 'competent' worker as described in *Practitioner Competencies for Alcohol & Drug Workers in Aotearoa – New Zealand* (ALAC 2001b). Descriptions of what constitutes a 'professional' or competent Pacific worker mainly related to the worker's skills in providing the advantages and accessibility of Pacific and Palangi contexts in dealing with a range of Pacific clients.

Participants also recognised that a good work ethic, together with sensible time management and the ability to use technology, was vital for meeting the high standards of clinical work required.

4.7.4 Training and Staff Development

While not all participants had formal A&D training, they agreed that relevant A&D and mental health training is appropriate. A number of key themes emerged.

i. A&D Training to be Relevant to Pacific Peoples

Many participants said that their A&D and mental health training had been largely from a Palangi perspective and delivered by non-Pacific trainers. They said it would be valuable to have Pacific modules or Pacific trainers involved in the training.

ii. Pacific Knowledge of and Experience with Pacific Communities

The majority reported that Pacific A&D workers are expected to have a combination of relevant tertiary qualifications and experience, plus knowledge of Pacific communities and networks.

iii. Training Support from the Service

Almost all participants reported that they undertook A&D training for the first time when they started at the A&D service, and many received management support for undertaking further training, including tertiary and postgraduate qualifications. Some are currently completing certificates, diplomas or degrees.

iv. Conferences and Workshops

Almost all agreed that attending A&D conferences and workshops, especially with Pacific presentations, helped their A&D understanding. However, many said that non-Pacific conferences also needed to incorporate Pacific papers delivered by Pacific workers.

APPENDIX 1: DEMOGRAPHICS OF PARTICIPANTS (N = 31)

Gender	Age Group	Ethnicity	Island or NZ Born	Language Fluency	Location	Core Business	DHB or NGO
Male = 61%	Under 30 = 26%	Samoan = 42% (6% mixed Palangi)	Island born = 61%	Samoan = 26%	Auckland = 65%	A&D = 39%	DHB = 23%
Female = 39%	31-40 = 19%	Cook Island = 10%	NZ born = 39%	Cook Island = 6%	Hamilton = 6%	A&D/Social service = 35%	NGO = 77%
	41-49 = 19%	Tongan = 25%		Tongan = 35%	Wellington = 13%	Mental health = 26%	
	50+ = 36%	Niuean = 10%		Niuean = 13%	Christchurch = 16%		
		Mixed = 13% Pacific (Samoan/Tongan & Tokelauan)		English = 100%			
				1 PI language = 81%			
				>1 PI language = 12%			

APPENDIX 2: INTEGRATING PACIFIC PROCESSES INTO 'CONNECTION BUILDING' (RAPPORT) AND ASSESSMENT

Participants described using a combination of the following techniques to integrate Pacific processes into 'connection building' and assessment.

- The worker minimises any processes that are a barrier to building relationships, such as excessive written recording.
- The worker maintains 'respect' as a key concept throughout – participants believed that if you respect another human being regardless of culture, it will be reflected in your language, body language and counselling sessions.
- The worker helps the client to feel comfortable, such as by directly asking them about their needs and observing their body language.
- The worker shares with the client a little about themselves, such as where they are from and their general background, eventually leading to an explanation of their role as an A&D worker. They then ask the same (open-ended) questions of the client in conversation mode, as well as any prompting the client to explain more about their family history and where they are from.
- At this stage the discussion will not raise any direct A&D questions, but the worker will be mentally storing any A&D issues and redirecting topics that would enhance connection with the client. The worker uses the language (Pacific or Palangi) that is most appropriate to the client.
- Note that while sharing information about oneself is frowned upon in some Palangi disciplines, most participants perceived it to be an important process for building trust with Pacific clients and gaining in-depth information that would not normally emerge with direct A&D questioning. Workers needed to be selective on what to disclose, and many reported that this process often opened doors for clients to disclose personal information.
- If the client has little or no knowledge of their culture or seems resistant, the worker redirects their approach while maintaining the goal of forming connection with the client. This can be done by finding common interests with the client, such as their favourite music or sports, or with older clients discussions about issues in the islands or spiritual experiences. Participants said it was not uncommon for sessions to start and end with prayer. This whole process can take up most, if not all, of the first session with the client.
- Trust-building is crucial to this sense of connection. Most participants said that it was only when clients were truly connected with workers that clients were motivated to change their thinking, feelings and behaviour. If trust was not there, it was hard for the client to be honest, let alone motivated to change their problem A&D behaviour.
- While connection-building happens first with the client, it is equally important to build connection and a relationship with their family. In addition to the worker's knowledge, the client's stories will give valuable information on how best to approach the family. Given

the timeframes that many participants reported they were given to work with Pacific clients, the connection process with the individual may be all they have time for. However, most participants reported that they preferred to work also with families in depth if their services allowed enough time.

- The worker minimises the paperwork and written recording (such as on assessment forms) during the session. Most participants commented that assessment contents can emerge naturally through discussions, without the forms, a process that is especially crucial for working with Pacific youth.
- After the first session, the worker determines when and how to use the assessment form according to the individual client. Most participants reported that forms could be filled in with clients who were open and with whom connection was easily established. However, if clients appeared uncomfortable, the form was used as a guideline to direct questions and completed immediately after the session. Participants said that workers' cultural and clinical judgement in deciding how and when to use the forms was crucial because it could be either a barrier or an enhancement to the assessment.
- Most participants commented that workers should be transparent and honest with all processes, including being upfront with clients about what they can and cannot do for them.

APPENDIX 3: LIST OF PARTICIPATING SERVICES

AUCKLAND

- PIDAS (Pacific Island Drug & Alcohol Services)
- Lavea'i Trust
- Pacificare Trust
- Lotofale Community Mental Health
- Pacific Motu Trust
- Tupu Services

HAMILTON

- Pacific Peoples' Addiction Services Incorporated
- Te Runanga o Kirikirioa: Rongo Atea Alcohol & Drug Residential Treatment Service

WELLINGTON

- Taeaomanino Trust
- Tanumafili Trust

CHRISTCHURCH

- Pacific Island Evaluation Incorporated
- CADS (Community Alcohol & Drug Services)
- Odyssey House Trust (Youth programme).

PHASE II:
A STUDY OF THE DELIVERY OF ALCOHOL AND DRUG SERVICES TO PACIFIC PEOPLES – THE PERCEPTIONS OF CLIENTS, FAMILIES AND SERVICE MANAGERS

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1.0 INTRODUCTION

The PADOPT Phase II study adopted a framework that focused on the 'blending of social science and Pacific methodologies'. It aimed to show how cultural approaches (such as the Samoan 'va fealoaloai', the caring for interpersonal relationships) could sit alongside scientific methodologies (such as qualitative and quantitative methodologies) to ensure that both cultural and research concerns were addressed.

The study involved qualitative face-to-face focus groups and/or interviews with clients and their family members and a paper-based survey with managers or team leaders.

MAIN FINDINGS

The key findings are summarised on pages 60-88, with a conclusion that clients and families generally thought that the treatment interventions provided by the participating services were effective and culturally appropriate – largely a result of the clinicians' genuine concerns for clients and families and the culturally appropriate mechanisms, processes and atmosphere established in Pacific services.

It also concludes that education packages for Pacific A&D clients and families need to incorporate Pacific concepts, languages and processes that are culturally appropriate and provide clinically relevant information.

From the service manager's perspective, the issue of workforce development needs further investigation, as feedback suggested that the extent to which services engage in workforce development is influenced by funding. Other important areas include issues of staff supervision, database management, education programmes and the definitions of outcome measures.

The study also found considerable variability in the types of information and level of detail services collected – which may make it difficult to make worthwhile comparisons in developing national standards of service delivery.

The following pages detail the recommendations made as a result of this research.

2.0 RECOMMENDATIONS

Using the report findings, the research team makes the following overarching recommendations:

- that the findings of this report be appropriately adopted into the development of Pacific A&D policies, at national, regional and local levels
- that ALAC, as the funder that commissioned this report, champion the implementation of these recommendations.

It also makes the following recommendations for clinical practice, service delivery and workforce development.

2.1 CLINICAL PRACTICE RECOMMENDATIONS

ELEMENT
• Compare internationally validated assessment tools used in routine clinical practice with proposed locally developed, Pacific-focused assessment tools. • Develop a Pacific outcome measurement tool to address the cultural and clinical outcome indicators inherent in Pacific service delivery approaches. • To meet the needs of Pacific A&D 'New Zealand-born' youth clients, review current Pacific A&D treatment interventions and service delivery approaches to identify relevant processes/mechanisms. • Review A&D education programmes delivered by Pacific A&D services to assess the impact and effectiveness of the content, tools and delivery of A&D information. • Assess the 'education' of Pacific clients by Pacific providers, to capture how individual interactions transfer information that influences behaviour.

2.2. SERVICE DELIVERY RECOMMENDATIONS

ELEMENT
• Design and pilot (after appropriate consultation with key stakeholders) a framework for formative and process evaluation to assess the application of existing Pacific service delivery tools, intervention processes and/or practice models of care. • Clarify the avenues available for Pacific services to contribute to relevant DHB and/or national, regional or local funders' policy-making. • Develop a national A&D database capable of synthesising and generating appropriate minimum baselines to capture demographics, identifying trends and treatment gaps for Pacific A&D services across the country. • Establish appropriate and representative working parties to build on current collaborations between agencies and sectors.

2.3 WORKFORCE DEVELOPMENT RECOMMENDATIONS

ELEMENT
• Define cultural supervision appropriately so that systems can be developed to cater for workforce and client needs adequately. • Provide regular and equitable training and education for all staff, including managers and administrative staff, in cultural, clinical and administrative competencies where relevant.

3.0 RESEARCH METHODOLOGY

This research is informed by both quantitative and qualitative research. The quantitative approach was used to gather information from managers and team leaders, while information from clients and family members was gathered and analysed using qualitative research.

3.1 METHODOLOGICAL FRAMEWORK AND METHODS

3.1.1 Blending Social Science and Pacific Methodologies

The Western qualitative and quantitative methodologies used in this study stem from social science and a methodological framework in which information collection and analysis are systematically tested.

However, while the lessons gained from this body of knowledge have proved rewarding, they have also proved antagonistic for indigenous non-Western peoples, like those from the Pacific. The need to blend social science and Pacific methodologies has in New Zealand emerged alongside indigenous Maori calls to address monocultural research (Smith 1999). This has given rise to the twin development of Pacific-specific and culturally sensitive mainstream research methodologies.

Tamasese et al (1997) find that research needs to be 'consensual', where 'democracy' and the 'judgement' of those at the treatment services interface (i.e. clinicians, clients and families) are given higher priority than the 'expert'. This blending of methodological and cultural approaches helps to maximise participant responsiveness.

3.1.2 The Research Approach

This project documented consumers' and families' perceptions of 'best practice' received from A&D services they had attended. Cross-referencing these with the perceptions of clinicians and managers working in the services, it then makes recommendations on:

- culturally appropriate methods for assessing intervention outcomes for Pacific peoples
- establishing and enhancing consistent national, regional and local standards and models of care.

Both can contribute significantly to improving the care of Pacific clients within New Zealand A&D services.

To ensure that cultural, ethical and professional concerns surrounding the relationship between the researchers and the participants were carefully considered, the project adopted Pacific principles such as the Samoan 'va fealoaloai' (caring for interpersonal relationships) and the

Tongan 'feveitokai'aki' (respect) (see Health Research Council 2004) when organising focus groups and collecting and feeding back on focus group data. In line with Pacific cultural etiquette, food and 'meaalofa' or cultural gifts (e.g. petrol vouchers) were provided in recognition of the cultural importance of the meetings and their spirit of sharing. With the guidance of the project's advisory board, these Pacific cultural principles and practices were also adopted in implementing the research design.

3.1.3 Client/Family Focus Group Design and Implementation

The qualitative research with clients and family members comprised five focus groups (one with family only, one with clients only and three with both clients and family) and two individual interviews. All used a set of questions based on project aims but also provided participants with the opportunity to discuss related topics not directly covered in set questions and/or by the interviewer.

This 'general inductive' approach to focus group design and analysis drew on grounded theory methods (Glaser 1992) where discussion focused more on participants' interests than those of the researcher. This aspect of qualitative research aims to document and interpret from the frame of reference of people living (consumers and families) and working (service providers and nominated key individuals) with A&D disorders. By theorising on what mattered to the participants, 'treatment' and policy can be informed from a 'bottom-up' approach.

The initial design sought one client and family focus group for each service that agreed to undertake the managers' survey and be part of the project more generally. However, with 13 services agreeing to be part of the project it became clear that, owing largely to cost constraints, it would not be possible to recruit from all participating services. Instead, the team developed a sampling framework that enabled some regional and service-type representation,[3] consisting of seven focus groups, six from the three main urban centres (three from Auckland, two from Wellington and one from Christchurch) and one from a rural centre, Hamilton. These four regions were determined by where the participating Pacific services were located and their Pacific population density.

A total of seven clients and five family members were interviewed. Of the seven clients, two were from DHB-based services and five were from NGO services. Unfortunately however, the logistics of combining client and family focus groups became too difficult, so some client interviews were conducted separately from family focus groups.

Clients and family members were invited to participate in the study by key staff members from the seven chosen services. Participants were provided with oral and written explanations of the

[3] 'Representation' in this case is not meant in the quantitative sense of providing a representative sample of the total population; it is meant in terms of providing at least one voice from the desired region/place and/or service type.

project aims, the focus group process and the objectives. Participants also provided verbal and written consent before any discussion took place.

The two main fields of enquiry for the client and family group discussions were:

1. What experiences and perceptions do you have of the assistance, treatment and/or intervention programme(s) that you and/or your family member received from the A&D service you/he/she attended?
2. How useful was the assistance, treatment and/or intervention programme for you and/or your family to meeting your/his/her recovery needs?

All interviews were held either entirely in the English language or using a mix of English and Samoan. Service workers provided Samoan translations where necessary. All interviews/focus group sessions took approximately one to two hours and all but one were audio taped. Notes were taken of the session that was not audio taped.

The sessions provided an opportunity not only to collect research data but also to reconnect or connect people, the key service worker, client and/or family member with the researcher and advisory group member (helping with the research process).

3.1.4 'Manager' Survey Design and Implementation

The project used a paper-based survey to gather information from managers and team leaders on:

- current service delivery practices
- service infrastructure design
- service relationships with clients and their families
- service relationships with the wider community
- workforce development strategies used by Pacific A&D services.

The 13 services that had been part of Phase I were invited to continue their participation in Phase II. However, owing to timeframe issues and the complex logistics of face-to-face meetings, not all were able to continue their participation. Two additional services were later invited to participate, with a total of 12 finally involved in Phase II. Where managers were not available, team leaders were asked to fill out the survey instead.

All survey responses were aggregated to show general trends or patterns, while a documentation review of relevant service files was undertaken where necessary.

4.0 RESEARCH FINDINGS

4.1 CLIENT INDIVIDUAL/FOCUS GROUP FINDINGS

4.1.1 Participant Profile

All seven client participants were male. Three were between 20 and 30 years old, three were aged 41 to 50 and one was aged over 60 years. Four were Samoan, one Tongan, one Cook Island and one Tokelauan (he was also competent in speaking Samoan). Of the seven, three were past clients while four were currently receiving treatment from Pacific A&D services.

Clients either had been referred to the service from an intersectoral service (such as the criminal justice system or a mental health service) or were self-referrals. One said they found the service by looking through the telephone book. All had accessed Pacific services as outpatients.

4.1.2 Key Themes

Ten themes emerged from the discussion and analysis of the clients' data and form the reported results and discussion in this section:

- Being informed
- Treatment interventions and/or counselling sessions
- Rapport building
- Ethnicity matching
- Cultural stigma
- Having a relationship with God
- Access issues
- What would help the service?
- Client expectations
- Informing families and communities.

Theme 1: Being Informed

Clients said they had been given access to information about A&D use verbally in seminar-type sessions run by services, audio-visually using video programmes or in written material. They highlighted video presentations as useful for sometimes dry and complex information about A&D use and its effects. For example, they recalled information on early warning signs of A&D dependency and the effects of A&D use on the brain and a person's emotional state. Pamphlets also provided them with this kind of information.

One client commented that having knowledge about A&D use and its effects made him feel more confident (better prepared) to work with and accept help from his Pacific A&D clinician. Another described getting help on his communication skills and their importance to his recovery.

Clients also commented that seminar-type sessions and written material offered more general information on health and wellbeing, such as how to live a healthier life through keeping a healthy body.

The knowledge about A&D use gained through Pacific services also helped some clients to build the confidence to inform others about the effects of A&D, and in turn made them more aware about how to deal with their own urges.

One client commented that not only did he feel comfortable sharing with the service staff but his family also felt open to do so. He noted that he and his family were able to ask questions openly – on A&D issues generally and on his treatment intervention specifically.

One client commented that in addition to the information he had already received from the Pacific service he attends for A&D treatment, he would find some video resources about anger management helpful. He suggested that the video include a scenario of someone who has an anger management problem and is able to get help. The video would detail the type of help he could get through mock demonstrations. Another client commented that he would like services to implement prevention plans that enforced a 'zero use' strategy, as this could help to deter other young people going down what he said was the same destructive path.

Theme 2: Treatment Interventions and/or Counselling Sessions

Clients described their treatment interventions as involving 'one-to-one' counselling sessions where Pacific A&D clinicians worked with them to set goals. A goal for one client was to work towards giving something back to the community.

Counselling sessions took no longer than one and a half hours each, with some variation in the number of sessions required to achieve an individual desired outcome. Clients preferred seeing Pacific A&D clinicians, largely for language reasons but also because of a sense of cultural affinity.

Clients saw counselling sessions as opportunities to get help in (re)gaining some direction in their recovery from A&D use. They noted that their counselling sessions usually involved clinicians providing a description of the treatment interventions possible and mapping out plans with them that ultimately worked towards zero use. One client, however, would have preferred a more 'forceful' treatment or counselling approach. He remarked that Pacific A&D clinicians needed to be more dictating in their approach; to him, they were the experts; that was why he was referred to and went to them; and they should have been able to tell him what to do rather than expect him to tell them.

For some clients it was important to have the same clinician throughout the treatment process, although sometimes this was not possible. One commented that although he was overseas for a long time during his treatment, his Pacific A&D clinician (through the service) had been prepared to continue his treatment and provide necessary help. This had been possible with the help of his family, particularly in accessing medication, and when he returned from overseas his treatment resumed. For him, continuity of care was important for his recovery and was only possible because of the rapport and trust he and his family had built with the service.

One client described his treatment as a process of being 'reborn', that there was a transformation from being 'bad' to being 'good'. Most described their treatment interventions as positive, saying services were a positive influence in helping them to overcome the stigmas associated with their A&D problems.

Some clients noted that although they initially went to a service for a particular reason, other issues were uncovered during counselling or treatment that involved a much wider treatment focus than first anticipated. They commented that this was a useful process because it gave them a clearer picture of their situation.

Overall, clients described the services they attended as being generally open and direct in their approach – that is, that Pacific A&D clinicians would tell them exactly what their problem was and their assessment of their situation and offer solutions and possible preventive measures. Clients noted that by and large clinicians supported them in every step of their treatment and where they had been able to put clinicians' treatment advice into action it had actually worked. One client said that while telling his Pacific clinician he had been caught drink-driving, he realised that his problem was that he would always say 'yes' to driving his friends home despite having had a few drinks himself. He felt he was 'unlucky' to have been caught. However, he took on board his clinician's advice of learning to say 'no' when this happened.

Theme 3: Rapport Building

Clients said that rapport with their A&D clinicians was the most important part of ensuring their support for a service and/or treatment intervention – so it was important that clinicians demonstrate kindness and respect. They said that:

- being approached with kindness made it easier for them to attend services
- building rapport with their clinicians meant they could make a connection and find it easier to talk about their situation
- they were more willing to accept advice and be able to put it into action when they felt respected by and could relate to their clinicians.

Theme 4: Ethnicity Matching

Many clients were unable to speak English, so understandably wanted services that could communicate with them in their Pacific language of origin. To them, it was important to be able to

engage a service that offered advice and treatment in ethnic-specific languages. They also pointed out that having a clinician with a similar cultural background helped them to engage appropriately with them and the intervention advice they offered.

Services' cultural awareness allowed not only for family involvement in the intervention process (where appropriate), but also for the use of traditional meeting methods, such as holding discussions while sitting cross-legged on mattresses on the floor. The use of Pacific motifs, ornaments and other settings impressed clients, who found they helped to provide a friendly environment for them. One commented that not all Pacific peoples will agree on every service delivery approach, but that word of mouth is often the best gauge of how well a service is doing. As a result of his positive experience with a service he often tells the service that it 'should keep up with what they're doing regardless of negative comments from others'.

Clients stated that services also provided a 'family' environment where they could share a meal, usually lunch, with staff and engage in extracurricular activities that helped to build trust between client, their families and the service.

Building a responsive client environment requires understanding client needs. One client said he had previously accessed a service that made him feel like a 'loser', but that the support he received during treatment with a Pacific service had helped him to respond more to the treatment. He was most impressed with the availability of young Pacific staff and found that as a young Pacific person himself he could relate well to his clinician. He described the Pacific A&D clinicians at the service as 'down to earth' and friendly and said they came across as genuinely wanting to help clients towards recovery.

Clients said that staff photos on the wall was a good thing, and that seeing familiar faces each time they accessed services helped them to feel there was continuity, collegiality and a sense of family in the service. They found this important in helping them to feel they were coming into a family; that they were not just another number on a list, but people whose lives were important.

This notion of family, of positive support among Pacific services, was captured by one client:

> '[They] build up my confidence. They tell me how good I look every time I come here. I appreciate that. I appreciate when they say that. It makes you feel good about yourself. They're not trying to pull me down or anything. They're not trying to judge me. They lift up my spirits, to look forward and focus.'

For each of these reasons clients found ethnic-specific services desirable.

Theme 5: Cultural Stigma

For many clients, acknowledging they had an A&D problem meant having to deal with the cultural stigma associated with it.

Saving face is an important part of Pacific cultures, so addressing their A&D problems is a delicate process. Clients said that in these cases it was important to have access to culturally sensitive services.

Theme 6: Having a Relationship with God

One client commented that going to church and having a personal relationship with God would help to prevent others going down the path of A&D abuse he had experienced.

Theme 7: Service Access Issues

One client commented that access to A&D services was also about access to other related services. He noted how the help he had received towards his recovery included non- clinical help, such as developing some basic skills in seeking employment. He commented that having access to this help from people with whom he already had built a trust relationship enabled him to see the future more positively.

Other clients listed anger management and/or domestic violence counselling and budgeting and life skills advice among the non-A&D-specific programmes offered by the A&D services they attended. Life skills programmes usually involved sessions on New Zealand society and how it could differ from Pacific societies. Clients found this type of programme useful as it gave them access to different ways of understanding the pressures of their lived environments. Some acknowledged that these services were not available in all A&D services and that access to them might require referrals.

Contrary to anecdotal support for 'one-stop shop' services, one client noted that having services specialising in discrete issues was not a problem. For him, it made sense to have different needs met by different services, as long as information was available about where to get help for those needs. It also required respective services to be able to make or pick up referrals efficiently to ensure continuity of care. Some clients also noted that A&D services located away from highly public areas were more attractive, because this kept those conscious of social stigma out of the public glare.

Clients also commented that one of the Pacific services' positive features was their willingness to provide services after normal business hours. One client stated that opening after 'normal business hours' (i.e. 8am to 5pm) worked well for him and his family because they worked during normal business hours and travelled some distance to get there. He said that the ordeal of getting there was always worthwhile because of the smiling faces of the staff who greeted him and his

family upon arrival. Such attributes made this service accessible more at the personal level than anything else.

Theme 8: What Would Help the Service?

When asked what they thought might help services to meet their needs, clients suggested:

- **more funding**: overall, clients appreciated services' efforts in helping them with their situations and were aware that they often operated on very limited budgets. They suggested that more money be 'poured into services to support and recognise their good work'
- **'flash Pacific-friendly places'**: although clients believed most services operated in adequate facilities, they said some could do with a make-over – that some decorative changes might help lift the spirit of the place. Some suggested having more Pacific A&D posters on the walls and photos of Pacific friendly faces. One described the service he accessed as needing a 'flash place' that was still 'Pacific friendly'. For example, he found that although the building was not 'flash', the mattresses on the floor were a uniquely Pacific idea and they should be kept
- **day or residential care facilities**: a few clients argued that services should also provide residential or day care facilities. One was very supportive of this, noting that it might provide a more preventive method for those at the beginning of their treatment interventions. He said he would have appreciated such a service, even for the day, and that at the beginning of his treatment he had been reluctant to go home because he believed it was 'the root of his problem'. He commented that having such facilities available could provide much-needed support at a vulnerable time. However, another client disagreed, stating that residential facilities encourage drug dependency because residents were given medication when staying there.

Theme 9: Client Expectations

Clients expect courtesy from staff. They said it was important for staff 'not to look down on them' and one commented that harsh words would turn someone away. Clients also expected access to relevant and appropriate information through appropriate language resources.

Theme 10: Informing Families and Communities

Clients said that as well as informing clients about the effects of A&D use, it was also important to inform their families and their general communities. Suggestions on the best ways to do this included community meetings, pamphlets, community-inclusive conferences, church seminars and specific radio or television programmes and/or radio and television advertisements.

They also recommended information pamphlets written in ethnic-specific languages, especially for people for whom English was not their first language.

Clients suggested that television advertisements were a way of informing the wider community about the effects of A&D use on Pacific peoples, and argued that they could reach those Pacific peoples that other media did not. They described as 'powerful' advertisements showing how A&D affects the liver or brain when used excessively or illegally. One commented that he had had the opportunity to attend an A&D expo with a Pacific A&D clinician and was exposed to an array of information about A&D use and A&D services, some of which he had not been aware of previously.

4.2 FAMILY FOCUS GROUP FINDINGS

4.2.1 Participant Profile

Of the five family members who participated, four were female and one was male. Three were aged between 41 and 50 years, one was between 51 and 60 years and one was aged over 60 years. Three were Samoan, one was Tokelauan and the other was Rarotongan. They came from either the Auckland or Wellington regions, and each was either a spouse or a parent of a client.

4.2.2 Key Themes

Nine themes emerged from the family data and form the results and discussion in this section:

- Families 'in a dark place'
- Families play an integral role in client recovery
- Services are safe, respectful places
- Clients need the 'right' A&D clinician
- Services give access to relevant information
- Pacific service delivery
- What would help the service?
- Family expectations
- Informing families and community.

Theme 1: Families 'in a Dark Place'

One family member noted that families of A&D clients are often sitting in a 'dark place' and that the service's role is to provide help – to shed light into the darkness.

Theme 2: Families Play an Integral Role in Client Recovery

Family members sought to remind services of their important role in the client treatment and recovery process. They implored services to include families in clients' treatment interventions.

The participants in one family focus group noted that families were an important source of information on clients' real recovery progress, particularly for those clients living at home with family. One noted that changes in a client's behaviour were obvious to them – for example, he seemed more willing to listen to advice from his family after attending his Pacific A&D service than before. The client was also succeeding in sport and other areas of his life – encouraging

signs for the family. Families can play an important role in client treatment and recovery by reporting on positive developments like these.

Family members noted that familial support can take many forms. As one family member commented, some walk alongside clients and have hands-on input into interventions, while others prefer to support from a distance i.e. letting the Pacific A&D clinicians do the hands-on work while they support in other ways.

Theme 3: Services are Safe, Respectful Places

One family member noted that she had been sceptical about the service her family member was attending, but that much of her scepticism was laid to rest when she came to know the service. She stated that she now felt 'safe' in the help the service delivered.

Another family member recalled an incident when relatives were treated disrespectfully at a particular service. The family subsequently became very cautious about social services. However, they commented that the Pacific service currently accessed by one of their family members seemed to understand the client and the family and were able to work well with them. This person felt the service showed respect for the client and the family and was impressed by it.

Family members found that services that were respectful showed genuine concern for, gained responsiveness from and had a positive influence on clients and families. For a number, their involvement with or support of a client was enhanced by the support they received from the services.

Theme 4: Clients Need the 'Right' A&D Clinician

Family members argued that their client family members needed the 'right' type of A&D clinician – one who could demonstrate genuine commitment to and interest in the client and the ability to get along with family members, to communicate and inform them of the client's treatment and how they could best help the client. Family members described how impressed they were with the A&D clinicians currently helping their client family members. One stated that the 'right' A&D clinician is one who displays 'genuine interest'.

Another family member described her involvement with one service to which a client was referred because he had found himself in trouble with the law. The family member was sure that the client was going to jail, but with the service's help she was able to support the client without too much stress and the service was able to help with the client's court documents. This family member believed that without the service's support, especially the clinician, her own relationship with the client and with other family members would have suffered more.

Another family member gauged 'genuine interest' from regular follow-up calls made by the clinician to the home about the client's health and how the family were doing. They suggested

another indicator of 'genuine interest' as the willingness of the Pacific A&D clinician to attend out-of-hours events, such as sports events with which the client was involved. Other family members recalled similar accounts of Pacific A&D clinicians who had gone out of their way to ensure their clients' needs were addressed where possible.

Theme 5: Services Give Access to Relevant Information

Family members noted that services can be places to access relevant information on A&D, their effects and the treatment options. One in particular said that she and the client family member were taught 'many things' about A&D from a particular Pacific service, including the definitions and causes of alcohol abuse and the principle of moderation.

Family members were also interested in information on domestic relationship problems, noting that services also provided help with these issues. They were aware of the relationship between domestic violence and A&D abuse, with one saying she was able to attend discussions held by the service on this topic and that they were very useful as they helped her husband's drinking problems and their marriage and generally improved their family life. For her, it was important to offer anger management programmes that included both the client and the family.

Theme 6: Pacific Service Delivery

One family member, through tears, spoke of the excellent service offered by one of the Pacific services with which she had contact. The tears were tears of joy for her client family member, who was successfully engaging in treatment and was well on his way to recovery. According to this family member, his recovery story was filled with trials and tribulations and owed much to the family's perseverance – and that they owed much of the success to the help they had received from the Pacific service. The genuine desire of service staff to help them touched them all, especially the client family member.

It was surprising to discover that many family members did not know the official names of the Pacific services – instead, they were identified through particular staff members. Only those family members who had affiliations with a service or services for a long period of time were more familiar with their names. One person pointed out that whether a service was good or not depended on its staff, so if clinicians did their job right this reflected positively on the service and vice versa. The performance of Pacific A&D clinicians was therefore integral to the performance of Pacific A&D services.

Theme 7: What Would Help the Service?

- **More funding for more staff:** one family member said that Pacific services were under-funded as they seemed to do a lot of hard work, helping not only clients but also families of clients (where appropriate). It was suggested that funding for more staff be the first priority given the importance of having continuity of staff and the recognition that this was more a staffing and/or resource issue than anything else.

- **Office space improvements**: one family member said that improvements could be made to the physical appearance of certain services' office space, with extensions to current office plans to allow for extended family involvement.
- **Late opening hours**: for family members who worked during normal business hours, it was important to have services available outside these hours, especially for those who lived outside areas where services were located.

Theme 8: Family Expectations

Like clients, family members said that their main expectation of the A&D services they attended was that they (namely staff members) show them genuine respect. Positive receptions by all staff members, including those at the front desk, were important to gaining positive family involvement.

One family focus group raised the expectation that services conduct house-calls, as part of either a family-client meeting or a follow-up or information dissemination strategy.

Theme 9: Informing Families and Community

Suggestions on ways to inform others about A&D and their effects included pamphlets written in ethnic-specific languages and disseminated at community or church meetings or other similar media. Family members also said that educational sessions could be run at these sites, but that they needed to be run by Pacific services, mainly for language reasons. They mentioned church as an important dissemination site because of its continued centrality in the lives of Pacific peoples in New Zealand.

4.3 'MANAGER' SURVEY FINDINGS

4.3.1 General Respondent Profile

The 'manager' survey respondents came from 12 services: three Pacific DHB-based services, one mainstream DHB-based service and eight Pacific NGO services. Four were based in Auckland, one in Hamilton, three in Wellington and four in Christchurch.

Of the 12 services, four were primarily mental health services with an A&D arm. Of these four, two were DHB-based and two were NGOs. The remaining eight services were primarily A&D-specific.[4] Of these, one was mainstream, one DHB-based and the remaining six NGOs.

The services whose core business was mental health were located in Auckland and Wellington, while the A&D-specific services are more widely spread between the four survey sites.

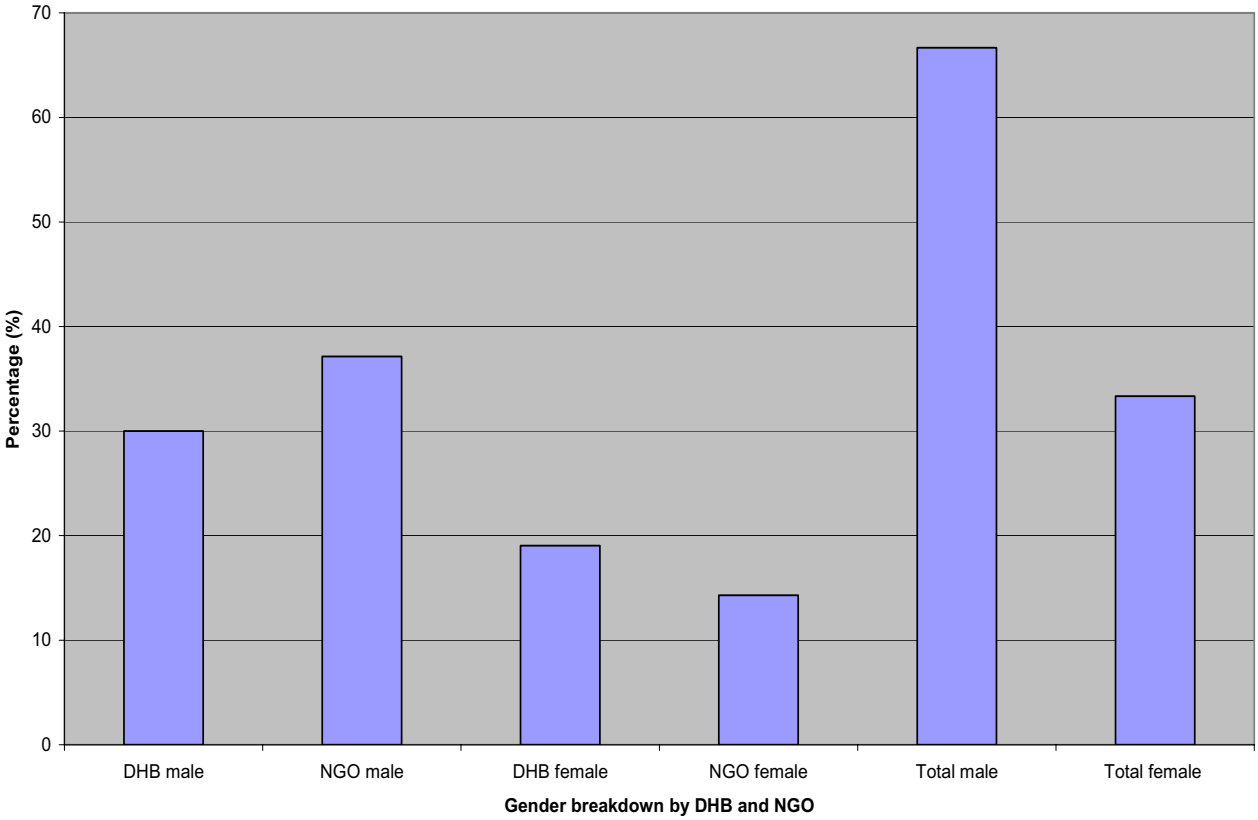
[4] The phrase and/or label 'A&D-specific services' is used here to denote services with core teams that deal primarily with A&D issues. It does not include references to the wider governance structure under which those teams may sit. This latter component is relevant when service teams for A&D and mental health practise as separate entities but in terms of overall governance sit under the same management umbrella. This situation is reflected in the three categories noted in Table 2 despite only two categories listed above.

4.3.2 Survey Findings

Staffing Composition: (i) Gender

Respondents reported on the number of male and female workers currently employed within their services and their ethnic breakdown. Of a total of 105 workers in the 12 services, 67% were males (30% from DHBs, 37% from NGOs) and 33% were females (19% from DHBs, 14% from NGOs) (see Figure 1 and Appendix 9, Table A for raw figures).

Figure 1: Gender breakdown of staff in the participating DHB and NGO services



Staffing Composition: (ii) Ethnicity

As illustrated in Figure 2 (see Table A in Appendix 9 for raw figures), the ethnic-specific breakdown of the staffing composition was:

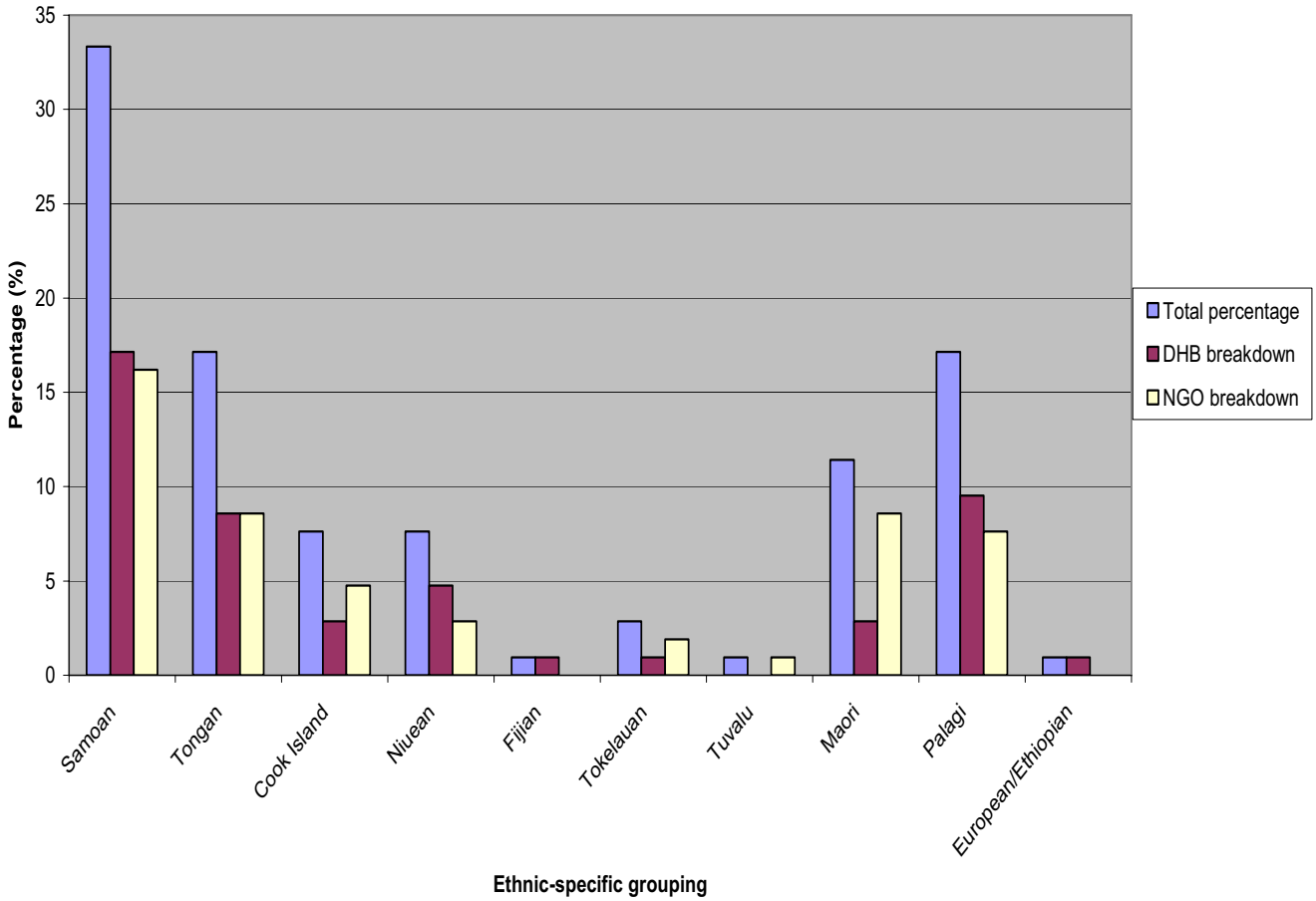
Pacific workers:

- Samoan 33%
- Tongan 17%
- Cook Islands 8%
- Niuean 8%
- Tokelauan 3%
- Fijian 1%
- Tuvaluan 1%

Non-Pacific workers:

- Maori 11%
- Palangi 17%
- European/Ethiopian 1%.

Figure 2: Breakdown of ethnic-specific staffing composition in the participating DHB and NGO services



Staffing Composition: (iii) Staff and Full-Time-Equivalent (FTE) Positions

All respondents identified staff positions as:

- counsellor/Pacific A&D worker
- health professional nurse/doctor/psychologist
- Pacific support worker
- cultural advisor (e.g. matua)
- traditional healer (e.g. fofo)
- team leader
- cultural supervisor
- clinical supervisor
- consumer advisor
- family/significant other advisor
- manager
- accountant
- admin support/admin
- domestic
- community liaison (DHB-based).

The survey did not cover part-time staff, just full-time-equivalent (FTE) positions within each service. This recognises that, while services use a number of different employment agreements and part-time positions are important, giving full-time status to a position lends it a level of importance that contributes to identifying trends in service composition.

As illustrated in Figure 3, of the 10 services that responded to the question about FTE staff positions, some had at least three – a team leader, a Pacific support worker and a Pacific A&D worker – and this applied whether the service was DHB based or an NGO. Only one service (DHB based) noted full-time health professional positions. It is likely that the NGO services included health professionals in the category ‘subcontracted’ or ‘part-time’ staff, not included in the figures below. Finally, it is of interest to note that NGOs rather than DHB-based services held the most full-time positions.

Figure 3: Breakdown of full-time staff positions

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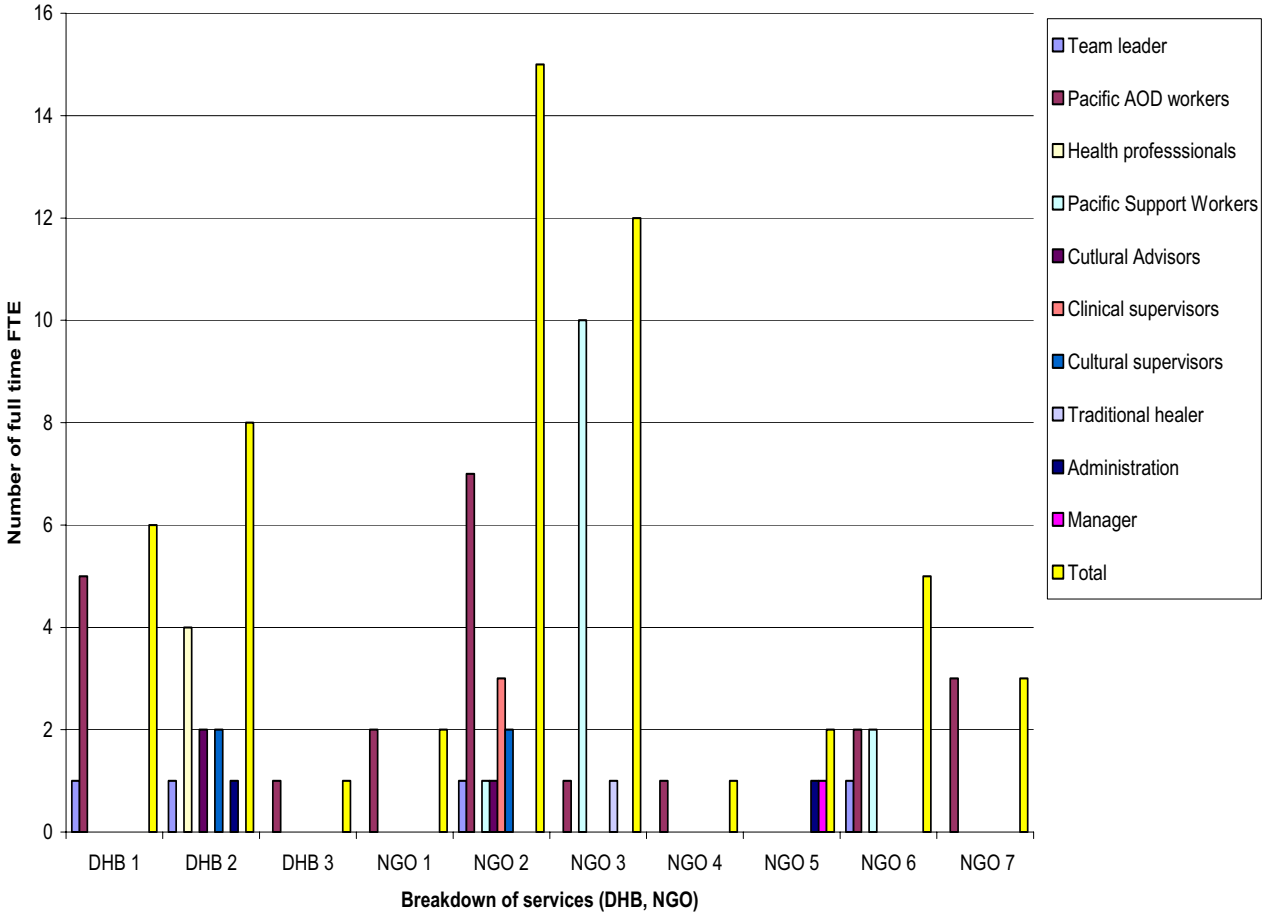

Service Structure Types

Managers were asked to describe how their services were internally structured in relation to service hierarchy and staff composition. Table 1 lists the different structure types in the survey (see Appendix 8); respondents were asked to signal the structure that best captured that used by their service.

DHB-Based versus NGO Services

As Table 1 shows, there appears to be no standard structure type. However, there were at least two levels in each service structure: managerial and frontline worker.

Table 1: Service structures in DHBs and NGOs

Service structure	NGO	DHB-based
Manager + clinical director + matua + mental health workers (clinical and non-clinical).		1
Team leader + Pacific consultant advisor + consultant psychiatrist + clinical nurses + family therapist + consumer advisor (mental health services).		1
Manager + clinical team leader + nurses + psychiatrist + clinical psychologists + social worker + A&D workers.		1
Service clinical director + service manager + matua + senior administrator + business manager + quality manager + family advisor + consumer advisor + projects + service medical officer + service team leader + A&D workers + mental health workers (clinical and non-clinical).		1
Manager + A&D workers.	2	
Chief executive + cultural advisor + service managers + A&D workers.	3	
Consumer + staff + manager + governance board + community.	1	
General manager + team coordinators + A&D workers + other social service teams.	1	
Manager + cultural advisor + clinical team leader + A&D workers.	1	
TOTAL (n=12)	**8**	**4**

'A&D' Centred, 'MH Centred' or 'A&D and MH Centred' Services

In making distinctions between the services that catered mainly to an A&D-specific clientele and those mainly to a mental health-specific clientele (and the implications of this for service structure), the different services were separated. Respondent answers (which incorporated notions of governance) also led to a third category of service or service structure that incorporated both an A&D-specific team and a mental health-specific team under the same service/governance umbrella. This accounts for the third column in Table 2.

Table 2: Service structures; 'A&D' centred, 'MH' centred' or 'A&D and MH' centred

Service structure	Mainly A&D centred	Mainly MH centred	Both A&D and MH centred
Manager + clinical director + matua + mental health workers (clinical and non-clinical).		1	
Team leader + Pacific consultant advisor + consultant psychiatrist + clinical nurses + family therapist + consumer advisor (mental health services).		1	
Manager + clinical team leader + nurses + psychiatrist + clinical psychologists + social worker + A&D workers.	1		
Service clinical director + service manager + matua + senior administrator + business manager + quality manager + family advisor + consumer advisor + projects + service medical officer + service team leader + A&D workers + mental health workers (clinical and non-clinical).			1
Manager + A&D workers.	2		
Chief executive + cultural advisor + service managers + A&D workers.	1	1	1
Consumer + staff + manager + governance board + community.		1	
General manager + team coordinators + A&D workers + other social service teams.			1
Manager + cultural advisor + clinical team leader + A&D workers.	1		
TOTAL (n=12)	**5**	**4**	**3**

Outpatient versus Residential Type Services

For outpatient and residential type services, respondents were asked to note, where appropriate, whether their services were one or the other. Table 3 provides respondent answers.

Outpatient services are defined as those that clients attend for treatment, while residential services are those where clients live at the treatment facility. Most DHB-based and NGO services were outpatient services.

Table 3: Service structure; outpatient versus residential

Service structure	Outpatient	Residential	Outpatient and residential	No answer
Manager + clinical director + matua + mental health workers (clinical and non-clinical).	1			
Team leader + Pacific consultant advisor + consultant psychiatrist + clinical nurses + family therapist + consumer advisor (mental health services).	1			
Manager + clinical team leader + nurses + psychiatrist + clinical psychologists + social worker + A&D workers.	1			
Service clinical director + service manager + matua + senior administrator + business manager + quality manager + family advisor + consumer advisor + projects + service medical officer + service team leader + A&D workers + mental health workers (clinical and non-clinical).	1			
Manager + A&D workers.	2			
Chief executive + cultural advisor + service managers + A&D workers.	2	1		
Consumer + staff + manager + governance board + community.				1
General manager + team coordinators + A&D workers + other social service teams.	1			
Manager + cultural advisor + clinical team leader + A&D workers.			1	
TOTAL (n=12)	**9**	**1**	**1**	**1**

Service Delivery: (i) Client Database

Respondents were asked to supply the number of clients currently with their services. These ranged from 10 to 300, but most of the clients for the service with the largest client base (i.e. 300) were not Pacific.

All four DHB services had electronic client databases. Two NGO services reported that they did, but most of the rest were still developing them. The services with electronic databases or in the process of developing them required customised software.

All services routinely recorded information on client demographics, cultural identity, dependence severity, other addictions, criminal/legal involvement, family and significant others, appointment times, arrivals and missed appointments, assessment tools and screening tools. This information informed clients and their families of progress and recorded client sessions with A&D workers. It also informed service planning, reports to funders, research and evaluation. One service noted that such information also informed a 'national database'.

In services using paper-based client database systems, Pacific A&D clinicians were required to keep information in clinical files. However, this practice will change once they adopt online client database systems.

Service Delivery: (ii) Clinical Practice – Access, Screening and Assessment Access

Client access to clinical services usually happened through formal referral systems, but some informal processes were also involved. According to DHB respondents, their services were accessed through:

- self-referrals
- referrals from related institutional organisations e.g. hospitals, justice or corrections services, primary health organisations (PHOs), community alcohol and drug services (CADS) and related mental health services
- referrals from family.

According to NGO respondents, clients accessed their services through:

- self-referrals
- referrals from general practitioners (GPs)
- referrals from related institutional organisations e.g. hospitals, justice or corrections services, PHOs, CADS and related mental health services
- referrals from family
- referrals from other NGOs e.g. City Mission
- referrals from churches and wider community networks.

Screening and Assessment Tools

- Of the range of available and locally developed tools used for assessment and screening, some had been given names representing Pacific health belief models and concepts (e.g. the Fonofale and Lalaga models).

Most respondents also used mainstream screening tools with Pacific clients. These included:

- the Alcohol Use Disorder Identification Test (AUDIT)[5]
- the Severity of Dependence Scale (SDS)[6]
- the Leeds Dependence Questionnaire (LDQ)[7]
- the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) multi-axial formulation[8]
- the CAGE Questionnaire[9]
- the Michigan Alcoholism Screening Test (MAST).[10]

They also noted the use of the 'harm reduction' and 'therapeutic community' models of intervention in their assessment processes.

Most (seven of the ten services that responded here) rated the importance of assessments in:

- informing Pacific A&D consumers about their progress
- assessing the effectiveness of A&D services.

Only one manager noted that the assessment process could also be an evaluation of the assessment tool and its effectiveness in gathering data.

One manager commented that a person's ethnicity was important, not only in terms of their birthplace but also in terms of their upbringing (island or New Zealand raised). They related its importance to the value of the 'therapeutic community' treatment model, as it picks up that some Pacific youth relate more to Palangi concepts. Another respondent noted that despite the availability of the above models and tools, and the differences between Pacific and mainstream models, services still needed to 'try what works best for the client's issues'.

Service Delivery: (iii) The Process

One manager commented that medical practitioners needed to understand that assessments of Pacific peoples should recognise their differences and work at a pace that suits them. The manager had the impression that medical practitioners were not allocating enough time for appointments to meet Pacific clients' needs.

One service commented that language was important in developing Pacific-specific processes for screening and assessments – and that understanding Pacific languages as well as the English language was important for service delivery.

Respondents endorsed a number of client assessment processes, ranging from brief assessments conducted in-house to service-developed assessments conducted externally, family-based assessments, comprehensive A&D assessments and combinations of these types. They also noted that service delivery processes included team meetings, planning sessions and

[5] See Saunders et al 1993.

[6] See Gossop et al 1995.

[7] See Raistrick et al 1994.

[8] See Hassin and Grant 1994.

[9] See Bush et al 1987.

[10] Saltstone et al 1994.

supervision time conducted in Pacific-specific ways, involving both Pacific and English languages. Services supported comprehensive holistic approaches that included cultural and clinical assessments with a multidisciplinary approach.

Service Delivery: (iv) Pathways to Treatment and Recovery

All services' pathways to treatment and recovery involved both Pacific and mainstream models and processes.

All DHB services reported having a clinical manual that contributed towards their clinical pathways. NGO services did not use clinical manuals, but a number commented that their treatment and recovery plans used:

- a 'service manual' that covered intervention and treatment (IT) assessment, IT plans and policies and IT occupations to fit their health and disability plans
- 'referral and assessment processes' that began at admission
- 'lifestyle plans' that included goals, recovery plans and objectives within a holistic framework.

Only three NGO services said they had documented pathways towards treatment and recovery. These pathways consisted of:

- case reviews every six to eight weeks
- clinical studies with interviews every two to three months throughout treatment
- care plans and lifestyle plans reviewed every six months.

While all Pacific-specific services incorporated a Pacific health belief model (e.g. the Fonofale model), only one indicated it used traditional healers as part of its pathways to treatment.

Respondents were asked if their treatment and recovery pathways and/or interventions covered:

- spirituality (identity, feeling stronger in oneself, prayer)
- mental wellbeing (thoughts, feelings and behaviour becoming more appropriate)
- physical health (change, improvement)
- social/family (relationships, functioning improved)
- substance use.

Overall, they said that while they were confident a range of needs were met, they could not say for sure because there was no formal measure to evaluate this.

There were differences in the way respondents from different regions reacted to the 'spirituality' element. It formed a major aspect of current intervention pathways in the more highly Pacific-populated regions (Auckland and Wellington), but not as importantly in regions with low Pacific population density areas (Hamilton and Christchurch).

Respondents also highlighted that A&D issues needed to be addressed in context i.e. that it is important not to treat A&D problems in isolation. They argued that pathways to treatment and recovery need to take account of the problem's multidimensional nature. All services stated that the intervention pathways they currently adopted considered this multidimensionality – that is, that issues relating to clients' mental/psychological wellbeing, physical health needs, cultural/social/family needs and substance use needs were addressed as part of a holistic approach to problems.

Respondents were concerned about a lack of clarity on and commitment to service delivery for Pacific peoples and the lack of dedicated funding to meet their service and client needs. One commented that they found it difficult to make mainstream services understand the value of 'culturally appropriate' processes and practices, such as the need to give meaalofa (or cultural gifting) and food and other cultural practices.

Managers stated that successful Pacific treatment and recovery pathways relied on having people of the same cultural backgrounds as clients. One said that cultural background meant a person's 'values, beliefs, practices, way of life, likes, dislikes and way of thinking' and argued that when we understand all these we understand the person and are better able to help.

According to one service, the role of community support workers is to work through clients' personal backgrounds and devise plans suitable for their recovery. Some managers also indicated that age and gender were important factors when devising appropriate client-focused pathways to treatment and recovery. Others identified factors such as religious affiliation, sexual orientation, family dynamics, client roles and responsibilities and current pressures.

Service Delivery: (v) Outcome Measures

Respondents were asked what outcome measures their services used. Many were unclear what an 'outcome measure' was (see Section 5 – 'Discussion' – for more elaboration), but when taking respondent replies as a whole, it is possible to gain a sense of how outcomes and outcome measures might be understood.

In response to a question on what impact a person's cultural background might have on their achieving successful outcomes and recovery, managers replied:

- certain delivery styles
- certain language uses
- certain client-tailored (matching) approaches, which included the choice to engage in Pacific services
- client-focused, high-quality services.

DHB-based respondents did not identify any indicators to measure Pacific A&D clients' recovery. One service manager commented that they should be developing these indicators, while another

stated they were in the process of formalising measures, particularly those seen to be Pacific oriented. Only three NGO services identified indicators to measure recovery, which included:

- clinical interviews/studies that are followed up every three months
- four-weekly reviews assessing participation
- information from families
- regular case reviews by clinical management
- regular drug screens
- self-reporting questionnaires.

One Pacific-specific service noted that the cultural activities it used within its service delivery practices needed to form part of outcome measure indicators.

When asked about mechanisms to validate service delivery processes, increase workforce capacity and capability, or improve research and evaluation data, managers responded that client and staff feedback and some information mapping might be useful.

Of those services that did not have mechanisms for measuring recovery, all commented that they were wanting to progress in this area and one was currently seeking help to develop them. Of interest was one NGO service, which noted that due to its current service structure it was unable to conduct clinical treatments, so it referred clients to a DHB-based service for the clinical components of treatment.

The services wanting to develop processes for measuring service outcomes suggested strategies that appeared to focus more on service/staff performance outcomes and consumer/family feedback on satisfaction levels with the service intervention than on outcomes for clients themselves.

Six respondents noted that these outcomes were measured through questionnaires completed by clients (e.g. client satisfaction surveys) and were primarily for assessing the effectiveness of the A&D service. Services also used questionnaires completed by Pacific A&D clinicians and family members, where a rating scale was completed by the Pacific A&D clinician.

Other services indicated measuring consumer outcomes via tools and/or screening methods for drug use and/or by analysing self-reporting questionnaires filled out by clients and their families, criminal history records, treatment notes, and individual and/or group evaluation forms. Each was highlighted as relevant for measuring service outcomes. Another service used evaluation forms to measure short-term outcomes, but understandably found it difficult to measure outcomes beyond one year.

Respondents said that potential outcome measurements or indicators should cover:

- disability issues

- the existence and recurrence of recognised symptoms
- issues relating to social/family/significant others
- levels of satisfaction with services
- non-substance-use-related issues
- quality of life/wellbeing issues
- spiritual wellbeing issues
- substance use issues.

When rating how their services decided on solutions for Pacific A&D clients, DHB-based services responded that they did not rate funder requirements as important. However, three NGO services found this influential in the decision-making process. The most important mechanisms overall included team planning, client satisfaction and having suggestion boxes and client satisfaction surveys.

One service commented that recommendations from clinical assessment teams are regarded highly for specific interventions, but that this is done in consultation with Pacific A&D clients. Another highlighted the importance of engaging the local community and involving consumers and families in service planning, and one service manager focused his answer more on internal strategies, using performance development, 360 feedback and letter/complaint processes.

Three NGO services indicated they used outcome measures to make funding decisions about services and included other areas such as research, treatment delivery, service accountability and building evidence for positive interventions and appropriate financial models.

Finally, managers were asked whether they thought a client's ethnicity was a factor in achieving successful outcomes and recovery. All NGO managers replied that it was very important; that a good understanding of a client's cultural background and dynamics helped to develop a realistic and achievable plan of recovery.

Pacific A&D Client/Family Involvement

One mental health service manager chose not to complete the section on Pacific A&D client/family involvement, as they did not routinely provide interventions for A&D clients. This meant responses were received from three DHB-based services.

Client Involvement

All services reported that gaining client feedback was important, with all NGO services and two out of three DHB services having mechanisms for client feedback. A number also had designated consumer advisors, and one was in the process of employing a consumer advisor to help in encouraging client involvement.

Surveys appeared to be the most commonly used tool for measuring consumer satisfaction. Of the three DHB services, only one had documented consumer satisfaction in the previous five years and none had done so in the previous year. Two services measured consumer satisfaction during and at the end of treatment (it was assumed individual workers did this with individual clients during sessions). Other more formal mechanisms included meetings (for either verbal feedback or written feedback through tools such as client satisfaction questionnaires), case reviews, participation groups, morning and afternoon reviews, client review sheets, one-to-one counselling, specific focus groups, session evaluation forms, evaluation forms and evaluation fono.

Most NGO services had recorded consumer satisfaction levels within the previous five years and as recently as the previous year. Five indicated they measured consumer satisfaction during individual sessions and/or at the end of treatment, a couple once a week, one a month after treatment and another negotiated with clients the most appropriate feedback time. Only one service indicated how this was done, commenting that clients were asked to give verbal feedback during individual treatment sessions and/or asked fill out an evaluation form at the end of treatment.

Services said that measuring consumer satisfaction was important because it:

- informed the A&D worker on the client's progress
- informed the client on their own progress
- made some assessment of the effectiveness of A&D services
- contributed towards funding decisions about services for clients.

Most of the NGO services rated funding decisions as an area influenced by consumer satisfaction, however two services found this to be not at all important.

Services also used informal feedback avenues, with one NGO noting that clients sometimes gave feedback through informal discussions.

Managers were also asked what they would like put in place to help confirm the value of referral, assessment, intervention and discharge processes for Pacific clients. One commented that evaluation forms were the norm, but noted that these tools needed to include a clinical measurement tool that was 'Pacific user-friendly'. Other managers echoed this sentiment, saying they would like specific Pacific assessors to be involved in helping services to decide on and plan around their short- and long-term goals. They believed this planning process should also involve clients or a consumer advocate.

Family involvement

'Family' was widely defined to include extended and immediate family members. According to respondents, families become involved with services because of their desire to help their client family members. Services recognised the need to involve families in client treatment and recovery pathways – but as one respondent pointed out, the involvement of families or significant others depended on clients' wishes. Nevertheless, all services understood that, for service planning purposes, family involvement was both culturally and clinically appropriate.

All services said they actively involved families and significant others in activities such as assessments, devising care plans and educational sessions. Formal mechanisms available to families across various services included:

- community dinners
- couples' counselling
- family educational sessions
- family information days
- family support activities
- harm-reduction group sessions
- men's groups
- monthly multi-family group sessions
- networking with Pacific elders and other Pacific providers
- relapse-prevention groups.

Services used family/whanau questionnaires to help them meet families' needs. Providing a comfortable environment for families included ensuring that the physical environment was safe and inviting.

Just as services provided advisors or advocates for clients or consumers, some had family advisors and advocates. One service had a designated family advisor who was helping it to be more family inclusive, while another commented that family members could sit on its board of trustees and contribute through that channel. Families also contributed to services as volunteers, with one manager noting that a large number of volunteer workers were clients' family members.

Although none of the DHB-based services had ever formally measured family or significant other satisfaction levels, one did note it had received informal feedback from families earlier in the year. On the other hand, NGO services reported a number of mechanisms to measure family satisfaction, including questionnaires, feedback on multi-family group sessions, surveys, family fono and family evaluation forms. All services used the information to some degree to inform all relevant parties on client progress.

Relationships with the Community

Managers were asked to comment on other sectors with which their staff regularly engaged. The most common was mental health services followed by the criminal justice sector.

Only one DHB-based service stated that it regularly engaged with NGOs, PHOs, Work and Income New Zealand (WINZ) and Child, Youth and Family Services (CYFS). However, NGOs had high interaction levels with other NGOs and community services, including WINZ, CYFS, PHOs and Pacific DHB-based services. Other organisations listed by NGO respondents included:

- Alcohol Health Watch
- budgeting services
- churches
- Citizens Advice Bureaux
- Community Law
- the Family Violence Network
- Housing New Zealand
- Maori providers
- the Salvation Army
- schools
- the Strengthening Families Network
- Whitireia Polytechnic.

Services were asked how beneficial their staff believed building relationships with outside sectors were in enhancing client outcomes. Respondents replied that, in general, intersectoral relationships offered moderate to major benefits for client, family and (ethnic) community outcomes.

All respondents saw intersectoral relationships as an important part of their work towards enhancing the outcomes of Pacific A&D clients and family members or significant others.

A&D Education for Pacific A&D Clients, Families and Communities

Two of the three DHB services did not provide any A&D education, with one commenting that it did not have a contract for this. The service that did provide A&D education did so to a range of other service providers such as mental health services, NGOs, the New Zealand Army, the Prisoners' Aid and Rehabilitation Society, Women's Refuge, prison officers, probation officers and service planners. However, it was unclear if these were Pacific specific; they were more likely to be delivered within a mainstream context.

Seven of the eight NGO services reported providing A&D education to clients, families, alternative schools, Pacific community groups, specific youth focus groups, training programmes (for

example the YMCA), the Salvation Army, as part of community projects (for example, at-risk youth), Pacific churches, Pacific organisations, and to any place that invited them to speak.

DHB-based services' education programmes were delivered primarily through lectures, while NGO education programmes were delivered through workshops, seminars, camps, in-service, the media (for example radio and newspapers), churches, halls, homes and lectures. They were also conducted in the appropriate language (for example English and/or Pacific language) and manner (for example with Pacific food provided). One service reported offering the community free transport to A&D seminars, while another service reported using PowerPoint presentations and overhead projector presentations. Two commented that educational programmes were interactive, with participants encouraged to be involved in discussions.

Resources for DHB programmes came from within the services themselves. One service explained that this was to maintain the quality of information, to inform, to de-stigmatise people's attitudes and to explain service provision choices for potential clients.

One of the services that did not provide an A&D education programme offered A&D and dual-diagnosis education through the mainstream setting.

Services reported that they informed communities of A&D education programmes in their areas through networks and media advertisements. Access was also available to anyone who contacted the services directly by a visit, phone or letter.

Most services said that Pacific A&D workers generally delivered A&D programmes, with four of them reporting that this was also done by training coordinators or training teams and team leaders. Only three had designated people providing the service, while two said they contracted others to deliver programmes, such as the Roger Wright Centre and the Hepatitis C team. Other people, such as volunteers and guest speakers, were also invited to present A&D education programmes.

Services believed that A&D education programmes were effective in preventing or reducing related harm, increasing awareness within the community and encouraging early referral for help. They also saw them as tools for:

- trying to prevent people starting alcohol or substance abuse
- helping families to understand substance abuse dependence and behaviour
- encouraging discussion on issues facing the community
- enabling greater communication between the younger and older generations.

Managers commented that education raised awareness by helping people to recognise early signs, seek support and keep themselves safe. The knowledge people gained through A&D education programmes empowered them; they gained facts about A&D intake and its harmful

effects; and it was hoped that this knowledge deterred them from excess use or even motivated them to refrain from A&D use altogether. The A&D programmes also promoted a forum for people to talk about and ask questions around this sensitive issue in a safe environment, surrounded by people in similar positions – and the understanding generated through them encouraged people to become more actively involved in other issues facing Pacific peoples in their communities.

Managers commented that education must be provided in a culturally appropriate way and that culturally appropriate resources and handouts must be provided, with contact numbers in case they are needed.

DHB education services were accessed via DHBs and via NGO partnerships with DHBs. They were delivered primarily by clinical teams and coordinators and NGO trainers, as well as with Pacific A&D workers in specific circumstances. The resources for NGO-run A&D education programmes came from various sources, for example DHBs, ALAC, the Ministry of Health, the Internet, the Foundation for Alcohol and Drug Education (FADE), NZ Care and services' own resources. One manager commented there was a great need to develop local resources relevant to the community, and that this required innovation, creativeness and room to expand.

Workforce Development: (i) Staff Training and Development

Eight services (three DHBs and five NGOs) reported staff undertaking formal tertiary education, with some undertaking postgraduate study. While not all study topics were directly related to A&D issues, managers noted the importance of up-skilling staff in this way. A number of services encouraged staff to seek training from tertiary institutions outside their regions, with the rationale that they needed to find the best source for training, even if it was outside the region.

All services noted that they provided staff with opportunities for A&D-specific training. One encouraged attendance at service education programmes, related conferences and workshops.

Workforce Development: (ii) Supervision

All services provided supervision to their staff, with supervision types including professional, group or peer, administrative, clinical and cultural.

Three of the four DHB services provided some form of supervision, with the main type being at peer and administrative levels. However, all clinical staff had access to relevant clinical supervision available within the wider DHB structure. This is not as readily available to NGO services, with one service commenting on the need for appropriately qualified A&D clinical supervisors.

All NGO services and a couple of DHB-based services provided cultural supervision for staff. Three managers recognised the need to clarify the term 'cultural supervision' and the need for supervision models that are useful, appropriate, acceptable and accessible.

Managers also noted that the resource requirements for supervision need to be recognised, as it requires both manpower and funding to be effective. Determining costs requires a definition of suitable supervision and suitable supervision timeframes. One manager noted that supervision services, especially cultural supervision, could be outsourced to appropriate community personnel, which could create problems with quality control and accountability.

In comparison with DHB services, NGO services provided more forms of supervision. While DHBs provided more peer and administrative supervision, most NGOs indicated they provided group supervision plus professional role and cultural supervision. Five of the eight NGO services said they provided clinical supervision while four provided administrative supervision. Only one service provided all forms of supervision.

The questionnaire asked managers to indicate staff positions that had access to supervision. Of the list provided, all staff had access to supervision.

NGOs identified a wide range of supervision gaps in their services, with most relating to cultural supervision issues, especially for team leaders. Generally supervision was accessed from within the service or through external agreements and paid for by the service.

Workforce Development: (iii) Future Opportunities

Five services had formal A&D workforce strategies. The strategies of two involved current organisational development and long-term focus plans, which in turn involved identifying areas for training and encouraging individuals to develop them.

Another service was aiming to develop its data on co-morbidity and A&D needs and its impact on caseloads in order to advise on current and future A&D workforce development. Managers attributed the lack of a Pacific A&D workforce strategy to the lack of appropriate and available funding.

Seven services (two DHBs and five NGOs) stated they were able to set aside specific budget allocations for workforce development. However, the exact amount depended on overall budget allocations. New staff orientation and training were part of core business training budgets for both service types.

5.0 DISCUSSION

This section addresses 13 issues that raised some controversy and/or that needed further exploration.

AN INVITING, FRIENDLY, RELAXED ATMOSPHERE

Providing an 'inviting' service or atmosphere is not exclusive to Pacific services; it should be expected of all services.

Clients and families stressed its importance in forming their perceptions of services – and said it also influenced their responsiveness to treatment interventions and advice. Sometimes we forget the value of a smile or a friendly greeting in the health professional world, but such things are valued by those who seek help for health needs. Fortunately, clients and families described pleasant initial encounters with Pacific A&D services that continued throughout the treatment and recovery processes.

A relaxed, Pacific-friendly atmosphere can be enhanced by interior decoration. Clients commented that a combination of Pacific posters, photographs, mattresses and ornaments on walls and floors gives a sense of invitation, a look and appeal that they admire. They and their families appreciated these attempts to give a Pacific-friendly look, but said some buildings occupied by services looked rundown and could benefit from a new building or a coat of paint.

The point at issue here is that the way a service looks and the way staff approach clients and families are just as important as the specific treatment interventions. In fact, the suggestion was that 'treatment interventions' may well be extended to include these more 'external' service factors.

BEING CULTURALLY RESPONSIVE

There has been a recent shift in the health sector towards formally recognising the cultural diversity of New Zealand's society, manifested in the drive for culturally competent workers.

Cultural competency requires a knowledge of various cultural groups and their beliefs, values and practices. Pacific A&D clinicians recognise that an effective Pacific A&D clinician is one who has sound knowledge of A&D issues and their Pacific culture and has the skills to integrate this knowledge appropriately.[11] Participants' comments suggest that Pacific A&D clinicians are showing cultural competencies at various levels, and that developing cultural competencies is an ongoing process.

[11] See also PADOPT Phase I report.

The pan-Pacific approach that services have adopted offers A&D care that helps to meet clients' diverse ethnic needs without making assumptions. For example, it provides the opportunity for clients who do not want to work with people from their own ethnic groups to select workers from other Pacific ethnic groups.

It is assumed that clients engaging in ethnic-specific services want an ethnic-specific staff match. This offers advantages in that the A&D clinician already has the intrinsic knowledge and experience of that particular culture, and it helps in assessing culturally appropriate treatment processes, family interventions, intersectoral collaborations etc. The only drawback with the approach is the limited number of Pacific workers available to match Pacific consumers.

The issue here is how to assess for cultural competency. While tools and frameworks for assessing clinical competencies have been developed and tested, cultural competency frameworks and/or tools are still being developed and tested, both for generic application in the health sector and for specific applications within each health sub-sector.

'EXTRA MILE' WORK

Participants described situations where Pacific A&D clinicians demonstrated 'extra mile' work, for example providing lunch for clients, spending time with them on extracurricular activities such as training at the gym, and making special efforts to get medication to clients while they were overseas. Clients and family members value these 'extra mile' tasks.

The issue here is how to recognise these tasks adequately within funding and service policy constraints.

ISSUES RELATING TO YOUTH CONSUMERS

The issue of the approach for Pacific 'New Zealand-born' youths has emerged not only within the data for this report but also from other related projects (Agnew et al 2004). It is not a new issue, nor is it unique to the A&D field.

Addressing the issue requires an understanding of why it is relevant and its future implications. Literature suggests that Pacific New Zealand-born youths are in a unique position, where they live in and are often caught between two different worlds – the Palangi and the Pacific (Tiatia 1998). This situation arises as a result of living with their Pacific collectivist heritage (well maintained in migrant enclaves) within a Western-individualist society. This makes growing up difficult for many Pacific New Zealand-born youths owing to their ability to move between two cultures that hold inherently different worldviews. Tensions inevitably arise.

Pacific New Zealand-born youth generally associate themselves with the Western youth population in their practices. But many still have strong affiliations with Pacific migrant enclaves that operate in a more gerontocratic and family-oriented system. This is most prevalent in urban

centres with high Pacific population densities. One manager commented that a Pacific client they dealt with related better to Palangi concepts – and this alerts us to the dangers of assuming that all Pacific peoples want access to Pacific-specific treatments.

Government projections that the future Pacific population living in New Zealand will be predominantly New Zealand-born indicates that the level of integration into mainstream New Zealand society is higher than that for earlier generations. This is evidenced by the large numbers of New Zealand-born Pacific peoples living in New Zealand who have English as their first language. Urgent efforts need to be made to develop frameworks catering to the diverse needs and contexts of the Pacific population today.

WORKING WITH CLIENTS AND FAMILIES

One of the strengths of effective clinical practice is the development of a positive therapeutic relationship between the client and the clinician. Psychotherapy literature indicates a definite correlation between the therapeutic relationship and improved treatment outcomes (Howego et al 2003; Singer 2001).

One of the elements supporting this therapeutic alliance is the matching of 'Pacific' clients with 'Pacific' A&D practitioners. In trying to resolve the question of 'which is more important: the technique or the relationship?' Niolin (1999) finds that both contribute to overall therapy effectiveness. Empathy is acknowledged to have an important role in quality therapeutic engagement for increasing the motivation for change (Singer 2001). Singer describes the empathic experience as a 'vicarious experience in which the empathiser "tastes" the recipient's experience'. He sees empathy as a 'bridge from the objective to the subjective' and an important element in rapport-building (Singer 2001). For the participants in this study, it was important that their total experience was understood and rapport-building was the first step towards achieving this goal.

Working with Pacific consumers often means also working with their families. However, this is not necessarily desired for all Pacific consumers, and Pacific staff working with Pacific clients need to bear this in mind. Families reported that by participating in service programmes for client recovery, they demonstrated support for both the clients and the service. The obvious benefit of involving families is that it provides more realistic ongoing support for clients after treatment. Services also provide support for families and vice versa, particularly with the volunteer service that many families members also provide.

Building trust and rapport with Pacific consumers and family members was important to family members. This requires positive attitudes and/or cultural understanding, which involves a basic grasp of cultural protocols and their importance when working with clients and their families.

Gaining cultural awareness helps to ease misunderstandings of monoculturalism between Pacific clients and/or family members and non-Pacific health professions and services. A relaxed, supportive and caring environment may be all the 'cultural appropriateness' required, for as one Pacific A&D clinician stated, it just needs a 'cup of tea… [and a chat to get] to know each other'. Clients commented that without this cultural connection and a 'relaxed' environment, it was often hard for them, especially those who were traditional Pacific clients, to respond to any advice or treatment offered.

While they did not dispute extending the definition of 'family' to include extended or other family groupings, families cautioned services on expecting a 'one size fits all' model for Pacific family involvement in client recovery or intervention processes. The realities of family life in New Zealand mean extended family support is not as prominent as it once was, at least in the islands.

INTERSECTORAL COLLABORATION

Pacific A&D services have established effective working relationships with other groups within their own and related sectors.

Although the data indicates that NGOs do this better than DHB-based Pacific services, it is important to bear in mind their different organisational contexts. The wider DHB structure includes many related organisations, while NGOs, as independent organisations, do not have this luxury. NGOs need to forge interagency collaborations.

In any case, the issue of intersectoral collaboration is about how it benefits clients. All respondents agreed that, for Pacific clients, there are benefits in building effective intersectoral relationships. For Pacific services, given the small community involved, the need to work together is even more imperative.

WHAT PARTICIPANTS SUGGESTED WOULD HELP PACIFIC SERVICES

The New Zealand health sector has a stated commitment to provide culturally appropriate services to Pacific peoples (Ministry of Health 1997).

Clients and families said they had received outstanding cultural and clinical help from services, and they expressed the need to give due recognition to their good work. Issues arise in how best to address these recommendations within service funding and policy constraints. The point of interest here lies not so much in the recommendation for increased staffing numbers or salary increments, but in the positive judgements of families and clients about the participating services in this study.

WORKFORCE COMPOSITION

The current Pacific A&D workforce is ethnically diverse, comprising Samoan, Tongan, Cook Islands, Niuean, Fijian, Tokelauan, Tuvaluan, Palangi, Maori and ethnically mixed groups. This is

representative of the general Pacific population as per the New Zealand Census (Statistics New Zealand 2001).

Unfortunately, the data collected did not discriminate for age; this would have provided interesting correlations with the fact that no respondents noted youth-specific workers among their workforce. Given the youthful population of Pacific peoples in New Zealand and the predominance of Pacific peoples (adult and youth) in violent offending (Newbold 2000), the trend towards a higher youthful A&D population is more than likely. And, given that English is the first language of most of this population group and that many have not set foot on the shores of their island homelands, the culture of this population will also more than likely be significantly different from that of its parents.

The issue arising here is that, given these cultural differences, the question of ethnic matching may or may not be the primary marker for cultural appropriateness. Although this is not an issue for the present, it is nevertheless important for policy and service planners alike.

WORKFORCE DEVELOPMENT

Workforce development is considered a complex and dynamic area and underdeveloped in research (Ministry of Health 1995; Kill 1997; Ministry of Health 2002; Health Workforce Advisory Committee 2003). Support from the Ministry of Health includes initiatives aimed at developing workforce capacity, such as the establishment of the Ministry of Health mental health workforce development awards in 2003. This allows for the professional and cultural development of mental health workers, including A&D workers. Some staff from the services involved in this study are recipients of these awards, and tertiary education is encouraged by the sector and managers alike.

Early discussions on workforce development in New Zealand indicate that little attention has been paid to the development of the mental health workforce. As a result, many services lack the necessary skills and competency to deliver quality services that can appropriately blend cultural and clinical components.

Just under half of the Pacific A&D services in New Zealand stated they had a workforce development strategy. In DHB services, workforce size and other policy concerns are, in the main, dealt with at higher managerial levels of the organisation as a whole, with frontline services often making little contribution to DHB policy-making.

The issue becomes one of how to improve the involvement of Pacific services' management in relevant DHB (regional) and national policy-making. Funding constraints effectively limit NGOs' autonomy in terms of their desired workforce, but within these constraints NGOs do have relatively more autonomy to be creative in supporting staff training initiatives.

SERVICE SUPERVISION ISSUES

Although supervision within both DHB and NGO services is accessible at all levels, there are issues with the required supervision type and frequency.

According to managers, effective supervision requires both manpower and funding. While frameworks for clinical supervision are relatively set within professional codes of conduct, similar frameworks for cultural supervision are still being developed.

The issue here is one of definition. The methodology for determining appropriate supervisory structures needs to be developed through a collaborative process by relevant stakeholders.

DATABASE ISSUES

While most services are adopting electronic databases, the routine data collected from all Pacific A&D services varies considerably. All services collected client demographics, but some also collected information (such as presenting symptoms) with differing levels of detail. These differences in the type and process of electronic data collection between services will make it difficult to make any comparisons that may contribute to informing national service delivery standards.

Managers also criticised current database frameworks as being not 'Pacific friendly'. This suggests the need for further analysis.

ACCESS ISSUES

Clients and families, especially working clients and family members, appreciated some services opening after normal business hours. As with the issue of raising worker salaries, this highlights the need to investigate whether this applies more generally across the Pacific client and family populations.

BEING INFORMED/EDUCATION PROGRAMMES

Education was an important issue for focus group participants, those interviewed and survey respondents alike. While the literature on the usefulness of drug education mostly refers to school-based education, White and Pitts (1999) found little reliable evidence of its effectiveness. There was a major discrepancy between the literature and the data on this issue.

The definition of 'education' is clearly open to debate, but the Ministry of Youth Development (2003) recommends a number of 'best practice' elements for drug education. These include requirements for the education to:

- have a 'harm-minimisation' focus (which includes the option of abstinence)
- be relevant to the community for which it is being provided

- have a clear conceptual relationship between the programme that is being delivered and the outcome that is desired
- be targeted appropriately at the group and the problem
- include individuals, families and communities.

Elements of these requirements were seen in the services' 'education' strategies, but they tended to occur on an ad hoc basis. They relied more on the interest and enthusiasm of individual Pacific A&D clinicians than being clearly thought-through strategies that took account of client or family requirements.

Researchers often make a distinction between impacts (a programme's immediate and/or medium-term effects) and outcomes (the longer-term effects) (Ministry of Youth Development 2003). It was clear in this study that participants and respondents did not distinguish between them, so it is recommended that 'outcomes' of existing 'education' strategies be evaluated to inform the development of rigorous and reliable programmes that are useful for Pacific peoples accessing A&D services.

Respondents commented that education programmes were an integral part of their intervention programmes, particularly as a prevention approach and as a tool to increase public awareness. However, data from respondents indicates that not all services have the manpower, resources or capacity to provide A&D education.

Those services that do provide education programmes believe they are useful and necessary for preventing or reducing related harm, increasing awareness within the community, encouraging early referral for help and de-stigmatising people's attitudes. Education programmes relay knowledge to help people make informed decisions.

Clients and family members commented that they were in favour of receiving training and education on A&D issues – and that one of the most important factors was the incorporation of culturally appropriate Pacific concepts, language and processes.

OUTCOME MEASURES

Respondents were unclear on what an outcome measure was, with service outcomes apparently more familiar to managers than client outcomes. Managers sometimes seemed to confuse client outcome measures with client satisfaction, despite the fact that, according to the definition provided by Teeson et al, the former encompasses much more than client satisfaction:

> 'The effect of an individual's health status that can be attributed to a treatment intervention' (Teeson et al 2000).[12]

Currently there is no tool to meet the requirements for a Pacific outcome measure in New Zealand. Services use individual outcome tools, such as client questionnaires and survey forms, to provide information for service and client outcomes. However, these reveal only part of the information needed to assess client and service outcomes. Moreover, the information required also needs to incorporate clinical and cultural concerns – so there is a need for a specific outcome tool for Pacific services capable of addressing such concerns.

For Pacific services, there is a need to focus on core values, beliefs and practices and to frame them appropriately within outcome measurement frameworks. Such values and beliefs incorporate Pacific notions of spirituality, family, mental and physical health and the holistic ways in which they come together.

Merging these cultural values and beliefs into clinical paradigms is no easy task, but with the right input it can be done. Ultimately the goal of A&D outcome measures and the routine measurement of treatment outcomes is as noted by Deering et al (2004: 48) – 'to improve the quality of treatment provided to consumers'.

A Pacific outcome measurement framework therefore needs to incorporate pan-Pacific and ethnic-specific models (for example, the Fonofale). It should not only focus on A&D use changes but also identify things such as relationships with families and productivity in the community as indicators. The 'New Zealand-born' Pacific youth issue versus the adult 'Pacific island-born' issue will also need to be considered when designing such a framework and/or its indicators.

[12] We recognise that there are various definitions and understandings of outcomes. This report uses the one established by Teesson et al (2000) for consistency with the Alcohol and Drug Outcomes Project (ADOPT) project and because it is more in line with the health outcome definition used and advocated by the Ministry of Health. It states: 'a health outcome is a change in the health of an individual, or a group of people or population, which is wholly or partially attributable to an intervention or series of interventions' (AHMAC 1993).

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APPENDIX 1: PARTICIPATING SERVICES

AUCKLAND

- Lavea'i Trust
- Lotofale Community Mental Health
- Pacificare Trust
- Tupu Services

HAMILTON

- Pacific Peoples' Addiction Services Incorporated

WELLINGTON

- Health Pasifika (MHS)
- Pacific Community Health (PaCH) – Vakaola
- Taeaomanino Trust

CHRISTCHURCH

- CADS (Community Alcohol Drugs Services)
- Odyssey House Trust (Youth programme)
- Odyssey House Trust (Adult programme)
- Pacific Island Evaluation Incorporated

APPENDIX 2: PARTICIPATING SERVICES' GENDER BREAKDOWN

Ethnic groups	DHB male	NGO male	DHB female	NGO female	Total DHB ethnic-specific	Total NGO ethnic-specific	Total of ethnic-Pacific groups
Samoan	11	10	7	7	**18**	**17**	**35**
Tongan	3	5	6	4	**9**	**9**	**18**
Cook Island	2	5	1	0	**3**	**5**	**8**
Niuean	3	0	2	3	**5**	**3**	**8**
Fijian	0	0	1	0	**1**	**0**	**1**
Tokelauan	0	2	1	0	**1**	**2**	**3**
Tuvalu	0	1	0	0	**0**	**1**	**1**
Maori	3	9	0	0	**3**	**9**	**12**
Palangi	9	7	1	1	**10**	**8**	**18**
European/Ethiopian	0	0	1	0	**1**	**0**	**1**
Totals	**31**	**39**	**20**	**15**	**51**	**54**	**105**

	%
DHB male	30
NGO male	37
DHB female	19
NGO female	14
Total male	67
Total female	33

APPENDIX 3: PARTICIPATING SERVICES' DATABASE SYSTEMS AND COLLECTIONS

Service type	Database system	Routine data collected
1. DHB	Healthlinks	Client demographics, for example gender, age, ethnicity (i.e. nationality), severity of dependence, types of other additions.
2. DHB	Allegra system and Individual service system	**For both Allegra and Individual service system**: Client demographics: gender, age and ethnicity. **For Individual service system**: Language fluency; New Zealand born vs island born; clients' parents' ethnicity; consent for Pacific clients to access service rather than any other; presentation (for example first, second… relapse); key family member; record of attendance; assessments required for clients, for example clinical, cultural, needs, supported accommodation; barriers to treatment, for example trust, language, poor understanding of protocols; treatment types – resources they're tapped into, for example psychology, counselling, cultural; delivery models, for example care management, key work; other services, for example interpretation, consumer education.
3. DHB	Healthcare Community Database	Gender, age, ethnicity, New Zealand born vs island born, address, treatment plans, care plans, objectives, Housing New Zealand forms, hazard forms and other forms, assessment details.
4. DHB	Patient Management System (PiMS)	Gender, age, ethnicity, address, contact phone numbers, residency, visits/appointments – excluding liaison visits, community agencies, written stats, Triage Contact Information summary, accessibility to develop, family/significant other involvement with key worker and client.

5. NGO	CURRENTLY MANUAL. IN THE PROCESS OF DEVELOPING AN ELECTRONIC DATABASE	Ethnicity, address, referrer, marital status, nationality, first-time client, notes, phones, client ID, contact name – supporter's name, contact type – relationship.
6. NGO	Microsoft Excel	Gender, age, ethnicity, comprehensive assessment notes, referrer.
7. NGO	Manual system	Age (date of birth), ethnicity, address, telephone number, client attendance.
8. NGO	Currently manual. In the process of developing an electronic database	Gender, age, ethnicity, language fluency, New Zealand born vs island born, NHI number, medical history background – GP to provide. Needs assessment, marital status, risk management, history/background of the client.
9. NGO	Microsoft Excel	Gender; age; ethnicity; language fluency; New Zealand born vs island born; diagnosis, medical treatment; belief/religion; cultural belief towards mental illness; referrer; doctor (GP); traditional belief towards traditional healer; substance-cannabis use; relapse; risk; care plan; date client enters the service; date client exits the service; next of kin.
10. NGO	Currently manual. In the process of developing an electronic database (Microsoft Access)	Gender, age, ethnicity, New Zealand born vs island born, employment, contact details, marital status, whether child or extended family or partner is the client, place of birth, status of counselling, ex-client box, Pacific cultural period of schooling. Headings: A/C; A&D; Anger management; Solvents.
11. NGO	Microsoft Access	Gender, age, ethnicity, language fluency, how many times in service, history records – interventions in the past that have been offered, contact person – phone numbers, contact details, sexual orientation, referral agency. New database: Appointment times, days in treatment, Pacific-P, Maori-M, Other-O, including Palangi. Good for DHB stats; monthly inventory – reported three monthly. New programme can be adapted to the service for e.g. Salvation Army.
12. NGO	Currently manual. In the process of developing an	Information not provided.

	electronic database	

GLOSSARY

The following terms refer to concepts used within this document. Note the definitions of some terms may differ from their conventional definitions. Participants also used some terms interchangeably.

A&D An abbreviated term for alcohol and other drugs.

Assessment Obtaining information about the nature and severity of the problem, reasons for the importance of the problem in the individual's life, and alternatives to the problem, and identifying and agreeing on the strategies to deal with the problem.

Betelnut Betelnut comes from the nut of the betel palm and is common throughout the South Pacific and South East Asia. Its generic name is *Areca catechu L*. Its specific name refers to the native for a strongly astringent drug, extracted from the wood of *Acacia catechu*. Chewing betelnut results in red-stained teeth and rotting gums.

The betelnut ingredients contain a potent muscarinic agonist that causes a range of parasympathetic effects (Asthana et al 1996 cited in Sullivan et al 2000).

Building connection A process of developing rapport with a client or families using Pacific processes and practices (e.g. sharing genealogy, finding common interests, spiritual discussions) in order to enhance trust with the clients or families. A therapeutic relationship is developed between the client and the therapist based on the establishment of connection.

Client The individual seeking help for A&D issues or a specific issue. In the mental health field, the term 'consumer' is more appropriate.

Client-match Matching clients with counsellors/therapists based on similarities. This is normally ethnic group, gender, age group (e.g. youth are usually seen by younger counsellors) or New Zealand born versus island born.

Clinical Any work related to clients.

Clinical supervisor	A person with clinical expertise in the relevant field (e.g. A&D) and a focus on helping workers in all areas of clinical work. A Pacific clinical supervisor is expected to have both clinical and cultural knowledge and skills.
Database	A computer system that records relevant information on a service, particularly client-related information.
DHB	District health board. A government structure that funds specific health-related services such as Pacific A&D and Pacific mental health services.
DSM-IV	Diagnostic and Statistical Manual of Mental Disorder version 4. A manual used for the medical diagnosis of different disorders.
Dual-diagnosis	An individual with a co-existing diagnosis of A&D and mental disorder.
Education programme	A programme designed to raise awareness of A&D-related issues; usually the detrimental effects of A&D on physical, mental, social, spiritual and community wellbeing.
Follow-up	Normally used in the A&D field to refer to the last stage of treatment where a client's progress is monitored after the last counselling session (normally between one and two months later). 'Continuing care plan' is referred to mainly in the mental health field and includes both follow-up and the implementation of a treatment plan in the community.
Fono	A Samoan term used generically in this report to refer to a 'meeting of peoples'.
Functional analysis	The method normally used for collecting A&D information, specifically the events and cues before use (antecedents), the effects of specific drugs, and the consequences and reasons for using.
Gerontocracy	A system of government by elders.
Holistic approach	A Pacific approach to A&D and mental health issues that incorporates the spiritual, mental, physical and family dimensions

and perceives life as an integrated whole (whole person). In addition, the approach to the individual is from the perspective of the collective and all issues related to A&D are discussed and addressed.

Intervention A specific prevention measure, activity or approach designed to change a behaviour or way of thinking.

Kava A beverage made with the dried and pulverised root of the kava shrub mixed with water (Milner 2003). It contains chemicals that act as a depressant drug, slowing down the central nervous system. It typically causes relaxation and numbness in the body.

Matua A term that has been adopted by the New Zealand Pacific mental health sector to refer to a cultural elder. It denotes a person of senior rank and status with high skill levels and/or competence in ethno-cultural protocols, rituals, language and history. This person is also familiar with New Zealand-based Pacific mental health issues.

Mixed ethnicity Individuals who are from and identify with two or more ethnicities, whether Pacific/Pacific (e.g. Samoan/Tongan) or Pacific/non-Pacific (e.g. Samoan/Palangi) or a mixture of these groups.

New Zealand born and island born

The term ‘New Zealand born’ refers to those Pacific peoples who were born and/or raised mostly in New Zealand. The term was volunteered by the participants as part of current jargon and is not intended to be used as a label. It describes a particular orientation or way of identification by some of the participants who are more aligned with local New Zealand culture. It is often used in comparison with the term ‘island-born’, which in this document means those who were born and/or raised mainly in a Pacific island. The term ‘island born’ refers to a more traditional orientation or identification of some of the participants.

NGO Non-government organisation. A non-government structure that is funded to provide specific services such as Pacific A&D and Pacific mental health services.

Outcome	The effect on an individual's health status that can be attributed to a treatment intervention. Measuring outcomes involves the process and tools used to determine outcomes objectively.
Pacific A&D clinician	Broadly defined as a person working in the A&D/mental health field. It widely incorporates Pacific peoples employed as clinicians, clinical nurses, community support workers, social workers, A&D workers and counsellors.
Pacific processes	Practices and ways of doing things that are specific to certain Pacific ethnic groups. Some Pacific processes are common to all Pacific ethnic groups – for example, a holistic approach, the involvement of families, the use of Pacific concepts and language to enhance understanding or experience, and the understanding of New Zealand-born versus island-born individuals.
Palangi	A Tongan word widely understood by other Pacific cultures that refers to the Western body of knowledge, contexts or culture. It also refers to white-skinned people from Western societies. Different Pacific ethnic groups have their own words or variations of this spelling e.g. in Samoa it is spelled 'palagi'.
Psycho-education	An educational approach that integrates psychological principles with clients' understanding to raise their awareness of and enhance their insight into their issues.
Screening tool	An instrument (normally a questionnaire) used to identify the individuals who have A&D-related problems and those who may not. The most popular is the AUDIT (Alcohol Use Disorders Identification Test). A comprehensive assessment normally follows if the individual has A&D problems.
Service	An agency that delivers services or interventions (service delivery) to clients and families.
Spirituality	The various beliefs, perspectives and experiences integral to the life of Pacific peoples that cannot be measured objectively e.g. dreams, prayers, Christian beliefs and practices, and relationships to past ancestors, or a process and experience of connection that cannot be explained readily.

Therapeutic relationship	The relationship between a client and a therapist based on the establishment of connection that has a positive outcome for the client.
Traditional healer	A chosen individual with the right and authority to cast out spirits and create herbal medicine for healing purposes. Each Pacific ethnic group has its own definitions and practices.
Treatment intervention	A specific prevention measure, practice or approach designed to help a client and/or family. Some interventions are based on Palangi frameworks and some are based on Pacific values, beliefs and practices. Participants in this document used 'treatment intervention' interchangeably with Palangi and Pacific approaches, models, practices, processes, interventions and treatments.
Worker	The role for which an individual is employed. 'Worker' is used interchangeably with counsellor, therapist, clinician, mental health worker, practitioner and community support worker.