A Qualitative Descriptive Study of Tū Tahanga, a Kaupapa Māori Adapted Violence Prevention Programme, in a Forensic Mental Health Inpatient Unit

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signature: Francis Zabdiel San Pedro Florencio

4th October 2019

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Ehara taku toa i te toa takitahi, engari he toa takitini

My success is not my own, but from many others

Whakataukī – Māori Proverb

The completion of this research project is not due to my own strength alone, but from the many people who have supported, guided and encouraged me to persevere.

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Abstract

Introduction: Forensic mental health services are tasked with rehabilitating service users with mental illness and offending behaviour. Service users are provided with a range of interventions that target mental illness and address the risks associated with recidivism and may include violence prevention programmes. Such programmes are Eurocentric in their orientation, yet the majority of forensic mental health service users in New Zealand are Māori, the indigenous people of New Zealand (Ministry of Health, 2007). Therefore, an evidence-based violence programme was adapted in an attempt to be culturally responsive to Māori service users. The Tū Tahanga programme is a kaupapa Māori (Māori orientated) violence prevention programme delivered in an inpatient forensic mental health unit in the Auckland Regional Forensic Psychiatric Services.

Aim: The aim of this study is to qualitatively describe this programme and explore the experiences of participants in the programme. The research purpose is to uncover this kaupapa Māori adapted violence prevention programme and the impacts it may have on Māori service users.

Method: This research employed a qualitative descriptive methodology. This research methodology is grounded in the realist/essentialist ontology which asserts that the reality of a phenomenon is discoverable through the narratives and the language of the people within it. The data collection was done through one-to-one interviews from a total of 11 participants. The participants were group facilitators, staff and service users who have been involved in the programme.

Results: The results are presented thematically. Six themes are identified altogether. These are 'The ManAlive Process', 'The Kaupapa Māori of Tū Tahanga', 'The personal impacts of violence', 'mirroring', 'whanaungatanga' and 'suggested improvements'.

Implications: The findings of Tū Tahanga show that Western violence prevention programmes can be culturally adapted to increase their responsiveness to Māori service users. This study provides a valuable understanding of a violence

prevention programme in forensic mental health for Māori service users within the New Zealand context. The findings of this research can inform mental health clinicians on the way violence prevention programmes can be delivered to indigenous mental health forensic service users and overall, potentially improve violence rehabilitation outcomes.

Chapter I: Introduction

The World Health Organization reported that 470,000 deaths occur globally due to violence-related behaviours (World Health Organization, 2018). Violence has been identified by the World Health Organization as a serious international issue impacting the health and wellbeing of individuals, families, and communities. The organization has urged the health sector "to take a much more proactive role in violence prevention" (Wong & Gordon, 2013, p.461). There are many variations in the definition of violence, but in essence, violence is defined as acts intended to cause physical injury to another person that also results in additional psychological harm and stress (Howells et al., 2013). Depending on the severity of violence, it could also lead to maldevelopment, deprivation, and worse, death. In addition, violence has been linked with substance abuse, chronic illnesses such as diabetes, heart conditions as well as mental illness and trauma (World Health Organization, 2018). Violent offending on the other hand is a category of violence that breaches legislative codes (Howells et al., 2013). In New Zealand, violent offending can range from minor assaults to serious cases of manslaughter and murder (Newbold, 2011).

Violent offending and the impact of violence continues to be a major crisis throughout the world. Reports of violence are prevalent, and one only has to access any form of media to see and hear news of violence in their own country and around the world (World Health Organization [WHO], 2018). Violence can be inflicted through physically, sexually, psychologically or neglect. Furthermore, violence can be self-directed through self-abuse and suicide. Violence can also be inflected interpersonally either through family or partner or directed to any members of the public and community (WHO, 2018). New Zealand (NZ) is no exception. New Zealand statistics show an alarming rate of violence in the country, with the NZ Police reporting that between June 2018 to June 2019 reports of violent offending against people accounted for 23% of all crimes and assault cases totalled 50, 373 (NZ Police, 2019).

Internationally, a link between some forms of mental illness and the risk of violence is widely recognised (Blackburn, 2004). However, this link is not necessarily causative but rather some factors enable mental illness and offending. These factors are abuse of alcohol and/or drugs and the symptomology of untreated mental illness.

Psychiatric symptoms related to persecutory and paranoid delusions and disorganized thinking can increase risk of violent offending through heightened arousal states (Mental Health Commission, 2002; McKenna et al., 2017; Mullen, 1997). Furthermore, antisocial behaviours, problem gambling, broken and unhealthy relationships, lack of engagement in meaningful occupation, and cognitive deficits are other factors that mediate mental illness and offending (Barnao & Ward, 2015). However, a history of violence and threatening to act violently remain the strongest risk for violence. Forensic mental health service users are a heterogeneous group and the nature of the relationship between offending behaviour and the mental illness can vary. Furthermore, mental illness is a broad label and not all mental illness has been associated with violence. For example, anxiety disorders and depressive symptoms with no psychotic symptoms have not been associated with violence (Ahonen, Loeber & Brent, 2019).

There are different associations between mental illness and violent offending. However, in some circumstances, no relationship exists. It is well documented in the literature that the vast majority of people with mental illness are not any more likely to commit violence compared with the general population (Ahonen et al., 2019; Mental Health Commission, 2002; McKenna et al., 2017). Firstly, as discussed earlier, it is possible that untreated symptoms of mental illness, particularly persecutory, paranoid delusion and disorganized thinking, can contribute to offending. However, it is important to consider that in such circumstances, other factors are generally present that mediate the violence, particularly if the person is also abusing alcohol and drugs and has underlying antisocial personality traits (Ahonen et al. 2019; Hodgins, 2008; Mullen 1997). Secondly, mental disorder and offending behaviour can be both linked in their origin and expression. For example, people with behavioural disorders such as antisocial personality disorders, conduct disorders and oppositional defiant disorders have an increase risk of violence towards others that is part of their clinical presentation (Ahonen et al., 2019; Hodgins, 2008). Lastly, offending and its consequences can become a major contributor to the development of mental disorders. The qualitative study of DeHart, Shapiro and Clone (2018) presented narratives of prisoners and the impacts of incarceration. The study described that isolation from families led to tremendous feelings of stress and loneliness and escalated any pre-existing substance abuse and mental disorders. The prisoners also described how their incarceration mediated the development of mental disorders in their children, such as the

development of depression, anxiety and antisocial traits such as delinquency (DeHart el al., 2018). Mental illness alone is not a causative factor of violence but rather there is the presence of other factors that can mediate both mental illness and violent offending.

It is established in the literature that there is over-representation of people with mental illness in the criminal justice system (McKenna & Martin, 2013). This is the case in New Zealand, where a number of offenders convicted of violence also present with mental illness. The Department of Corrections (2016) found in their study of prisoners in New Zealand that 62% of prisoners have mental disorders or substance use disorders, with 20% having both substance use and mental disorders. Almost 24% of prisoners were seen to experience from mood disorders and 23% from anxiety disorders and post-traumatic stress disorder (Department of Corrections, 2016). In the more serious end of the violence spectrum, a study in New Zealand found 5% of those that committed homicides in 2000 were by people that were mentally unwell (Simpson et al., 2006). This is the very population cared for by the forensic mental health services who support people found not guilty for reasons of insanity or unfit to plea for violent offences. The diversion away from the criminal justice system into the forensic mental health system is the starting point of a mentally ill offender's journey towards recovery.

Forensic mental health service users come with complex behavioural and psycho-social challenges. These are issues that must be addressed through rehabilitation. Forensic mental health services provide interventions from across different health disciplines to provide for the rehabilitative needs of service users (McKenna & Martin, 2013). The rehabilitative needs of forensic mental health service users are addressed through medical, psychosocial and occupational interventions. For example, psychiatric medications are used to minimize and eliminate symptoms of mental illness (Barnao & Ward, 2015). Occupational interventions aim to support forensic service users find value and introduce meaning into their routines and activities. Another approach is the use of psychotherapies or psychological intervention groups (Barnao & Ward, 2015).

Another need is related to a lack of cultural identity, which requires cultural interventions. Cultural interventions seek to strengthen the sense of cultural identity and belonging of forensic mental health service users (Easden & Sakdalan, 2015). It is

established in the literature that the lack of acknowledgment of the cultural needs of indigenous populations in health services leads to indigenous people under-utilising services and associated poorer health outcomes (He Ara Oranga, 2018; McKenna & Martin, 2013; McKenna et al., 2015).

Addressing violent and offending behaviours are crucial part of forensic mental health rehabilitation. The Ministry of Health (2007) census of forensic mental health services stated that the threat of violence or enacting violence is the most common offense perpetrated, accounting for 59% of total offences committed. Nine percent of index offences relate to sexual offending and the other 32% are offences related to other offences against a person, arson, property offences and drug offences (Ministry of Health, 2009). Addressing violent behaviours enables forensic mental health service users to progress in forensic mental health rehabilitation from secure units to eventually living in the community. A service user's ability to consistently demonstrate understanding and awareness of their violent behaviour, refraining from violence, and engaging in prosocial ways of being with others are indicators of recovery success (Barnao & Ward, 2015; Blackburn, 2004).

Another aspect that must be considered is the ethnic composition of forensic mental health service users. There is a disproportionately high number of Māori forensic mental health service users, who accounted for 48% of the population of forensic mental health service users at the time of the 2005 NZ forensic mental health census (Ministry of Health, 2007). In 2014, the number of Māori forensic mental health service users remained relatively unchanged at 43% of the total population in NZ (Te Pou o Te Whaakaro Nui, 2015). This number also reflects the high proportion of Māori in both the general mental health system and the criminal justice system. In 2015, Māori service user's accounted for 26% of all mental health service users, while only comprising 16% of New Zealand's population (Ministry of Health, 2016). Similar patterns exist for rates of imprisonment, with Statistics New Zealand (2012) reporting that Māori prisoners accounted for 51% of the total prison population in 2012. Due to the high number of Māori interfacing with the criminal justice system, forensic mental health services are faced with the challenge of providing care that is responsive to the needs of this population group. Such an approach in care is aligned with the Ministry of Health priority

to reduce disparities amongst the Māori population and commitment under the Treaty of Waitangi (Ministry of Health, 2017a).

The need to provide services responsive to the cultural needs of Māori is established in the literature (Wratten-Stone, 2016). It is recognized that Māori have a different worldview when it comes to understanding and addressing health issues. In contrast to the predominant paradigm of Western medicine that focuses on diagnosis and symptom treatment, the Te Ao Māori (Māori world view) of health is holistic and encompasses other dimensions of health that transcends beyond the physical. Given that mainstream services operate within the western biomedical model, this leads to Māori under-utilising and disengaging from mainstream health services. Wratten-Stone (2016) completed a literature review which presented the need for spiritual, ancestral/genealogy and familial relationships of Māori that need to be recognized in the assessment, planning, and treatment of mental illness. When these are considered, the engagement and health outcomes of people improve. Wratten-Stone (2016) has used case studies of services and psychological treatments which demonstrate kaupapa Māori (Māori principles) (models of health such as Te Whare Tapa Whā and Te Wheke that recognise the wider holistic health of Māori, such as wairuatanga [spirituality] and whanaungatanga [working together]), have assisted in engaging Māori service users.

Simpson et al. (2006) looked into the outcome of service users rehabilitated through a New Zealand forensic mental health service and found that the majority of service users, (approximately 60%) integrated and successfully lived in the community after cessation from forensic mental health services with no reoffending of any kind (Simpson et al., 2006). This study concluded that rehabilitation work in inpatient care and assertive community forensic mental health care follow-up can translate into successful recovery for forensic mental health service users. Given the substantial work being done with forensic mental health service users to reduce risk of violent offending, it is timely to consider formal research to illuminate the violence prevention programmes being carried out in forensic mental health services.

The setting for this study is based at the Mason Clinic, (the Auckland Regional Forensic Psychiatry Services [ARFPS]). It serves the Auckland region, the country's most populous region. It provides rehabilitation to service users with severe mental health

disorders and serious criminal offending. One of the violence prevention programmes utilised in the forensic service is the Tū Tahanga programme. Tū Tahanga is a violence prevention programme based on the ManAlive programme (developed in the United States) and is delivered in a low-secure kaupapa Māori mental health inpatient unit. Similar to the given definitions of violence, the ManAlive programme defines violence as acts that can cause physical and psychological trauma to a person through emotional, verbal, sexual and physical means (ManAlive Sacramento, 2018). Although modelled from ManAlive, the Tū Tahanga differs from ManAlive in that Tū Tahanga has incorporated Māori kaupapa into the delivery of the programme. Currently, not much is known about this programme, and it is this interest that lead to this research endeavour.

Chapter 2: Literature Review

The literature review section outlines the search strategy utilised to formulate the literature review of what is known currently in violence prevention programmes. The subsequent sections explore violence prevention programmes utilised internationally in prisons and forensic mental health contexts. The later section focuses on violence prevention programmes used in New Zealand, with a section on programmes utilised for Māori. The last section focusses on the ManAlive violence prevention programme, from which the Tū Tahanga programme was designed.

Literature Search Strategy

The following section describes the search strategy applied in finding the current literature on the use of violence prevention programmes in forensic mental health services. In the literature search strategy, the words "violence reduction/prevention/intervention programme" AND "forensic mental health/psychiatry" were applied to the EBSCO database.

The result was only three articles were found and those were irrelevant to the topic of interest. The words "violence intervention programme" was then used and yielded approximately 159 results. To narrow down the search further, the word "forensic" was added in the search strategy and it yielded 95 results. Even then, there were irrelevant results such as school violence, family violence, and sexual violence, that are outside of the scope of this research. Nonetheless, there are a handful of articles that came up that were pertinent to the review topic.

However, these articles remained limited. Hence, to widen the scope of the literature review, articles describing violence intervention programmes run in prison systems were also included. The Scopus database was also used which yielded 400 results when the words "violence intervention" were used. The words "mental health" were used to narrow down the results further and it yielded 66 results. Similar inclusion criteria were used as described above to narrow down further the 66 results.

The relevant literature identified were then used to search for other relevant literature. Most of the literature selected for the literature review is within the last 10 years. Those that are outside the 10 years were included if they were identified as being relevant to the research, had relevance to the specific New Zealand context or were seminal literature.

The use of article references also expanded the topic and uncovered some key authors. These authors were applied to the search, to see who had been citing them (in Scopus and Google Scholar) to find other relevant literature. The New Zealand Research database was also searched to look for papers submitted within New Zealand universities that investigated violence prevention programmes. To date, violence reduction studies in New Zealand have focused heavily on family violence and these articles were not considered. In total, there are 79 sources used for this research.

The results of the of search strategy are presented diagrammatically using a simplified Prisma Diagram as shown below

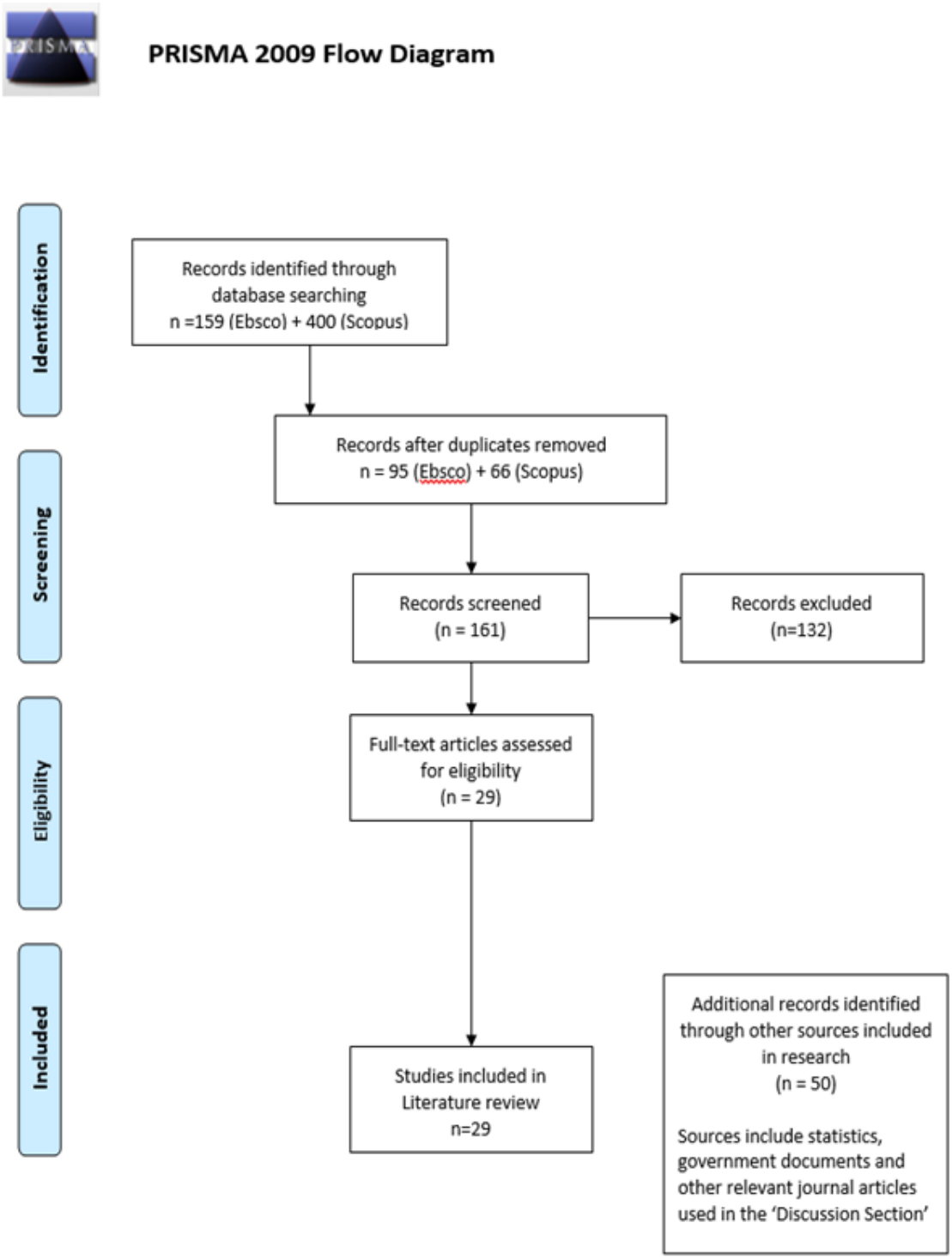

Diagram 1 derived from Ottawa Hospital Research Institute and University of Oxford (2015)

Violence Prevention Programmes in Prisons

In reviewing the articles retrieved, there were a number of articles which researched violence prevention programmes used in prisons. It is essential to look into the violence reduction programmes being delivered in prisons before delving into the forensic mental health context. The rationale for this decision is that the programmes being delivered in the forensic mental health services have originally been developed in prisons (Braham et al., 2008). Over time, such programmes were adapted to suit the specific needs of offenders with mental illness (Barnao & Ward, 2015; Nagi, Davies & Shine, 2014).

Barnao and Ward (2015) provide a suitable overview of the history of the development of violence prevention programmes in prisons. The risk-need-responsivity model of offender rehabilitation, or RNR model, (Andrews, Bonta & Hoge, 1990 as cited in Barnao & Ward, 2015) is considered to be the original violence prevention model of rehabilitation. The RNR model has been developed for criminal offenders to reduce their offending behaviour and provides a model which guides therapy for this population group. In brief, the RNR model asserts that to deliver successful therapy to violent offenders, the 'risk, 'need' and 'responsivity' need to be considered. The 'risk' pertains to the offenders' level of dangerousness and likelihood of reoffending. The intensity of treatment should match the level of risk and its associated criminogenic factors, this is the 'need principle'. The criminogenic factors are dynamic factors that can be changed and treated to decrease likelihood of reoffending. Examples of criminogenic factors are substance use, social relationships, lack of meaningful occupation, emotional and mental state. Finally, the delivery of therapy must accommodate the offender's level of readiness, intellectual capability, and cultural background to ensure maximum engagement, this is the 'responsivity principle' (Barnao & Ward 2015). Over time, the RNR model has been utilised as an umbrella model in which offender rehabilitation internationally has been based. The RNR model has been evaluated and modified to be applied to different prison contexts, and research has been undertaken regarding 'what works' in general offending and in targeted aspects of offending. The stream of research coming through gave rise to the "what works" literature that outlines best practice of the RNR model depending on the context to which it is applied (Barnao & Ward 2015).

As knowledge progressed and research regarding violence reduction advanced, violence reduction programmes became more specific and targeted. There is the acknowledgment that offenders may have different reasoning and perpetuating factors that enable violence to occur. It is these heterogeneous factors of offenders that have been the focus of current violent prevention treatments (Olver, Wong, & Lewis 2013; Tew & Atkinson, 2013; Wong et al., 2012; Wong & Gordon 2013). Polaschek (2013) identified different levels of forensic violence reduction programmes based on the offender's level of risk and offending. Firstly, low-level intervention programmes suit prisoners with few behavioural concerns and show an attitude conducive to engaging in programmes. Mid-level intervention programmes are for service users with wider problem areas, such as interpersonal skills, affective dysregulation, and cognitive deficits, but still showing interpersonal strengths and the motivation to change. Finally, high-level programmes deal with complex prisoners with multiple problem areas such as cognitive deficits and affective dysregulation, resistance to change and treatment, and limited insight. Polaschek (2013) argues that therapists and programme facilitators are vital to the success of programmes. They must be skilled, equipped and are able to dynamically respond to offender issues as they arise.

One such prison-related programme is the Aggressive Behaviour Control (ABC) Programme (Wong & Gordon, 2013). The ABC programme was developed originally in Canada in the mid-1990s. Wong et al. (2012) described the ABC Programme as having a theoretical basis on cognitive behaviour theory, social learning theory, and the 'risk need responsivity' model. The aim of the programme was to reduce risk of violence and recidivism. The programme was described as evolving, because as it was being implemented, new practices and approaches were developed. Critical to the ABC programme was linking service user's violent behaviour with criminogenic factors such as attitudes towards crime, the person's belief system, aggression, and cognitive limitations. As the programme progressed, service users' other domains were addressed such as educational needs, work and life skills, and fostering healthy relationships (Wong et al., 2012). It was noted that open communication between the staff and service users was vital to improve service user and staff relationships. Evaluation of the ABC programme showed positive results. The evaluation found that although the 'treated' offenders and 'non-treated' offenders had a similar level of risk for

reoffending, the treated group showed less severe offending than the non-treated group. Using sentence length as measure of offence severity, the treated group's sentence length averaged at 27.7 months whereas the control group's sentence averaged at 56.4 months (Wong et al., 2012).

Another violence prevention programme for prison populations is the 'Chromis programme' (Tew & Atkinson, 2013). The Chromis programme was developed in response to psychopathic offenders with a high risk of serious offending. Case studies of participants from the Chromis programme have shown the effectiveness of the group in lowering anger. There was also reduction in physical and verbal incidences of violence and aggression (Tew & Atkinson, 2013)

The Chromis programme draws inspiration from cognitive-behaviour approaches but also includes five principles of acknowledging the complex needs of offenders and these are: control and choice, future focused, novelty, stimulation, and credibility. The programme acknowledges the complex needs of prisoners. Thus, the programme aims to incorporate what is personally relevant for prisoners, include these aspects into the therapy to maximize prisoners' responsivity to the programme. Control and choice are about acknowledging that change can only happen if an individual sees the need for change. Future-focused aims to understand the past of the participant in light of what they would like to achieve in the future and finding alternative ways to achieve those through pro-social actions. Novelty and stimulation are about acknowledging that participants are prone to disengagement and therefore keeping a fresh approach by using novel and stimulating materials to maintain interest is vital. Collaboration and transparency aim to avoid game playing, mistrust, and manipulation of participants by continually engaging them in the dialogue for the betterment of programme content and delivery. Finally, status and credibility pertain to acknowledging that participants are the experts of their life. Critical to the programme is the programme facilitator. Programme facilitators present themselves not as experts but as those who facilitate learning and role modelling of pro-social engagements.

A qualitative study was also undertaken by Tew, Bennett and Dixon (2016) about the Chromis Programme. This study provided an insight into the experience of prisoners utilising the violence prevention programme. The study was retrospective

and three of the service users were residing in a high security prison and one in the community. Four themes emerged and these are: 'It's me and what I want matters' which is about the participants feeling in control of their own treatment and rehabilitation; 'reaping the rewards' highlighting the positive changes in their behaviour and way of relating with others after the programme; the third theme is 'its treatment itself that makes things hard' as participants highlight issues with the programme such as length of time, content repetition, and the paperwork that needs to be completed alongside the programme. The fourth theme is the 'make or break external influences' which highlights the staff, other participants and the environment of the group that impact the engagement of participants both positively and negatively.

A key point in this fourth theme is that it is important for participants to see their group facilitators role model what is taught in class. Another key consideration in this fourth theme is the value of individual sessions, particularly when other participants in the group are perceived as barriers to engagement. This study has highlighted that offenders value taking ownership in their rehabilitation. Facilitators are integral to the rehabilitation success through role modelling and maintaining the integrity of the programme. There are internal processes of the group and external influences that impact the responsivity of offenders, and individual sessions are vital aspects of the programme that can help ameliorate these issues as well as assess and acknowledge the level of risk (Tew et al., 2016).

Ware, Cieplucha and Matsuo (2011) highlighted the need to provide intervention to serious violent offenders and presented the Violent Offenders Therapeutic Programme or VOTP. It must be noted though that this programme caters for violent offenders who are repeat offenders in the criminal justice system. The VOTP explores the offender's life patterns, understanding of offending, non-criminal thinking, victim empathy, the offence cycle, and relapse prevention. The programme runs for 12 to 14 months, two hours per session and delivered three times a week. The maximum number of participants is 10. Ware et al. (2011) reported that preliminary evaluation of this programme yielded positive results, reporting a reduction in anger and criminal thinking and an increase in empathy (Ware et al., 2011).

In conclusion, from these violence intervention programmes utilised in the prison context, it is clear that there are similar underpinnings of these programmes. Parallel to the RNR model, violence prevention programmes need to assess and acknowledge the level of risk of their target group, to provide therapies specific to the criminogenic needs of the offenders, and therapies to match the level of their responsivity. Belief systems, interpersonal relationships, and cognitive-behaviour links are common components for these violence prevention programmes. Therapists and facilitators are integral in engaging offenders in therapy, as they are responsible for developing the therapeutic alliance and the role modelling of pro-social behaviours.

Violence Prevention Programme internationally used in forensic mental health

The violence prevention programmes used in forensic mental health are adaptations of programmes used in the prison system (Blackburn, 2004). Offenders with and without mental illness will generally commit offences for similar reasons and there is evidence to suggest that programs designed for non-mental ill offenders have been found to be effective for mentally ill offenders as well (Barnao & Ward, 2015; Blackburn, 2004). The key difference for service users in forensic mental health services is that mental illness has contributed to the violent act being committed. Some violence with this population is mental health related and some violence is part of the way a person behaves (Blackburn, 2004). If violence relates to the person's behaviour, it is considered criminogenic. Hence, violence prevention programmes are used to address violence as a criminogenic need that has to be understood and changed (Blackburn, 2004).

The diversion of mentally ill offenders from the judicial prison system to the forensic mental health services has meant that forensic mental health hospitals are tasked with providing care that is inclusive of the mentally ill offender's psychiatric and criminogenic needs (Barnao & Ward, 2015; Blackburn, 2004). Service users with enduring mental illness and criminogenic behaviours are generally viewed with pessimism. Engaging forensic mental health service users in such programmes is a complex and challenging task. Reasons such as anti-social personalities, minimization of violence, suspicion, and lack of interest are common barriers amongst this population group in engaging with therapy. Furthermore, some forensic mental health service users

have entrenched belief systems that have developed over the years. Shifting these to novel, prosocial beliefs is lengthy and fraught (Braham et al.,2008). Furthermore, forensic mental health service users also come with traumatic experiences that add complexitity to their clinical presentation, treatment and rehabilitation (Yakeley, 2018) .

However, the study by Wong and Olver (2015) has identified that such pessimism should not be the case. Although truly challenging for clinicians, Wong and Olver (2015) highlighted that programmes aimed at anti-sociality and dysfunctional lifestyle can be an effective approach in reducing violence for the forensic mental health population. The current best practice approach in violence intervention programmes with forensic mental health service users are derived from cognitive behavioural and the RNR model. There is evidence to suggest these programmes aid in reducing violent behaviour (Braham et al., 2008; Daffern et al. 2018; Nagi, Davies and Shine, 2014; Wong, Gordon & Gu, 2007).

The Violence Reduction Programme, or VRP, is currently the most widely used and recognized intervention for violence in criminal rehabilitation and is currently also used with forensic mental health service users (Wong et al., 2007; Wong & Gordon, 2013; Wong et al., 2012). In accordance with the RNR model, VRP is based on the 'psychology of criminal conduct' (PCC), and the 'transtheoretical model of change'. The PCC attempts to understand the entrenched belief system of an individual that perpetuates violent behaviour (Wong & Gordon, 2013).

The model of transtheoretical change categorises the offender's readiness for change into five stages, namely pre-contemplation, contemplation, preparation, action, maintenance, and relapse (Prochaska et al., 1992). The delivery and content of the programme are adapted to suit the service users' stage in readiness for change. For example, in the pre-contemplation stage, the clinician works in building a therapeutic alliance with the offender and creating dissonance with the offender's goal and the offender's current situation. In the contemplation stage, the therapist works alongside the offender to elicit their own motivations and reasons for change. In the preparation stage, the offender and therapist work together to identify a plan of action to achieve short and long-term behavioural changes. In the action stage, the offenders are given

opportunities to practice what has been taught in day-to-day living. In the maintenance phase, the offender's learning and practice are further extended by giving more opportunities to continue in building gains made and planning for relapse prevention. In the relapse stage, offenders are given the opportunity to reflect on the relapse, to apply skills and lessons learnt to continue the recovery journey (Wong et al., 2007).

A pilot study of VRP by Wong, Gordon and Gu (2007) looked into the application of VRP on four offenders in prison, with one having diagnosis of paranoid shizophrenia. All had long histories of dysfunctional childhood relationships, violent criminal behaviour and substance misuse. Upon completion of VRP, interviews from the facilitators and the offenders were collected. The interviews showed improvement in the offender's behaviours (Wong et al., 2007). For example, offenders felt they were more able to talk to the facilitators about their emotions, as well as avoid and think through high-risk situations. Furthermore, even when the offenders had relocated, they reported that they were able to utilise what they have learnt in the VRP. From the evaluation of VRP, what seems to be critical is the quality of the facilitator, having therapies that target the belief system and delivering the sessions according to the offenders' readiness to change (Wong et al., 2007).

The Violent Offender Treatment Programme, or VOTP, is another violence prevention programme used for forensic mental health service users in the UK (Braham et al., 2008). The VOTP is modelled from VRP and incorporates addressing both psychiatric and criminogenic needs. It addresses arousal, emotional instability, distorted images of masculinity and interpersonal skills deficits as well as psychiatric needs, such as delusions and command hallucinations. Individual sessions are incorporated to improve responsivity and provide a more intensive approach with service users. There are 92 sessions in the programme. Braham et al. (2008) evaluated the programme based on the responses of 10 out of 13 service users who completed the programme fully. After the programme, the participants scored lower in risk for violent recidivism using a psychometric scale, the Violence Risk Scale. The participants also scored lower in anger expression and a higher score in outward anger control. The participants also had lower impulsivity scores compared to pre-treatment. The clinical team of the participants also assessed the participants pre and post the programme. The results were a better understanding of the offence, acceptance of guilt, increase in acknowledging

personal responsibility, increase in empathy and reduction in minimizing violence and its impacts (Braham et al., 2008).

Another study by Nagi et al. (2014) looked into the 'General Treatment and Recovery Programme' that is delivered in male forensic mental health service users in a low secure unit in the United Kingdom. This programme is based on the cognitive behavioural model focusing on change motivation, development of knowledge, personal insight, personal skill development, managing risky behaviours and early warning signs, and future planning. The rationale for the group is that low secure settings provide critical opportunity for forensic mental health service users to engage in rehabilitation programmes as they are nearing the transition to the community setting. Overall the experience of the programme was positive for both the staff and the forensic mental health service users. Participation in the group was at 82%, and all participants were classified as 'good' at the end of the programme in regards to knowledge acquisition of the skills taught. The staff were also pleased about the programme content, delivery, format and length. However, staff elicited that there was room for improvement regarding the service users' understanding of the programme modules and participation in group discussion. The study noted the importance of the group facilitator in fostering engagement and attendance, giving evidence to the importance of the therapeutic relationship with the facilitator as a key driver for positive group engagement.

A recent study by Daffern et al., (2018) evaluated the impact of a violence reduction programme called 'Life Minus Violence-Enhanced' or LMV-E among forensic mental health service users in England. The LMV-E programme is cognitive-behaviour treatment based that draws inspiration from current knowledge in aggression across the lifespan, social cognition, learning theory and empathy. The treatment programme is intensive, providing 300 hours of therapy spread over a minimum of 125 sessions and spanning approximately 10 to 12 months. The programme was delivered on an inpatient basis to 33 service users, who were evaluated pre and post treatment using quantitative assessment tools answered by the participants, group facilitators and clinicians. The study concluded that the service users who participated in the LMV-E showed reduced aggressive behaviour, better social problem-solving skills and reduction in feelings of irritability and tension. The notable discussion point in this

study is that in addition to the programme, other factors can contribute to reducing offending behaviour of forensic mental health service users, such as positive therapeutic rapport with clinicians and overall high quality of care in the inpatient unit (Daffern et al., 2018). This study alludes that the programme alone is no panacea in violence prevention. The overall environment of the inpatient unit that provides a therapeutic milieu for rehabilitation is also important.

Magnavita (2011) described an aggression-minimization programme that was deployed in an inpatient psychiatric unit in Italy that incorporated both a violence intervention programme and improving the physical environment of the inpatient unit. The programme was part of a quality improvement project to decrease incidences of violent assaults in the unit. The aggression-minimization programme was combined with the redesign of the interior space of the unit according to the needs and recommendations of the forensic mental health service users. The programme deployed a violence prevention programme that focused on general aggression, violence minimization, conflict resolution, effective communication, and other relevant skills training to enhance pro-social engagement. The results have been promising in decreasing violence incident rates from 18-22 cases per year to 0-5 cases per year following the intervention. The study stipulated that not only frequency was reduced, but also the severity of violent acts as well. This study adds evidence that therapeutic programmes and the therapeutic milieu of the inpatient unit improves violence rehabilitation for forensic mental health service users.

Adding to the theoretical underpinnings of violence prevention programmes in the forensic mental health context and the value of therapeutic milieu of the inpatient unit, there is the recognition that complementing group therapy with individual sessions may also be beneficial in the overall violence rehabilitation of forensic mental health service users. A recent article by Yakeley (2018) summarised psychodynamic approaches to violence that are better used in an individual session than a group approach. Yakeley (2018) argues the importance of recognizing psychodynamic complexities of forensic mental health service users. For example, individual therapy can aid service users in exploring their own experiences of loss, trauma, remorse, and empathy. On the other hand, group therapy, enables forensic mental health service users to work with others to develop a deeper sense of awareness and insight towards others.

Yakeley (2018) also highlighted the key role of therapy facilitators and mental health clinicians in role modelling pro-social ways of engaging with forensic mental health service users that can help ameliorate propensity for violence.

O'Brien, Sullivan and Daffern, (2016) argued that an integrated individual and group-based therapies for forensic mental health service users can potentially provide a best practice model. O'Brien et al., (2016) described the current best practice in group therapy for violence in the forensic mental health population and that is Dialectical Behavioural Therapy, or DBT. DBT is a modified version of cognitive behavioural model and incorporates the principles of the RNR model. What this study shows is the potential for better outcomes in violence rehabilitation through taking advantage of one-on-one therapies that can supplement the skills, lessons, and practices taught in group therapies. O'Brien et al., (2016) further emphasized that one-on-one sessions can be used in pre-group engagement by promoting willingness to engage and by exploring potential interpersonal issues that may inhibit appropriate participation in group settings. During the treatment group, one-on-one sessions can provide opportunities to solidify gains made. Finally, post-group, one-on-one therapy can provide an avenue for reflection and evaluation of the applicability of skills learnt from the group. What is clear from this study is that one-on-one sessions, as part of group therapies for violence reduction rehabilitation, provides a dynamic approach that would otherwise be absent in a group violence intervention programme alone.

In conclusion, the violence prevention programmes in forensic mental health services are designed to address both criminogenic and mental health needs of its target population group (Nagi and Davies, 2010) and these programmes are modelled from prison settings. The RNR model and cognitive behavioural therapy model provide theoretical underpinnings to these programmes. It is acknowledged that in working with forensic mental health service users, the therapist and group facilitator's responsivity to the needs of the forensic mental health service users is vital for continued engagement in rehabilitation and role modelling. Combining group therapies with individual therapies appear to provide a more effective approach, encompassing the different unique needs of each forensic mental health service users. The therapeutic milieu of the forensic mental health unit itself also improves violence treatment outcome to forensic mental health service users.

Violence Prevention Programme in New Zealand

It is important to consider the approaches in violence prevention programmes occurring within the New Zealand context. A notable violence prevention programme used in the New Zealand prison context is the use of 'high risk special treatment units, HRSTUs, which can be considered as therapeutic communities (Polaschek & Kilgour 2013). Currently, there are four which operate nationally. One is the Te Whare Manaakitanga which opened in 1998. The second and third are Waikeria prison and Spring Hill Corrections Facilities that opened in 2008. The fourth is in the Christchurch Men's Prison that opened in 2009. These HRSTUs succeeded from the rehabilitation model based on the Montgomery House Violence rehabilitation programme in the 1980s. As prisoners show progress in their rehabilitation, they are given opportunities for 'release to work' parole for employment in the community.

These HRSTUs are facilities specifically designed for high risk offenders. The special treatment unit provides in-house structured violence intervention programmes based in cognitive behavioural therapy and the unit serves as a community where the prisoners can practice what is learnt within a structured environment. The cognitive behavioural therapy in HRSTUs targets linking aggression and violence, as well as social information-processing to treat the criminogenic needs of the prisoners. The violence reduction programmes also draw from other criminology theories such as 'Farrington's Integrated Cognitive Antisocial Potential Theory' and Moffitt's life-course persistent offender theory (Polaschek & Kilgour 2013). The study concluded with its evaluation that service users who have completed the programme within these HRSTUs demonstrate more prosocial and positive behaviour compared with the prisoners' pre-programme presentation (Polaschek & Kilgour, 2013).

Similarly to the HRSTUs as described previously, another study by Polaschek (2011) evaluated a high-intensity rehabilitation programme for high and medium risk prisoners in New Zealand, being run in a unit called the Rimutaka Violence Prevention Unit. The programmes in this unit are also based on cognitive behavioural therapy. The programmes focus on identifying different factors that can help decrease violent behaviours. Factors such as mood, empathy, moral reasoning, interpersonal

communication and relationships and post-release management of risk are considered important factors to be addressed to decrease violence. The programme facilitators vary from senior psychologists to final year psychology students. The study had 112 participants who either completed or partially completed the programme lasting a total of 330 hours across 28 weeks.

To evaluate the impact of this unit, a comparison evaluation study was conducted to compare the treated prisoners with a matched control group drawn from a national prisoner computer database of those who did not do the programme. The evaluation concluded that the Rimutaka Violence Prevention Unit programmes resulted in less reoffending, and that if re-offending was committed by those who completed the group, the violence occurred further past post-release at an average of 3.5 years.

From these studies based in the New Zealand prison context, it appears that violence prevention programmes are often based within a therapeutic milieu, in treatment units. Consistent with international evidence, the violence prevention programmes are based on a cognitive behavioural therapy. A notable finding too is the value of therapeutic communities in violence rehabilitation.

Violence Prevention Programme for Māori

Violence prevention programmes for Māori have been predominantly examined within the prison context. This is because the Māori population continues to dominate New Zealand prison statistics. About half of all prisoners in New Zealand are Māori (Statistics New Zealand, 2012). Furthermore, Māori have the highest reimprisonment rates accounting for 49% and the highest reconviction rates of 69% (New Zealand Department of Corrections, 2007). Given these statistics, it is vital to consider the way violence prevention programmes are delivered to this population group. Providing rehabilitation that is responsive to the cultural needs of the Māori population has been identified as a vital component that can improve responsivity (New Zealand Department of Corrections, 2016). The New Zealand Department of Corrections (2016b) has launched an initiative to reduce reoffending of the Māori population as part of their 2016 ‘Change lives: Shape futures’ strategic plan. An integral focus of this plan is to deliver tikanga (values) based violence intervention programmes that are responsive to Māori. For

example, the Department of Corrections currently have a programme called Mauri Tū Pae, which is a medium intensity kaupapa Māori rehabilitation group programme for Māori male prisoners with diverse offending needs. This group is reviewed regularly to ensure its integrity and effectiveness.

Mauri Tū Pae (Hape, 2017) is underpinned by Western violence prevention therapeutic models of cognitive behavioural therapy, dialectical behaviour therapy and the RNR model delivered within a kauapapa Māori framework of wairua (spiritual), whānau (family), manaaki (respect), kaitiaki (guardianship) and rangatira (responsibility) (Hape, 2017; New Zealand Department of Corrections, 2015). The Mauri Tū Pae programme is provided for a maximum of 10 Māori men in a group. The programme has 137.5 hours of contact time. The programme aims to reduce violent behaviour by teaching the participants problem-solving, conflict resolution and managing of thoughts and emotions. Although formal evaluation of the programme is yet to be done, there is evidence to suggest the value of the Mauri Tū Pae programme. For example, there is the overall completion rate of 88% in the year 2016-2017 intake. Furthermore, participants reported having a renewed understanding of violence and taking ownership of their actions, lives, and identity (Hape, 2017).

A report compiled by Jigsaw and the Ministry of Health (2014) highlights the current violence prevention programmes designed to increase responsiveness for Māori. It is important to note though that this report is aimed at addressing family violence. However, this report provides integral principles when working with Māori and provides insight into the current approach being undertaken in New Zealand to address violence in the Māori population. The report stresses the importance of working with families and extended families to provide safety plans for an individual. For example, a key theme that has emerged from this report is the need for clinicians to work in partnership and collaboration with family members and the community to provide a safe environment for the child and mothers. It must be noted though the examples provided in this report are descriptions of initiatives being led by clinicians in New Zealand.

Violence prevention programmes for Māori have been examined within the prison settings predominantly. It appears that Māori violence prevention programmes remain

based on cognitivebehavioural therapy and the RNR model. The inclusion of whānau (family) within these Māori violence interventions programmes appears vital.

ManAlive Programme

The ManAlive programme was developed in the 1980's in California, United States of America, as a violence prevention programme by men for men with violence against their partners and children. Although initially designed for men with domestic violence, the ManAlive programme was used to address violence issues within the prison population (Gilligan & Lee, 2004). The core of the ManAlive programme challenges the so called 'old male role belief system' that perpetuates violent behaviour among men. The 'old male role belief system' asserts that violent men had learnt sets of attitudes, values, and expectations based on male dominancy, control, and authority. There are four apparent behavioural patterns that fortify this belief system that need to be addressed to help men with their violence. These four behaviours are denial, minimizing, blaming, and collusion. Denial pertains to not taking accountability for one's violence. Minimizing is about diminishing the impacts of violence. Blaming is about the belief that others are always at fault. Lastly, collusion is justifying the violent acts committed (ManAlive Sacramento, 2018).

The ManAlive programme utilises cognitive behavioural techniques to help men identify and address these behavioural patterns (Adams, 2003). Men in the ManAlive programme are also taught assertive training to replace passive and aggressive ways of engaging with partners, by showing them active listening, practicing empathy, expressing feelings, appropriate handling of negative feedback, and giving and receiving commendations. This is done by role-playing with each other and alongside the ManAlive facilitator. An essential expectation of the ManAlive programme is that men who complete the programme become role models who will advocate against violence in their own communities (Adams, 2003).

ManAlive was adapted as a violence prevention programme in the prison in San Francisco, USA (Gilligan & Lee, 2004). The ManAlive programme was part of San Francisco's County Sheriff Department's initiative called the 'Resolve to Stop the Violence Project' to provide violence prevention programmes within an all-male prison

dormitory. The ManAlive programme focussed on the violent behaviour that caused their incarceration. Another component of the ManAlive programme in prison was the inclusion of volunteers from the community who gave moving and powerful testimonies of the impacts of violence on their lives. The impact of these testimonies was confronting for the prisoners and there were reports that prisoners became remorseful and were persuaded to address their violence. These testimonies appear to impact on the prisoners in a two-fold way. Firstly, it helped participants to understand the impacts of violence in their lives as victims and witnesses of violence. Secondly, they also realised the suffering and loss they had caused to their loved ones due to their own violent acts and its grave consequences on their future lives (Gilligan & Lee, 2004). Evidence of ManAlive in prisons has shown the positive impact of this programme. For example, in the first month that ManAlive was introduced in one prison unit, there was only one violent incident and there were none in the next twelve months (Gilligan & Lee, 2004). Compared with the control group of prisoners on a different unit who did not have the ManAlive programme, the control group had 28 violent incidences. Furthermore, those who did 8 weeks of the ManAlive programme had a 46.3% lower rate of recidivism compared to those who did not do the ManAlive programme. Overall, the study concluded there was an 83% reduction in re-arrest for violent crimes in one year after release from prison for those who completed the programme, compared with matched controlled prisoners who did not complete the programme. That means the likelihood of violent re-arrest rate for completers of the programme was 6% while non-completers had a re-arrest rate of 33%. (Gilligan & Lee, 2004).

The study by Coombes, Morgan and McGray (2007) considered the impacts of the ManAlive programme delivered in a community setting. This study is significant for this literature review as the study was done in New Zealand. This study was linked to the New Zealand Family Court and found that 56% of offenders who completed the ManAlive programme, as part of the Court orders between the years 2005-2006, had no further records of violent occurrences. Another study by Walters (2010, as cited in Deene, Coombes & Morgan, 2013) indicated those who completed the ManAlive programme as part of a Family Court order had reoffending rates of 48% while those who did not complete the programme had 63% rates of reoffending. Although there are limited published studies of the ManAlive programme evaluations, there is evidence to suggest that the ManAlive programme can be an effective violence prevention programme.

To date, there have been no studies looking into violence prevention programme specifically within the New Zealand forensic mental health services. However, Easden and Sakdalan (2015) looked into the clinical diagnostic features and dynamic risk factors of forensic mental health service users in New Zealand. The study concluded that the forensic mental health service users present with multiple clinical issues such as psychiatric disorders, substance abuse, and personality disorders as well as having committed very serious violent offences. More importantly, Māori forensic mental health service users are over-represented, accounting for 40% of the total forensic mental health population (Easden & Sakdalan, 2015). As well as treatment needs to target clinical issues, it is vital that the treatment provided is responsive to the cultural needs of the Māori forensic service users. This study identified cultural programmes especially for Māori forensic mental health service users that promote the development of cultural identity such as Te Reo Māori (Maori language) groups, wānanga programmes (teaching Maori cultural 'knowledge') and kapa haka (traditional Māori performing arts). However, there was no mention of violence prevention programmes for Māori forensic mental health service users. With the increasing awareness to provide culturally informed programmes in forensic mental health settings, it is timely to consider what value would a culturally adapted violence prevention programme add to the rehabilitation of Māori forensic mental health service users.

In conclusion to the literature review, it is important to note that studies on violence prevention programmes in forensic mental health services have been undertaken in Canada, Europe and USA (Daffern et al., 2018; Hornsveld et al., 2015; Wong et al., 2012) However, no studies have been conducted in the New Zealand forensic mental health services let alone specifically amongst Māori forensic mental health service users. With violence prevention programmes being implemented in forensic mental health services in New Zealand, it is timely that research is undertaken to provide an understanding about culturally modified programmes and the perceived value of using such programmes. This gap in knowledge provides an opportunity for a study to be conducted in the hope of providing understanding on this vital area. The study will provide some understanding of the impact of a culturally modified programme on indigenous Māori service users. Hence, the research aims are to describe what the Tū

Tahanga programme is and to explore the experiences of people involved in the Tū Tahanga programme.

Chapter III: Methodology/ Methods

Methodology

This research aims to describe a specific violence prevention programme targeting Māori (called Tū Tahanga) and to explore the experiences of people within it. A qualitative descriptive study was deemed an appropriate methodological approach to explore this research question, given that little is known about the intervention.

The seminal work of Sandelowski (2000; 2010) highlights that qualitative descriptive research is useful in presenting findings that "stay close to their data and to the surface of words and events" (2000, p. 336). Qualitative descriptive research is also useful when the research aims to uncover the stories of individuals who are involved in experiencing a particular reality. This is to understand the context and settings of the reality and to present the findings literally and flexibly (Colorafi, & Evans 2016). Given there are no studies done on this particular topic, it is useful that findings are presented close to its reality and with minimal interpretation and inference from the researcher.

The qualitative descriptive approach will be of an experiential orientation which means the narratives have a focus on what the participants think, feel and do and inevitably how they make sense of the Tū Tahanga programme. This experiential orientation assumes the reality of Tū Tahanga is made implicit through the use of language. Hence, the theoretical framework of this qualitative descriptive research is based on the realist/essentialist ontology which asserts that reality of a phenomenon exists and can be captured and discovered through the language and narratives of individuals within it (Terry, Hayfield, Clarke & Braun, 2017).

Sampling Method

There are three categories of research participants included in this study. The participants are the group facilitators, service users, and staff. The reason for the inclusion of all these participants is to allow a holistic understanding of Tū Tahanga.

By doing so, the research findings will be representative of all participants. The following outlines the selection process for the participants.

The inclusion criteria for service users are those who have participated in the Tū Tahanga programme, are living in community housing, and are willing to be interviewed by the researcher. To widen the inclusion criteria, service users may not necessarily have attended all the Tū Tahanga sessions but have a personal engagement in the group and are willing to discuss their thoughts and feelings about Tū Tahanga retrospectively. Service users living in the community were seen as suitable participants because they are already well in their recovery and are able to give informed consent. Furthermore, as service users are already living in the community, they are high functioning and are already engaging in prosocial activities and meaningful occupations. This means that their narratives may provide insight into how the Tū Tahanga programme may have contributed to their recovery.

To be consistent with practice that is less coercive, the researcher conducted the recruitment by facilitating the choice of participants. For example, the place of interview conducted was chosen by the service user. For recruitment, service users were informed about the study through poster advertisements and by word of mouth from staff. Poster advertisements were placed in step-down accommodation and staff in these types of accommodation are given extra posters, information sheets, and the researcher's contact details should a service user express a wish to participate in the study. Service users were then able to contact the researcher by informing their staff or via the researcher's mobile phone.

When service users showed an interest in participating, the service users were given the information sheet (see attached Appendix E) with the opportunity to ask questions of the researcher. Service users were also informed that the information they shared is solely for the purpose of the research and in no way will influence or impact on their care.

Staff participants were also recruited through poster advertisements and by word of mouth. The staff participants came from different backgrounds and thereby provided a rich diverse opinion on their view with the programme. Similarly to the process above,

once the staff expressed interest to take part in the research, they were informed of their rights such as the right to withdraw at any time and that information shared was solely for research purposes. The inclusion criteria for staff was that staff must have participated in the Tū Tahanga programme.

The facilitators were the first participants in the research, and they were interviewed jointly. This interview was with the primary facilitator, who is a Māori cultural advisor and the secondary facilitator who is a psychologist. The interview was done intentionally as a joint interview as the facilitators requested this format.

The total number of participants was 11. For this research project, this number of participants was sufficient and within the recommended sample size of six to fifteen (Terry, Hayfield, Clarke & Braun, 2017). In qualitative studies, the key importance in the appropriateness of sample size is that data should be sufficiently rich enough in order to determine concepts and themes.

Data Collection

Data collection was done through face to face interviews and recording the narrative using a voice recorder which is in keeping with the traditional data collection method for qualitative descriptive analysis (Terry, Hayfield, Clarke & Braun, 2017). Given that interviews were done face-to-face, participants were not anonymous. However, the participant's privacy and confidentiality were protected by ensuring that the data collected did not contain any personally identifying information and no personal identifying features were published.

The process of data gathering of the dialogue was opened by the researcher asking an open statement *"Please tell me about the Tū Tahanga programme."* Other questions that were asked included: "*Describe for me what happens in the Tū Tahanga programme", "Tell me about the kaupapa Māori approaches of the programme?"* and *"What is Tū Tahanga for you?"* (see Appendix H, p. 118, for detail of interview schedule)

The interviews are intentionally open-ended questions, asking participants about their thoughts and experience of the programme. This is useful in exploring in-depth their experience and it provides avenues for clarification. The researcher also asked questions about the kaupapa Māori approach of the programme. In practice, the course of conversation was led by the participants with the researcher asking probing questions to elicit deeper meaning to the participant's explanations and narratives. Data collection for each participant came to a conclusion once the participant deemed what they have shared was sufficient information and could not expand any further.

To promote service user's choice, service user interviews were carried out in the place of their choosing and according to their time and date of availability. Interviews for data collection were approximately 40 minutes each. Similarly to data collection from service users, staff interviews were carried out in the time, date and location as preferred by the staff.

Data Analysis

The data was analysed using conventional content analysis or CCA, which is a specific type of qualitative content analysis (Hsieh & Shannon, 2005; Sandelowski, 2000). CCA is a chosen method in which there is little known about the phenomena being studied as it allows codes and categories to flow from the data. Codes and categories are developed from data and these are modified and refined as more data is collected. Codes are action-oriented words or labels, which synthesise a group of similar sentences and phrases. In CCA, collection and analysis of data is done simultaneously, and both mutually shape each other. Table 1 provides an overview of the process.

Step	**Data Analysis**
1.	***Familiarisation and coding:*** Familiarisation is a key process in qualitative descriptive research. Familiarisation is the act in which the researcher engages with the data through an intentional and purposive immersion process. This is achieved by listening to the data, transcribing the data, listening to the data in a constant iterative process. The researcher has achieved this familiarization as the researcher himself transcribed all data and made

	personal notes and internally immersed himself in the process, which aided the development of codes. Coding is the process in which words, phrases, or sentences are highlighted and picked systematically as they elicit particular meaning. Codes are developed from reading the interview transcriptions and highlighting any similarities or repetition of ideas. Coding is also an iterative and flexible process that can change and become more meaningful as the researcher continually analyses the data. It must be noted though that there is no right or wrong coding, but rather the codes must make sense to the researcher and can be related back to the research question. The researcher collected codes by going through each interview transcript and noting it down to a separate page. The researcher has also discussed his codes with his supervisor to provide further feedback and guidance in the coding process. For reference, the researcher has also 'indexed' codes and quotations based from its source, whether it is from the facilitators, staff or service users. The codes and quotations are further specified by giving each facilitator, staff and service users a numerical identifier. Hence there were 'Facilitator 1', 'Facilitator 2', 'Staff 1', 'Staff 2', 'Staff 3', 'Staff 4', 'Service User 1', 'Service User 2', 'Service User 3', 'Service User 4', and 'Service user 5'.
2.	***Developing categories:*** Categories are ideas or themes that sum together the thoughts of a cluster of codes. The researcher had developed categories from codes by grouping together codes from different interview transcripts that shared similar meaning and contexts. Categories were drafted by the researcher through a 'tree diagram', with a rationale as to why. The researcher drafted a tree diagram of all the categories with codes underneath. The tree diagram showed a bird's eye view of all the data collected and aided categorising codes. Furthermore, the tree diagram provided a way in which the researcher could shuffle and reshuffle codes and reconsider categories simultaneously to develop the best fit. Data collection and analysis occur simultaneously and is an iterative, cyclical process. As new data became available to the researcher, the data were then embedded in the tree diagram. This allowed categories to develop further and

	substantiate any current findings and progress. The researcher had also done this process of categories alongside supervisors to provide guidance and further clarity.
3.	***Theme development:*** Data collection and analysis were considered complete once saturation occurred and participants had been interviewed. Saturation was reached when no more new data were collected, and no more categories were made. The findings were then presented in an organized, descriptive summary that best fitted the data. The overall collection of concepts led to the formation of the theme. The theme was the overall story of the data which captured the distinct meaning of the phenomenon as described by the participants. For this research, six themes were identified. These were, 'The ManAlive Process', 'The Kaupapa Māori of Tū Tahanga', 'The personal impacts of violence', 'mirroring', 'whanaungatanga' and 'suggested improvements'. The findings are presented in the 'Findings/Results' chapter.

Table 1: Data analysis steps
(Hsieh & Shannon, 2005; Sandelowski, 2000; Terry, Hayfield, Clarke & Braun, 2017)

Trustworthiness

Trustworthiness is the concept used as a measure to assess a qualitative study's validity. The article by Elo et al. (2014) focused specifically on assessing the trustworthiness of qualitative descriptive studies. There are five criteria used in assessing a qualitative study's validity and these are credibility, transferability, dependability, confirmability, and authenticity. The trustworthiness of this study will be discussed in accordance with these five criteria to attest its overall validity.

To establish credibility, research participants were identified and described accurately to confirm the suitability of research participants in answering the research question. By doing so, the research's credibility stands congruent with its intended focus and how well that focus has been justified (Elo et al., 2014). As identified in the methods section, research participants of this study consisted of the service users, staff and group facilitators to gain representation from all people who participated in the Tū Tahanga

programme. The total number of participants were 11 who enabled rich collection of narratives to produce the results of the research.

Dependability pertains to the transparency of the research process and its suitability to the overall research aim. Dependability is established if others can follow the decision process of the researcher (Elo et al., 2014). For this research, the process of data collection, data analysis, and findings presentation have been described in the research method section. The data have been collected using face-to-face interviews and transcribed by the researcher to ensure full immersion in the data from collection to analysis. The researcher used codes and concepts to develop the findings through utilisation of concepts, maps, and manual coding of the findings. Furthermore, the researcher has done the analysis alongside the supervisors to ensure academic congruency and accuracy.

The transferability of a study pertains to the extent in which findings can be applied and transferred to other settings and that findings, therefore, can be extrapolated (Elo et al., 2014). From the researcher's perspective, the research participants, data analysis, results formulation and the research context (New Zealand setting, forensic mental health and focus on indigenous population group) are described in detail and the findings from this study are specifically relevant to this setting. It is possible that the findings from the research can help inform clinical practice in violence prevention group therapies in other indigenous population groups and mental health service users.

The conformability of the research is about the accuracy of the data collected and that its analysis represents the information research participants have provided (Elo et al., 2014). The conformability of this research is assured through the detailing of the research methodology, from data collection to analysis, and to findings presentation as well as the regular academic oversight the researcher receives from the supervisors that strengthens the integrity of the research.

Finally, the last criterion of authenticity refers to the research being able to present a range of realities that is congruent with the phenomenon described by the research participants. For this research, the methodology of qualitative descriptive analysis was specifically chosen for the purpose of presenting the narratives of the

participants as close to the reality as possible with minimal interpretation from the researcher. As not much is known regarding the violence prevention programme modified within a kaupapa Māori principle, it is vital that findings are presented as close to the narrative as possible to give light to this otherwise unfamiliar territory. Authenticity is particularly shown in the results section wherein quotes from participants are used extensively to justify explanations to show that findings are reflective of the participants' voice.

Ethics

All service users involved in the study are under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and/or the Criminal Procedure (Mentally Impaired Persons) Act 2003. Service users are treated involuntarily and represent a particularly vulnerable population. Forensic mental health service users are stigmatised and discriminated and therefore feelings of disempowerment are present (McKenna & Martin, 2013). Hence, this study was conducted in such a way that it minimised any potential harm or trauma to service users. This was done by ensuring service users were fully informed about the nature of the study and involvement would not impact on clinical decisions, or care and treatment planning. Although service users consented to participate they could withdraw from the study at any point and any of the information they gave could be withdrawn by them should they wish. The participants were informed of their rights according to the Health and Disability Commissioner (2012).

Ethics approval was sought and approved for this research project. Research approval was gained from the Auckland University of Technology Ethics Committee, the Waitematā District Health Board Māori Research Committee, and the Mason Clinic Taumata group. Ethics was approved from AUT in December 2017 and January 2018 consecutively. The research and ethics proposal detailed the components of the research process (see Appendices for detail).

Additionally, the cultural approvals were gained from the Waitematā District Health Board Awhina Māori Research Committee and the Mason Clinic Taumata group required further consideration. The researcher presented the research project to the Mason Clinic Taumata group. In the latter, the researcher verbally presented the aims

of the research and how research will maintain true to the principles of Treaty of Waitangi. Furthermore, the researcher presented the research project to the Mason Clinic research group. The Awhina Waitemata District Health Board Māori Research Committee gave locality approval in view that the research will be conducted according to its cultural recommendations. The locality approval was received in April 2018.

Treaty of Waitangi Obligations

To keep true to the principles of Treaty of Waitangi, the researcher used the principles as outlined by the Te Ara Tika: Guidelines for Māori research ethics (Hudson et al., n.d.) to guide the research practice. The Treaty of Waitangi obligations of mana, whakapapa, manaakitanga, and tika are considered in this research and have been interwoven as the research was carried out.

Mana refers to the autonomy of an individual or of a group. In this research, this was upheld by ensuring that potential participants were fully informed prior to participating in the study and were able to give informed consent. Whakapapa refers to protecting meaningful relationships formed. This was upheld by presenting the research to the cultural staff of the regional forensic mental health service Taumata, and the District Health Board Māori research advisor. Within the forensic mental health service, the researcher had consultation with Māori stakeholders such as the programme facilitator, unit manager, and gained the support of the forensic mental health service kaumatua.

As the researcher engaged with participants particularly during data collection, the researcher endeavoured to be respectful and sensitive to this engagement. Manaakitanga refers to cultural and social responsibility and the respect for others (Hudson et al., n.d.). Manakitanga was upheld by seeking cultural advice from my cultural advisor (the service kaumatua) throughout the research and by protecting the dignity of the participants by ensuring they were informed, able to give consent, and were engaged with respectfully. Tika refers to the appropriateness of an approach at a given situation or circumstance. In research, this refers to the approach and design. For this research, data collection took the form of interviews thereby upholding the Māori tikanga of ‘kanohi ki te kanohi’ meaning face to face. Most importantly, this research

was conducted in view of informing clinical practice when working with the Māori population to deliver care that is responsive to the population's specific needs and to the improvement of health outcomes.

Chapter IV: Findings / Results

This chapter presents the findings of the research. Firstly, this chapter outlines the sample description, followed by the detail of the themes. There were six main themes identified. These were 'The ManAlive Process', 'The Kaupapa Māori of Tū Tahanga', 'The Personal Impacts of Violence', 'Mirroring', 'Whanaungatanga' and 'Suggested Improvements'. The ManAlive Process had sub-themes of 'checking in and checking out', 'emotional awareness', 'continuum of violence', 'personal coping skills' and 'certificate of completion'. The kaupapa Māori of Tū Tahanga had sub-themes of 'the bridging of kaupapa Māori and ManAlive', 'Māori facilitator as a role model', 'hohou rongo', ' Te Whare Tapa Whā' and 'setting the space'. The final section of this chapter presents the findings using a visual diagram (Diagram 2) that shows the relationships of the themes with each other.

Sample Description

There was a total of 11 research participants in the research. There were five service user participants; three males and two females. All were past inpatient service users in the low secure kaupapa Māori unit. There were four staff participants with each coming from different health disciplines.

	Facilitator	**Staff**	**Service Users**
No. of Participants	2	4	5
Description	Primary Facilitator (Māori Cultural Worker) Secondary Facilitator (Psychologist)	Occupational Therapist Doctor Manager Nurse	Three male service users Two female service users

Table 2: Summary of the research participants

Theme One: The ManAlive Processes

It was clear in the narratives, the practices of the Tū Tahanga group that had translated from the ManAlive programme. These practices were checking in and checking out, emotional awareness, understanding the continuum of violence, personal coping skills and receiving a certificate of completion. These practices provided the components of the violence intervention process of the programme.

Checking in and Checking out

Firstly, 'Checking in' and 'checking out' were the group's colloquial terms for the specific practices occurring at the beginning and at the end of each session. Checking in and checking out were practices wherein participants would share their thoughts, feelings, and opinions. Participants were encouraged to share any notable experiences they had during the week that might be of benefit to the wider group. Checking in and checking out were the equivalent of the expression *"how are you?"* which sought to elicit the current state of each participant at the beginning and at the end of the session.

The value of checking in and checking out was that it promoted open communication amongst facilitators and service users. The process provided opportunities for participants to talk about any problems or issues they may have had. It reinforced, in an appropriate and constructive manner, the need to deal with challenges early to reduce any potential provocations or displays of aggressive behaviours. Checking in and checking out promoted responsive behaviour over reactive behaviour.

> *"…if you've got any raru (troubles), mamae (hurts) or any problems you have a chance to talk about it with the collective and with the whānau and resolve it as it needs to. So, it's a check in and check out system. So, check in the morning and check out in the afternoon. The Tū Tahanga programme gave all the individuals the skills to participate fully in the check in and check out. And they can talk about whether it be emotional or something that is sitting on their chest, the problem." (Staff 3)*

Furthermore, check in and check out provided added value for staff to gauge what was going on with service users. Although staff are also participants in the Tū Tahanga, the checking in and checking out provided staff opportunities for assessment and care as necessary. A staff member highlighted this in his narrative below:

> *"I knew that patients, whanau or staff can talk about – you get a good gauge how the unit was. So, if there is any problems that runs the course of eight hours throughout the day so we would find out how the unit is for the afternoon. Most times we stay back in the wharenui and whoever was experiencing or having a bad time can stay back and talk. The skills they learnt in Tū Tahanga they can openly discuss and verbalize." (Staff 3)*

Being specific with language was important for checking in and checking out. By being specific, service users were taught to clearly communicate to minimize misinterpretation, assumptions, and judgements. Staff and facilitators have recognised that unclear communication was a common cause of frustration and unmet needs, which in turn could lead to violent provocations.

> *"We want them to be specific. In life, we are all too general. We need to get into the specifics because otherwise that's assumptions are made and judgments are made just because of generalized conversation rather than someone being specific or you being specific and so there is assumption. And then hello, there is a story there" (Facilitator)*

Part of checking in as well was to identify how service users had looked after themselves during the week. Looking after oneself appeared to be any enjoyable acts that service users did for themselves. They were then encouraged to share them with others in the group.

> *"…and how did you nurture yourself this week. And I can say 'I nurtured myself by having a warm bath and then an expensive coffee'. That's a way of nurturing yourself…There's the check in, the nurturing. My name is [service user's name]. My emotion is content. Because my weeks been alright, I feel good." (Service User 1)*

Checking in and checking out were also considered safety mechanisms for service users and staff. At the end of Tū Tahanga, there were always opportunities to talk, to listen, to ask questions and to seek assistance.

> *"Being able to check out at the end. It's a safety mechanism as well. No one is leaving there agitated, upset or they have questions they can ask again." (Facilitator 1)*

However, having genuine checking in and checking out had been recognised by the facilitators as a practice that service users struggled with and was a challenge.

> *"And then we do the check ins…And sometimes it can be really short as they wanna just check in with the same stuff and they don't really wanna take time, look inside and take time" (Facilitator 1)*

A way to respond to this challenge was by giving service users structure and aspects about themselves they could share with others during checking in and checking out. An aspect that service users were encouraged to share was their current emotional state.

Emotional Awareness

Practicing emotional awareness was encouraged during the checking in and checking out sessions. This seemed to help service users to engage in the group process.

> *"So, the actual checking in that they did initially- identifying their emotions, feelings and their thoughts stuff like that" (Staff 4)*

Being emotionally aware was the second practice of ManAlive. Being able to identify and express one's emotion to others clearly was a standard part of the ManAlive training. Learning about different emotions was integrated into Tū Tahanga sessions and was consistently revisited. Service users were schooled in learning the eight emotions. These emotions were excitement, passion, happiness, contentment, fear, anger, hurt and sadness. A service user was able to state all these emotions during the interview and there was a sense of pride in him in being able to recount these clearly.

"Then start off with your name. Then, the number of sessions you've done in the group. Your experience right now out of the eight emotions coming into the group so you share your emotion at the time. You got excited, passionate, happy, content, afraid, angry, hurt or sad. Then you gotta share what you feel on that day" (Service User 1)

In addition to encouraging service users to verbalize their identified emotion, the facilitator also used a visual aid in the form of a board containing the eight emotion words.

"And they learn about emotions in Tū Tahanga….In Tū Tahanga, there is a big board and they look at that and they say yea, 'that's my feelings'." (Facilitator 1)

It was clear that being emotionally aware was a vital process of the group and staff saw the value in doing so.

"It's important for people to identify their thinking and their feelings and that is really important." (Staff 4)

Moreover, being emotionally aware helped service users in beginning to take ownership of their emotions. By becoming emotionally aware, the service users understood that emotions belong to them alone. The facilitator emphasised this ownership of emotions during Tū Tahanga sessions.

"And helping them to understand that actually you hurt, they didn't hurt you. You hurt, so getting them to own their emotions rather than blame the emotion on someone else. I'm hurt, exactly." (Facilitator 1)

Being emotionally aware and taking ownership of emotions provided the foundation for service users to express their emotions verbally. The expression of emotions has numerous benefits for service users. For example, expressing emotions provided cathartic experiences for service users. It appeared that through such expressions, service users felt a sense of liberation from violence. Service users recounted how sharing their feelings during Tū Tahanga sessions had made them feel positive and better afterwards.

> *"It's pretty good if you go there feeling sad and you come out feeling happy. It means the group is actually make you feel emotion, from being sad to feeling happy." (Service User 1)*

Another service user described how sharing his emotions in the group helped him release his frustrations and in turn also made him feel positive. It became clear that the Tū Tahanga group turned out to be an outlet for service users to share their frustrations.

> *"It made me feel good. I let it out, instead of bottling it up. Like I said, when I get violent, I'm in my inferior and I'm sad, down, and I be there for a long time and when I told them about my fatal peril I felt better after that." (Service User 3)*

Staff also recognised the value of knowing the current emotions of service users. For example, when service users expressed being sad, it provided an opportunity for staff to respond and assist to the needs of a client.

> *"We always have someone feeling sad or not quite right but it's the group that supports the individual and acknowledges that OK you are having a bad time and we're gonna support you…When those check ins and check out happens and people talk about their feelings and thoughts" (Staff 3)*

Interestingly, understanding emotional awareness was instrumental for service users in reconciling with others when service users felt hurt from the actions of others. By being able to voice feeling hurt, service users were able to communicate the potential for reconciliation. Staff described how they witnessed reconciliation of two service users during a Tū Tahanga session and the process was started by a service user sharing their hurt to the other person.

> *"It was about the person about how they were hurt by the other person and they shared their story and they got to share how they were hurt by the person and the other person had to listen to the pain…Everyone becomes sensitive and attuned to the people around them; the emotions." (Staff 2)*

A crucial realization of being emotionally aware was service users being able to link their emotion of anger as a starting point in becoming violent. Out of all the

emotions, anger was the main emotion service users talked about. By being able to identify anger and its link to their own violent tendencies, service users were able to personally gauge how close they were in potentially becoming violent.

> *"A lot of it is about anger, and how do you manage your anger. It's basically what I feel about the group, any issues…It was the anger issues for myself" (Service User 5)*

Another service user was able to link his anger to his violent tendencies.

> *"Pretty while ago but it is help to do with anger. Yeah and also um, then furious over…I still get angry but not as before. But anger is emotion. Everyone gets angry. No one can say they never get angry. Even the priest gets angry."" (Service User 3)*

By identifying their specific emotions and its link with violent tendencies, service users were able to learn and understand the deeper principle of the 'continuum of violence'.

Continuum of Violence

As service users became more capable in identifying their emotional state, they learned and applied specific words that provided a framework in helping them understand the process of becoming violent. These framing words were borrowed from ManAlive and conceptualised violence as a continuum. The words conceptualized violence as separate from the individual and one can choose whether to take violent action or an appropriate non-violent response when aroused. These words were 'hitman', 'authentic self', and 'fatal peril'.

> *"The whole of ManAlive. That's the crux of the violence. It's the fatal peril, the moment we have to decide where we gonna go with this. What's happening with us. And then, the fact that they are in the programme, what does that hitman look like. We repeat that a lot before we move into the other side, which is the authentic self…" (Facilitator 1)*

The consistency in the understood meaning of these words was evident amongst the research participants. Hitman was described as a violent persona. This was the persona that does violent acts. The authentic self was the rationale, non-violent persona

that thinks about the consequences of violence and takes control of emotions and actions. Fatal peril was the point of decision making wherein an individual would have to choose to be the hitman or the authentic self. The primary facilitator described these words clearly and their relationship in his narrative below.

> ***"****Fatal peril in ManAlive terms is when you have a choice, or are triggered. If you are going to take the path of the violent person or your gonna take the part of communicating what's happening to you at that moment. That's the point where they have only a split second to make a choice. It's a training, to train them that at that second that they have a choice and they can make the choice. And we go through what leads. And the hitman is that part of them that does the violence….. We repeat that a lot before we move into the other side, which is the authentic self, you introduce them to a side they don't know, but then they may have an idea of what that is anyway" (Facilitator 1)*

Service users were able to demonstrate their knowledge of these words and use them in framing violence as a continuum. The following quotes were from four service users. The quotes showed the consistency of understanding of these words and their application in the day to day life of service users.

> *"The one 'I notice my fatal peril', 'hold my fatal peril'…fatal peril is decision." (Service User 1)*
>
> *"Hitman is like you getting angry, tension, mood swings, having ideas of getting angry or violate, hitman is like violating yourself and others. And any form of violating too - verbal, physical, emotional." (Service User 1)*
>
> *"The authentic self is the person that what we have to be all the time. But if you crash the car, and you think what the hell is going on, then you go to your hitman. The authentic self is what I ought to be" (Service User 3)*
>
> *"Like you face the acceptance of the authentic self and then the hitman self. We acknowledge that we have those self. Then we label that hitman". (Service User 4)*
>
> *"I think its yourself. Hitman is yourself. Yeah. The hitting self." (Service User 5)*

As service users learned to understand the meaning of these words, they were able to link this with their own emotions, thus providing a more robust framework in understanding their own violent processes. In the following example, for this service user, it was when he feels down or sad that he becomes more violent. Hence, when he

acknowledged that feeling of being sad, he was able to remind himself to go back to his authentic self, be assertive, and avert any potential violent responses.

> *"Like I said, I want to be the authentic self. As soon as you see yourself becoming the inferior or the hitman, you have to come back to your authentic self. When you feel down, or someone says something to you. You have to come back to your authentic self. You have to be assertive." (Service User 3)*

This service user was also able to link his feelings of being scared with his fatal peril and could sense when he would be approaching this crucial point.

> *"The inferior, that's when I had my fatal peril. It scared. I would have my fatal peril because I feel down or I get growled at." (Service User 3)*

Another service user demonstrated the connection between his feelings of anger and his hitman.

> *"What I do remember is the hitman. Fade your hitman. Hold my hitman. Something like that. I think it was to do with anger." (Service User 5)*

These framing words also assisted staff and service users to create common knowledge about violence. This enabled the staff and service users to understand each other through common words. It assisted staff in reinforcing the understanding of violence amongst service users.

> *"It's a very useful programme to give people concepts to hang on to. Words mean that they mean something for them, that they learn over and over, you know. And it's very boring for the facilitators but for them it has meaning. You know, I learnt something from it… code words for them to hang stuff." (Facilitator 2)*

Staff had also commented on how learning these words had equipped service users to talk about violence in a way that would make sense to them personally. The words enabled service users to have a more thoughtful reflection of themselves in how they progress towards violating.

> *"…some of the language can be hard to wrap your tongue around – fatal peril. But then hitman, hitman and things like that. I think [facilitator's name] within this programme, he challenged people to really understand and unpack how they violate – there was no 'I physically violated', you have to break it down, break that down so you have a better understanding". (Staff 3)*

By understanding the continuum of violence through the use of these framing words, what became critical was that service users developed a sense of ownership and accountability with their violent tendencies. By identifying their fatal peril and the violence of their hitman when expressed, service users were able to divert from their hitman and turn towards their authentic self when they are standing at the crossroads of fatal peril.

> *"I am quite sensitive. So, I go to my fatal peril a lot. I do get down, violence, violence, nah…I get angry, everyone gets angry but I'm not as bad as I used to be. Like if someone gets angry to me, I go to my inferior before, I would go "what did you say?" [in an angry tone], but now I would put my head low, and go back to my authentic self. I get a bit down- It's just a word- but I'll try and go back to my authentic self. I get name drop but I go back to my authentic self. I still remember the names they use at me many years ago, but I go to my authentic self." (Service User 3)*

A service user described that identifying their hitman was a pivotal moment in their understanding of violence. The hitman was their historical self who had experienced violence and deep hurt. However, the service user learnt that the hitman does not need to be expressed anymore, and he can choose not to be violent. Identifying the continuum of violence had paved the way for service users to utilise personal coping skills to avert violent behaviour.

> *"And saying actually' is my hitman –[it] has history and that person hurt me. You are able to start to see the connectedness of the feelings, accepting it, and taking some tools of what we have learnt and ok; this is how I will deal with it. And then you are accepting it, not tuning it out. You [are] utilising the tools. That is part of wellness, that is part of being whole." (Service User 4)*

Personal Coping Skills

Personal coping skills was the fourth ManAlive process. By understanding the continuum of violence, service users had identified that fatal peril was a critical action point to avert the hitman and becoming violent. For example, for this service user, he understood that he could deal with his anger differently than before when he would just keep it to himself until he lost control.

> *"And I'm glad I took away you know there is a way to deal with anger. There is an answer. You don't have to bottle it up inside yourself and let it blow up." (Service User 5)*

The way to avert violent responses by utilising coping skills is different for each service user. For one service user, he realised that removing himself from the situation when he gets angry was his coping skill to avoid violent verbal outbursts, which would have occurred in the past.

> *"I get angry, everyone gets angry but I'm not as bad as I used to be. Like if someone gets angry to me, I go to my inferior before, I would go "what did you say?", but now I would put my head low, and go back to my authentic self" (Service User 3)*

For this service user, his success towards his violence recovery was not becoming angry and getting into trouble 'over little things' anymore.

> *"Learning to be in touch with my true self…you know you won't cause trouble or get angry over little things. Or going into inferior which makes you sad." (Service User 3)*

Service users described other numerous ways on how to deal with their violent tendencies with personal coping skills. Service users acknowledged the violent ways they had expressed themselves when angry and frustrated. Through the Tū Tahanga programme, service users felt more readily equipped in responding more appropriately to potentially provoking situations.

> *"It's pretty good knowing it. Before I did not know how to do with it. Before I hold anger inside of me and then it will boil over after a period of time. It will boil over. Now, I can let it drift away." (Service User 5)*

Another service user verbalised his practice of coping skills when he would feel angry or provoked to avoid becoming violent.

> *"Nah, I didn't think I had a problem with violence. And then as I did the programme, I learnt skills and tools of, um …reducing my violence. Like even on daily basis each day. On daily basis, I learnt skills and tools, to cope with my violence, anger or moody." (Service User 1)*

For another service user, he learned breathing techniques in Tū Tahanga, that served him in reducing his anger that would otherwise lead to violent acts in the past. The service user was pleased in knowing that violence was not the only way he could express frustration and anger, but deep breathing helped him release these negative emotions.

> *"It's when you release (service user breathes out as a demonstration) your negative emotions and you are, instead of acting upon it, you breathe, let is fade away all the anger and the negative energy… And I'm glad I took away you know there is a way to deal with anger. There is an answer. You don't have to bottle it up inside yourself and let it blow up." (Service User 5)*

Another service user described how deep breathing helped to relieve stressful emotions that would have otherwise driven him towards violent behaviours. He credited the Tū Tahanga programme in teaching him an effective coping mechanism that he did not know before.

> *"Even just deep breathing. Breathe in with your nose, breathe out with your mouth. Um, cleaning helps with my stress. Tū Tahanga helped me a lot not to be a violent person anymore. Cuz' I've never talked about. I didn't know this until I've done the programme" (Service User 1)*

Being mindful was another coping skill service users used in reducing their violence. For service users, being mindful was a release of pent up emotions. Being mindful allowed service users to have a positive mindset by focussing on things they were thankful for and realising that others deserve respect. This service user knew the practice of being mindful through the Tū Tahanga programme.

> *"It's just like being mindful. It's something I never used to do. I never used to be mindful. When you talk about that; it's like a*

release…Mindful is good. When I was not mindful, [service user's name] is not thankful, [service user's name] does not say thank you, [service user's name] does not say sorry. But being mindful is like respect. It's like respecting a person, being mindful." (Service User 1)

Another form of coping skill was the use of hand gestures. These hand gestures replaced verbal expletives or violent physical expressions when experiencing confronting and upsetting situations. Using the hand gestures appeared to be used as an alternative way of venting out. A service user described and demonstrated this hand gesture:

"I remember how to solve things that are like in situation where we might be angry or situation towards other people…There was a time we did those hand things, signs." (Service User 2)

From these narratives coping skills were an important process the service users learnt to avert becoming violent. Each service user found effective ways of using coping skills personally. Finally, after engaging with Tū Tahanga and learning the group's process and practising what has been learnt, service users would receive a completion certificate from the facilitators.

Certificate of Completion

Receiving a certificate of completion was the last component of the ManAlive process. The certificates were prepared by the facilitators and were presented to service users upon completing all the Tū Tahanga sessions. The Tū Tahanga programme spans for approximately 20 weeks, with one session conducted once a week. For service users, the certificate provided solid and tangible evidence of achievement. Service users also collected certificates from other programmes they have completed.

"Certificate are cool, aye! Like you look at it, and then when you see, you complete the 20 sessions, 20 days. And you see, you complete 20 weeks. The certificate yea, when you look at the certificate, it's like you accomplish something. Like accomplishment. And makes you feel cool. I've done something. Yeah, I keep it. I have like 25 certificates in my room; mind over mood, kapa haka, recovery support. Yeah, I got about 25 certificates in my room." (Service User 1)

Another service user echoed the same sense of pride when he completed the Tū Tahanga programme and received his certificate. This service user contemplated hanging the certificate on his wall to showcase his achievement to others. Moreover, the significance of putting the certificate on the wall served as a reminder of the journey he made over the years of rehabilitation in the forensic mental health service.

> *"I think it is good. I still have it in my room. it's a certificate of achievement. You achieved it. If you do it again, you get another certificate. I put it in my folder. I got about 15. In [name of workplace], I get more certificates. And maybe, I hang it on the wall, and I say to people, it's the courses I've done. And yeah, good!" (Service User 3)*

The certificate also served as a testament that they could accomplish something worthwhile. The certificate provided an incentive to attend and complete other groups. For some service users, receiving the certificate was an emotional event. The certificate of completion provided a sense of achievement that balms the disappointments and self-doubts service users had experienced in the past.

> *"When I was at school, I never got a certificate." (Service User 1)*

Facilitators also recognized the value service users placed in receiving completion certificates. The facilitators understood that certificates were proof of the recovery of service users through forensic mental health services. Service users would present certificates as evidence in their clinical reviews and other reviews, such as parole board hearings, that ultimately make decisions about their care and future. Service users understood that presenting these certificates to these reviews showcased their recovery and would yield to more favourable outcomes regarding their care and future.

> *"Certificates are like their passport to get out of here. Tū Tahanga is no exception. But that doesn't mean they don't learn anything from the programme. It's just means they need to have some proof. The proof is for special review panel, or for the parole board. Or to whoever will need to make decision about their future." (Facilitator 2)*

In conclusion, the ManAlive process consists of checking in and checking out, emotional awareness, the continuum of violence, personal coping skills and receiving the certificate of completion. These practices provide a transitional framework in which

forensic mental health service users progress through the violence prevention programme.

Theme Two: The Kaupapa Māori of Tū Tahanga

The Kaupapa Māori adaptation to Tū Tahanga is the second theme of the findings. This theme captures the kaupapa Māori principles that have been integrated into the Tū Tahanga programme. There are four sub-themes, and these are 'The Bridging of Kaupapa Māori and ManAlive', 'Māori Facilitator as a Role Model', 'Hohou Rongo', 'Te Whare Tapa Wha' and 'Setting the Space'.

<u>The Bridging of Kaupapa Māori and ManAlive</u>

In the past decade, there was recognition by the regional forensic mental health service of the need to design, implement and deliver culturally responsive programmes for Māori forensic mental health service users. This is a reflection of the local District Health Board (Te Aranga Hou, n.d.) and Government requirements (Ministry of Health, 2014) to reduce the disparity experienced by Māori regarding poor mental health outcomes. This disparity was recognised by the participants in this study, given that the majority of service users presenting to forensic mental health services are Māori.

> *"We [Māori] are overrepresented in prisons and psychiatric facilities, and there is always – and everyone is always looking for the way forward." (Staff 3)*

Something different needed to be done to cater specifically for the needs of Māori forensic mental health service users. To address the needs of Māori mental health service users, service providers recognized the need for incorporating kaupapa Māori into service delivery. The overall aim of this incorporation was to make the service more culturally responsive. It has been recognized that incorporating kaupapa Māori into service delivery has the potential to improve responsiveness to Māori service users and in turn improve the overall health outcomes for this population (He Ara Oranga, 2018).

This awareness led to reconceptualising how the current programmes running in the service could incorporate kaupapa Māori. The challenge was taken by the kaupapa Māori forensic mental health inpatient unit to be "*the best in clinical and the best in cultural" (Staff 3*) in the programmes offered to Māori forensic mental health service users.

A research participant (staff 3) gave an account of how Tū Tahanga started in the forensic mental health inpatient unit. Before Tū Tahanga, ManAlive was running in the forensic inpatient unit. The ManAlive programme was brought into the forensic service in 2000 when Hamish Sinclair, the founder of the ManAlive programme, came to the forensic mental health service. The ManAlive programme was adapted by the inpatient unit and was being facilitated by a psychologist.

> *"Tū Tahanga started, the journey started in the kaupapa service in 2006. In that time, we had ManAlive. It was ManAlive running through the service… He [founder of ManAlive] done the training in the service and the service was committed to it. When we moved into the kaupapa Māori, we had strategic plan was to bring in kaupapa Māori programmes. And so, what we did was augment ManAlive and kaupapa Māori concepts." (Staff 3)*

The challenge was then to reconceptualise ManAlive to incorporate a Māori perspective. To do so, it needed to have a Māori facilitator who understands the process of ManAlive, who could also deliver its content within a Māori framework. The initial process of incorporating kaupapa Māori into ManAlive started by identifying a suitable Māori programme facilitator. The forensic mental health service's Māori cultural worker was trained to carry out the vision of transforming ManAlive into a violence intervention programme with a kaupapa Māori adaptation.

> *"My part of my experience is, what makes it kaupapa Māori, what makes it more culturally applicable is the facilitator has the understanding of that particular culture, who comes from that particular culture and can communicate the nuances of that culture." (Facilitator 1)*

The Māori cultural worker went to San Francisco, USA, in 2014 to learn about ManAlive personally. The cultural worker worked and learned alongside Hamish Sinclair. In addition to being mentored by the founder of ManAlive, he also saw how

ManAlive was delivered in various settings such as in prison, and to minority population groups, especially with America's indigenous population. Having gained new knowledge about the ManAlive programme and an understanding about how kaupapa Māori could be incorporated into this, the Māori cultural worker was able to instigate the genesis of Tū Tahanga, precipitating the beginning of a kaupapa Māori adapted violence prevention programme in the forensic mental health service.

> *"So, while he was away, he [the facilitator] spent time with Hamish Sinclair, pretty much the coordinator, the man alive guru. And he spent time at the prison system, he spent time at 'lifers', he spent time with I guess the lesbian and gay groups and he also spent a little bit of his time in the indigenous groups as well. So, part of his journey, I suppose was to work out what are the nuts and bolts of ManAlive. And so, when he came back, he came back with the mātauranga, all that knowledge." (Staff 3)*

The role of the Māori cultural worker was pivotal in the genesis of the Tū Tahanga programme. This role of the Māori cultural worker developed further as he became a role model to Māori forensic mental health service users in addressing violence.

Māori Facilitator as a Role Model

Role modelling was an integral Māori practice done in Tū Tahanga. From the narratives of research participants, role modelling was championed by the primary facilitator who was Māori. The essence of role modelling comes through from the visible manifestation of the primary facilitator's desire to address his violence and help other people, especially Māori forensic mental health service users in addressing their violence.

> *"But I think also, it's the facilitation. I think it works, [Facilitator 1] himself has got their nature and it think it takes a person with a skill… I think the whole idea of Māori facilitator is important. That's the package and the deal. Yeah, I think it makes a huge different. The person who is facilitating." (Staff 2)*

Another staff participant echoed the importance of having a primary facilitator who was Māori and was conscientious in addressing his violence. The primary

facilitator was described as someone approachable and attuned to the emotions and needs of others around him. However, being Māori alone was not sufficient but also the Māori facilitator's positive virtues that placed him to be an inspiration to others through his actions.

> *"And [facilitator name] is a fantastic role model. He is someone who addressed his own violence. He can't and does not want to be violent. He can't go around hurting someone's feeling. He is very conscious of what he says and does. He tries not to be violent and that's fantastic role model to the group. He was not a violent man. He is really open working with issues and inspires everyone else. That's really powerful in the group. And the fact that people owning their violence, talking about their violence, and I was really happy to do it" (Staff 1)*

Although limited in his elaboration, a service user also acknowledged the value of having a Māori facilitator.

> *"We had [primary facilitator] running it, which was quite good." (Service User 5)*

Furthermore, the facilitator himself acknowledged that being Māori had positioned him well to engage and communicate with Māori forensic mental health service users more sensitively.

> *"My part of my experience is, what makes it kaupapa Māori, what makes it more culturally applicable is the facilitator has the understanding of that particular culture, who come from that particular culture and can communicate the nuances of that culture." (Facilitator 1)*

The facilitator acknowledged that his capacity to role model was because he was a participant before in ManAlive and therefore had his own personal experiences to draw from.

> *"I ended up in San Francisco to train and from that training, and my time at Man Alive I had realization of what works and what doesn't work and what might work better from my experience. I started Man Alive February of 2008 as a participant of the group not as facilitator." (Facilitator 1)*

Role modelling was a crucial cultural component of the programme that showed Māori service users that change is possible. The Māori facilitator inspired service users to have a belief in themselves that addressing violence was possible. A Māori practice that was specifically role modelled in helping service users deal with potentially provoking and conflicting situations was hohou rongo.

Hohou Rongo

Hohou rongo is a Māori term that translates to 'make peace' (Moorefield, 2011). In the context of Tū Tahanga, hohou rongo was used to mean conflict resolution. Being in a violence prevention programme, it was inevitable that differences in ideas would arise that could lead to developing conflicts. In such instances, staff facilitated hohou rongo to bring resolution between Tū Tahanga participants.

> *"There are times I remember, like one time hohou rongo that happened after the group between a man and a woman and the man was snipping and snarky and I can't remember what it was but that was the thing we do afterwards. Just to bring them peace." (Staff 4)*

Hohou rongo appeared to be an essential part of Tū Tahanga. Hohou rongo not only brought resolution between individuals, but it also enabled listening and empathy development towards one another. This helped service users to deal with challenges from others. Differences of opinion may occur and words from others may hurt during a group session. However, it was only through mutual communication that resolution could be achieved. Hohou rongo modelled to service users more constructive means of conflict resolution, thereby unlearning violent ways of dealing with conflict.

> *"…the case that I saw, it was about the person about how they were hurt by the other person and they shared their story and they got to share how they were hurt by the person and the other person had to listen to the pain, from what has caused and from the discussion, and at the end during that time of hearing the story, they reflect on… then that person during that time, was thinking, and then apologised." (Staff 2)*

Hohou rongo went beyond supporting individuals to make peace with one another. Hohou rongo was also utilised to resolve personal conflicts service users may be experiencing. As a service user described below, there were times when issues and

problems are brought by service users into the Tū Tahanga group. If such is the case, there was the choice that one may choose to leave the group and have hohou rongo done individually. For this service user, the process of hohou rongo had helped them process feelings of anger appropriately and they left the session feeling happy.

> *"So, you go in the group feeling angry, then you come out of the group feeling happy…If you got any angry issues and get angry you gotta leave the group. If you feel like hitman and then you gotta leave the group. There is zero tolerance in being angry in the group. (Service User 1)*

Staff also saw hohou rongo as a process staff could utilise to support service users in making sense of their internal conflict. The staff's narrative below captured this individualised practice of hohou rongo when a service user highlighted an issue regarding their family.

> *"So people might bring up process, and it could be quite involved like family and it's not something that's easy to process in the group. And so, we would catch up with people outside the group" (Staff 4)*

Hohou rongo was a kaupapa Māori practice done in Tū Tahanga to practice conflict resolution within the group. Hohou rongo also appeared to be utilised by staff as a one-to-one session especially when service users present with issues and problems, they may not feel comfortable addressing within a group setting. Practicing hohou rongo, especially when done through one-to-one work with service users, highlighted that violence impacts one's holistic health. As touched on by the quote of Staff 4 above, talking about violence can bring up personal impacts of violence in one's life. In that instance, it was the impacts of violence in the family life of a service user. The kaupapa Māori approach of utilising the Māori model of health, Te Whare Tapa Wha, was another cultural component of Tū Tahanga.

<u>Te Whare Tapa Whā</u>

The Te Whare Tapa Whā was an integral kaupapa Māori concept described by both staff and service users. Staff and service users understood health using the Te Whare Tapa Whā model and discussed how violence impacted their holistic health. The

‘Te Whare Tapa Whā’ is a Māori model of health conceptualized by Mason Durie in 1984 (Ministry of Health, 2017b). The model conceptualised health using a whare (house) built with four walls. Each wall represents domains of an individual’s wellbeing and health. The Te Whare Tapa Whā model asserts that to achieve optimum health, all walls need to stand strong equally. Any deterioration on any wall means the house cannot stand, thereby representing compromised health. The four walls are Taha Tinana which represents physical health; Taha Wairua that represents spiritual health and energies; Taha Hinengaro that represents mental health including thoughts, feelings, and emotion; and lastly, Taha Whānau which represents family and belonging with others (Ministry of Health, 2017b).

Staff identified the Te Whare Tapa Whā as a vital component integrated into Tū Tahanga. The model was seen as the right fit to aid the understanding of service users’ of the broad impacts of violence in one’s life. The staff iterated the components of Te Whare Tapa Whā and how Tū Tahanga supported service users in building up their walls.

> *“The Te Whare Tapa Whā is an easy model. It’s a health model that has those factors that are incorporated in what we call mental health. Yes, you know every time people talk about the feelings it is the hinengaro. So that’s one aspect. Quite often we talk about the spirit. The wairua. It is very much incorporated in the whole way we think about well-being. Easy to see, the family, the spiritualty, our mental health, the feelings and emotions and the physical health. So, all of that is incorporated in Tū Tahanga. The thing is the philosophy of Te Whare Tapa Whā is that when one wall is weak, it weakens the whole house. So, it’s about spending time and building it up. Getting some support to help you. So that’s what very much is Tū Tahanga.” (Staff 4)*

As much as possible, Te Reo Māori (Māori language) was also incorporated in the sessions to enrich the cultural component of the Tū Tahanga. For example, to aid the learning of Taha Hinengaro, words describing emotions were written in Te Reo Māori.

> *“The terms they use on the wall, which they put up. So, people can describe what they are feeling and there are Māori terms on that.” (Staff 4)*

It appeared that the intentional teaching of Te Whare Tapa Whā in Tū Tahanga was successful as service users were able to understand the impacts of violence in their life using the Māori health model. As a service user described:

> *"That's why I'm telling you, it's the realization of Te Whare Tapa Whā in Tū Tahanga. But I do remember that you could reflect the aspect of Tū Tahanga using the Te Whare Tapa Whā and see how it did affect the Te Whare Tapa Whā and how we can use the tools in Tū Tahanga to influence the Te Whare Tapa Wha…It's all to do with violence, our recovering from that. Violence is a learnt thing. And it's about unlearning it." (Service User 4)*

The service user further reflected on the impacts violence had had on her life personally using Te Whare Tapa Whā.

> *"There is just genuineness, with the respect to the Te Whare Tapa Whā component. We were not only looking at our violence personally, but we are also looking at the impact of violence in our family, in our minds and mindset. The impact of violence in respect to the physical, if there is self-harm involved. Other component of that is the spirit." (Service User 4)*

A service user described beautifully her closing thoughts about the Te Whare Tapa Whā and its place in violence intervention for Māori mental health forensic service users. There was a clear understanding that if one is to be successful in their recovery from violence, all four walls of the whare must be considered and rebuilt strongly once again. The Tū Tahanga programme was instrumental in helping service users understand health and the impacts of violence in a holistic way. It was also stressed the process of healing from violence takes time and intentionality for each person.

> *"The reality is something happened to the house that's why we are here, if it's not the walls, it will be flat and that needs to be rebuilt again. And yeah, I think it has been beneficial." (service user 4)*

<u>Setting the Space</u>

Setting the space was a cultural process identified by staff and service users. Setting the space was a practice that sets the cultural milieu of Tū Tahanga. Setting the

space consisted of utilising the wharenui (communal space) as a place of gathering and doing a karakia (Māori prayer) before and after each Tū Tahanga session.

> *"Well, Tū Tahanga is definitely within the kaupapa. It is in the whare. It was opened and closed with prayer, karakia. So generally, with kaupapa we have that." (Service user 4)*

> *"Like we start and finish with a karakia. Some of the processes like how, they get together in the wharenui and get a resolution." (Staff 1)*

Tū Tahanga was held in the inpatient unit's wharenui. In Māori, the wharenui is a communal space where meetings and gatherings are held (Moorfield, 2011). According to the research participants, the wharenui provided an environment that fosters unity, understanding, and acceptance amongst its visitors. Delivering Tū Tahanga in the wharenui provided a therapeutic milieu that enabled participants to work with each other in violence prevention within a cultural space.

> *"The wharenui is the ultimate space for discussion, for healing... But when you enter the doors, basically you enter into the house of peace. So, I think its inherent with most of our whanau that when you come into the space there is an expected level of behaviour and respect and it does not really matter if you are a staff or whai te ora (people seeking wellness; service users)… You come in with trying to heal, trying to help people and better yourself…Anyone who comes through here who has intent of healing." (Staff. 3)*

Additionally, having the Tū Tahanga in the wharenui fostered a space in which people can be genuine with one another and themselves. Even though located within the inpatient unit, the wharenui was not considered a clinical space that tends to focus on diagnoses and medical treatment. Rather, the wharenui was a spiritual space that empowered people to recognize and reflect their values and precepts.

> *"There is genuineness there and you can feel it…It has to do with the space because you are in the whare…We are not sitting in a clinical space but in a whare…We are in the wharenui." (Staff 2)*

Performing a karakia was another crucial practice that sets the cultural milieu of Tū Tahanga. At the beginning of each Tū Tahanga sessions, a karakia was said by a member of the group. Karakia is the Māori word for prayer (Moorfield, 2011). For the

Tū Tahanga participants, the karakia signified that everyone had gathered to address the issue of violence. The karakia signified unity and respect amongst the participants.

> *"Setting the space and making the space safe. They understand that principle culturally. Like when they do a karakia. That sets a tone that everyone knows. If working on generic things, like everyone is equal." (Facilitator 1)*

For some service users, the karakia was an act that sets them up to be attentive and respectful to the group. The karakia can also be done in other languages other than Te Reo Māori, particularly to allow service users to have the chance to open the group in another language, which they feel more comfortable.

> *"We begin with a prayer. Yeah, and it gets us focussed in the moment. It can be in Māori or English" (Service user 5)*

The kaupapa Māori of Tū Tahanga begun from its conception. The kaupapa Māori practices of hohou rongo, using the Te Whare Tapa Whā and setting the space provided the cultural adaptations of the programme.

Theme Three: The Personal Impacts of Violence

The personal impacts of violence explored the realisation of service users' own violence and also in being victims of violence. This realisation was a powerful epiphany for service users. Engaging in the Tū Tahanga group was critical for service users to come to this realisation. This awareness made service users realise how their violence impacted on others and has aided coming to the realisation that they themselves have been victims of violence in the past. A service user eloquently described the Tu Tahanga's purpose of bringing about one's awareness of violence.

> *"Tu Tahanga it was a group that focused on recognizing how our perspective towards violence impacts ourselves and others…The intention was to bring consumers of the service to the awareness of how their violence affected others and how other people's violence brought them here." (Service User 4)*

The awareness of being violent also came with the realisation of its consequences for service users. It was evident to service users that violence was a major contributing factor that resulted in them beinginto the forensic mental health service.

> *"Most of us in [forensic service's name] get here because of violence offences." (Service User 3)*

The Tū Tahanga was an instrumental programme in helping service users recognise violence.

> *"Until I did Tū Tahanga, I didn't understand my violence. I didn't think I had a problem with violence until I did the programme. And yeah, I'm like yea, I've done this and that, and this." (Service User 1)*

Other service users also emphasised how the Tū Tahanga was pivotal in helping them recognise their violence.

> *"In things we talked about, I didn't think there was a problem until I actually realize I have a problem. I have to sort my s*** out. Um, yeah just the programme yeah, we talked about what makes me realize I did have a problem. But before those groups, no I don't have a problem." (Service User 1)*

Another service user had the same realisation of their violence and its negative impact on him and others through engaging in the Tū Tahanga programme. Being violent for this service user was his way of life and he was not able to realise that violence is inappropriate until it was taught to him.

> *"Just finding out that violence is not a good thing to do. I knew that before but I only learnt about it. Cuz' I was quite violent before I came to [the service name]. They were telling me it's not normal…When I was at prison, I thought violence was normal". (Service User 3)*

It was not only service users who were challenged with their own violence, but staff too who also attended the Tū Tahanga programme. For staff, the Tū Tahanga group was more than just bringing awareness of their violence but also being committed to the process of addressing violence consistently in whatever form it may take in their lives.

> *"So for me, its acknowledgement of my own violence and determination to be removed from violence. To be less violent than I could be." (Staff 1)*

Staff also stressed that awareness of one's violence is a universal lesson. Everyone who comes into the Tū Tahanga group had to have the intention of addressing their violence.

> *"I suppose that's one of the biggest positives that I see – you see young men and women, staff come through here. No one is exempt through the Tū Tahanga process." (Staff 3)*

Staff exemplified their awareness of their own violence through disclosures in the group discussions.

> *"And the staff are learning it as well. And if they are willing to disclose, they are also addressing their own issues within the group as well. So, there are times nurses would share their own stories." (Staff 3)*

A strong message that was understood by service users was that violence is unacceptable. Violence can take many forms, but all forms are to be avoided. There was the realisation that any violent acts cannot be justified.

> *"Just finding out that violence is not a good thing to do. I knew that before, but I only learnt about it. Cuz' I was quite violent before I came to [forensic service's name]". (Service User 3)*

As service users came to understand their violence, it also made them realise how they had been victims of violence from others in the past. As for Service User 3 who thought 'violence was normal', it was a turning point for him realising that he grew up in a family where violence was pervasive. This realisation of his past experiences of violence moved him to eliminate any forms of violence in his life. Service User 3 exemplified that service users often come from families where intergenerational violence is prevalent.

> *"If I wanna get a missus and I get angry, I can hit her. Because that's all I knew when I was a kid. So, this is the cycle. The reason I didn't get into relationship is because I knew I would hit my kids and my wife. So I said, I wanna kill that cycle. My nana did it to my dad; my dad did it to my mum. I wanna break that cycle if I get a partner." (Service User 3)*

An interesting point raised by female research participants was the perspective that the Tū Tahanga group needs to acknowledge that female forensic mental health service users have been violated before becoming violators themselves.

> *"But there was definitely a need for females as well to be able to have the same content and approach; but you probably be looking at having more females as survivors of abuse…like they were violated, then they violated." (Service User 4)*

Service users' awareness of their violence toward others and being victims of violence was a constant journey of personal reflection. This personal reflection enabled service users to be more aware of their actions towards others. Coming to Tū Tahanga made service users aware that violence can also be subtle. This was brought about as they listened to each other during sessions in the group and gained an understanding of different perspectives other than their own.

> *"Violence is violence. Like emotional manipulation. Physical manipulation. Name calling. Whatever name calling and those things can hurt people. But the great thing is it what's good about, it made us think about in every level on how we engage with others. Because generally you can get out of the group soul searching and you can leave the group knowing I never thought of that in that way and you leave wondering. And perspective of emotions around violence." (Service User 4)*

Tū Tahanga appeared to have been beneficial for service users in addressing their violence. The Tū Tahanga was instrumental for service users in understanding violence through their actions and the actions of others. In addition to this internal change, there was also a phenomenon occurring outside of Tū Tahanga that reinforced the violence prevention work of service users. This external phenomenon was identified as 'mirroring'.

Theme Four: Mirroring

Mirroring was an interesting finding drawn from the analysis of the data and was an external process that was occurring outside of Tū Tahanga. It pertained to the way of life in the inpatient unit that 'mirrors' what happens in the Tū Tahanga.

In the narratives of the research participants, as much as they would describe what happens in Tū Tahanga, there were also parallel observations made on how their way of life in the inpatient unit was similar to the practices of Tū Tahanga group. Unlike in traditional ManAlive groups wherein participants come from their communities and only meet during the ManAlive session, in Tū Tahanga all participants were part of the same community and that is the shared inpatient unit. Belonging in the same inpatient unit that mirrors the similar processes of Tū Tahanga enabled the reinforcement of the learnings gained in Tū Tahanga in a communal context. This led to the building of trust and accountability amongst the service users.

> *"I think, they have known each other for a while and there is an element of trust. And the space has allowed them to build that… like how the space is set up. Like they eat together, and the same whanau do the same carvings… And so when I think, it's almost like they have to form connection, in that space and it blooms. Cause if you don't form connection, or face to face, or sit down and eat with people, you really do not have obligations to reciprocate." (Staff 2)*

The ManAlive processes and the Māori cultural processes were effectively mirrored in the inpatient unit. The following are excerpts of the research participants' narrative that identified the way of life in the unit having similar processes with Tū Tahanga.

Checking In and Checking Out

Checking in and checking out were practiced in the inpatient unit. The checking in happened at the beginning of the day and the checking out happened in the afternoon. The checking in and checking out were routine practices of the inpatient unit. The inpatient unit's checking in and checking out were also held in the wharenui and were opened and closed off by a karakia, thereby mirroring the cultural process of 'setting the space'.

> *"We follow a process of checking in and checking out. So, in checking in, the process never changes. It happens at 8:30 every morning. It's almost like Tū Tahanga is a live programme… It happens every day…the check-out process that happens at 20 past three every afternoon." (Staff 3)*

Emotional Awareness

Service users continued to demonstrate emotional awareness outside of the group when in the inpatient unit. Service users were encouraged to share their emotions as they would if they were in Tū Tahanga. A staff emphasized how this practice of emotional awareness would normally occur during the inpatient unit's routine checking in and checking out.

> *"So check in the morning and check out in the afternoon. The Tū Tahanga programme gave all the individuals the skills to participate fully in the check in and check out. And they can talk about whether it be emotional or something that is sitting on their chest, the problem." (Staff 3)*

Continuum of Violence

As service users become more familiar with the continuum of violence as taught in Tū Tahanga, they could identify when their peers in the unit were becoming aroused.

> *"You have to be real at it. Sometimes its ok to be angry, [but] I don't want to bring those emotions out. But someone being angry and venting, is like "What the heck is goin' on there?". That happened in the unit." (Service User 4)*

Personal Coping Skills

Part of the coping skills taught in Tū Tahanga was the use of hand gestures to replace verbal expletives that one might use when upset, frustrated or angry. These hand gestures then provided an appropriate alternative in venting out negative emotions in a non-violent manner with their peers in the unit.

> *"So, we learnt this sign that means "what the f***?". So the idea is you don't say the words, you sign them with a gesture...and this means "what the f***?" [mimes a hand gesture] so instead of swearing; It was comfortable and how it would translate in the unit." (Service User 4)*

Role Modelling

Role modelling of pro-social engagement was not just practised by the facilitators, but also by staff. As the service users and staff were present within the same inpatient unit, there were a number of opportunities to role model and to witness role-modelling from one another.

> *"The kaupapa of the unit where we run it from is a community. The learning is done together. So, the staff can understand the content the patient are learning but would also help in using the same language and ways of communicating with the patient." (staff 3)*

Hohou Rongo

Hohou rongo was also applied in the inpatient unit and was part of the day to day living. The statement from Staff 3 below describes how staff would conduct hohou rongo in the wharenui when service users and staff presented their issues.

> *"So, if there's a problem day to day would be called out and come into the wharenui. And senior member of the staff or a cultural advisor would come with you with the whanau. We are not just talking about patients but also about staff and they would come in the wharenui and get discussion. So that process we are talking about is that hohou rongo - conflict resolution." (Staff 3)*

The practice of hohou rongo in the inpatient unit has led to it being perceived as a safer unit.

> *"There is less violence, we hardly had any violence in the unit. I saw a process called hohou rongo was easier to facilitate in the unit. So hohou rongo is like conflict resolution – because Tū Tahanga showed them a process of dealing with conflict, stress and whatever it is." (Staff 3)*

Te Whare Tapa Wha

The Te Whara Tapa Whā was also reinforced in the inpatient unit. The intentional teaching of Te Whare Tapa Whā in the inpatient unit was effective in aiding service user's understanding of the impacts of violence on their holistic health.

> *"They take into consideration Te Whare Tapa Whā. It was something that was taught to us as being part of the kaupapa service… Te Whare Tapa Whā was taught in the unit. (Service User 4)*

As the way of life in the inpatient unit mirrored the processes of Tū Tahanga, this gave light to the way service users and staff engaged with one another within the same inpatient unit. There was an inherent culture of working together amongst the staff and service users towards recovery. The last theme that was identified highlighted this culture of Whanaungatanga, the sense of meaningful belonging and connection with others (Moorfield, 2011), that underlined the way of life in the inpatient unit.

Theme Five: Whanaungatanga

By definition, whanaungatanga is a Māori word that means to build relationship with others that gives a sense of belonging (Moorfield, 2011). The whanaungatanga that was described by research participants built a therapeutic relationship wherein everyone felt safe, respected and included. The whanaungatanga developed because of the values shared by the participants as they endeavoured to live harmoniously together in the inpatient unit.

> *"Together, I think it was quite good actually. Being in [inpatient unit] where I was learning it. We are always doing things in a group. We always do something in a group." (Service User 5)*

Unlike ManAlive, wherein participants would come from their communities, all the participants of Tū Tahanga belonged to the same community. This community was the forensic mental health inpatient psychiatric unit. Belonging in the same community provided the Tū Tahanga participants with the unique experience of being with one another within the context of daily living. This being with one another allowed for mutual support and encouragement in recovery from violence. A staff member captured the essence of whanaungatanga metaphorically by describing the community of service users and staff 'strengthens people like a thread' implying resilience in numbers.

> *"I found that process strengthened people like a thread. Like how we do. Like people have offended but it's about healing together… That's what I got from there… and have this pockets of group where people are healing together." (Staff 2)*

The sense of whanaungatanga was fostered as participants were able to know one another for a significant period inside the programme and in the inpatient unit. There was a sense of almost a cyclic process wherein the dynamics of people within the inpatient unit was carried into Tū Tahanga. Likewise, dynamics developed within Tū Tahanga were taken back into the inpatient unit. A service user described that through living with other service users in the inpatient unit for a long period, the relationship they established made them realise their shared humanity.

> *"…but also the other thing, after having lived in the company of other people within the service, you get to know them for who they are as you encounter them. You know what, there are some really lovely people here - who have really beautiful spirit." (Service User 4)*

Service users also iterated how their sense of relationship with others had grown due to the nature of being in each other's lives in the inpatient unit and in doing groups together, such as Tū Tahanga. Because of this constant togetherness, friendships were formed, and therapeutic relationships with each other developed thereby strengthening further the sense of whanaungatanga.

> *"Well it wasn't always positive, as we are stuck with each other. Positive? We made some good friends yeah." (Service User 5)*

A staff member reflected how the inherent nature of living together in the same inpatient unit meant that service users learnt to live harmoniously with each other. These relationships were taken by service users in the Tū Tahanga group that allowed them to have genuine empathy and understanding amongst themselves. As a result, service users supported one another in their recovery from violence.

> *"Like they eat together, and the same whanau do the same carvings. And so, they are building relationship which you don't get again in other services you know, like you don't get the chance to build relationship with people you are healing with you know, and so, when I think, it's almost like they have to form connection, in that space and it blooms. Cause if you don't form connection, or face to face, or sit down and eat with people, you really do not have obligations to reciprocate. But I guess in other programmes, so you are forming a bond. It also feeds into the group." (Staff 2)*

As service users strengthened their whanaungatanga, trust with each other was strengthened.

> *"I think, they have known each other for a while and there is an element of trust." (staff 2)*

Another staff member described a lasting impression from witnessing whanaungatanga being described by service users in their clinical review panels. Whanaungatanga evolved into a sense of familial relationship with other service users and staff.

> *"Some of the memorable ones were in special patient review panels to the point where some would talk openly about feeling part of the whanau and talking about identity, talking about being part of the group. It is the first time in their life they felt being part of a group and a family. Those are the moments that really hit you and they would tell you, yeah we argue but we are like any other family but it's the first time I felt to be part of a family." (Staff 3)*

The staff further commented that whanaungatanga aided service users in developing a strong sense of identity and culture. This strong sense of identity and culture fostered further understanding and relationship with one another. The whanaungatanga also strengthened service users' sense of spirituality. This narrative empathised the inherent understanding of health being holistic amongst Māori service users and the importance of whanaungatanga in addressing those areas. There was iteration about the inpatient unit being identified as a vital setting in which whanaungatanga was practised, which inevitably also fed back into the dynamics of the group that runs in the unit, such as Tū Tahanga.

> *"I would be assuming but I think there's a general theme about whanau, about whanaungatanga, it's about the support, it's about the group, it's about moving forward. We talk about identify, we talk about the importance of culture and the culture that comes through. I mean we saw improvement in people felt culturally grounded, people felt identity is improved and then we talk about the spiritual – the spiritual component and you just felt and there's a lot more heart in the unit. (Staff 3)*

The sense of whanaungatanga was strong amongst the service users and it was evident in their narratives. For this service user, she took away this feeling of being

connected as something that helped her engage in the programme. The facilitator had been instrumental in establishing relationships between individuals in the group. The sense of whanaungatanga aided the engagement of service users in Tū Tahanga.

> *"He [facilitator] made us connect in a good way… He [facilitator] got us all connecting together. It was a good feeling. 'Cuz they keep me on the move." (Service User 2)*

Interestingly this notion of whanaungatanga was also practised by non-clinical staff working in the inpatient unit. This was an interesting phenomenon to note that the sense of whanaungatanga is deeply engrained into the culture of the inpatient unit. Such practice of whanaungatanga left this service user with a strong sense of self-worth.

> *"But in reality, the people on the floor, the multi-skill to all the way through the axillaries are, they are the people that take time to ask how we are, these are the people who gives us the hugs, day to day, in a daily basis. This is in kaupapa- they give off themselves like they know about your family, what is going on, they make you feel you are still a person worthy of care and appreciation. Like there are days where, this is such a bleep, and they will go yeah that was such a bleep and they still care. The staff in Tū Tahanga is really great because you really get to feel that about the other person." (Service User 4)*

In conclusion, the findings have described Tū Tahanga as an integration of the ManAlive violence prevention processes and kaupapa Māori practices. The experiences of the participants being involved in Tū Tahanga has made them understand the personal impacts of violence. Also, the life in the inpatient unit 'mirrors' the practices of Tū Tahanga that overall cemented their recovery from violence to day-to-day application. The whanaungatanga that is strongly embedded in the culture of the Tū Tahanga programme and in the inpatient unit provided a sense of meaningful relationship and thus a therapeutic community for forensic mental health service users. The last theme, suggested improvements, explores the perceptions of the participants regarding how Tū Tahanga can be improved.

Theme Six: Suggested Improvements

In the course of data analysis, research participants raised suggested improvements for Tū Tahanga. These suggested improvements were identified and thematically organized to present these clearly. There were four suggested

improvements identified. These were ‘improving attention of service users during the group, ‘tensions in having authentic disclosures’, ‘inappropriate engagement from staff’ and lastly, ‘the need to acknowledge gender-specific issues in violence for women’.

Making Tū Tahanga more responsive to the limited attention span of service users

Making Tū Tahanga more responsive to the limited attention span of service users was a suggested improvement. The reason being was that keeping the attention of service users during group sessions was challenging. The attention span of service users was impacted by internal and external factors. The internal factors identified by participants were the Tū Tahanga’s perceived long session duration and some sessions being perceived to be too complex. The external factors identified were room temperature and the sedating effects of antipsychotics.

Staff identified that the duration of Tū Tahanga session was long. Each session was two hours approximately. Staff noticed service users losing interest and engagement as the session progressed.

> *“Session needs to be at this particular time but because of the population you deal with you have to pull it back because of their attention span. They just tired and they can’t follow you.” (Facilitator 1)*

Staff attributed the long duration to the size of the group. By having many people in the group, a staff member believed group discussions and processes took longer than they were supposed to take.

> *“Is that the group itself was, the duration of the group was long. I think it could have been two hours per session. So the duration of the group was long. I think there were a few draw backs. In the sense that, maybe the group was so long is that there are many people in it.” (Staff 4)*

Staff also thought that some of the sessions’ contents were too complex. If sessions were simplified, sessions could then be made shorter and thus improve the engagement of service users.

> *“Can it be change so more people can embrace it? I think yea. It can be simplified down. I think it is really complex in parts” (Staff 1)*

The long duration of the group meant service users would lose their focus over time. The narrative below was from a service user who described how his thinking would drift elsewhere during the group as he found it hard to sit and stay focussed for the whole duration of a session.

> *"It would go for quite a long time. It's hard for people to stay focus. It was for hour or hour and a half. It was a long time to be just sitting. And then you trying think of something…Even I found myself drifting off now and then. And I'm quite a focussed person." (Service User 5)*

Losing focus and drifting off were common experiences shared by many service users. The quote below was from another service user who described feeling sleepy during Tū Tahanga sessions.

> *"Sometimes, when you have karakia in the morning, I close my eyes I nod off, then open eyes again and nod off." (Service User 1)*

There were also external factors outside the Tū Tahanga that impacted on the attention span of service users. Service users described how the hot temperature would impact on their attention span as well as the sedating side effects of antipsychotic medications. The quote below from a service user reflected these external factors that impacted his ability to concentrate.

> *"Well, it was in the room where we were. It was quite hot. I think the heat. Yeah, that's what I found for myself. Ah, not really some people did not wanna know the topic. And the medications did not help." (Service User 5)*

<u>Creating a safer space for authentic disclosures</u>

Integral to the Tū Tahanga, service users had to authentically disclose their thoughts regarding violence. Through disclosures, service users would have the opportunity to learn from each other and support one another in their recovery from violence. Disclosing was encouraged by the facilitators as there was great value in doing so. Service users were informed that disclosing will not disadvantage them in any way and what is shared in the group is for the purpose of learning.

> *"So everyone can retain that part of themselves. And has the freedom to speak. They have the understanding that they can speak whenever as they need to without any thought that they will be judged or go down in clinical note or get stored or change their medication. Nothing anything like that. It won't disadvantage them." (Facilitator 1)*

However, service users remained very cautious when it came to disclosing information and there was a process of screening that happens with them internally. There was a sense that one cannot be truly authentic in the group when disclosing for fear of possible repercussions. Hence, creating a safer space for authentic disclosures was another area for improvement. The quote below by a service user shows that there was a fear amongst service users fearing that what they say will be recorded in their clinical notes and inevitably, impact on their care.

> *"Maybe when I told you that when I'm angry or people are angry, people wouldn't be saying that. Because they don't wanna get in trouble. Staff will write in the notes and ask why you get angry." (Service User 3)*

Another service user pointed out there were ground rules in Tū Tahanga, which intended to protect those disclosing information by instructing listeners not to be judgemental, nor to give opinions. The rationale for this ground rule was to instil a safe environment in which people can disclose. Ironically, these rules appeared to prevent service users from fully disclosing what they think of others' disclosure for fear of disagreement and possible tension.

> *"Because we are taught not to be judgemental, not to give opinions – there are all these rules. And because of all the rules, you cannot actually express yourself honestly. Because there are the conditions: no judgements, no comments, no opinions…" (Service User 4)*

Staff identified a level of coercion for service users to participate in Tū Tahanga. As programmes were seen as therapeutic for the recovery of service users in the forensic mental health system, there was an unspoken understanding that participating in groups would reflect well on service users and would yield more favourable treatment outcomes. These dynamics within the forensic mental health services may have pressured service users to disclose even if they did not feel comfortable, perhaps leading to distrust and ultimately resentment of the system.

> *"I have some ethical issues forcing people into groups, pressuring them to disclose, things they are uncomfortable it…then there is a level of coercion underneath being forced. It would look really good if you come… When they share and those that don't share, those that share get rewarded. So yeah, that usual forensic dynamics." (Staff 1)*

Better preparation for staff participating in Tū Tahanga

As Tū Tahanga was inclusive of everyone in the unit, staff attendance was crucial and encouraged. Staff participation has the potential to encourage service users and create consistency in the learnings of Tū Tahanga. The role modelling of staff disclosing about their commitment to being less violent has been a vital component of Tū Tahanga. However, there were notable instances wherein staff may have inadvertently compromised the therapeutic milieu of the Tū Tahanga. The quote below was from a staff member who remembered a fellow staff member disclosing his violence towards their children. Retrospectively, the staff member viewed this disclosure as inappropriate. The staff proposed that staff may need to be briefed and orientated firstly before coming into the Tū Tahanga group.

> *"I remember a PA (psychiatric assistant) talked about how he smashed his kids. You know, don't be like that. Don't bring that into the group. That's some serious s***. You just smashed your kids this morning, don't bring that into the group…So maybe some guidelines so people are aware of." (Staff 1)*

There were also instances where staff would dominate the discussion during the session, leaving little time for service users to disclose and have their own issues and challenges identified. Given the Tū Tahanga would have approximately 15 to 16 people, allocating reasonable time for each participant to speak was challenging.

> *" So we have 10 patients. And they all had to participate. And there could have been as many as 5 or 6 staff. So it was a big group… it is important for staff member to facilitate some of the discussion. I can't remember, but there is a tendency for example if there are six staff members in the group there is a tendency for them to dominate the group" (Staff 4)*

Finally, another aspect that was seen as disruptive to the therapeutic milieu of the group was the inconsistency of the staff present. Staff in the inpatient unit are on shift work and therefore gaining uniformity of people attending Tū Tahanga was

challenging. Having consistent people in the group would aid in creating an atmosphere of familiarity that generally would promote feelings of safety in a group setting.

> *"The other five staff who are asked to attend may be rostered on or rostered off and I don't think that helps the group sometimes." (Staff 4)*

The need to acknowledge gender-specific issues in violence for women

The last issue identified by research participants was the need to acknowledge gender-specific issues about women in the Tū Tahanga programme. The staff and the service user who identified this issue were both women and the only women in the research participant cohort. For the women research participants, there were issues regarding women and violence that could be explored and addressed much better. For example, a suggestion for Tū Tahanga to acknowledge gender-specific issues was to identify that female mentally ill offenders would be likely to have extensive historical violent trauma before addressing any of the violent behaviours of women.

> *"But there was definitely a need for females as well to be able to have the same content and approach, but you probably be looking at having more females as survivors of abuse and then abused. Like they were violated then they violated." (Service User 4)*

From the staff's perspective, even though she believed that the gender mix in Tū Tahanga remained beneficial overall, there were still some issues that women would like to have raised in confidence with other women, such as tensions with patriarchy.

> *"I guess there are women's issues today that tension with patriarchy, like male presence in a scenario that makes it unsuitable and it's kinda like women need their space. I think for Tū Tahanga the mix works, because it does work, and it just does. It's not identifying with just one gender but with the women group, it will just be centred on women's issues." (Staff 2)*

The female research participants acknowledged this limited recognition of gender-specific issues for women, and violence could perhaps have been addressed much better if there was a woman facilitator in Tū Tahanga.

> *"But they were both males. So that was unfortunate. It would have been good if they have a female facilitator to represent the female service users in a different perspective as well for the future." (Service User 4)*

In conclusion, there were several suggested improvements highlighted by the research participants. These were to make Tū Tahanga more responsive to the limited attention span of service users, creating a safer space for authentic disclosures, better preparation for staff participating in Tū Tahanga, and to acknowledge gender-specific issues of violence pertaining to women. These suggested improvements would provide a way forward for the future development of Tū Tahanga. These suggested improvements, alongside the other findings of this research, are to be discussed in the final chapter.

Summary

The diagrammatic model (Diagram 2) below summarises the findings of the research. The Tū Tahanga programme is at the intersection of two different paradigms – the kaupapa Māori and the ManAlive violence prevention programme. This signifies that Tū Tahanga is grounded in these two paradigms. The 'mirroring' process is the seamless reflection of Tū Tahanga that occurs in the forensic inpatient mental health unit. The 'mirroring' process is also located at the intersection of the ManAlive and Kaupapa Māori. This signifies the presence of those two paradigms in the mirroring process that occurs in the inpatient unit.

It is important to notice too that the Tū Tahanga and the mirroring are coloured in medium-shade brown. This is a gradient shade to the light brown colour of ManAlive and the dark brown colour of Kaupapa Māori. This symbolises the balanced approach of the Tū Tahanga programme of the ManAlive and the kaupapa Māori paradigms. The whanaungatanga provides the overall green backdrop of the diagram. The green backdrop symbolises the encompassing influence of whanaungatanga in the dynamics of the Tū Tahanga programme and within the forensic inpatient mental health unit. This means that everything that is done within the Tū Tahanga and the forensic inpatient mental health unit is grounded in a mutually shared therapeutic relationship people have with one another.

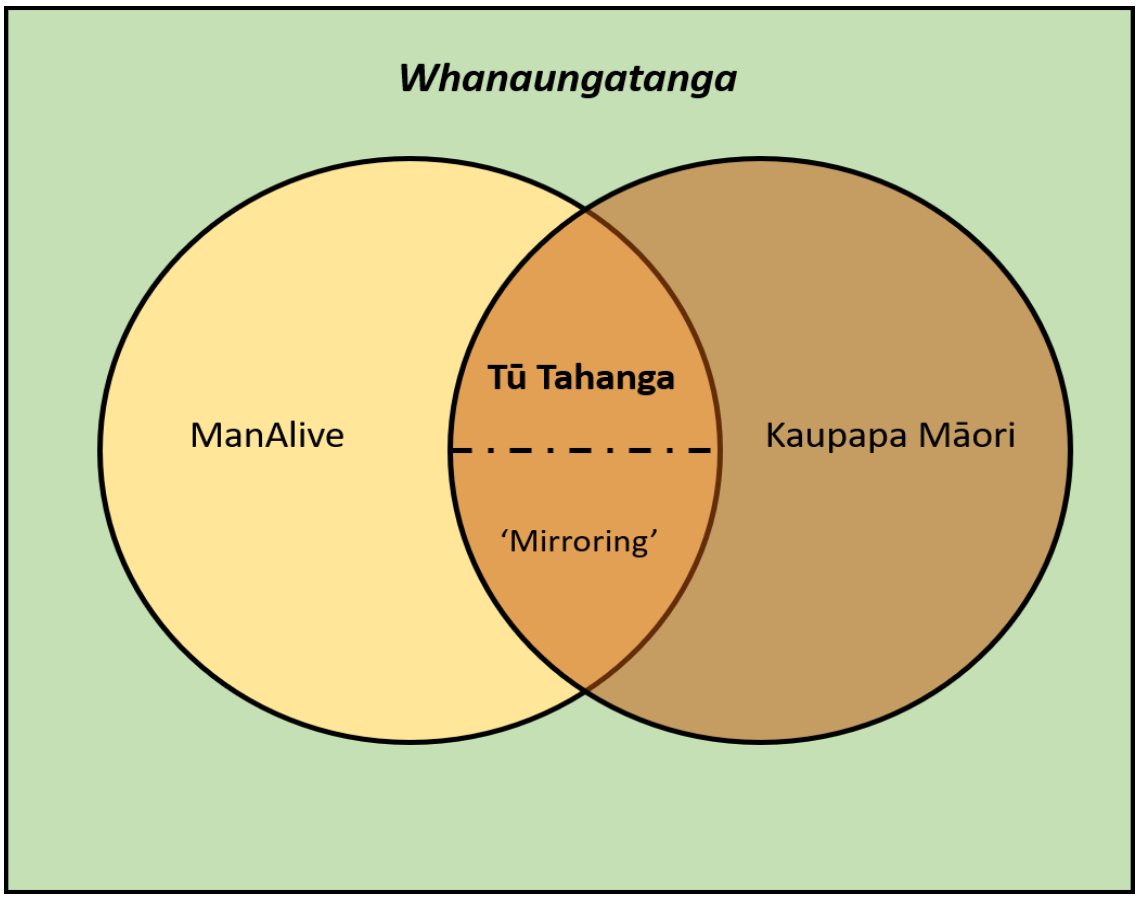

Diagram 2: Diagrammatic model of the findings.

Chapter V: Discussions and Recommendations

Introduction

This research aimed to describe what the Tū Tahanga programme was and to explore the experiences of people involved in the Tū Tahanga programme. The study utilised qualitative descriptive analysis. The narratives from 11 research participants were collected and analysed to form codes which were developed into themes. The themes identified are 'the ManAlive process in Tū Tahanga', 'the kaupapa Māori practices of Tū Tahanga', 'mirroring', 'the personal impacts of violence', and 'suggested improvements'.

The findings of this research are important given Māori service users account for the highest ethnic group in forensic mental health services (Easden & Sakdalan, 2015; Ministry of Health, 2007). Consequently, innovative ways in care delivery are being sought to provide the best care for this population by tailoring interventions to meet their specific cultural needs. The findings of Tū Tahanga have shown that Western violence prevention programmes, such as ManAlive, can be culturally adapted to increase their responsiveness to Māori service users. Research in culturally informed rehabilitative programmes is a growing field of interest (Ministry of Justice, 2017). According to Braham et al. (2008), many of the violence prevention programmes are based on cognitive behavioural therapy and the risk-need-responsivity model. Yet, such models remain insufficient when applied to an indigenous population group (Ministry of Justice, 2017). Programmes are most effective when delivered according to the unique needs of the treatment group. For example, integrating cultural aspects into a programme is paramount to enhance the receptivity and engagement from the treatment group (Gutierrez, Chadwick & Wanamaker, 2018).

The meta-analytic review by Gutierrez et al. (2018) that examined indigenous offenders who received culturally adapted violence prevention programmes in comparison to indigenous offenders who received Western generic violence prevention programmes showed that those who received culturally adapted programmes have a significantly lower rate of recidivism. Gutierrez et al. (2018) review highlighted that these lower rates of recidivism were driven by higher participation, lower attrition rates,

improved learning retention and higher satisfaction in culturally adapted programmes. It is suggested that being with other indigenous people in a culturally adapted violence prevention programme provides a therapeutic community that is crucial in violence rehabilitation (Ashdown et al., 2019; Guitierrez et al., 2018). Thus, ensuring that programmes tailored to the needs of the indigenous population can lead to more favourable treatment outcomes (Easden & Sakdalan, 2015; Gutierrez et al., 2018; McKenna et al., 2015; Wratten-Stone., 2016).

The following discussion will outline the relevance of adapting international evidence-based approaches for New Zealand, the key research findings, limitations, recommendations, and research implications.

Translation of International Evidence-Based Approach within the New Zealand Context

This qualitative study of Tū Tahanga has shown that it is possible to adapt international current approaches to violence prevention for the New Zealand practice context. Although coming from two opposing paradigms, the Western worldview and the Kauapapa Māori world view, Tū Tahanga exemplified that integration is achievable in providing a unique violence prevention programme fit for Māori forensic mental health service users. As described in the sub-theme of 'The Bridging of Kaupapa Māori and ManAlive', the support from the service that encourages innovation in practice and having a suitable clinician who has the vision as well as clinical and cultural expertise, are vital to navigating the complexities of designing and delivering culturally adapted programmes.

The New Zealand Health Research Strategy 2017-2019 outlines the current Government's vision for health research (Ministry of Business, Innovation and Employment [MOBIE] & Ministry of Health [MOH], 2017). A strategic research priority of the Government is to see the translation of research into clinical practice. There is a wealth of evidence-based research internationally and New Zealand is yet to fully adopt these resources to the local context. This leads to missed opportunities for better health outcomes. Furthermore, the research strategy prioritises research that will benefit Māori health as Māori continues to experience the greatest health disparity

amongst New Zealand's ethnic groups. The Government continues to seek innovative ways to respond to this inequality (MOBIE & MOH, 2017).

This Tū Tahanga research aligns with the Research Strategy's vision. Tū Tahanga has adapted an international best practice approach to violence prevention to address the needs of forensic mental health Māori service users. It is hoped that this research will continue to inspire innovations in practice that draw from evidence-based research and local clinical knowledge that will seek to improve Māori health outcomes. The following sections will discuss the ManAlive process and Kaupapa Māori practices of Tū Tahanga.

The ManAlive Process of Tū Tahanga

The findings of this Tū Tahanga research gives light to the Western violence intervention aspect of Tū Tahanga through revealing the fidelity given to the ManAlive process in the programme. The ManAlive process in Tū Tahanga emphasises the importance of communication and disclosure through the checking in and checking out processes. The service users then embark on emotional awareness in understanding the continuum of violence. Service users are then taught personal coping skills to refrain from violent behaviours. Overall, the Tū Tahanga programme runs for 20 weeks with one session occurring a week. Each session runs for approximately 1.5 to 2 hours in duration. The group would have approximately up to 16 participants. At the end of the programme, service users are recognised with a certificate of completion.

This ManAlive process of Tū Tahanga, which has a strong focus on communication, emotional regulation and building up personal resources, is also consistent with the generic international best practice suggestions for violence prevention programmes in forensic mental health services (Daffern et al., 2018; Hornsveld et al., 2015; Magnavita, 2011; Nagi & Davies, 2010; Nagi et al., 2014). For example, Daffern et al. (2018) investigated the impact of the 'Life Minus Violence' programme in a forensic mental health inpatient unit in England. This programme has specific sessions including 'emotional acceptance' and 'how I got here?' which links emotional dysregulation to violent behaviours. Nagi and Davies (2010) reported the 'General Treatment and Recovery Programme' delivered in a low secure forensic

mental health unit. The 'General Treatment and Recovery Programme' is also based on cognitive behavioural therapy and focuses on areas including emotional identification, emotional regulation, and social problem-solving skills. Likewise, the study of Hornsveld et al. (2015) investigated the 'Aggression Replacement Training' programme in a forensic outpatient psychiatric service in the Netherlands. This programme included sessions targeting anger control, developing pro-social skills and moral reasoning with the overall intention of replacing antisocial behaviours with prosocial behaviours. All these programmes seemed to have made positive impacts on the recovery of forensic service users from violence on forensic service users' recovery from violence (Daffern et al., 2018; Hornsveld et al., 2015; Nagi & Davies 2010). The commonalities of the programmes focus on emotional recognition, emotional modulation, and building up personal strengths to curb violent behaviour. There is a strong link between emotional regulation and offending behaviour amongst forensic mental health service users (Nagi et al., 2014, Nagi & Davies, 2010, Hornsveld et al., 2015). The ManAlive process of Tū Tahanga is similar in its approach.

The Kaupapa Māori Practices of Tū Tahanga

Kaupapa Māori practices of Tū Tahanga are added to this best practice approach. It is this cultural adaptation specifically that is unique to this programme. The kaupapa Māori practices that have been identified are the 'Māori facilitator as a role model', 'hohou rongo', 'Te Whare Tapa Whā' model of holistic health and the use of a specific cultural space as depicted in the 'setting the space' theme. Each of these findings will be discussed critically.

The role modelling demonstrated by the Māori facilitator is central in instigating inspiration for service users to desist from violence. The genuineness of the facilitator in therapy is paramount to the success of the programme. A facilitator whom service users can relate assists in bridging the divide between a Western violence intervention programme and the cultural worldview of Māori. Yakeley (2018) has highlighted the crucial role of the therapist in role modelling behavioural change during rehabilitation for forensic mental health service users. Furthermore, Nagi et al., (2014) argued there is further value when therapists are also based in the same forensic mental health unit as their service users. This helps to strengthen the therapeutic alliance between the

therapist and the service user, which is crucial for the success of treatment programmes (Nagi et al., 2014).

The need for bridging between indigenous population groups with mainstream mental health services by an indigenous individual who understands both systems has been illustrated in other literature. McKenna et al. (2015) described the role of an Aboriginal mental health liaison officer in an urban Australian mental health service. This study found that the Aboriginal mental health liaison officer improved the accessibility of the indigenous people to mainstream mental health services by 'brokering' understanding between the indigenous service users and clinicians. This led to positive clinical outcomes for indigenous service users (McKenna et al., 2015). This pivotal role of the Aboriginal mental health liaison officer parallels to the Māori facilitator of Tū Tahanga, who possesses both the kaupapa Māori mātauranga (knowledge) and technical knowledge components of the violence prevention programme.

Furthermore, in Māori culture, the tane (male) as role models is a powerful catalyst to instigate change to other tane. Mataira (2008) argues that Māori men ought to, metaphorically, 'step into the fire' and become leaders and to work alongside other Māori men in addressing violence. To do so, Māori men are to "speak out, speak up and speak to issues" (Mataira, 2008, p. 38) of violence and address it from the place of aroha (love), tika (uprightness) and pono (genuineness). As discussed in the Māori role modelling section, these are the virtues that have been exemplified by the Māori facilitator and in turn inspired Māori service users in addressing their violence.

Hohou Rongo was revealed as another important component of the kaupapa Māori practices in Tū Tahanga. Hohou Rongo is the process of conflict resolution that brings in all affected parties. Conflict resolution is a fundamental skill taught in a violence intervention programmes in the forensic mental health context (Hornsveld et al., 2015; Magnavita, 2011; Nagi & Davies, 2010). Hohou rongo is rooted within the kaupapa Māori of 'kanohi ki te kanohi' meaning 'face to face'. Conflict resolution is an important component of violence prevention. Service users are taught specifically how to identify conflict and how it can be addressed appropriately. Hohou rongo is practised within the Tū Tahanga group, or separate to the group if all group members are not

involved. It might, therefore, occur on a one-to-one basis. Through intentional and meaningful engagement by staff with service users, favourable outcomes are achieved and conflicts are resolved appropriately.

The integration of a one-to-one session with group-based programmes is a best practice approach in violence prevention (Nagi & Davies, 2010; O'Brien, et al., 2016). While group therapy promotes learning together and ensures fundamental principles are taught, individual approaches provide an in-depth exploration of service user issues as well as providing safer therapeutic space to disclose that may otherwise be difficult in a group setting (Yakeley, 2018). Furthermore, individual approaches to therapy provide clinicians opportunities for targeted approaches that are specific to service user needs (Yakeley, 2018). Hohou rongo as a practice of conflict resolution, through a one-to-one session or within the group, is an essential component of the violence prevention work of Tū Tahanga. It needs to be noted though that from the analysis of the findings, hohou rongo seems to occur ad hoc as staff and facilitators see the need arise, rather than a prescribed practice for each service user in the Tū Tahanga group.

Te Whare Tapa Whā is another cultural component of the Tū Tahanga programme. The Te Whare Tapa Whā is a well-known Māori model of holistic health conceptualised by Mason Durie in 1984 (Ministry of Health, 2017b). The use of Te Whare Tapa Whā has gained traction in the delivery of health services to Māori since its conceptualisation and its influence to inform practice continues to endure. As Wratten-Stone (2016) has highlighted, that to improve engagement of Māori service users within mainstream Western health services, it is unequivocal that there has to be the recognition of a wider Māori holistic view of health that goes beyond the individual and the physical, but also incorporates mental health, spirituality and family relationships (Wratten-Stone, 2016). The importance of a holistic view of health for Māori is also supported by the study of Nakhid and Shorter (2014) who investgated the narratives of Māori ex-prisoners regarding rehabilitation programmes in prison. The study showed that those programmes deemed most helpful by Māori were those that incorporated the healing of wairua (spirit) and whanau (family) relationships. The participants also recognised that physical health is equally vital for them (Nakhid & Shorter, 2014). The findings in this research adds further evidence to the need to

incorporate a holistic view of health through Te Whare Tapa Whā in violence programmes to increase the significance of the programme for Māori service users.

Finally, the ‘setting of space’ reflects the way Tū Tahanga adopts the cultural norms of kaupapa Māori. The ‘setting of space’ utilises the wharenui (meeting house) and karakia (prayer). This finding is significant in that it enables Tū Tahanga to be consistent with traditional Māori practices and makes the programme seem to be more familiar and welcoming to Māori service users. The impact of using the wharenui and undertaking karakia sets a respectful ambience for everyone in Tū Tahanga and in turn, improves the engagement and focus of the service users. Incorporating cultural practices that are consistent with the indigenous people’s way of life is found to be effective in making violence rehabilitation programmes more engaging (Gutierrez et al., 2018)

The findings of this study indicate that the kaupapa Māori practices incorporated into Tū Tahanga have made the programme more responsive to the Māori forensic mental health service users. The inclusion of kaupapa Māori within the rehabilitation framework to Māori has the potential to increase positive outcomes, though it was beyond the scope of this study to determine this. There is evidence to suggest the value of including a cultural framework in violence prevention programmes for Māori. A qualitative study of Ashdown et al. (2019) investigated the rehabilitation experiences of Māori men in a therapeutic community called Moana House. The Moana house therapeutic community offers programmes including those that target violent offending and substance addictions for Māori men who have offending histories. The research has shown that this therapeutic community works for Māori men because their cultural needs and family relationships are incorporated into their treatment. In addition to cultural considerations, Ashdown et al. (2019) highlighted the value of having a supportive therapeutic community, in which rehabilitation can be done collectively. This notion of a therapeutic community parallels the finding of 'mirroring'.

Mirroring

Mirroring is an unexpected finding that came about in the analysis of the data of this study. The mirroring that happens in the inpatient unit mimics the process of the Tū Tahanga programme, therefore reinforcing the learnings from Tū Tahanga. The mirroring process cements the violence prevention practices and enables service users to assimilate their learnings into daily living. The outcome of this process is the gains from Tū Tahanga which continue to translate into daily life in the inpatient unit. The inpatient unit has become a therapeutic community in the recovery of violence.

The notion of therapeutic community has also been examined in New Zealand in the context of prisons (Polaschek & Kilgour, 2013; Polaschek, 2011). The Rimutaka Violence Prevention Unit in Wellington, New Zealand, hosts up to 30 medium and high-risk prisoners for violence rehabilitation who are nearing release eligibility. This unit provides intensive therapy groups that are also based on cognitive behavioural therapy (Polaschek, 2011). The study of Polaschek (2011) concluded that the Rimutaka Prevention Unit had a positive effect on violence rehabilitation. When compared with 'untreated' offenders as a control group, the 'treated' offenders from the prevention unit had a lower rate of reconviction after 3.5 years on post-release follow up. Following the opening of the Rimutaka Violence Prevention Unit, there are other notable violence prevention units for the forensic prison population in the New Zealand Unit known as 'High-Risk Special Treatment Units' (Polaschek & Kilgour, 2013). In brief, these high-risk special treatment units adapted a cognitive behavioural therapy model as well as incorporating both group and individual therapy within the community of staff and offenders in the unit.

Post-treatment from these special treatment units has shown that offenders who completed the programme had made progress from their violence recovery (Polaschek & Kilgour, 2013). Compared to Polaschek's (2011) study of the Rimutaka Prevention Unit which had quantifiable results showing positive recovery from violence utilising comparing reconviction rates, there are no quantifiable results in this Tū Tahanga research study. However, the learnings from Tū Tahanga are still evident in their lives, as service

users continue to remove themselves from violence by utilising the skills and practices according to their narratives.

Consistent with the findings of 'mirroring', there is evidence to suggest that a community of staff and service users within a structured setting has therapeutic value. The studies of Daffern et al. (2018) and Magnavita (2011) described that in addition to violence prevention programmes, the positive therapeutic rapport with clinicians and the supportive milieu of mental health inpatient units all significantly contribute to the violence rehabilitation of mental health service users.

The Tū Tahanga programme appears to work as the learning in this group is essentially 'mirrored' in the way of life in the inpatient unit, cementing the learning every day and thereby decreasing the chance of service users slipping back to their old ways of violence. Through mirroring, service users were able to continue their gains from Tū Tahanga to the day-to-day living in the inpatient forensic mental health unit.

Impacts and Potential

Although this study was not an evaluation of people's involvement in Tū Tahanga, people did talk about its impact and the potential for the future. The personal impacts of violence for service users had been the realisation of their violence and being victims of violence. This realisation is a paradigm shift for service users. Coming to terms with their violence towards others led to the service users realising their personal experiences as victims of violence from their past. This finding is consistent with literature that forensic mental health service users are both the perpetrators and victims of violence (Yakeley, 2018). It is acknowledged that exposure to physical and emotional traumatic events in an early age predisposes the individual to developing antisocial behaviours in the future (Yakeley, 2018). Hence, therapy must also focus on helping service users develop remorse, empathy, and insight to break this chain of violence.

This phenomenon of violent offenders being also victims of violence gives light to the wider social issue that is prevalent in New Zealand, that is intergenerational family violence. As one service user reflected, it was the violence from grandparents and parents that he associated with having the most profound impact on his violent

offending. Commonly, abusers are often victims of violence themselves and their perpetrators are family members (Yakeley, 2018). According to the New Zealand Family Violence Clearinghouse (NZFVC, 2017), the rate of family violence in New Zealand continues to increase with a total reported cases of 118, 910 in 2016. Moreover, family violence in New Zealand takes a significant amount of police time, accounting for 41% of frontline police time (NZFVC, 2017). By ethnicity, Māori accounts for the highest proportion of family violence resulting in death totalling 77% of all cases from 2009 to 2015 (Family Violence Death Review Committee, 2017). The prevalence of intergenerational family violence amongst forensic mental health service users suggests there is a need to address this issue. The Tū Tahanga programme has been instrumental for service users to gain insight on breaking the cycle of violence.

Whānau ora is a health strategy by the New Zealand Ministry of Health to improve health outcomes for Māori (Te Puni Kōkiri, 2011). The Whānau ora strategy recognises the critical role whānau (family) plays in the overall health of Māori (Te Puni Kōkiri, 2011). The strategy recognizes the collectivist nature of Māori culture. To make positive changes to an individual, their whānau and their wider community need to be considered. Te Puni Kokiri (2011), the Ministry of Māori Development, has recognised there is a great need to incorporate whānau in violence prevention programmes for Māori. There is the recognition that the whānau and the wider Māori communities understand the drivers of offending for Māori well, and their inclusion in violence prevention programmes could potentially create lasting changes in violence reduction in the future. Jigsaw and the Ministry of Health (2014) have provided case studies of clinician-led violence prevention strategies with whānau to combat family violence specifically for Māori. The result of these strategies is promising (Jigsaw & Ministry of Health, 2014). Thus, incorporating a service user's family input into violence prevention programmes may provide a valuable addition for Tū Tahanga. Given the impact and potential further adaptations, it is important that Tū Tahanga is thoroughly evaluated before adaptations occur.

The Tū Tahanga programme has been instrumental for service users to understand the personal impacts of violence in their lives. This personal impact highlighted the wider social issue of intergenerational family violence amongst forensic mental health service users. Inclusion of sessions that address intergenerational family

violence and trauma informed care, in violence prevention programmes can be valuable. The Whānau ora health strategy can provide a way forward on how violence prevention programmes can be informed to respond to the intergenerational family violence issue.

Limitation

Given that this is the first study on Tū Tahanga and the study was primarily exploratory, there are important limitations to the study to be considered. The time gap between this research and the last involvement of participants with Tū Tahanga, the method and the exploratory focus of the research will be discussed.

One limitation of this research is the three to a four-year gap between this research and the participants' actual involvement in Tū Tahanga. It was an ethical requirement that we could not engage with current in-patients, rather involving people now residing in the community who had been through the service. This period meant that research participants at times verbalised feeling a sense of inadequacy in providing a rich description of their narratives. This time-lapse maybe confounded by some service users also having cognitive deficits (Barnao & Ward, 2015). Such deficits did seem to impact on some interviews being completed in a brief time. Carrying out the research closer to the time of programme completion could potentially rectify this issue. Nonetheless, the majority of the eleven research participants were able to engage in rich descriptions of their involvement in Tū Tahanga.

This research, although focused on a Māori issue, did not use an indigenous kaupapa Māori research methodology. There is the potential that such an approach could be a better fit for this research. The indigenous methodology asserts that research regarding Māori needs to occur within the kaupapa Māori framework (Smith, 1999). The kaupapa Māori framework asserts that research should be done by Māori for Māori. The framework is drawn from Te Ao Māori (Māori worldview) and kaupapa Māori (Māori principles). A kaupapa Māori framework also recognises the validity and legitimacy of mātauranga Māori (Māori knowledge) and te reo Māori (Māori language) to inform research.

The reason for this view is that other research methodologies are based on the Western worldview, which is insufficient to authentically represent the truth and realities of Māori. Kaupapa Māori methodology is emancipatory from the Western worldview and is a reclamation that Te Ao Māori (Māori worldview) is a legitimate form of knowing and understanding (Smith, 1999).

Despite utilising a qualitative descriptive methodology, the researcher still sought to carry out research that was respective of tikanga Māori (Māori custom). The researcher strived to practice within the Māori ethical framework as set out by the Health Research Council of New Zealand (Hudson et al., n.d.). The Māori ethical framework set out four principles for researchers to adhere to when engaging with Māori for research. The four principles are 'tika', relating to research design, 'mana' relating to justice and equity, 'whakapapa' relating to relationships and finally, 'manaakitanga' relating to cultural and social responsibility.

For tika, this research employed a qualitative descriptive methodology that meant the data collection method was kanohi-ki-te-kanohi (face to face). The principle of Mana was upheld as participation in research was entirely voluntary to protect the autonomous rights of Māori service users, and any risks and benefits of research have been explained before engaging with the interviews. This was to ensure that participants gave informed consent. Whakapapa was upheld through the rigorous consultation the researcher was involved with the District Health Board, the Auckland Regional Forensic Psychiatry Service Taumata (Māori cultural advisory group) and the AUT university ethics committee. Lastly, manaakitanga was upheld through the researcher carrying out the interviews acknowledging the participants' dignity through respectful engagement. The kaumatua played an integral cultural role in advocating for this research to be carried out. The kaumatua also provided his support by providing periodic check ins with the researcher during the research process. Data collected was protected to ensure the privacy and confidentiality of the participants.

Lastly, this research is exploratory only in nature and further rigorous evaluation is required. The study is of a qualitative descriptive design used to explore a kaupapa Māori adaptation of a Western violence prevention programme. The results have shown positive impacts on the recovery of service users from violence. However, there is only

a small number of participants confined within a very specific context, which is a forensic mental health inpatient unit. Therefore, further evaluation of the impacts of Tū Tahanga is warranted.

Nonetheless, this research adds to the growing field of health research of indigenous people, particularly for Māori. As much of research in the field of violence prevention programmes is quantitative in nature (Barnao & Ward, 2015), this qualitative study adds a unique perspective and understanding about culturally specific violence prevention programmes.

Recommendations

Amongst the suggested improvements research participants raised, a significant finding was the need to consider a gendered approach to violence programmes for female forensic mental health service users. This gendered issue was raised by female staff and service users who found that, as females within the group, the female perspective could have been further explored.

Much of research undertaken in violence prevention programmes in forensic mental health settings is with male forensic mental health service users and there is a significant gap considering the experience of female forensic mental health service users in mixed-gender violence intervention programmes (O'Brien et al., 2016). McKeown and Harvey (2018) highlighted that female violent offenders experience historical abuse and trauma-related mental health problems, personality disorders, parenting issues, and substance abuse. The study highlighted that early experiences of violence are likely to precipitate violent behaviour in the future. Female offender violence also tends to be driven by affective, cognitive and behavioural patterns. Although the population group of McKeown and Harvey (2018) focuses on the female prison population, the results of this Tū Tahanga study gives weight to consider the unique rehabilitative needs of females amongst the mental health forensic service users. Mixed-gendered violence prevention programmes may be insufficient to address the needs of the female population group. As a way forward, it may be worth considering a separate violence prevention programme for female forensic mental health service

users. Or possibly, adjunct mixed-gender programmes with female-only groups to provide an exclusive space for females to discuss issues that are separate from men.

There are also other 'suggested improvements' that need considering. For example, the sub-theme 'making Tū Tahanga more responsive to the limited attention span of service users has shown that forensic mental health services present with an added layer of complexities that make engagement in group therapies challenging. Some forensic mental health service users find it challenging to sustain engagement for one and a half up to two hours of a Tū Tahanga session. Balancing the appropriate length of time remains an active process for the facilitators who consider the need to cover the content and practices of the programme while being mindful of the attention span of service users. This balancing act of content delivery against responsivity impediments from psychiatric symptoms (such as motivation and compromised cognitive functioning) is an ongoing issue in delivering violence prevention programmes to mental health service users (Nagi & Davies, 2010). Hence, it is argued that individual therapeutic approaches are considered a valuable addition in violence prevention programmes, as they provide a targeted approach to the unique needs of a service user (Nagi & Davies, 2010). The need for programmes to be dynamic and responsive to the unique needs of forensic mental health service users, away from a one-size fits all approach, is consistent with the literature (Blackburn, 2004).

The 'risk-need-responsivity' model that has guided violence prevention programmes widely used in forensic mental health services is consistent with this finding of programmes needing to be dynamic (Wong et al., 2007). The 'risk-need-responsivity' model postulates delivery of programmes must be responsive to the characteristics of the target group. It is known that forensic mental health service users experience cognitive deficits and decreased social skills, alongside psychiatric pathologies that negatively impact on motivation and engagement (Blackburn, 2004; Nagi & Davies, 2010). Furthermore, this population often use psychotropic medications extensively, which have known sedative side effects that further implicates the ability to remain focussed and attentive (Braham et al., 2008; Wong et al., 2007). Thus, there is a constant challenge for therapists and facilitators to utilise their clinical judgement and experience to continually evaluate the responsivity of service users to the programme. As highlighted by Nagi and Davies (2010), although the standardisation of

therapies may provide consistency in delivery, the flexibility and dynamics of the programme are equally important to maintain its relevance for forensic mental health service users.

'Creating a safer space for authentic disclosures' is another suggested improvement. Although service users are told that disclosure is part of therapy and that it would not affect their care and treatment in any way, service users were sometimes guarded while participating in the group. Service users disclosed according to what they deemed reasonable to be shared in the Tū Tahanga group. There is fear of having potentially negative consequences if what they disclose is contrary to the expectations and values of the forensic mental health system. Such tension in authentic disclosure is consistent with the literature regarding people's experience of being in a violence prevention programme. Tew et al. (2016) investigated the experiences of male prisoners in engaging in a violent prevention programme whilst in custody. This study found that prisoners can be 'untrusting' of others around them, particularly as what they say can potentially be misinterpreted and impact on their progress through the institution. Similarly to the findings of Tew et al., (2016), service users in Tū Tahanga carry the perceived need to showcase their 'best self' that would lead to favourable outcomes in their recovery. Given this dynamic in group settings, group facilitators need to be sensitive to the group participants and find ways to make the setting more welcoming for authentic disclosures. Moreover, to elicit truthful and authentic disclosures, one-to-one intentional individual approach may be valuable to address this issue (O'Brien et al., 2016).

'Better preparation for staff for group participation' is the other suggested improvement. Staff input is valuable in violence prevention programmes. Staff presence in violence prevention programmes has the potential to improve compliance to regimes and maintain motivation for change (Tew et al., 2016). However, staff also bring added complexities to the programme. As shown in the findings, the presence of staff in Tū Tahanga sometimes led to staff dominating the group discussions. Staff training regarding their inclusion might offset this risk. Preparing selected staff on how they can contribute to the programme ensures that input from staff is maximised for therapeutic purposes. Tew et al. (2016) identified that staff who have been intentionally trained and selected to assist in the programme impact positively on prisoners' engagement and

progress in the violence prevention programme. The study found that trained staff meant that skills and behaviours taught in the programme were role modelled (Tew et al., 2016).

Research Implications

The implications of this research have relevance in clinical practice, education, research, and policy. This research has provided an understanding of the violence intervention programme within a kaupapa Māori paradigm. This research brought to light current practices in New Zealand forensic mental health services that aims to provide a responsive approach to the over-representation of Māori in such services. The study has shown that it is possible to integrate successfully Western practices of the violence intervention programme with kaupapa Māori practices.

In clinical practice, the Tū Tahanga research has shown that it takes initiative from clinicians to provide innovative ways of practising to provide care that is responsive to the unique needs of the people they serve. It is the meaningful integration of current evidence-based research into the reality of practice that makes a difference. The clinician's experience on how evidence-based care can be modified and made relevant for their service users, as well as the service's support, are pivotal to the translation of research into practice. It is via this 'championing' of clinicians, such as the Māori cultural worker being supported by the service, that innovative ways in practice can be forged. Tū Tahanga remains early in its stage of development and evolution, with the need for refinement to the changing needs and demands from service users and the forensic service. Yet, this research study has provided a valuable understanding of a current kaupapa Māori adapted violence prevention programme within a forensic inpatient unit. This is a step forward towards better care and treatment for forensic Māori mental health service users.

Regarding policy, this research is timely in the light of the recent New Zealand National Mental Health Inquiry, He Ara Oranga, which was released in December 2018 (He Ara Oranga, 2018). The Inquiry highlighted the unmet needs of the Māori population group in mental health services and the critical role mental health services have in providing culturally responsive care to address these needs. Programmes such

as Tū Tahanga stand as an exemplar into the opportunities for improvement in care delivery for Māori mental health service users. Furthermore, the Inquiry sets out that being protected from violence is an integral part of improving mental health, alongside addressing other social issues. Thus, there is a need for further implementation of programmes, such as Tū Tahanga, and the subsequent evaluation of their benefits (He Ara Oranga, 2018).

Regarding education, the research adds evidence for clinicians working with Māori of the value of culturally informed practice. In New Zealand, it is part of the health professional's competence to practice accordingly to the service users' cultural identity. For example, the New Zealand nurses Code of Conduct (Nursing Council of New Zealand [NCNZ], 2012) states that nurses are to practice in a way that acknowledges and respects Māori health consumers' needs. Furthermore, nurses are to practice in a way that seeks to reduce the Māori health inequalities which exist (NCNZ, 2012). Thus, educating staff, especially non-Māori staff, of the value of culturally modified programmes and the support cultural innovations in practice is vital to improve health outcomes for Māori service users.

Conclusion

This Tū Tahanga qualitative descriptive research study gives a unique understanding of how a Western violence prevention programme, ManAlive, can be adapted with kaupapa Māori to make a unique programme responsive to the cultural needs of Māori forensic mental health service users. The 'mirroring' that takes place in the inpatient unit, which has become a 'therapeutic community', is a significant finding. Belonging in the same inpatient unit that parallels the processes of Tū Tahanga has meant that violence recovery occurs in both the group setting and in the day-to-day life of the service users. This study is exploratory in nature and there are further avenues for research in the future. Yet, this study is relevant and provides a valuable understanding of violence prevention programmes in forensic mental health for Māori service users within the New Zealand context.

Personal Reflection

Completing this research project has been a valuable learning experience for myself professionally and personally. I had the opportunity to work alongside experienced clinicians and academics whom I would not have the chance of working with if I had not been through this research. My personal experience with them enriched my nursing practice and widened my understanding of forensic mental health. I have also developed further appreciation of the violence prevention work occurring in the forensic mental health service. Furthermore, as this research has a focus on Māori, this experience had extended my understanding of kaupapa Māori and Te Ao Māori. Working for a formal research project for the first time is already unnerving, let alone a research that has a focus on Māori. Despite the 'ups and downs' of this research, I am joyful that I was able to see this through with the support of people. It is a privilege to be part of a project that has potential to impact positively on Māori service users and to contribute to the growing knowledge of indigenous research in Aotearoa/New Zealand.

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Appendix A: AUT Ethics Application Approval 2019

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

15 January 2019

Brian McKenna
Faculty of Health and Environmental Sciences

Dear Brian

Ethics Application: **17/412 The experience of participants in a kaupapa Maori introductory violence and anger reduction programme in an inpatient setting (Tu Tahanga)**

On 15 January 2018 you were advised that your ethics application was approved.

I would like to remind you, that it was a condition of this approval that you submit to AUTEC the following:

- A brief annual progress report using the EA2 Research Progress Report / Amendment Form, available at http://www.aut.ac.nz/research/researchethics/forms, or
- A brief Completion Report about the project using the EA3 from, which is available online through http://www.aut.ac.nz/research/researchethics/forms. This report is to be submitted either when the approval expires on 15 January 2021 or when the project is completed;

It is also a condition of approval that AUTEC is notified if the research did not proceed or any adverse events occurring during the research. If there has been any alteration to the research, (including changes to any documents provided to participants) then AUTEC approval must be sought using the EA2 form.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please contact us at ethics@aut.ac.nz.

Yours sincerely

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: francis.florencio@aut.ac.nz; David Healee

Appendix B: AUT Ethics Application Approval 2018

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

16 January 2018

Brian McKenna
Faculty of Health and Environmental Sciences

Dear Brian

Re Ethics Application: **17/412 The experience of participants in a kaupapa Maori introductory violence and anger reduction programme in an inpatient setting (Tu Tahanga)**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 15 January 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: francis.florencio@aut.ac.nz; David Healee

Appendix C: AUT Research Proposal Approval 2017

11th December 2017

Francis Florencio
23A Bentley Avenue
Glenfield
Auckland 0629

Dear Francis

Thank you for submitting your PGR1 Research Proposal application for the Master of Health Science.

Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences, by the Postgraduate Research Committee at their October 2017 meeting.

Details are:

Current programme:	Master of Health Science
Enrolment:	Thesis enrolment part-time 2x 51 weeks
Student ID	1082467
Topic:	The experience of Maori forensic service users and facilitators in utilising a kaupapa Maori introductory violence and anger reduction programme in an inpatient setting
Primary supervisor:	Brian McKenna
Secondary supervisor:	David Healee
Cultural advisor:	David Kaire (Mason Clinic Kaumatua)
Start date:	19th March 2018
Expected completion date:	13th March 2020

For more information about the programme of study, please refer to the *Postgraduate Handbook*.

The AUT website for forms and handbooks is:
http://www.aut.ac.nz/being-a-student/current-postgraduates/academic-information/postgraduate-forms

Yours sincerely

Professor Erica Hinckson
Associate Dean (Postgraduate Research)
Postgraduate and Research Office
Faculty of Health and Environmental Sciences

Cc Primary supervisor Brian McKenna

Appendix D: ADHB & WDHB Māori Research Committee Approval 2018

18 April 2018

Francis Florenco
Mason Clinic
Waitematā District Health Board
Auckland

Re: The experience of Māori forensic service users and facilitators in utilising a kaupapa Māori introductory violence and anger reduction programme in an inpatient setting.

Thank you for providing the following documents the:

- Application forms
- PGR1
- PIS/CF
- Ethics application and responses

The study is a part of a student's academic requirements for a Masters. The study is exploring participant's experience of the Tu Tahanga intervention, a kaupapa Māori anti-violence programme implemented in the Māori forensic mental health service, Mason Clinic.

The student's supervisor approached the Māori mental health team at Mason clinic and indicated there was a resource available to do some research. The team identified that they would like the Tu Tahanga intervention explored. The student met with the supervisor and drafted up a research proposal. A meeting with the Taumata at Mason clinic then followed where questions were raised and answered. The Taumata has offered cultural supervision to support the study. The study was presented to the ethics committee at AUT and amendments made to the study to address the issues raised.

Given the nature of the study I would suggest the establishment of a Māori reference group to oversee the study at identified milestones such as when the proposal has been completed, when the literature review is in draft, when the findings section is in draft and so on.

Comments:

- Cultural contact details are required on the participant's information and consent forms. I suggest the cultural supervisor

On behalf of the Waitemata and Auckland District Health Boards Māori Research Committee the study has been approved.

Heoi ano

H.A Wihongi

Dr Helen Wihongi

Research Advisor – Māori/Senior Research Fellow
He Kamaka Waiora/Waitematā and Auckland DHB
Level 1, Kahui Manaaki – Building 5
North Shore Hosptial/ Auckland 0740, New Zealand
p: +64 9 486 8920 ext. 43204, m: + 64 21 0203 1167
email helen.wihongi@waitematadhb.govt.nz

Appendix E: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

January 2018

Project Title

The experience of participants in a kaupapa Māori violence prevention programme in a forensic inpatient mental health setting (Tū Tahanga).

An Invitation

I am Francis Florencio, a registered nurse working in the Mason Clinic Community Team and a Masters of Health Science student at AUT University. I invite you to take part in this study to explore people's views of the Tū Tahanga programme.

What is this research about?

In this research, I am working with my supervisors to try to understand what happens in Tū Tahanga, how it helps people and how it can be improved. I am also completing this project as part of my masters' qualification. Once the project is complete, the findings will be published in a journal article, and presented at the Mason Clinic, AUT University and possibly other relevant gatherings.

How was I identified and why am I being invited to participate in this research?

Information was sent out on a flyer and I appreciate you contacting me. I am interested in talking to you. You have done the Tū Tahanga programme in the past while you were in an inpatient unit and will have views about it.

How do I agree to participate in this research?

Your participation in this research is your choice and will not affect your care in any way. You are able to withdraw from the study at any time. If you are keen to join, I will give you a consent form that you will sign as record of your participation. If you choose to withdraw from the study, which you can do at any time, then you

will be offered the choice between having anything you have said removed, or allowing it to continue to be used for the study. However, once the findings have been produced, removal of your data will not be possible.

What will happen in this research?

The study will take place in the form of a face-to-face interview. I will ask questions about your thoughts, feelings, and opinions regarding being a part of the Tū Tahanga group. This interview will last about 45 minutes and can take place where ever is best for you. What you tell me will then be used, in addition to other participants' views, to produce a final report. The data collected will only be used for the study purposes and will not be used in other ways.

What are the discomforts and risks, and how will this be alleviated?

In the unlikely event of emotional discomfort you will be encouraged to speak to your responsible clinician, key worker or consumer representatives. Also, please do not hesitate to contact me or the supervisors regarding any of your concerns. You can withdraw at any point during the interviews if you feel you do not want to do it any further. Participation is entirely up to you.

Our discussion will not be shared with the clinical team because it is only for this study. However, should something come up during our discussion that may pose a danger to yourself and/or others, I will need to inform your doctor of this.

What are the benefits?

There is no direct benefit to you as a participant. However, the knowledge gained from this study will provide understanding about the participants' thoughts about the group and identify things to improve the Tū Tahanga program. Completion of this study will also contribute towards my Masters' qualification. The results of the study will also be published in health professional journal magazines to help educate the wider health professional audience.

How will my privacy be protected?

The recordings of the interview will only be used by me and my supervisors. Interviews will be taped. As we do the interview, I will have a note book with me to record things about our conversation. These records help me to make sense of all that I am told. The recordings will not be shared with any persons within mental health

services. Anything that might identify you will be removed and will not be published. Data storage is also protected by password security.

However, it is a possibility that if someone knows Mason Clinic well, they may have an idea who you are, given that there is only a small number of people have been through Tū Tahanga.

What are the costs of participating in this research?

Your time will be the main cost in your participation. The interviews may last between 45 minutes to an hour. You can indicate the time and duration beforehand and I will try my best to accommodate your availability. Interviews will be conducted in a safe, private room in a place of your choice.

What opportunity do I have to consider this invitation?

You can contact me any time to consider joining this study and you can ask me questions you might have regarding this study. Once again, joining the study is completely your choice and you can withdraw.

What compensation is available for injury or negligence?

In the unlikely event of emotional discomfort, you are able to speak to your responsible clinician, nurse or consumer representatives. Physical injury is not expected risk for participation in this study.

Will I receive feedback on the results of this research?

You can request to have feedback regarding this research. Upon publication of the study, I can send you a summary of this study if you would like.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Professor Brian McKenna
brian.mckenna@aut.ac.nz
021 100 0093

Or

Cultural Supervisor
Mr. David Kaire
David.kaire@waitematadhb.govt.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC:

Kate O'Connor
ethics@aut.ac.nz
921 9999 ext. 6038

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Francis Florencio
francis.florencio@aut.ac.nz
021 720 101

Project Supervisors Contact Details:

Prof. Brian McKenna
brian.mckenna@aut.ac.nz
021 100 0093

Dr. David Healee
david.healee@aut.ac.nz

Mr. David Kaire
David.kaire@waitematadhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee on 16th January 2018 AUTEC Reference number *17/412*

Appendix F: Research Poster Advertisement

"The experience of participants in a kaupapa Māori violence prevention programme (Tū Tahanga) in an inpatient setting"

Hi, my name is Francis, a student at AUT University and nurse at Mason Clinic. I am interested in interviewing people, service users and staff, to find out what they think about being involved in the Tū Tahanga group programme which was offered at Mason Clinic. If you have participated in the past in that group, and would like to give your views it would be great to hear from you! Your views would greatly help improve the programme in the future. I am also completing this project as part of my Masters' studies.

If you are keen to receive more information, please contact me on my mobile 021-720-101 or inform staff at your step-down accommodation whom can contact me on your behalf. We will then arrange a time and place to meet and I will give you more information about the study.

AUT Ethics Ref no: 17/412

Researcher Contact Details:

Francis Florencio
francis.florencio@aut.ac.nz
021 720 101

Appendix G: Participant's Consent Form

Consent Form

Project title: The experience of participants in utilising a kaupapa Māori violence prevention programme in an inpatient setting.

Project Supervisor: Prof. Brian McKenna, Dr. David Healee and Mr. David Kaire (Cultural Supervisor)

Researcher: Francis Florencio

( ) I have read and understood the information provided about this research project in the Information Sheet dated _____

( ) I have had an opportunity to ask questions and to have them answered.

( )I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

( ) I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

( ) I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

( ) I agree to take part in this research.

( ) I wish to receive a summary of the research findings (please tick one): Yes( ) No( )

Participant's signature: .....
Participant's name: .....
Date:

Primary Supervisor
Professor Brian McKenna
brian.mckenna@aut.ac.nz
021 100 0093

Cultural Supervisor
Mr. David Kaire
David.kaire@waitematadhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee
AUTEC Reference number 17/412

Note: The Participant should retain a copy of this form

Appendix H: Interview Schedule

Research Interview Schedule

The following questions were used as guide during the interview process. The questions were deliberately open-ended to allow research participants to discuss their thoughts and opinions as they see fit. Simple verbal prompts such as "please tell me more", "aha" and the use of pauses were also used during the interview to encourage research participants to elaborate further. The interview would be completed once the research participants deemed they had nothing more to add and wanted to finish off the interview.

- "Please tell me about your experience of Tū Tahanga?"
- "Please tell me about the kaupapa Māori approach of Tū Tahanga?"
- "Please tell me about any memorable/notable moment for you in Tū Tahanga"
- "Please tell me any significance of Tū Tahanga for you"
- Please tell how do you think Tū Tahanga can be done differently?
- "Are there anything else you would like to add or say?"

Appendix I: Whakamārama Kohiko - Glossary of Te Reo Māori

Aroha	Love, compassion or empathy.
He Ara Oranga	A report compiled by The New Zealand Government inquiry to Mental Health and Addiction. This report was published in November 2018.
Hohou Rongo	To make peace and resolve conflict.
Kaitiaki	A guardian or steward
Kanohi ki te kanohi	Face to face. To make contact in person.
Kapa haka	Māori cultural performance. A Māori war dance.
Karakia	Prayer
Kaumatua	A Māori elder
Kaupapa Māori	Māori philosophy, principles and ideology
Mana	Authority, power or influence.
Manaaki	To support and take care of
Manaakitanga	To care for others
Māori	The indigenous people of Aotearoa/New Zealand
Mātauranga Māori	Māori knowledge
Pono	Genuineness
Rangatira	Chief
Tāne	Male
Te ao Māori	The Māori world view
Te Puni Kokiri	New Zealand Ministry of Māori Development
Te Reo Māori	Māori language

Te Whare Tapa Whā	A Māori model of holistic health conceptualized by Professor Sir Mason Durie in 1984. Māori health is symbolized as a house with four walls. Each wall represents a person's physical, spiritual, family/relationships and mental health that altogether accounts for a person's overall wellbeing. Each wall is explained below.
Taha Tinana	Physical health
Taha Wairua	Spiritual health
Taha Hinengaro	Mental health
Taha Whānau	Family/interpersonal relationships
Tika	True, correct and accurate
Tikanga	Code of conduct, customs
Te Tiriti o Waitangi/ Treaty of Waitangi	New Zealand's founding document signed in 1840. The treaty was signed by British Crown representatives and Māori chiefs
Tū Tahanga	The violence prevention programme subject of the research. The Tū Tahanga programme is based on the ManAlive Programme that is adapted for forensic mental health Māori service users
Wairua	Sprit or soul
Wānanga	Education
Whakapapa	Genealogy
Whānau	Family
Whānau ora	Family health
Whanaungatanga	Sense of family relationship. It describes deep and meaningful relationship with others
Wharenui	Meeting house