Where do they go?

***Roy Bergquist** reviews centrally funded treatment options for antisocial behaviours in New Zealand youth*

Introduction

The treatment of antisocial behaviour in adolescents is a matter for debate in this country. Many of the methods used historically, such as residential care, in general appear to be unsuccessful and have not helped the steady increase in numbers needing treatment. A paradigm shift away from the benefits of residential care and institutionalising is evident with the emergence of more family/community-based models of treatment.

Māori and Pacific youth are over-represented statistically in this group of young people, which raises questions for treatment. Is this statistic reflected in the type of programmes available and is this client group being catered for culturally? Where do they go and what happens when they get there?

New Zealand studies of treatment options currently available and their effectiveness are rare. Young people are dealt with by a large number of sectors and organisations, often with a lack of a coordinated approach.

Although this review looked mainly at youth in the youth justice system, there was also spillover into youth that were being treated for antisocial behaviour through mental health, alternative education, drug and alcohol, and youth development services. It aimed to discover what was currently available as treatment options in terms of services to Māori from iwi-based social services, and to uncover treatment options provided by other non-governmental organisations (NGOs). Little was known about the effectiveness of available treatments, and what research there was tended to focus on short-term results rather than the maintenance of long-term outcomes.

Focus of the review

My question 'where do they go?' was what drove the research and developed out of my interest in where young people go for treatment for antisocial behaviour and what happens when they get there. The objectives were, first, to demonstrate the interdepartmental spread of treating young people with antisocial behaviours. The second objective was to provide a nuts and bolts look at the make-up of different treatments available. Thirdly, by entering that world, my objective was to uncover issues and themes common among treatment providers. My final objective was to take the themes gathered from providers to focus groups to help uncover their policy implications.

My purpose for this inquiry, which was driven by an apparent lack of research, was to provide

information to professionals working in the field relating to what was available, exploring perspectives on best alternatives. Added to this was my passion for working with youth offenders and their families, and a desire that the study may benefit them in some way.

Current treatment options

The following programmes were reviewed.

Te Waireka
This was a kaupapa Māori youth residential drug and alcohol programme in the small Hawke's Bay town Otene.

Ronga Atea
A residential youth drug and alcohol programme in Hamilton, built on the marae.

Community Approaches
A non-residential programme for young people and their families based in Mt Roskill, Auckland. The programme was a police initiative.

Intensive Clinical Services
A Hutt Valley Health programme, based in Lower Hutt in Wellington, which used the Multisystemic Therapy (MST) model of treatment.

Mirror Youth Day Programme
Located in Waitati, Otago, and catering for 13- to 17-year-old boys and girls affected by both drug and alcohol, and behavioural issues.

Youth Culture and Development
A 20-week life skills day programme for 14- to 16-year-olds in Christchurch, which came out of the Youth Offending Strategy developed by the ministries of Justice and Social Development.

Te Kaupapa te Whakaora
An alternative education programme in Christchurch for young people aged 12 to 16.

Staff

The research highlighted a shortage of good staff available, including Māori and Pacific Island employees, and that often staff were hard to keep, partly because of the extremely difficult nature of the work. Other reasons were the perceived low rates of pay and the need for the right mix of skills and life experience. Specialised training for working with young people displaying antisocial behaviours was not always available and participants often felt that generic training was not sufficient. The requirement for staff working in this area was increasing and the work was becoming more specialised. Self-care and professional development were important features to consider when employing staff, as it was very stressful work on the frontline, and important for staff to plan a way forward professionally.

Teamwork was an important element of the work and should be supported through effective management and clinical/cultural supervision, including having clear professional development and effective training. Leaders should be encouraged into positions that fully utilise their strengths as, in the past, people have ended up in management positions because of their longevity of employment as opposed to their training and skills. Staff requirements have changed with a move from residential care to more home-based interventions, and the staff involved with home-based intervention needed strong engagement and family therapy skills. Although treatment fidelity is vital, programmes are only as good as the people operating them.

Education

The type and quality of education offered to young people on programmes varied greatly. Young people were often under-educated,

especially in the areas of reading and writing, and it was difficult to find an education system that worked while young people were in treatment or to establish workable relationships with schools. This group of young people were over-represented with learning disorders, illiteracy and innumeracy, and conflict was apparent in whether it was a good idea to keep these young people in the classroom or not. When a young person leaves the school system without being able to read or write there is little hope that they can gain employment and lead a responsible and productive life.

Whānau and family

Māori and Pacific Islanders were over-represented in some areas, especially violent crime. It was evident that colonisation has had a detrimental affect on many Māori youth. There is a need for more cultural input into programmes and better partnerships with iwi, as young Māori and Pacific Islanders need to realise the strengths and benefits associated with their ethnicities, as well as feeling connected. This could be achieved through knowing who they are and where they came from.

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Kaupapa Māori programmes can also work well with Pākehā and other ethnicities, and having a bicultural policy would not be exclusive to other cultures. One treatment provider was marae-based and investigation would be worthwhile to see if this idea could be expanded. An important aspect of kaupapa Māori programmes is to ensure Māori governance and to have a kaumatua on board. We live in a multicultural society and treatment provision needs to reflect this.

Mostly families are in the best position to effect change with a young person, as they know them the best and have a long-term investment. Often these families need tools and resources to do this, including coaching. Evidence has shown us that home-based interventions are more effective than residential care, and if young people are in residential settings the families need to be involved.

Marginalised families must not be blamed for their predicament, as they have not chosen to be in that situation. People working with these families are often dealing with intergenerational dependency and social isolation, and research shows that these families can be extremely difficult to work with because they are often involved with gangs, drugs and crime. Many of the families have had bad experiences dealing with government agencies and it takes a special type of person to be able to work with these families and be a catalyst for change. It is more effective to work with families in their usual environment as there they can learn to access resources available in their community and changes have a better chance of being sustainable.

Funding

It appears that there is plenty of money being spent on young people with antisocial behaviour, but there is a lack of coordination between different sectors spending it, creating wastage. Sometimes young people are excluded from school through financial reasons and from schools being unwilling or unable to invest in behaviour modification to keep the young person at school. NGOs sometimes struggle for

funding and this may be both because there are too many of them and because funding submissions are lengthy and difficult.

Research

MST is a promising new direction for working with young people and families. Other innovative treatments from the US include Multidimensional Treatment Foster Care, which is being used in an altered form in Aotearoa New Zealand, and Functional Family Therapy, which is not in use here. Twelve-step recovery is a currently used option in Aotearoa New Zealand for treating drug addiction with young people. 'Te Whare Tapa Wha', a Māori model, is considered useful by many. Whānau as a model has also been presented by Māori as a treatment option (Durie, 2005). I think we are making progress with the current use of theoretical models.

Conclusion

The review of treatment options has shown that young people with antisocial behaviours are treated across a broad spectrum of government departments and NGOs. Although there are marked differences between the providers, their commonality is that they are working with young people with behaviour difficulties and sometimes with their families. There is a lack of quality research and evaluation about treatments and options in Aotearoa New Zealand, including a shortage of shared data. Often NGOs are not researched or evaluated because of a lack of funding. Stronger relationships need to be built between tertiary institutions and treatment providers that promote or enable research. We need to follow overseas trends where theory is research-based to prove its effectiveness. After reviewing the literature, it became obvious there was a shortage of evaluations completed on actual treatment programmes in Aotearoa New Zealand, with the exception of research on family group conferences. A lot of the research done was on risk factors and assessment, not on interventions.

In focus group forums I looked at and discussed the policy implications that affect the provision of treatment to this group of young people. There are many ways of approaching this social problem and often not enough meaningful research to determine which is the best approach. When overseas research was considered, family-based approaches appear to stand out.

This group of young people and their families is extremely challenging to work with, and I am very grateful to the research participants who freely gave their time to this study. Their work, which most people would prefer to avoid, makes a huge contribution to our society.

REFERENCES

Durie, M. (2005) 'Whānau as a model for early intervention in conduct disorders.' Paper presented at the Severe Conduct Disorder II conference.

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