A journey of identity: A rangatahi treatment programme for Māori adolescents who engage in sexually harmful behaviour

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This process evaluation focused on a community treatment programme designed for Māori adolescents (rangatahi) who had committed sexual offences against adults or children. We used qualitative and kaupapa Māori approaches to interview 23 participants (rangatahi aged 15 to 17, family members, staff and stakeholders) and observe group therapy and outdoor wilderness therapy excursions over 10 months. Participants found the Māori beliefs and processes, woven into westernised therapeutic theories and techniques, enhanced treatment by emphasising values essential to positive adolescent growth, including whānau support, the maintenance of relationships (including effective group work), and the importance of a secure identity (including finding positive Māori identities and role models). The personal qualities of the kaimahi (Māori staff) and their responsiveness to the issues facing Māori youth and whānau of mixed ethnicity contributed to the programme's success. Participants called for more support for cultural initiatives with sexually abusive youth to reduce community risk.

Keywords: Adolescent Sexually Harmful Behaviour, Cultural Treatment, Process Evaluation.

Introduction

It is now widely recognised that a significant proportion of sexual offences are perpetrated by adolescents (Lambie & Seymour, 2006; Margari et al., 2015). In New Zealand, adolescents who engage in sexually harmful behaviours are thought to commit around 15% of sexual abuse in the community (Ministry of Justice, 2009; NZ Police, 2018). For instance, between 1994 and 2012, young people under the age of 17 years old made up 13% of all individuals apprehended for all sexual offences (Statistics New Zealand, 2013). Due to the under-reporting of sexual abuse, it is widely acknowledged that these rates are an underestimation of perpetration. In the United States, between 30% and 50% of all child sexual abuse cases are perpetrated by young people under the age of 18 years (Vandiver, 2006).

Adolescents who engage in harmful sexual behaviours have been found to be a highly heterogeneous and diverse population on a range of factors, including the age and sex of the victim, the psychological and developmental characteristics of the adolescent and their family, and the social system (Gamache, Diguer, Laverdière, & Rousseau, 2012). Young people who sexually offend have been found to be more likely to have experienced significant childhood trauma, childhood exposure to pornography and sex, and subsequently high rates of anxiety and low self-esteem (Seto & Lalumière, 2010). In their meta-analysis, Seto and Lalumière also found that they often experienced social isolation from same-age peers, as well as disengagement from school. Research comparing sex-only adolescent offenders to adolescents who had offended in a range of ways found that sex-only offenders had lower rates of antisocial personality, psychiatric issues and substance abuse (Pullman, Leroux, Motayne, & Seto, 2014). It should also be noted that the majority of adolescents with harmful sexual behaviours do not have deviant sexual arousal patterns (Ryan &

Otonichar, 2016). Overall, these findings suggest the absence of significant psychopathology in the majority of adolescents with harmful sexual behaviours, although research trying to establish indicators and typologies is ongoing (Fox & DeLisi, 2018).

The economic burden of sexual abuse (Dopp, Borduin, Willroth, & Sorg, 2017; Lambie, Geary, Fortune, Brown, & Willingale, 2007), together with research identifying the adverse effects of sexual abuse to both victims' and offenders' quality of life, has resulted in an increase in research and treatment services for adolescent sexual offenders (Bouman, de Ruiter, & Schene, 2008; Steptoe, Lindsay, Forrest, & Power, 2006), involving group and individual interventions (Worling & Langton, 2016). Group work has been shown to facilitate group cohesion, openness and accountability among adult sexual offenders (Billing, 2009); similarly, group work with sexually abusive adolescents is considered a key treatment modality (Edwards et al., 2012; Rich, 2003). An extension of group work is the use of outdoor wilderness experiences with sexually abusive adolescents (Somervell & Lambie, 2009; Geary, 2007), found to be beneficial because they enhanced interpersonal relationships, improved adolescents' views of themselves, the intensity of the experience facilitated engagement in the therapy process and, most importantly, they aided in disclosure (Somervell & Lambie, 2009).

Whilst some research has been conducted into the effectiveness of several mainstream adolescent treatment programmes in New Zealand (e.g., Geary, 2007; Somervell & Lambie, 2009), there is yet to be a study looking at the success of programmes specifically designed for Māori youth who have engaged in sexually harmful behaviour. From the still sparse general literature on the treatment of individuals of Māori descent, it is evident that Māori-centred therapies assume that strengthening an individual's cultural identity during

therapy will lead to improvements in overall wellbeing (Durie, 2003; Huriwai, Sellman, Sullivan, & Potiki, 2000; Moeke-Pickering, 1996; Stuart & Jose, 2014). Improved treatment retention rates and greater life satisfaction have also been shown (Huriwai et al., 2000).

In research on offending, Owen's (2001) study showed a successful treatment programme for Māori youth offenders included opportunities to rediscover identity, whakapapa (genealogy/lineage, Huriwai et al., 2000), te reo Māori (Māori language), tikanga (customary values, practices and protocol) and history (oral traditions and mythology, Cherrington, 2003). With adult Māori sex offenders, promoting kaupapa Māori principles and practices during treatment helped individuals develop a meaningful identity other than that of a sex offender (Billing, 2009; Tamatea, Webb, & Boer, 2011) and increased confidence in the ability to change (Billing, 2009). In a community sex offender treatment programme, having whānau (family) members present and participating in the programme significantly increased respondents' willingness to make positive changes in their lives, for both Māori and non-Māori (Billing, 2009; Geary, 2007).

The aim of the current research was to focus on the cultural practices and processes of a programme used to treat Māori adolescents who had engaged in sexually harmful behaviour. It aimed to explore in-depth what was working well and what needed improvement from the perspectives of the adolescents, family/caregivers and programme staff.

METHOD
The Rangatahi Programme

The rangatahi programme was developed for Māori youth (*rangatahi*) and facilitated by Māori staff (*kaimahi)* from a specialised Māori team that had been formed in recognition of the specific needs of indigenous clients, within a larger mainstream provider. Treatment for medium- to high-risk Māori males, aged between 10 and 17 years, for up to two years, aimed to prevent recidivism, and included individual and group therapy sessions, system reviews with the rangatahi/whānau/support people and attendance at an annual wilderness therapy camp. Programme workbooks from the mainstream provider were used to supplement the individual therapy sessions. Adolescents were allocated to the programme if their referral indicated they were of Māori descent, and after assessments of recommended treatment intensity and supervision needs.

The kaimahi used a range of mainstream (CBT, DBT, behaviour modification, family systems, psychodynamic and narrative therapies) and Māori therapeutic approaches. Mainstream psychological approaches were used to specifically focus on the young person's behaviour and sexually abusive behaviour. Māori therapeutic approaches included a core cultural framework, *Te Whare Tangata* (The house of the people), a cultural model the kaimahi created that was simple, addressed sexually abusive behaviour and acted as a foundation for other Māori models.

Te Whare Tangata uses the carved meeting house (the *wharenui*) as a model because it has relevance to all of the rangatahi (regardless of the tribal area they come from).

The wharenui is a powerful symbol of identity and community (Durie, 2001; Moko-Mead, 2002; O'Connor & Macfarlane, 2002). It is seen as the most important building within a marae setting and is often referred to as sacred because it is an architectural representation of the physical body (often that of an important tribal ancestor); practices appropriate to the boundaries of the body can therefore be related to the building.

The aim of Te Whare Tangata is to reconnect rangatahi and their whānau with traditional Māori values such as *whakawhanaungatanga* (process of establishing relationships, relating well to others; Love, 1999), *manaakitanga* (the process of showing respect, generosity and care for others), and tikanga. Parallels are drawn between the marae, these values, sexually harmful behaviour, victims, the rangatahi, their whānau, friends, and community. Teaching Māori values to the adolescents was important because most had little or distorted understanding of Māori worldviews, that could even support their sexually harmful behaviour. (See Ape-Esera, 2016 for more detail on the model and its development by kaimahi.)

Qualitative evaluation and Kaupapa Māori research

This research was a utilisation-focused, process evaluation, defined as, "an evaluation done for and with specific, intended primary users for specific, intended uses" (Patton, 1997, p. 23). For such an evaluation, the researcher needs to establish a working relationship with intended users early on, to determine what is needed from the research. Furthermore, understanding the breadth and depth of treatment processes, not just the outcomes, is important in building effective interventions with sexually abusive adolescents (Geary, Lambie, & Seymour, 2011).

As the research was specific to individuals of Māori descent (intended users), it was important to acknowledge how Māori culture and ideas were considered in a *kaupapa Māori* research framework, which has been defined as, "research by Māori, for Māori and with Māori" (Rangahau website, 2015). The first author is of Māori and Samoan descent. A kaupapa Māori approach considers Māori worldviews and ideologies, acknowledges Māori cultural, political, and social realities, and seeks to redress power imbalances and bring concrete benefits to Māori (Walker, Eketone, & Gibbs, 2006). It acknowledges that the term Māori is broad and diverse, including multiple realities, dialects, protocols and political and organisational representations (Barnes, 2004; Walker et al., 2006).

Māori consultation took place throughout (Durie, 2011), with efforts made to ensure kaimahi participated in the development and implementation of data collection procedures, and Māori experts/colleagues were consulted during data analysis. Care was taken to ensure participants' views were correctly represented and that final outputs were balanced and not harmful to Māori. The research process took much longer than expected as considerable time was spent reflecting and formally documenting the processes and perspectives obtained.

In addition, participation in a peer Māori and Pacific Island research group, and establishing a research support network comprised of Māori academics and whānau from

the Taranaki and Auckland regions, were important, with confidential discussions covering research methodology and analysis (not identifying individual participants), Māori models, tikanga, and emotional support to stay culturally and spiritually safe in the topic area.

Qualitative methods, including interviews and group observations, are valuable when conducting process evaluations because researchers can explore programme dynamics whilst gathering rich information about the programme's functioning (Patton, 1990), and allow participants' subjective experiences and cultural understandings to be captured. Using an inductive approach (Patton, 1997), aiming not to test a theory, but to generate new ideas from the data collected (Thomas, 2006), was appropriate, given that this evaluation incorporated kaupapa Māori concepts, and focused on a population with whom research is limited.

Data Collection and Analytic Approach

Data sources were face-to-face interviews and direct programme observations (group and wilderness therapy), with reference to documents (workbooks, policy and procedural manuals, pamphlets and brochures, and the agency website) as relevant. Ethics approval was obtained from the University of Auckland Human Participants

programme. The three programme staff (*kaimahi*) identified as being of Māori descent, and two had more than five years' experience working with sexual offender populations. The four key stakeholder interviewees were external agency staff who worked directly with rangatahi participants (e.g., social workers).

Interviews explored: 1) Perceptions and understanding of the programme; 2) Programme's strengths/benefits and weaknesses/detriments; 3) Views on whether the programme met their individual and cultural needs; and 4) Recommendations for future improvements. Interviews ranged between 40 and 120 minutes, were audio-recorded, electronically encrypted for confidentiality, and transcribed by an independent transcriber who was fluent in Māori and had signed a confidentiality clause.

Direct programme observations offered insight into the programme's physical and social environment, including how Māori ideologies were incorporated into the programme, whilst making the least disturbance to the participants' regular activities. Twenty-eight two-hour weekly group sessions were observed by the first author over 7 months, with notes written up directly after sessions. One wilderness therapy camp and one outdoor excursion were also attended, where the researcher was a

Table 1. Participants

Interviewees (*n*)	Characteristics
Rangatahi - 7 Māori – 2 Māori/European – 3 Māori/Pasifika – 2 Age 15-17	Previous Māori experience: None 2, Minimal 3, Moderate 1, Extensive 1. Time in programme: 6 to 18 months (12 months - 4). Living in residence 5; with whānau 2. Sexually harmful behaviour: Sexual offending against a child/children 5; against an adult 2.
Whānau - 9 Māori – 3 NZ European – 6*	Biological parents – 4 Foster parents/whangai – 2 Residential caregivers – 3
Kaimahi – 3 Māori – 3 (with a range of te reo Māori and tikanga experience)	One was also involved in the tāne (Māori men) programme. Two had more than 5 years' experience. Male 2; Female 1.
Key stakeholders - 4	External agency staff including from statutory child agency, residential services, sex offender therapists etc.

Note.*Those not of Māori descent were still supportive of their adolescent attending a treatment programme specifically designed for Māori youth.

Ethics Committee.

Interviews with 23 participants included both programme users and providers (7 adolescent clients, 9 parents/caregivers, 3 staff and 4 key stakeholders – see Table 1). Clients and caregivers had to have been involved in the programme for at least 6 months. The seven Māori adolescent clients (*rangatahi*) were aged 15 to 17 years, of mixed ethnicity, and most reported limited exposure to Māori culture prior to entering the programme. The nine parents/caregivers *(whānau)* had participated in family group conferences/review sessions of the rangatahi and included biological, foster/whangai parents and residential caregivers; those not of Māori descent were supportive of their adolescent attending a Māori

participant-observer, joining in with the group bonding activities such as rafting, which helped the adolescents feel more comfortable with the researcher's presence during the disclosure therapy activities. All the data collected during direct observations were regularly debriefed, cross-checked and validated for consistency by the Māori programme staff.

Thematic analysis was chosen as it helps to make sense of the meaning of the data, and is compatible with inductive approaches to research (Braun, Clarke, & Terry, 2014). The analysis followed Braun and Clarke's (2006) approach, which involved systematically working through the entire dataset, identifying repeated patterns and coding by hand, then developing themes, which were refined

further by three researchers systematically re-coding and debating, until a consensus on a theme was reached, a lengthy but worthwhile process to include different perspectives (Klein & Olbrecht, 2011). Hammersley (2008) refers to such strategies, and the cross-checking with staff during data collection, as a kind of triangulation to "check the validity of descriptive inferences" from data (p. 24).

ANALYSIS

Firstly, the perspectives of kaimahi (staff) and key stakeholders on what worked well and areas for improvement in the rangatahi programme are presented, followed by the views of the rangatahi participants and whānau/caregivers. The results outlined below represent a consensus amongst research participants, worked through as part of the reflective kaupapa Māori and process evaluation discussions.

A brief overview is presented in Table 2. Themes were developed from both group observation data and interviews. Anonymised, verbatim interview quotes (with "um"s removed for readability) are marked (K) for kaimahi, (KS) for key stakeholder, (R) for rangatahi and (W) for whānau.

What worked well: Kaimahi and stakeholder perspectives

The clinical practices that worked well were the use of Māori models of treatment, including working with whānau to attend to whānau issues which may be hindering treatment progress; modulated workbooks

which provided structure for both staff and clients; and the positive Māori role-modelling of staff.

Māori models of treatment lead to better treatment outcomes

The kaimahi and key stakeholders reported that the programme was clinically effective because it was developed specifically by Māori for Māori, using Māori models of practice. "Māori staff have a greater understanding of these boys" (K). The clients' therapy and cultural needs were being met simultaneously:

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

Working with the whānau is important

Kaimahi stated that the programme was clinically effective because therapy emphasised the rangatahi within their family system, an important aspect of a Māori framework, rather than working from an individual perspective. This helped attend to whānau issues, which may have been preventing treatment progress.

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

Table 2. Summary themes of what worked well and areas for improvement.

Summary themes	Kaimahi and external stakeholders/referrers	Rangatahi and whānau
What worked well	- Māori models of treatment lead to better treatment outcomes - Working with the whānau is important - Modulated workbooks provide structure for kaimahi and rangatahi - Kaimahi role-model positive relationships	- Māori framework enhances experience - Kaimahi characteristics facilitate engagement - Positive experience of group work
Areas for improvement	- The kaimahi feel culturally undervalued - Clinical meetings need to be at home or marae - Experienced cultural supervisors and continuous cultural professional development needed - Need more people (Māori therapists, social workers, community kaiako/instructors); and more time (for induction, communication and discussion; and to develop more Māori treatment modules and resources).	- Group disclosure is challenging - More information needed for whānau throughout - Home-based meetings, resources for transport, resources for kaupapa Māori development/te reo etc

Modulated workbooks provide structure for kaimahi and rangatahi

The set programme modules (such as victim empathy or the cycle of offending) were helpful because the booklets were simple and visually appealing for the clients. In addition, staff indicated that the modules gave their therapeutic practice structure and simplified the process of monitoring a client's progress:

Having those modules set up for me, we don't follow it by the book but it's actually there so you can glimpse at it and work it to fit and actually know, yep, this boy's done this work...you got their goals and it's there, that's helped me. (K)

Kaimahi role-model positive relationships

A strength of the programme that was discussed by all of the key stakeholders was that the kaimahi demonstrated and reinforced positive male and female interactions, and modelled values such as co-operation and support:

They have a wonderful strength together. They complement each other really well and they support each other...the boys see it and can model it. (KS)

In addition to modelling positive relationships, staff referred to the programme employing older clinicians with diverse Māori backgrounds and how these characteristics facilitated the process of respect:

A person of an older generation which actually works ten times better than the Western concept that youth workers or the people working with youth should be young people ... brings in the values of respect. (K)

Areas for improvement: Kaimahi and stakeholder perspectives

While the Māori aspects were a strength, they were also a challenge, in terms of how staff cultural knowledge should be valued or how fully "kaupapa Māori" it was possible for the programme to be.

The kaimahi feel culturally undervalued

Kaimahi reported feeling overworked and undervalued in their role as Māori therapists, despite the commitment of the agency overall to work appropriately with Māori clients:

Knowing very well that a lot of the people in the other teams just cannot work with our people the way we do, so I feel that we're kind of undervalued. And I get that feeling of tokenism every now and then. (K)

They all possessed specialised cultural knowledge attained through living and working in Māori communities, rather than academia, that was not necessarily well-recognised or remunerated:

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

The limited availability of Māori clinicians trained in the field of sexual offending contributed to high workloads and, at times, wilderness programme cancellations. In addition, kaimahi workplace responsibilities extended beyond the programme, as they frequently crossed paths with clients and whānau in their respective Māori communities outside of work hours. "We have to be accountable to our people, to the community, to our clients, and to our families" (K).

A significant programme issue identified by the kaimahi was that the *kaupapa* (topic, plan, purpose, agenda) of the rangatahi programme was unclear, in terms of goals, direction and how it differed from the mainstream adolescent programme. From using "Western models" initially, they had developed the *Te Whare Tangata* model to use alongside other Māori and non-Māori aspects. There were contradictory views among staff on the quantity and quality of Māori kaupapa that should be taught to clients. Most of the rangatahi had limited or no exposure to their Māori culture prior to entering the programme, many were of mixed ethnicity, and all had to operate in both Māori and non-Māori (*Pākehā*) worlds, so some kaimahi felt a mix was inevitable:

The boys don't know what their culture is... I think I've learnt not to be too heavy on them about their culture because they don't know, so we just take it a step at a time ... I love my Māori world but the reality is they also have to live in the Pākehā world ... They don't struggle living in it, they struggle being comfortable in it. In both worlds actually. (K)

In contrast, one argued that a fully Kaupapa Māori programme would allow rangatahi to build a stronger cultural identify and a better sense of self:

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

Suggested improvements

The kaimahi stated that their treatment outcomes would improve if clinical meetings involving whānau were held at the clients' home or in a marae setting. They also felt their clinical practice and personal wellbeing would benefit from being given access to experienced cultural supervisors and continuous cultural professional development. More Māori male therapists and a Māori social worker were needed, and the kaimahi also suggested that *kaiako* (teachers/instructors) could be sourced from the community to teach traditional practices that aligned with a client's safety plan. Conducting a thorough induction process with new staff and reorganising team resources to enable greater communication and discussion were recommended. Finally, the kaimahi suggested that the programme could benefit from developing more Māori treatment modules and resources – which again would require more people and time.

What worked well: Rangatahi and whānau perspectives

Rangatahi and whānau focused on how the Māori framework enhanced treatment, how staff characteristics supported change (especially how crucial the

relationships between kaimahi and participants were), and how positive group work could be.

Māori framework enhances experience

Having a separate programme for rangatahi that incorporated Māori frameworks and philosophies was felt to be of benefit to this population. The rangatahi and their whānau reported that a Māori framework enhanced their treatment experience because it helped to decrease their resistance to the programme, including, for example, feeling less anxious about entering a "Māori" programme:

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

Another participant had been worried about "being in a group with Māori" because he had not been "brought up Māori" but had learned lots; similarly, a whānau member who had not been connected to their culture said, "The information we thought we knew about the marae was wrong. It made us feel good when we were told the correct information" (W).

The use of a Māori model and philosophies helped to strengthen participants' identity, wellness, sense of belonging and understanding around boundaries and consequences of behaviour. All of the rangatahi found the Te Whare Tangata model helpful and were able to correctly recount the symbolism behind it.

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

Furthermore, they understood how the model related to sexually harmful behaviour. For example, one rangatahi reported that the model helped him to understand the boundaries that exist when interacting with females and children as well as the consequences of violating these boundaries.

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

Emphasising the Māori concept of whānau and involving them in the treatment process was important to the rangatahi because they were able to showcase their personal achievements and at the same time get valuable feedback from whānau. System review meetings were viewed as an important place for the rangatahi to rebuild what had not always been functional relationships with their whānau.

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

Some of the whānau reported that their sons' confidence had grown exponentially over their time in the programme, with one respondent attributing this change to finally embracing his Māori identity, a "side of him that's been pushed down in the past" (W). In contrast to most participants' views, one non-Māori mother felt that the therapist exploring her son's Māori father's side was introducing an aspect of cultural "difference" that her son had not had an issue with before (the father had died). Other whānau acknowledged their reluctance to be involved but that had shifted:

I was pretty rude when I first came here ... "Oh just hurry up and get that over and done with, I wanna get out of here." I don't think like that anymore cause I know deep inside this is helping my son, and helping me. It's a journey for both of us. (W)

Other Māori practices included *karakia* (prayer/incantation; Barlow, 1991) to open and close all sessions, which rangatahi understood as part of "making everything we do in here tika and safe" (R). Karakia were performed in both English and Māori and more importantly, whānau acceptance and participation in the process was never assumed. The kaimahi were aware that many whānau were not of Māori descent; therefore, it was important to invite participation rather than expect compliance in a process that participants described as safe.

Rangatahi appreciated that staff were Māori, feeling they were less likely to judge and more likely to understand them than non-Māori staff, as this participant, who had experienced both the mainstream and rangatahi programmes, pointed out:

The mainstream group have a different approach to things. I expressed myself in that group just like I expressed myself here but they didn't understand. They couldn't relate back to my cultural needs. I felt out of my comfort zone like we are two different groups of people ... the Pākehā Europeans ... often we are the low people but when it's Māori to Māori, it's equal respect. (R)

Kaimahi characteristics facilitate engagement

The personal attributes of the kaimahi (especially humour and straightforward talk) helped to put participants at ease and were crucial to motivating engagement with treatment. Rangatahi really valued their relationships with the kaimahi, whose use of humour and relaxed style made the rangatahi feel connected and motivated.

They're kind of more laid back and you could joke with them ... The work was laid back which was good because that helped me do my work, it helped me, cause that's the way I feel comfortable learning and working so it was easy for me. (R)

The kaimahi style eased potentially volatile situations, and helped rangatahi move into the more emotionally demanding work they needed to do.

My therapist, he's a crack-up ... he's awesome, O for Awesome... I think of him as a mate. (R)

Whānau too appreciated the personal qualities and skills that the kaimahi demonstrated:

They approach on a level that they're just ordinary people too without the big therapist type thing, they are very natural and yet where the rubber hits the road and they have to say, "Look no, this is what is," they do it but they've layered it in very carefully. (W)

The kaimahi were also seen as positive Māori role models, as well as using case studies of famous Māori to help rangatahi see that being Māori did not have to be bad. "I used to think that Māori people are always bad and that's the way you have to be" (R). Diverse cultural needs were also handled well by staff, according to most whānau:

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

Having access to kaimahi of kaumātua status helped to reinforce the Māori cultural frameworks that were promoted in the programme, such as respect and perseverance. Some also commented that having Māori females involved was good in the "male-orientated" environment of the treatment centre, especially for female whānau.

Positive experience of group work

Participants spoke of positive experiences of group work. Groups built a sense of universality among the rangatahi, and the activities employed by the kaimahi, such as "blind trust" exercises, helped to challenge participants' preconceived ideas/assumptions and enhanced their sense of connection to other group members. Boys described the group wilderness camps as fun, building stronger bonds with each other, to make harder aspects like disclosures more effective:

Like on camp when we were going to do our disclosures, we had a bit of a fun time beforehand and then got into work instead of just getting straight to it. It gets me motivated to do the work. (R)

Whānau saw them as building life skills:

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

Areas for improvement: Rangatahi and whānau perspectives

Rangatahi acknowledged that disclosures were necessarily challenging but suggested the language and pace of questioning could improve. Whānau wanted more information about the programme and improved access through home-based meetings and transport resources.

The rangatahi shared that the presentation of disclosures in a group setting was challenging. Sometimes when the kaimahi were attempting to explore the adolescents' attitude and beliefs, they had difficulties understanding what was being asked of them, because they had not been shown how to explore their emotions, or the depth of the questions progressed too quickly:

I started getting mixed up with their words cause I couldn't understand them properly. I just got angry and then just shut myself down. It was just sometimes too many words and too fast and I just get frustrated and I just think they're intimidating me. (R)

One concern expressed by Māori was that those considered as "outsiders to the tikanga of the programme" could impact on the treatment process. This included unknown professionals attending group or whānau sessions (such as lawyers or social workers), or

confidentiality when going into other tribal areas. Participants reported there were times when the kaimahi failed to inform them about professionals attending group/whānau sessions. At the outdoor wilderness camps, rangatahi reported they felt embarrassed disclosing personal information in front of unknown professionals who had arrived, and therefore hesitated with their disclosure. One stated he was conscious that he was in a different iwi [tribal area] at the camp and was concerned about the confidentiality of the information being shared with the unknown professionals in attendance.

Some whānau wanted more information about what the programme would involve (e.g., an "information pack"), how boys were progressing, and who was at system review meetings and why (e.g., when lawyers, social workers or residential care staff attended). This could help both to advance the transparency of the programme and maintain participants' "buy-in".

Increased resources for both rangatahi and whānau were recommended, including meeting Māori graduates of offender programmes, more kaupapa Māori learning (e.g., learning te reo Māori), employing a Māori social worker and providing an adjunct group for whānau members. Accessibility could be improved through home-based meetings (as also recommended by programme staff) or the use of satellite offices, or at least providing more consistent funding for rangatahi transport to attend weekly group and therapy appointments. The experience of a home-based review meeting was very positive for whānau:

We all talk more here than we did at [the office]. We had questions but we wouldn't ask; being in your own house, we could. I never used to look forward to programme meetings ... I didn't know what the programme was about until they came here ... them coming here and explaining themselves ... made us open up. (W)

Similarly, taking more information to the wider community would be vital, through for example running education days at tribal hui. This would encourage whānau to be involved and understand rangatahi in treatment, but would also share the preventative concepts and Māori frameworks across a wider tribal setting.

DISCUSSION

Process evaluations of Māori sex offender treatment programmes are sparse and limited to adult populations (Billing, 2009; Tamatea et al., 2011), or youth in mainstream programmes (Geary, 2007). The key findings therefore advance limited knowledge in this area and are discussed in relation to existing literature.

Culturally appropriate approaches with sexually abusive Māori youth are helpful for engagement.

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

The benefits of culturally focused treatment programmes when working with indigenous populations have been acknowledged (Durie, 2003; Huriwai et al., 2000; Stuart & Jose, 2014; Thakker, 2014). Yet, it is difficult to understand the specific clinical factors through which a culturally focused approach affects an individual's wellbeing (Houkamau & Sibley, 2010; Thakker, 2013). The rangatahi programme data offer some insight into the cultural processes and practices that were clinically helpful; namely, use of the Te Whare Tangata model; use of karakia; stories depicting successful Māori who had overcome adversity; the importance of whānau involvement; and tikanga practices that were tailored to the rangatahi.

The use of Māori models and practices in the rangatahi programme was apparent throughout data collection. Most of the rangatahi were able to accurately recount the Te Whare Tangata model's cultural symbolism and how it encapsulated sexually harmful behaviour, and whānau could relate to it. Māori academics argue that the use of the marae (which includes the whare) in this context is suitable and symbolic because it is a vital part of Māori culture (Durie, 2001; Moko-Mead, 2002). For disenfranchised or marginalised Māori, the marae setting can act to reinforce Māori identity and restore sense of purpose (O'Connor & Macfarlane, 2002).

The effectiveness of karakia in a clinical setting has never been proven by scientific research, but anecdotal evidence suggests that these methods have been helpful in increasing engagement and retention through greater cultural suitability and relevance among addiction service users (Huriwai et al., 2000), adolescent and adult Māori sex offenders receiving treatment in the community (Billing, 2009; Geary, 2007), and incarcerated Māori sex offenders (Tamatea et al., 2011). Programme participants found the use of karakia to open and close sessions helped make them "safe".

The use of stories depicting successful Māori who had overcome adversity was also used on several occasions to challenge clients' negative perceptions of Māori. The positive role models of the kaimahi themselves were also powerful. The rangatahi were encouraged to contemplate the idea that ethnicity does not dictate, conduct or predetermine future aspirations. Many of the respondents reported that these concepts were initially unfamiliar and difficult to comprehend; however, once accepted, their motivation to become a "good Māori" and finish treatment increased significantly. Cherrington (2003) suggested that using Māori mythology in a clinical setting is helpful because it is meaningful, promotes Māori identity through the acknowledgement of Māori ancestors, allows clinicians to creatively explain an individual's personality traits and integrate concepts such as grief, change, and loss. Māori mythology is particularly helpful when working with young people and their whānau because it gives clients exposure to Māori families who were not perfect but who pushed through adversity to succeed (Cherrington, 2003).

Family involvement in the treatment of sexually abusive youth has been widely discussed (Anaforian, 2009; Billing, 2009; Geary 2007; McNeill & Gallardo, 2009; Tamatea et al., 2011; Williams & Cram, 2012), including improved treatment completion if family is active in the treatment process (Worley, Church, & Clemmons, 2012; Worling & Curwen, 2000; Yoder, Hansen, Lobanov-Rostovsky, & Ruch, 2015). From a Māori cultural perspective, researchers such as Durie (2003) and Love (1999) would argue that whānau/family involvement should always be considered in the therapeutic context because the mana of an individual and their whānau are intertwined to the extent that they are inseparable.

The concept of whanaungatanga, which emphasises the sense of belonging as a result of relationships and kinship ties (Moko-Mead, 2002; Williams & Cram, 2012), was a consistent theme, which emerged throughout data collection. Specifically, the adolescents' relationship with family and their wider community were carefully woven through every facet of their work and in-treatment social interactions were dictated by the whanaungatanga process. Most participants reported an improvement in family relationships as a result of the programme and that having family involved and supporting the treatment process gave them the opportunity to showcase positive progress and rebuild family trust. The whānau respondents reported that their involvement facilitated processes such as forgiveness, acceptance and togetherness. These findings give credence to the theory that family are a fundamental resource that support change for Māori adolescents (Huriwai et al., 2000; Stuart & Jose, 2014).

Kaimahi identified the need to tailor cultural practices to the cultural understanding and tribal affiliation of the rangatahi and the whānau, rather than just to the tikanga of their organisation. Huriwai et al. (2000) reported that matching tikanga is an issue faced by many Māori mental health clinicians left contemplating which tikanga to expose clients to – that of the therapist, the client or the iwi in which the organisation sits.

Although the benefits of using a cultural approach were undoubted, working in a Māori programme also had challenges for staff. Expectations from whānau and their respective communities about their work, including to continue as therapists despite feeling undervalued and overworked, were high; similar to expectations noted among Māori counsellors working in mainstream mental health organisations (Love, 1999). Love (1999) added that Māori counsellors can also experience conflict as a result of differing interpretations of counsellor-client boundaries and professionalism when compared with non-Māori clinicians. Because of the type of work, therapists in this area may experience high levels of stress and burn out (Sandhu, Rose, Rosthill-Brookes & Thrift, 2012), vicarious trauma, and potentially be a risk to clients (Billing, 2009). Therefore, it is important that kaimahi have consistent access to resources that will extend and reinforce their knowledge base, as well as increased access to clinical and cultural support, as recommended also in community sex offender research by Lim, Lambie, and Cooper (2012) and Geary (2007).

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

A strong client-therapist relationship during treatment was also imperative, with many rangatahi perceiving the

kaimahi as role models for positive relationships. Similar client-therapist relationship needs were also reported among mainstream sexually abusive youth receiving treatment in the community (Geary, 2007) and a recent systematic review highlighted that good relationships between adolescents and treatment staff was a crucial element of treatment (Campbell, Booth, Hackett & Sutton, 2018).

A key characteristic of staff was their cultural responsiveness, as noted, being aware of the acculturation issues of rangatahi and whānau, including the challenges of mixed race. This accords with Tamatea, Webb, and Boers (2011), who acknowledged that sex offender treatment programmes should be adapted to accommodate the cultural needs of those who participate and failure to recognise an indigenous person's cultural affiliation and values may result in the offender feeling alienated and neglected (Huriwai et al., 2000).

Cultural matching of client to therapist was important. Rangatahi reported that seeing a Māori therapist reduced their anxiety because they believed that they would be less judgmental of their personal circumstances and also understood the "Māori way of being". This was also evident in Turner and Manthei's (1986) study where Māori adolescents preferred Māori therapists because they were impartial and more understanding of their circumstances. Better treatment outcomes for users have been reported (Tamatea et al., 2011; Brown, St Arnault, George, & Sintzel, 2009) as clients stay longer and improve faster because of similarities in cultural beliefs and attitudes (Ape-Esera, Nosa, & Goodyear-Smith, 2009; Zane et al., 2005). In previous sex offender research, Māori adolescent participants and their caregivers found the inclusion of Māori therapists "essential" to the client-therapist relationship and in turn the therapeutic success (Geary, et al., 2011). However, while ethnically matching Māori clinicians with Māori clients is ideal (Tamatea et al., 2011), it is often difficult to achieve because of the limited availability of clinically trained Māori clinicians (Geary, 2007). Furthermore, international research states that similarities in therapist/client understanding of problem behaviour, willingness and interest to explore healthier coping strategies, and having shared treatment goals and expectations may be more important than ethnic matching (Zane et al., 2005; Imel, Baldwin, Atkins, Owen, Baardseth & Wampold, 2011).

Rangatahi and whānau appreciated the relaxed therapeutic style of the kaimahi and use of humour. While some sex offender researchers advocate caution using humour in a clinical setting, most have proposed that the careful integration of humour can lead to increased client-therapist rapport and create opportunities for therapists to explore clients' deviant sexual desires (Eisenman, 2000). In addition, humour can be a helpful means for staff to cope with the challenges of working alongside sexually aggressive populations (Sandhu et al., 2012).

Rangatahi and whānau reported that kaimahi characteristics facilitated engagement. In making sense of this in observations and analysis, an unexpected finding was how the rangatahi drew strong parallels between the staff members and relatives, including respected kaumātua, aunts or uncles, who had positively influenced them. Because of this association in their private lives, they were mindful of their behaviour around the kaimahi of kaumātua status and were more relaxed around the other staff because they reminded them of aunties/uncles who were fun and put them at ease. Moko-Mead (2002) and Love (1999) would attribute these views to the whanaungatanga principle; in particular, the idea that non-kin people can become like family through shared experiences. Western models of counselling may see these associations as inappropriate and potentially the result of a breach in counsellor-client boundaries, while in the setting of the current study, it was found to be culturally appropriate (Moko-Mead, 2002; Love, 1999).

Group processes are effective.

Peer relationships within the treatment programme were emphasised and continually reinforced through weekly group sessions, presentations, role-plays, and outdoor wilderness experiences. The wilderness experiences were particularly popular, not surprisingly, given the importance of peer friendships among this age group, and evidence that shared group experiences facilitate disclosure and change in relation to sexually deviant behaviours (Billing, 2009; Rich, 2003). Groups provide a supportive environment where sexual offenders learn basic relationship, communication, and social skills (Rich, 2003; Somervell & Lambie, 2009), whilst safely focusing on issues most relevant to sexual offending.

Strengths and Limitations

Strengths of this research were that it emphasised the perspectives of service-users, which are often overlooked in adolescent sex offender treatment studies, and that most of the interviewees were Māori. All the participants who agreed to participate in the research from the start completed the entire research process, but a limitation of the research was that rangatahi who graduated or dropped out of the programme were not able to be included, despite efforts to interview them. Whānau refused participation for some because they had "since moved on with their lives"; for others, contact details were out of date. Also, despite attempts to engage the management, they chose not to respond; team leader/management perspectives may have added more to the research.

Concluding comments

This process evaluation of a rangatahi programme showed that, by carefully weaving tikanga Māori beliefs and processes with westernised therapeutic theories and techniques, the kaimahi were able to create a unique treatment environment that emphasised values essential to positive adolescent growth including whānau support, the maintenance of relationships, and the importance of a secure identity. Furthermore, the personal qualities of the kaimahi and their responsiveness to the issues facing Māori youth of mixed ethnicity significantly contributed to the programme's success.

The findings of this study are important because they help to give credibility to the use of cultural initiatives with sexually abusive Māori youth. This current study clearly illustrates that sex offender treatment programmes need to accommodate the cultural needs of those who participate and failure to do so may result in disparate outcomes for its users and increase the risk to the community.

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