Pacific healthcare workers and their treatment interventions for Pacific clients with alcohol and drug issues in New Zealand

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Abstract

Aim To provide an overview of the treatment interventions and practices of Pacific alcohol and other drugs (AOD) services in New Zealand.

Methods Face-to-face interviews were conducted with 31 Pacific staff members from 13 services registered with the Alcohol Advisory Council of New Zealand National Directory. Issues around assessment, treatment interventions, outcome measures, service structure, and resources were explored.

Results Overall, the practices in District Health Board (DHB) and Non-Government Organisation (NGO) Pacific services were found to be similar. The clinical concepts of assessment, treatment, and outcome measures were not clearly understood by Pacific workers. This was due to the lack of attention towards Pacific concepts and practices and values. A holistic approach was viewed to be the best approach when working with Pacific clients based on health belief models, such as the *Fonofale* model.

Conclusions The findings of this study provide baseline data of treatment interventions and service practices of Pacific AOD services. There appears to be a Pacific way of working with Pacific clients. The most effective worker for Pacific people is someone who has sound knowledge of AOD, Pacific cultures and processes, and has the ability to integrate both *Palangi* (European) and Pacific knowledge to help the client.

Pacific peoples are an integral part of the New Zealand society with a presence throughout the country. According to the 2001 Census.[18] 231,801 people in New Zealand were of Pacific ethnicity with two-thirds living in Auckland. The majority are Samoan whose numbers have increased by 34% since the 1991 census, followed by Cook Island Maori, Tongans, Niueans, Fijians, Tokelauans, and then Tuvaluans.

The median age for Pacific peoples was 21 years, with an increasing number of New Zealand-born Pacific peoples. Pacific peoples' achievements are becoming increasingly known (particularly in sports) but so are their health-related statistics including alcohol and other drug (AOD) use.

Changing family and community structures triggered by migration and modernisation have resulted in altered patterns of AOD use as well as the population using them. These shifts are likely to have produced adverse consequences and increasing AOD related problems. Rapid social changes are clearly linked to these changing patterns and incidence of AOD use amongst Pacific people. In addition, Pacific peoples living

in New Zealand are exposed to both Western and traditional cultural influences and problems often arise from the coexistence of these two sets of values.[14]

The general AOD literature supports the inclusion of social, psychological, and cultural factors in the assessment and treatment of AOD-associated problems amongst indigenous people.[19] This is endorsed by New Zealand documents on Pacific issues,[10,11,13] which recommend that services designed for Pacific peoples must be responsive to their needs (based on consultation with Pacific communities) and have involvement of Pacific staff in the delivery.

There is a paucity of both quantitative and qualitative research in relation to AOD treatment interventions with Pacific peoples. Maori models of health and wellness such as the *te whare tapa wha* model[3] incorporating *te taha wairua* (spiritual dimension), *taha hinengaro* (mental dimension), *te taha tinana* (physical dimension), *te taha whanau* (family dimension), are more consistent with the Pacific belief systems and cultural practices. These models include key concepts that are integral to Pacific cultures such as the relation/connectedness between the individual, family, and community; and the holistic links between the mind, body, environment (social and physical), and spirituality.

The approach to treatment is often viewed by Pacific people as a collective concept that is understood not simply as a clinical event but as part of the experience of the whole 'family'. For example, for Samoan families, the reciprocity between the family and the wider Samoan community is the key to maintaining cohesion and communal ties.[7] Also the reciprocity between the family and the service provider is the key to satisfactory outcomes.[4] It emphasises the family and how it cannot be separated from 'culture' and 'caring', given that wellness and illness is perceived as a collective experience within the family.

The primary aim of this study was to initiate the process of evaluating the effectiveness of alcohol and drug treatment services for Pacific peoples in New Zealand. It documents and reports on current treatment interventions for Pacific clients across these services. This paper reports on information gathered from clinicians regarding current assessment and treatment models, outcome tools, and processes being utilised.

Methods

The method chosen for a particular piece of research depends on several variables. The first set of considerations concern the research question. Who or what are you researching? What do you want to find out? And what do you want to use the information for?

The characteristics of services 'by Pacific' 'for Pacific' people[20] are intricately tied up with beliefs about health, family, and community. According to Glaser [6] "the time has come for a methodology that focuses on the interest of the participants in favour of that of the researcher". The ambition of this research is to document and interpret from the frame of reference of the Pacific people the nature of treatment interventions for alcohol and drug issues. The researchers did not begin with a pre-determined hypothesis that would be 'proved' or 'disproved' within a positivist framework.

The methodology chosen for this research is rooted in Glaser's 'grounded theory;' [5] and the method: 'qualitative inquiry'. This in turn is heavily influenced by the paradigm of symbolic interactionism. Symbolic interactionism gives the tools to social psychologists to recognise what common set of symbols and understandings have emerged to give meaning to people's interactions, and systems theory asks "how and why does this system function as a whole?".[9]

It consists of three basic premises: people act towards things because of the meanings these things have for them; meanings are produced via social interaction; and these meanings are modified through an interpretive process used by people in managing the signs they encounter.[9]

The research team for this study was largely Pacific in origin and locate themselves in the role of 'empathic neutrality'. This is a term coined by Patton[15] who argued that the terms *objectivity* and *subjectivity* have lost their utility and he simply asks that the investigator adopt "a stance of *neutrality* with regard to the phenomenon under study". This means that the investigator has no pre-determined results to support; no particular perspective to push; and "does not manipulate data to arrive at predisposed truths." This credible qualitative inquiry is based on three elements:…rigorous techniques and methods at each stage of the research process; the credibility of the researcher; and a philosophical belief in the phenomenological paradigm.[15] Thus, the research team adopted a discovery-based method, a 'bottom-up' approach to research that is developed from participant's experiences. It is this function of generating participant-led data that led to its selection as a method for this project.

Identifying a sample—31 Pacific staff members from 13 services—registered with the Alcohol Advisory Council of New Zealand (ALAC) National Directory of Alcohol and Drug Services for Pacific People—were interviewed. These included services provided both by District Health Boards (DHBs) and Non-Government Organisations (NGOs). Care was taken to ensure that differences within the pan Pacific population in New Zealand were fairly represented. A 'purposive' (i.e. not randomly selected) sample of participants were identified based on their gender, age, ethnicity, Pacific Islands- or New Zealand-born, language fluency, geographical location of the participants, and the core business of the service.

Interviewing processes—Interviews were conducted by Pacific interviewers with individuals and groups depending on the way participants chose to give their information. All interviews were face-to-face and organised in a semi-structured way around the concerns of the participants. Key areas of interest included assessment, treatment interventions, and outcome measures from a Pacific perspective.

Data analysis—Information from the participants was recorded on tape then transcribed, and analysis began with line by line coding of each interview. A second round of analysis moved the data from a descriptive level to an aggregation which was then analysed thematically. This aggregated data was used to create a set of base-line information of assessment and intervention practices and outcome measures amongst Pacific providers. As a means of triangulating the reliability and validity of the data, a second researcher analysed a range of interviews to compare with that of the primary researcher, and material was fed back to participants for confirmation.

Results

Participants

More participants were male (61%), with 55% of the participants being Samoan; within this group, 19% were of mixed Samoan ethnicity (Samoan/Tongan, Samoan/*Palangi* (European), Samoan/Tokelauan, or Samoan/Maori).

Sixty-one percent of the participants were born in the Pacific Island (PI) nations. The current sample reflects the three main categories into which Pacific identities are often grouped: those born in the Islands and immigrated to New Zealand in their adult years; those born in the Islands and raised in New Zealand from childhood; and those born and raised in New Zealand.[12]

Just over half (55%) of the participants were over 40 years of age. All participants spoke fluent English with 81% fluent in one other Pacific language; 12% of this group being fluent in two Pacific languages. The majority reported that they conduct counselling and/or interventions in both Pacific and English languages. For the 19% who did not speak a Pacific language, they all reported that they understood much of the language but were unable to reply. One Samoan author referred to this as 'tautala

New Zealand born', a linguistic condition amongst New Zealand-born Samoan where they understand the Samoan language but are unable to converse in Samoan fluently[8].

The majority (77%) of participants were from NGO providers and 65% of the participants were from Auckland-based services. Most participants (74%) were from AOD-related services. However, 39% of this sample was specifically from AOD services (16% of this sample catered for Pacific dual diagnosis clients), and almost an equal number of participants (35%) were from AOD combined social services. About a quarter of the participants (26%) worked in mental health services. The findings differ depending on whether the participant worked within an AOD specific service, an AOD-related service or a mental health service.

Participating services were mainly organised into Pacific teams, with 5 of the 11 AOD services being managed by Samoan staff catering primarily for Samoan clients. Staff described a range of time spent working within the AOD field, from 6 months to 12 years with the majority being full-time employees. Most participants had some form of tertiary education though not always related to the addictions field.

Official job titles for those employed in AOD services varied widely despite there being little discernable difference between the actual work undertaken by 'counsellors'. More than 50% of staff had roles specific to working with Pacific youth (who speak English predominantly), therefore workers capacity to fluently speak a Pacific language was not vital. Alternatively, fluency is a requirement for working with an ethnic-specific group.

Some services have ethnic-matched, gender-matched, and/or age-group-matched roles while the majority of participants have integrated roles where they cater for a combination of either a particular ethnic group, age group (youth or adult), or gender. Matching clients and counsellor based on gender, age group, and ethnicity is important within the Pacific context as male counsellors have common experiences and understandings that are differentiated from women and vice versa.

Caseloads for AOD service participants were between 12 and 25 at any one time, but this incorporated interventions with both the individual and their family.

Mental health services participants estimated 30%–70% of their current Pacific clients had addiction problems; mainly younger males under 30 years of age, especially those presenting with psychosis. Discussions with these participants revealed that whilst there is a stigma associated with AOD and mental illness, Pacific communities and families appear more accepting of AOD issues than mental health issues, as addiction is seen to be preventable and external whereas the cause of mental illness is often attributed to the family.

Assessment

Many participants perceived that current assessment practices were 'foreign concepts' due to the emphasis on the 'individual' and the lack of attention to the process of collecting this information, such as establishing connection and building trust with the client within a Pacific context.

> "Assessment is new to many PIs, we have to keep in mind that we're seen to have power, you're a stranger so clients are suspicious and fearful, that's why you have to develop trust, without it clients will block things and not tell the truth"

> "We're relationship based people, the client will only open up if he thinks he's connected with the clinician, this is not a *Palangi* or PI idea, it's a human thing, we need to relate to the person we're talking to if we want them to open up"

All Pacific services adapted assessment forms into Pacific contexts. Dissatisfaction with the lack of cultural focus led participants to conduct their own cultural assessments when seeing Pacific clients.

Commonly reported useful frameworks for Pacific clients included the timeline, genogram/family tree, and the *Fonofale* model[2] as they take into account the cultural and family contexts as well as presenting issues.

A typical session was reported to be between 1 to 1½ hours with the assessment process taking one to four sessions to complete. Participants reported that clients were often seen where they felt most comfortable not necessarily at the service itself. Some preferred seeing clients at their home because this allowed them to assess the physical environment and family dynamics.

Whilst there was variation between services and regions, all participants reported using a specific format and process for assessment. DHB services had specific assessment forms and structured routines whereas NGOs were more flexible in their assessment process, but the requirements for NGOs appeared to mirror that of DHBs.

Tools predominantly used by DHB services were the Leeds Dependence Questionnaire (LDQ)[16] and Alcohol Use Disorders Identification Test (AUDIT).[17] Concerns about the current AOD assessment forms included difficulties in adapting *Palangi* assessment concepts to Pacific clients; barriers to building rapport; their time-consuming nature; and the fact that forms were designed mainly for adults and not for youth.

Forms were believed to be useful for agency requirements, accountability to funders and as guidelines for staff accountability. Despite the negative opinion, however, all participants agreed that assessment forms were necessary (particularly as a guideline) although they were unable to specify alternatives to current recording methods.

Some staff believed that the therapeutic relationship should have a deeper or 'spiritual' connection and not be just a 'surface' relationship where the client is connected with the worker mentally and cognitively. This is supported by Pacific writers who described spirituality amongst Pacific people as centred on the essential quality of relationships, and then Pacific therapy can be acknowledged as a spiritual process.[20]

Working with families was a more common practice amongst mental health workers as well as older Pacific workers within NGOs. This was mainly due to mental health services' specific expectations of community support workers and established community roles.

> "When we deal with A&D we deal with family and the home environment, we need to look at what systems that this person belongs to, it can explain their A&D behaviour"

Three-quarters of the participants, mostly older Pacific workers, had commitments within their community and many felt that some roles were part of their duty (e.g. matai/chief, church, and family roles).

Whilst all younger participants (<30 years) acknowledged the need to work with families, they also believed they were not well equipped to deal with older Pacific adults. Recognition of one's limitations due to the intergeneration gap is highly regarded, and it establishes that the young counsellor has knowledge of his or her Pacific culture.

Treatment interventions

> "The Pacific way of working means working with the whole person and whatever they bring to the table and helping them with the confidence to deal with it"

Treatment intervention was better understood by the majority of participants as another stage of 'helping' the clients and their families. Whilst participants perceived that some *Palangi* interventions can be readily adapted, all participants felt that treatment interventions with Pacific clients need to integrate knowledge from both *Palangi* and Pacific approaches. This perception is largely influenced by the obvious factor that Pacific people live in a *Palangi* society and are influenced by modernisation and *Palangi* systems in New Zealand. In addition, participants reported that many of their Pacific clients are either New Zealand-born, in a mixed relationship, or are of mixed *Palangi* ethnicity.

Many participants reported that they are either trying to develop a Pacific framework or have developed their own Pacific models for AOD interventions, which they trial and adapt to their working environment. The most commonly reported Pacific model that participants found useful in informing their approach was the *Fonofale* model. Whilst this model was originally developed for the mental health field, it is simple and captures key Pacific values, relevant to the AOD field.

The *Fonofale* model promotes a holistic view of health care. It utilises the metaphor of a house (a *fale*) to symbolise the wholeness of a Pacific person. The 'physical', 'spiritual', 'mental' and 'other' parts of a Pacific person make up the four pillars of the *fale*, while the aspects of 'culture' and 'family' make up the roof and base of the *fale*.[1]

The majority of participants saw working with the client as a 'spiritual journey'. Spiritual approaches are not easily measured, but are seen as a process of 'inner healing' for the client. Participants perceived that an essential aspect of therapeutic conversation includes discussing dreams, feelings, intuition, Christian principles, or conducting prayers during sessions. Spiritual approaches may have been expected more from older Island-born participants, but this was not the case. In fact, the spiritual approach was just as common amongst young, New Zealand-born, or *Palangi*/Pacific mixed participants.

All participants reported the need for the counsellor to be transparent and clear about the stages of intervention with the client. The counsellor needs to explain their role, what counselling means, and why the client has to see a stranger (counsellor). Roles such as 'counsellor/therapist', 'psychologist', 'social worker', or 'community support worker' are commonly viewed as *Palangi* roles and are often indistinguishable to many Pacific people. All participants acknowledged that many of their clients are unsure of what therapy is about and often they are naturally suspicious. This supported their argument for the need to develop rapport, connection, and trust prior to any meaningful AOD work being done.

All participants argued that Pacific staff are the most appropriate people for Pacific clients, based on the belief that a Pacific worker has in-depth knowledge of Pacific processes and meanings that the client can identify with or relate to. Whilst the advocacy for Pacific workers was well emphasised, many participants accept the reality that some Pacific clients may not want to access a Pacific service, see a Pacific worker, or have the choice to see a Pacific worker. In this case it was felt consultation by non-Pacific staff with Pacific workers was crucial.

Both mental health and AOD services identify following-up the client as a fundamental process in monitoring progress. Mental health services appear to have more structured follow-up processes partly due to the nature of mental illness, but also due to the roles of community support workers who focus on implementing continuing care plans. This process was less structured for AOD services. Whilst *Palangi* systems compartmentalise assessment, treatment, and follow-up, the majority of participants simply see this stage as a natural continuation of the counselling sessions.

Overall, an average AOD treatment intervention ranged from 3 to 4 months (about 6–10 sessions) with one to two follow-up sessions within a month after the last counselling session. On average, clients were initially seen weekly, reducing to fortnightly if the client was showing good progress. Clients who do not attend tend to be those mandated by agencies such as Community Corrections.

NGOs were more flexible to operate in a 'Pacific way', most NGO participants described continuing to do more interventions than those expected from funders (e.g. working with families and not just individuals, conducting more sessions than expected). This is mainly due to their perception that funding does not cover 'holistic approaches' and their experience of what works with Pacific clients.

Bilingual workers described that translating between languages is not only time-consuming but a skill that is not often acknowledged in the *Palangi* clinical field. It is widely recognised that many treatment-related concepts cannot be fully translated between cultures and often the essence of the meaning is lost when translated, hence the value of ethnic-specific workers.

Youth were recognised as a group that requires a specific approach. All participants reported that the involvement of parents or caregivers is crucial in the intervention process. The approach to youth and especially New Zealand-born youth was more consistent with the approach to youth in general. Discussions revealed that New Zealand-born Pacific youth try and integrate what they perceive as the Pacific culture taught by their parents and grandparents, but the Pacific culture that they experience is 'adapted' to New Zealand culture. Often this can cause conflicts and difficulties between parents and their children who are highly influenced by the *Palangi* culture.

Participants working with Pacific youth commented that client 'confidentiality' is contradictory with the Pacific expectation of involving significant others. Many acknowledged that session details were confidential, and that frequently youths did not want their parents involved but that it was beneficial for the youth in the long term if they gained the support of their parents. It was seen as a skill of the counsellor to assess the home environment and family circumstances (e.g. for the youth's safety) and engage parents positively from a cultural and educational angle without revealing session details.

The participants describe education programmes as an integral part of treatment intervention with Pacific clients, particularly as a prevention strategy. These programmes targeted not only the clients (psycho-education), but equally importantly the families and Pacific community (education programmes) with the aim of raising awareness but also for families and community to take responsibility by actively managing AOD issues.

Educational programmes are thought to be most effective when people are in their most 'natural' environment such as programmes delivered in churches, schools, or through Pacific media such as Pacific radio programmes. A significant number of participants have delivered at least one AOD programme on Pacific media or are currently running health programmes in their respective Pacific language on radio.

All participants described that traditional healing practices are useful for a variety of physical and mental health issues. Many had either direct or indirect experience with traditional healers, and a few reported that they practiced traditional healing themselves. The majority of participants described that using traditional methods to heal AOD issues in particular was 'uncommon' or that they were unaware of clients utilising healers; however, most participants supported the idea of utilising traditional healers for mental health issues.

Outcome measures

Unlike the assessment and treatment concepts, the majority of participants appeared puzzled by the concept of 'measuring' the effects of their treatment intervention with the individual. The idea of objectively 'measuring' the way a worker 'helps' an 'individual' was viewed as foreign. If measured, participants believed the process is equally important as the actual outcome of intervention.

Many described that measuring the true effectiveness of their intervention cannot be fully captured during the treatment intervention period—as change is long term and there are a variety of factors that could influence change in the client, some which could be attributed to the treatment intervention. Despite this, participants readily understood the concept of measuring the worker's performance to ensure they are effective with clients, but again the difficulty was in the translation of the *Palangi* performance tools and practices into Pacific contexts within the workplace.

Despite the lack of formal outcome measurements for Pacific people, all participants described a combination of informal processes that they utilise to evaluate the effectiveness of their work with clients. Observation and verbal feedback from the client was the most reported method of gaining information and was usually conducted at the end of treatment. Given that many participants work with families, their ongoing feedback was also crucial in gauging the client's progress.

Rapport with families from the beginning (assessment stage) is especially important given that their honest feedback and co-operation is needed at all stages of treatment. The key client changes that participants looked for were primarily positive behavioural changes and changes in relation to the client's treatment goals. Given that other areas of the client's life may be affected, all participants described that it is not sufficient to simply look at a reduction of AOD use as a measure of progress but other areas of the client's life needs to be equally addressed.

With regard to feedback processes, the participants felt that Pacific people are uncomfortable with, and can feel threatened by, written materials (questionnaires) because they may have negative connotations and imply that they too (client) are being evaluated. Despite being told that their responses are anonymous or confidential, clients may feel obligated and often record a more favourable response out of respect or shame.

Discussion

This piece of work represents the first stage of a larger more comprehensive review of treatment interventions with Pacific clients with alcohol and drug issues in New Zealand.

AOD workers see evaluation as crucial, and are keen to improve the content and intervention processes for capturing AOD assessment, treatment intervention, outcome measures, and service delivery to Pacific people.

The most effective assessments are those conducted by skilled Pacific staff with sound knowledge of AOD, Pacific cultures and processes, and ability to integrate *Palangi* and Pacific knowledge in a manner that would help the client.

The findings imply the need for clearly defined performance and outcome measures that accurately reflect Pacific processes and interventions. For instance, assessment is actually the first phase of 'helping' in the treatment intervention and needs to be recognised as this. The establishment of rapport is vital to the development of ongoing engagement with the client, and makes the initial stage more than merely completing an assessment form.

Clients should be encouraged to inform workers about the meaningfulness of interventions. Alternatives to written questionnaires given to Pacific clients should be considered, as questionnaires do not always accurately reflect their true opinions, even if questionnaires are translated to Pacific languages.

Client progress can be measured at different stages of the client's journey especially at the beginning (assessment stage) and at the end of treatment (after the follow-up period). Client-based outcomes should take into account social and environmental factors by recording verbal feedback from the client, families (as identified by clients), referrers and any relevant others involved with the client. A set of simple tools would be useful to capture this information.

Funders and other relevant agencies need to recognise and understand the clinical and cultural needs of Pacific workers in their approach to Pacific clients and families. This approach does not focus only on AOD problems and the individual; often interventions need to be intensive, longer, and incorporate families and significant others. Steps can be taken to empower Pacific workers to utilise Pacific processes and interventions that are 'effective' with their clients. These issues are not always included in the current funding contracts but are particularly important for the development of services and in building Pacific capacity and capability within the AOD field.

There is clearly an identifiable 'Pacific' way of working with Pacific clients. All participants applied elements of both Pacific and *Palangi* understandings of alcohol and drug issues to their practice. The degree to which this occurred depended on the age, gender, birthplace, and preferred language of the worker and the client.

Whilst there appeared to be no significant difference between Pacific interventions offered by NGO and DHB providers, there were differences in resourcing and service structure. Reporting and record-keeping requirements in DHBs were seen to take time away from 'Pacific processes' (in particular 'rapport' building) and inclusion of family in treatment. Any outcome measurement system needs to incorporate Pacific principles and processes.

There are a wide range of Pacific people who access services for AOD issues; and in order to provide appropriate interventions, Pacific AOD workers need to be competent in a variety of skills to meet these various needs. An effective alcohol and drug worker was described as someone who is of Pacific ethnicity with sound knowledge of AOD issues and Pacific culture, and has the skills to integrate this knowledge in the most appropriate way with the diversity of Pacific people accessing AOD services.

It was acknowledged that it is not enough to simply be 'Pacific' to work with clients. It is important to also have formal training and skills development. Conversely, approaching Pacific clients from a purely *Palangi* and/or clinical approach is also 'not enough'.

Whilst this study has limitations, it does provide baseline information which will enhance understanding and may support current intervention practices for Pacific people with AOD-related issues.

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