



child, youth
and family

towards well-being

RESPONDING TO THE NEEDS OF YOUNG PEOPLE

Te Kahu o Te Aorangi

The following guide for recognising and assessing the needs and strengths of young people is based on current best practice. It provides a framework for analysis but does not replace the professional judgement of social workers. It must be used within the supervisory practices and legal requirements and policies of the Department of Child, Youth and Family Services.



The Celtic knot is known to portray a circle of strength, bringing with it harmony, continuity and regeneration.



The koru design is based on the fern frond and symbolises growth, emergence, youth, energy and vitality.



The design represents two birds and is symbolic of a high vantage point, outward looking to the future and new beginnings.

SECTION 01

introduction

Acknowledgements

Karakia

Mihimihi

Pacific Peoples' dedication

Purpose of this guide

Kaupapa

Pacific Peoples' ideologies and philosophies
about mental health

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he karakia

Tui, tui, tuituia

Tuia te Hihiri Tapu a Io o te Rangi

No te Kahu o Te Aorangi

Kōkiritia rā ki te Ara-a-Rangi

Tākiritia rā te hihiri nei

Ki roto i te whenua a Papatūānuku

Mai ea, mai ea, mai te tipua

Mai ea, mai ea, mai te tawhito

I haere mai rā koe i a Whakahotunuku, i a

Whakahoturangi

Ko tōu manawa ko tōku manawa

Ko Tāne ka irihia

Aua kia eke, eke Panuku, eke Tangaroa

Tārewa tū ki te Rangi

Tūturu mai kia whakamaua kia tina!

Tina!

Haumi e, hui e.

Taiki e!

he kupu whakataki

E te mokopuna, he tamaiti purotu koe

Nō runga i te Kahu o Te Aorangi

Tae noa ki raro nei

Ki te Pito One Tapu a Papatūānuku

I whānau koe i roto i tēnei Ao Mārama

Te Whaiao ki Te Ao Mārama

Tihe mauri ora!

O mokopuna, perfectly conceived

From the pure elemental energy of the Universe above

Sustained by the sacred umbilical cord of Mother Earth

You were born into the World of Light

For the purpose of Fulfilment of life

I sneeze, 'tis the breath of Life!

he korero whakamārama

The theme expressed in the karakia and the kupu whakataki (preamble) of the mihimihi is that of 'Te Kahu o Te Aorangi', for which there are two distinct meanings. The first comes from the esoteric school of the ancient wānanga of the South Island, which would express the term in dialect as 'Te Kahu o Te Aoraki', The Membrane of the Universe, being the source of pure elemental energy, or pure thoughts and intentions. The second meaning is terrestrial in nature, and can be rendered as The Cloak of the Universe, thus conveying the life-giving force that emanates from the universe, becoming manifest in the real world.

he mihimihi

Tihei mauriora

Mai i ngā whetū i te rangi tae atu ki ngā mātā whenua katoa.

E aku rangatira

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

Hei tuatahi o ngā mea katoa

Ko te ara ki te Atua, nāna te tīmatanga

Kei a ia anō te whakaotinga o ngā mea katoa

Hei tuarua, kei te mihi ki te hunga wairua o te motu

Kua hinga i runga i ngā mauiuitanga me ngā mate katoa kua pā ki te kikokiko

Haere atu

Kei te mihi hoki ki ngā mate e kore e taea te tatari mā te mate hei tiki

Ko rātou te take o tēnei kaupapa whakamomori

Nā reira, haere koutou kei Paerau

Haere koutou i runga i te ara hīkoi i whakaae mai te Atua

Hei hikoitanga mō te wairua

Ko koutou tēnei e whakakī nei i ngā whāwhārua o te motu

Haere koutou, haere koutou, oti atu.

Me kī pēnei, ko koutou te hunga wairua ki a koutou.

Waiho ngā kōrero ki reira

Tihei mauri ora.

E aku rangatira o te motu, ngā koroua, kuia mōrehu, ngā whānau, hapū, iwi katoa, me ngā kārangarangatanga maha kei waenganui i a koutou

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

He mihi tēnei ki a koutou kia mōhio mai koutou ki ngā whakahaere kei roto i te Tari Awhina i te Tamaiti, te Rangatahi, tae atu ki te Whānau.

Ko ngā whaihanga e whai muri nei, ko ngā kōrero me ngā hiahia a ngā Kaimahi Māori o te Motu

Ko te tūmanako i wawatatia ai rātou ki te hoki ki ngā whakaaro o ā rātou tūpuna hei āwhina i a rātou ki te whakatutuki i ā rātou mahi i waenga i te iwi. Hei aha, kia hoki ki ā rātou tikanga, hei ārahi i tā rātou kaupapa.

Kei te mihi ki a koutou, kia aroha mai ki a mātou katoa.

Nā te mōhio ko ētahi o ngā rārangi kōrero e rerekē, ko te inoi ki a koutou, kia tautoko mai i ngā moemoeā mō tātou te Māori e mahi ana i raro i ngā ture a te Pākehā

Ko te wawata, kia tutuki ā tātou tikanga, hei tuatahi.

he whakamārama

From the Stars in the Heavens, to our ancestral grounds

My essence belongs.

To the elders of the land, greetings.

The creation of all things was by the hand of our Creator.

What He has created, He also takes away.

Secondly, to acknowledge the spirit of those who have passed on as a consequence of those things which afflict us.

We would like to acknowledge our young men and young women who have died before their time.

Hence the purpose for us to gather together.

Therefore, we acknowledge your return to Hawaiki and your journey on the pathway that was created especially for the wairua and to acknowledge them that gather in the resting places of the land.

Farewell in your long journey.

It is said that you greet those who await you and the words that take place there, remain there.

To the rangatira, our remaining koroua and kuia, whānau, hapū, iwi of the land, greetings.

The purpose of this greeting is to bring to your awareness the things that are occurring within the Department of Child, Youth and Family Services.

The things that follow are the discussions and desires expressed by Māori working in the Department throughout the land.

It is their hope that this vision will be realised.

The teachings left by the ancestors that they know well, will be developed to enhance the work with iwi.

We wish to acknowledge that some of the discussions presented differ from what has been said before.

We humbly seek your support and blessings in the developments to follow.

The dream is that we will practice from a Māori base first and foremost.

pacific peoples' dedication

Samoan

E muamua ona momoli ululapalapa o malo I maota aua le Atua ma lana pule faasoifua. TalSofa. Malo le soifua, malo le lagi e mama.

Matou te le toe alofia le vasalolola I ou paia o le ia iviivia, o le vao filifili. E leai se vave e mafai ona autalaina. Tulou, tulou lava.

Ae o le a faga tonu le malama aua lou silafia Samoa I le autu o lenei faamoemoe. O le fanua ma lona tapu a fanua, o le tagata foi ma lona faasinomaga. O alo ma fanau o le lumanai o aiga, nuu ekalesia ma malo.

O le sagalemu mo le ola manuia ma se lumanai fiafia, o loo I ou aao ma o tatou lima. O avega tausos faatasi a matua ma aiga faapea e o loo galulue I lenei matata. E fofoa mai I totonu o aiga ma siosiomaga malu, ina ia tutupu ae e aveva ma tagatanuu soifua manuia Manatua, o le au o matua fanau, o tofi mai le Atua!

Soifua

Tongan

Tala kei kapa te'eki to ki mala he koe hakau o e aho ni', koe fonua o e kaha'u.

Niue

Ko e mahani fakateaga ke he levekiaga ke he tau fanau ko e puhala kua nakai lata mo e atihakeaga he tau momoui ha lautolu. Ko e ekefakelea, po ke fahi/keli fakakelea ko e agahala kua nakai lata ke taute, ko e matafakatufono foki e mena ia ke he motu nei kua nonofo ai a tautolu. Ko e mena ia kia fakamalolo ke totoko atu poke fakaoti e mahani favale mo e ekefakelea ke he tau fanau, ha ko lautolu ko e tau koloa uho ne foaki mai he Atua ki a tautolu ke fagai, fakainu mo e fakatui, tuga a tautolu ne fagai, fakainu mo e fakatui e la ke he haana a fakaalofa hofihofi noa.

Ko e mena ia, ki a aua neke fakateaga ke he levekiaga ke he ha tautolu a tau fanau ha ko lautolu ko e tau auro, tau monuina mo e tau hukui ma tautolu haia ma e tau aho anoiha. Ki a leveki mo e fakahелеhele atu ki a lautolu, ki a fakauka mo e mahani fakamooli ke he feakiaga he tau momoui he tau fanau ha tautolu.

Ki a fakamonuina mai he Atua.

Cook Islands

Kia orana kotou katoatoa

Aiteite ua oki te turanga e te puapinga o ta tatou anau mapu uki ou e to ratou ngutuare tangata e pera katoa oki te kopu tangata i roto i to tatou iti tangata.

I na oki e, e no ta tatou anau mapu uki ou oki te tuataa ki mua tei te ngutuare tangata oki mate kopu tangata oki te akapapuanga atu e kia riro to ratou oraanga ki mua ei mea puapinga tikai na roto i ta ngutuare tangata e ta te kopu tangata aroaanga atu, akonoanga atu i ratou, e te tupuanga manamanata kore tikai. E noreira kia akariro ua ia rai ratou, ei kopu okotai.

purpose of this guide

The purpose of this guide is to inform social workers working for Child, Youth and Family, or Iwi Social Services, or in associated services, of the current best practice for recognising and providing effective interventions for young people at risk of adverse outcomes. It will provide information that will assist youth services workers. It does not replace sound social work practice, including regular consultation with supervisors. Information about culturally appropriate practice is included in each section.

Best practice will be delivered in accordance with the Children, Young Persons and their Families Act 1989, especially the provisions relating to young offenders outlined in the Objects, Principles and Duties of the Director General (now Chief Executive) in Sections 4, 5 and 7 of the Act. Attention is drawn to Section 4f that states, “they are held accountable, and encouraged to accept responsibility, for their behaviour and they are dealt with in a way that acknowledges their needs and will give them the opportunity to develop in responsible, beneficial and socially acceptable ways”. This means that, in addition to a response that holds the young person accountable for their offending and putting right the harm that they have done, young people need a

social services response that addresses those conditions inhibiting their chances of more positive life outcomes.

For most young people who have contact with Child, Youth and Family the current processes are sufficient. However, this is not true for all cases. Concern exists about a number of young people whose life problems or conditions, in one way or another, make successful intervention difficult. Such young people often come from life styles which may be characterised by substance addictions, mental health problems, lack of attachment to any significant others, conduct disorder or an abuse history. Many do not receive help until their problems become so severe that they come to the attention of the authorities as a result of their behaviour.

While the Youth Services Strategy is primarily focused on 14–16 year-olds it is recognised that there are many 12 and 13 year-olds facing multiple risks and with many needs beyond their chronological age.

It is expected that the screening and assessment tools programme and services in the Youth Services Strategy will be available to high-risk 12 and 13 year-olds.

The Youth Services Strategy focuses on the achievement of two outcomes:

- ⋮ *reduced offending and reduced re-offending*
- ⋮ *improved life outcomes (reduced behavioural problems, mental health disorders and suicidal behaviours).*

The intention is to provide information about the current best practice, including screening and assessment. Many of the services required to assist these young people are outside Child, Youth and Family and may be difficult to readily access. Nevertheless, these guidelines outline a process that has been agreed as the most appropriate to identify, complete an initial screening and assessment, and effect and manage a referral.

This guide contains language and assessment tools more common to mental health than welfare services. This is intentional, because a key element of the Youth Services Strategy is social workers' understanding and communication with colleagues in the health sector, especially mental health services. In order to make and manage referrals effectively, it is important to be able to convey information in a common form to achieve the best outcomes for the young person.

What should this guide achieve?

The most critical aspect of the successful implementation of this guide is the accurate recognition of young people who are likely to be experiencing mental health disorders. Young people with a history of offending or out-of-control behaviour typically have mental health disorders that will aggravate these behaviours. Use of this guide should improve the accurate and early recognition of

young people requiring services, improve the effectiveness of case management and ensure that appropriate services are targeted to the individual young person. This will lead to better life outcomes, shorter periods of contact with services provided by Child, Youth and Family and lower rates of recidivism. The success of the intervention will depend on the social worker's practice skills and knowledge about young people.

How common are mental health disorders and substance abuse?

One in five young people on Child, Youth and Family caseloads have a formal mental health diagnosis recorded on their file.

Mental health disorders are common¹ amongst 14-16 year-olds accessing Child, Youth and Family services. Alcohol, drug and substance abuse disorders are likely to be evident in 40% of the care and protection population and 54% of the youth offender population. Equally present in the care and protection and offender populations are depressive disorders (30%) and anxiety disorder (40%). Conduct and oppositional disorders are likely to be present in 85% of the youth offender population.

For a significant number of these young people their behaviours will be transitory and related to the influence of negative peer relationships and lack of boundaries. There is a group of young people who offend more frequently and are likely to have more severe and persistent mental health disorders – which in turn aggravate their offending behaviour.

¹ These estimates have been drawn from the Christchurch and Dunedin Child Health and Development Studies.

It is likely that most young people referred to Child, Youth and Family will have multiple mental health disorders (of which depression and substance abuse, and depression and anxiety disorders, are the most common).

Depression, anxiety and alcohol and drug disorders are treatable. Access to treatment is likely to result both in lower future needs for Child, Youth and Family services and lower risk of negative outcomes (such as re-offending and mental health disorders including suicidal behaviour).

How common are thoughts about, and attempts at, suicide?

Of all New Zealand youth aged 14-16 years, 21, on average, die each year by suicide. It is estimated that a quarter of those who die will be in contact with Child, Youth and Family services – or, on average, one death by suicide in a Child, Youth and Family area every two years.

The number of serious attempted suicides (requiring hospitalisation) for 14-16 years-olds is about 46 each year of which about a quarter are likely to be in contact with Child, Youth and Family services – or, on average, one to two in any Child, Youth and Family area each year.

The highest level of risk for a young person is generally associated with the presence of multiple mental health disorders. In any Child, Youth and Family population of young people 14–16 years, 50% are likely to have two or more mental health disorders and, of those who have a history of offending, 70% will have two or more mental health disorders.

Young people who have committed offences or have had prior contact with welfare services have the highest risk of suicidal behaviours of any of their age group.

The reasons for this are:

- ∴ *they have the highest rates of accumulated disadvantage for their age group*
- ∴ *two-thirds of the young people who access the Department's services have a history of offending and this group has the highest rate of mental health disorders (including substance abuse and conduct/oppositional disorder)*
- ∴ *the young people accessing the Department's care and protection services also have a high rate of mental illness (including substance abuse)*
- ∴ *young people are referred to the Department for care and protection following significant trauma (such as abuse and serious suicide attempt).*

The risk of suicidal behaviours is highest in the period immediately after the young person's offending has been detected and he or she has come into contact with the authorities. Care should be taken to ensure that the young person at risk has continuing access to support during this period.

Kaupapa

Whaingā

- 1. To provide a framework for developing Māori approaches within the current understanding of good social work practice.*
- 2. To ensure this framework advantages kaimahi Māori working with whānau.*
- 3. To incorporate tikanga when implementing the Youth Services Strategy.*

Kaupapa

Best practice will be delivered in accordance with the Children, Young Persons and their Families Act 1989, and specifically the provisions related to the principles, objectives and duties of the Chief Executive. This includes advancing the well-being of mokopuna, tamariki, rangatahi and their whānau, hapū and iwi.

Development and promotion of Māori practice will assist in the attainment of better outcomes for Māori.

Tūmanako

- 1. To assist non-Māori social workers to recognise the specific needs of whānau.*
- 2. To assist Māori social workers in developing, promoting and maintaining their Māori practice.*

Moemoeā

- ∴ the incorporation of Māori approaches to practice will reduce the rate of notification of recidivism to Child, Youth and Family*
- ∴ the acceptance of a 'by Māori for Māori' approach will assist Child, Youth and Family in realising improved outcomes for Māori*
- ∴ the validation of kaimahi Māori and their Māori practice will create a more dynamic workforce within Child, Youth and Family.*

pacific peoples' ideologies and philosophies about mental health

In general, Pacific Peoples do not traditionally consider mental illness to result from within, and be confined to, a person exhibiting certain types of disturbed behaviour. Most disturbed behaviour is considered to be a manifestation of an external ancestral spiritual force who has taken possession of the person because the person or his family have broken a certain custom or offended the spirits in some way. Well-being for Pacific Peoples is not seen on an individual basis but rather on a communal or collective basis.

The transition from life in the Islands to life in New Zealand brings to the fore a variety of factors and pressures affecting mental health. These factors and pressures include:

- ⋮ *problems with employment*
- ⋮ *adequacy of housing*
- ⋮ *sufficiency of income*
- ⋮ *extended family needs and obligations*
- ⋮ *food requirements*
- ⋮ *church obligations.*

Other factors and pressures also include the conflict between the Pacific Peoples' values, traditions and mores and those of New Zealand society, and the changing relationship between parents and children.

However there are also protective factors guarding against mental health disorders. These factors include:

- ⋮ *family support*
- ⋮ *community support*
- ⋮ *awareness and esteem for own culture*
- ⋮ *absence of substance abuse*

- ⋮ *non-violent home environment*
- ⋮ *self-esteem*
- ⋮ *adequate parenting.*

Pacific Peoples' beliefs about the causes of mental health and illness determine the way they respond to such illness. These beliefs, including the way in which the illnesses are treated, are quite different from those held by the Western medical profession. The views and beliefs held by Pacific Peoples may be traditional but are at the same time entwined with, or modified by, the Christian doctrine. These beliefs mean that Pacific Peoples may be reluctant to use Western psychiatric or psychological services.

The various Pacific Peoples' cultures do not have specific words or concepts in their respective languages that translate easily into the terminology of mental health disorders and psychological distress. However, there are terms that exist within the different languages that do relate to mental health. These are discussed in Section 2.

SECTION 02

cultural considerations

Cultural considerations

Cultural considerations for Māori

Cultural competencies for Māori

Concepts from the Māori world view

Cultural considerations for Pacific Peoples

cultural considerations

The influence of cultural factors must always be considered. Only by understanding the cultural context of the young person will the information about their behaviours, fears and thoughts be correctly interpreted. What may be accepted in one cultural situation may not be in another. In all cases, the social worker must endeavour to take account of the young person's perspective and be aware of the effect of their own preconceptions and beliefs.

Appreciation and consideration of cultural factors is important for all people in improving outcomes and the health of the community.

While culture is frequently based on ethnicity, the interpretation of culture should not be restricted to this. Groups with specific religious and social beliefs and norms may also need to be considered. Often, there will be religious/spiritual and social differences within ethnic groups.

The more the social worker is able to appreciate the cultural perception of the individual to whom they are offering assistance, the more effective the relationship will be.

This guide recommends that the social worker should endeavour to liaise with, or make a referral to, a culturally appropriate service or specialist when working with a young person whose culture is different from their own. This is clearly the case where the person's primary culture and language (e.g. Māori) is not that of the social worker. This would also include situations

where religious beliefs and values differ significantly. The offer to arrange and be supportive of a referral must come from the social worker. Decision-making should be guided by active professionalism and supervision.

Appreciation of how the young person views him or herself is critical. When working with a young person of the social worker's own ethnic group, it is important not to assume that the young person subscribes to the same cultural or world views as the social worker.

When dealing with a culture that is different from one's own, the social worker must obtain the advice of the appropriate cultural advisor/consultant, kaumatua, kuia, or religious or community leader. It may also be appropriate to seek the services of a local health service cultural advisor. The social worker will need to contact the young person's family, and the appropriate community resources, church or alternative health providers to gain an understanding of the young person's difficulties.

cultural considerations for māori

“Māori live in diverse cultural worlds. There is no one reality nor is there any longer a single definition which will encompass the range of Māori lifestyles. Some Māori are closely linked to established Māori institutions: marae, hapū, iwi. Others are involved in new institutions, strongly Māori, but not in any traditional sense, nor always readily distinguishable from the institutions of other New Zealanders. A Māori identity, even when vigorously defended, cannot be presumed to mean a conventional Māori lifestyle. Nor should it be forgotten that, for many Māori, cultural identity is a sophistication; it is more than enough simply to get through each day”.

(Durie, M. Whaiora; Māori Health Development. Auckland Oxford University Press, 1994 p.214)

Communication

Communication in a Māori world hinges on two assumptions:

- ⋮ *respect and responsibility are implicit in any exchange*
- ⋮ *everyone has something to say, whether they speak, or are spoken for.*

In a Māori world, reciprocity is the motivating principle in any exchange of ideas, words and actions.

All relationships are acknowledged and any actions taken are a function of those relationships.

Context

To minimise any potential misunderstandings in a relationship, the social worker must be mindful of the context in which it was initiated and developed.

Whakawhiti korero

These guidelines will improve the:

- ⋮ *recognition of imbalances in the whānau*
- ⋮ *effectiveness of interventions with rangatahi*
- ⋮ *understanding of a Māori world view*
- ⋮ *chances that whānau are not disadvantaged because of cultural ignorance*
- ⋮ *opportunity for kaimahi Māori to work more overtly in a tikanga context.*

cultural competencies for māori

These basic cultural competencies² and values underpin ALL competencies and have particular relevance to social work encounters with Māori clients and communities. Department of Child, Youth and Family Services' social workers are required to have basic skills and knowledge of Māori culture and customs.

Remember: Access to, or acceptance of, resource people with in-depth knowledge of te reo, tikanga and kawa will sometimes be necessary. Offices will need to identify people for this purpose.

Te Reo

- ⋮ *greetings and farewells are provided in Te Reo Māori*
- ⋮ *simple responses are encouraged in whānau dialogue*
- ⋮ *ensuring correct pronunciation in Te Reo Māori.*

Kawa

- ⋮ *having an awareness of customs*
- ⋮ *procedures of opening and closing meetings are known*
- ⋮ *marae familiarisation has occurred.*

Tikanga

- ⋮ *encompasses Māori values and beliefs*
- ⋮ *concepts and principles of tikanga of iwi are known and respected.*

Mana

- ⋮ *a critical element in the Māori being*
- ⋮ *the subdivisions of mana acknowledge the spirituality of individuals, land and ancestors.*

Whānau

- ⋮ *Who are they?*
- ⋮ *Do they identify themselves in a traditional or an urban context?*

Hapū/Iwi

- ⋮ *How do you access them?*
- ⋮ *What are these roles today?*
- ⋮ *View the Māori child in the context of the whānau, the hapū and the iwi.*

Pūao-Te-Ata-Tū/Daybreak

All social workers need to be familiar with the report *Pūao-Te-Ata-Tū* and its historical background:

“In order to minimise the dangers of cultural and institutional racism occurring within the organisation, the Ministerial Advisory Committee provided a statement of guiding principles and objectives that specifically exclude any racist interpretation. Recommendations One and Two of Pūao-Te-Ata-Tū are the only guiding principles and objectives provided by the Committee. They are specific to the Department of Social Welfare and were intended by the Committee to be lasting statements of commitment.” (K. Tauroa)

² Adapted from New Zealand Children and Young Persons Service Competency Programme, p.11.

concepts from the māori world view

Te reo Māori

“Ko te reo te mauri o te mana Māori”

The language is the life principle of mana Māori

- The Māori Language Act 1987 declared the Māori language to be an official language of New Zealand.
- The Māori Language Act 1987 brings recognition of the formal application of Māori language. However, recognition must also be given to the general use of Māori language.
- Under Article Two of the Treaty of Waitangi, Māori retained tino rangatiratanga (i.e. full authority, status and prestige) over their possessions, interests and customs, including the Māori language. All people of New Zealand should nurture and protect the language and be enriched by its preservation.

Kawa

Protocol – or custom – is respected as an essential and integral part of tikanga Māori and is determined by local tangata whenua. Essentially, it is about giving people the dignity and respect they are due.

Marae

The marae is the courtyard in front of the ancestral meeting house. The marae and the meeting house complement each other and serve as the focal point for tribal activities that enable Māori to continue their own way of life, within the total structure of their own culture, values and custom.

Mihi

Mihi – or greeting procedures – acknowledge and welcome a person or people gathered for some event or meeting.

Karakia

Karakia – or prayer – is the outward expression of wairua (spirituality), acknowledging the holistic nature of the principles of Māori culture. Māori have karakia at the beginning and end of meetings/gatherings and before a meal.

Tapu

Tapu – sacredness or respect – is the means whereby respect is shown to those things that have value.

Hui

Hui – or meetings/gatherings – are the coming together of people for a particular purpose where, if necessary, a majority agreement can be reached by consensus.



concepts from the māori
world view

Tikanga

Tikanga are rules of conduct based on values handed down through generations from common ancestors.

Each iwi has its own tikanga. As with kawa, it is essential that social workers are aware of these differences.

Pōwhiri

Pōwhiri are rituals of welcome afforded to manuhiri, dignitaries, new staff, openings of buildings and taonga that are received. Pōwhiri may include mihi, karakia and waiata (song). A pōwhiri generally involves a reciprocal response on behalf of those who are welcomed. When unsure, consultation with elders as to appropriate actions and behaviours is essential; for instance, someone to speak on your behalf.

Hākari

A hākari is a feast or meal given after a significant event e.g. wedding, unveiling, special function or tangihanga. It is an offering unifying the spiritual and physical elements. Hākari should be arranged whenever Child, Youth and Family is responsible for a welcome or pōwhiri.

Tūrangawaewae

A person's tūrangawaewae represents the standing place for Māori – the place where they have the right to be heard – where they belong. It is the marae to which the person is linked by ancestry. Tūrangawaewae gives Māori the feeling of belonging and identity.

Mana

Mana, like wairua, is a critical element in the Māori being. It is an umbilical cord, which joins the spiritual and physical worlds.

“From a Māori perspective, since authority is derived from the Gods, mana is defined as ‘lawful permission’ delegated by the Gods to their human agents and accompanied by the endowment of spiritual power to act on their behalf and in accordance with their revealed will. Such agents must be endorsed by below – that is by the people. Man remains the agent not the source of mana”.

(Māori Marsden)

Mana has a number of sub-dimensions. Each impacts on the other; all are interconnected. Here are a few:

Mana Atua

The mana everyone receives from God or the Gods, directly or through agents.

Mana tūpuna

The mana handed down through a succession of ancestors. Normally gifted by the senior descendant in each whānau, hapū and iwi.

Mana whenua

The mana that applies to individuals who come from particular territories.

Mana tangata

The mana normally vested in an individual by others because of social or human achievements.

concepts from the māori world view

Whānau – hapū – iwi

Tribalism is the primary source of Māori social strength. The traditional Māori system consisted of four organisation levels all linked to a greater or lesser degree by a common ancestor or event.

Waka

The largest of the units, consisting of a group of tribes whose ancestors reached Aotearoa on the same canoe.

Iwi

Members of a tribe or iwi were linked by descent from a common ancestor who was on one of the canoes and whose name they took. Tribal feeling was strong, and each tribe formed an independent, self-sufficient and self-governing set of groups under the leadership of the ariki.

Hapū

Tribes were divided into smaller organisations – the hapū. Since members of the hapū could trace their heritage to an ancestor several generations back, it comprised an even closer kin group than iwi.

The hapū took the name of their common ancestor and built their society around respect for their ancestor. Although they readily joined other hapū in times of war or ceremonial occasions, each hapū was responsible for its own government. Autonomy was fundamental. Rangatira,

the hereditary chieftains and leaders, who were expected to act wisely and with dignity, led the hapū.

Whānau

The basic social unit of Māori society, however, was the extended family or whānau. This consisted of up to about thirty people, under the direction or guidance of the kaumatua, the respected elder. Children, grandchildren and great-grandchildren, with their spouses, made up the whānau, which was responsible for making the basic day-to-day decisions.

In all matters of concern to the tribe or hapū, there was discussion among the heads of each unit – that is, kaumatua representing each whānau, and rangatira representing each hapū – before a decision was made.

Most decisions, however, were local decisions made by the whānau on the basis of kinship.

The Māori child in context

“Under Māori tradition, the importance attached to the child’s interests is subsumed under the importance attached to the responsibility of the tribal group through the tribal traditions and lore of inherited circumstances. The hapū or tribal group is bound to provide for the physical, social and spiritual well-being of the child and its upbringing as a member of a particular hapū. This responsibility would take precedence over a view of the birthparents”.

(Pūao-Te-Ata-Tū)

cultural considerations for pacific peoples

Traditionally, Pacific Peoples view these issues from the perspective of wellness rather than illness. Illness is perceived as an altered state of wellness. There are several dimensions that contribute to the holistic perception of a Pacific Island person's well-being. The following points must be considered when working with these people.

1) Communality: Pacific people are naturally communal people. The way of viewing the world and doing things is mostly driven by what is commonly perceived as acceptable to the community. They also draw strength and confidence from communal beliefs.

2) Family: Most Pacific Peoples' families are extended families, although in New Zealand some have made conscious decisions to be nuclear families. The family is the centre of the community and way of life. The family provides identity, status, honour, roles, care and support for their people. Belonging to a family is important.

3) Unity: Keeping the community and families together as a united entity is an important duty for Pacific People, especially those with leadership roles. This is because strength, wealth and pride come from their sense of belonging and staying united. Together, they feel strong and powerful but alone, they feel isolated, weak and lost.

4) Dignity: Pacific Peoples believe in the dignity and integrity of people. When they relate to one another, particularly in formal situations, they respect and maintain the dignity of others as well as their own.

5) Respect: Pacific Peoples learn from an early age to show respect when they relate to one another. Children are taught to respect their parents, elders and anyone who is older than they are. Also, they are expected to respect those in positions of authority and leadership. Respect is also earned through services to the family and community.

6) Humility: Pacific Peoples are expected to be humble and show humility when they relate with one another. Humility and humbleness are leadership qualities. They are important in the process of delivering an important message.

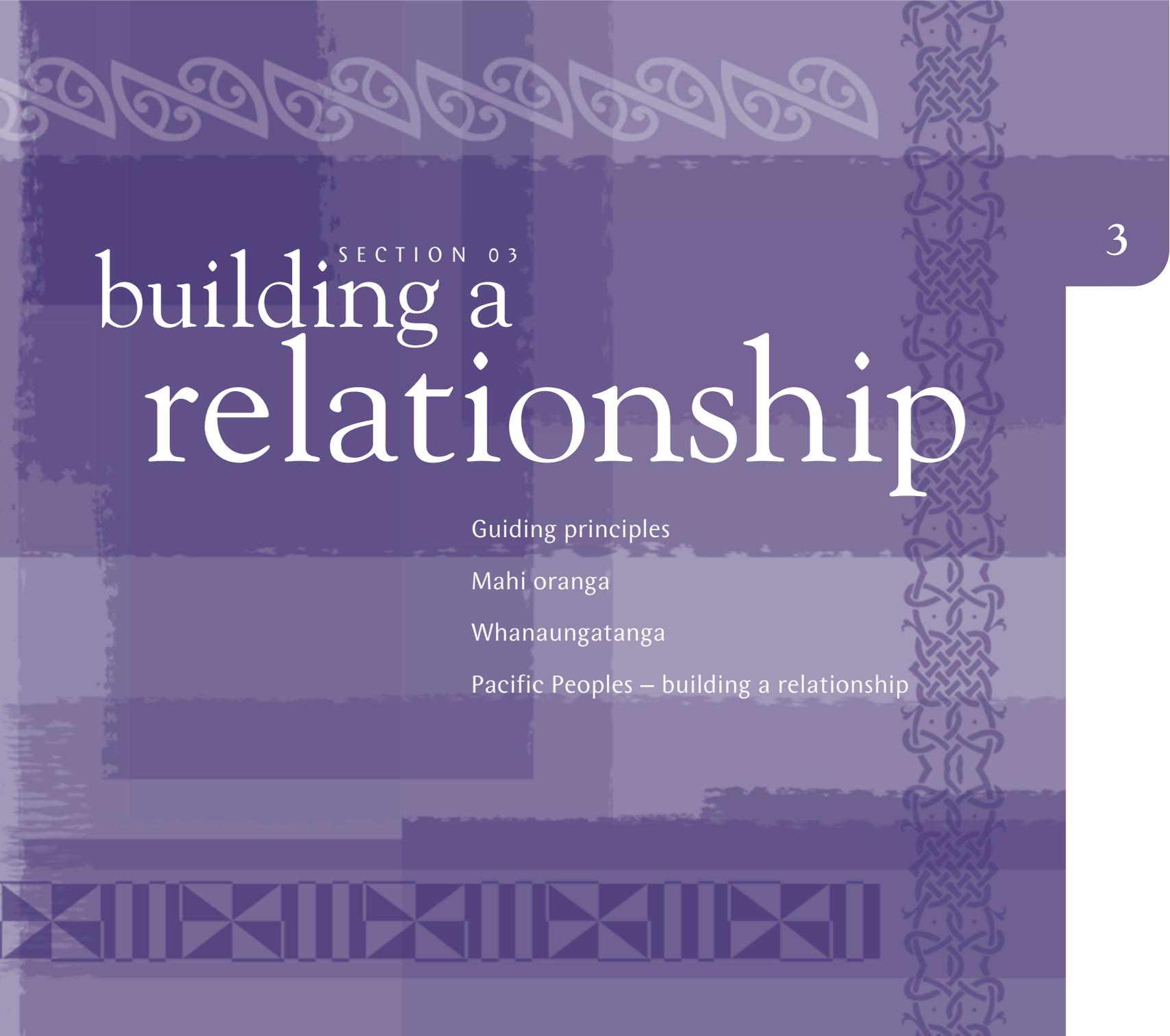
cultural considerations for

pacific peoples

7) Service: Pacific Peoples consider any work they do is for the betterment of their communities, families and selves. Service is the road to authority and leadership. It is their duty to serve.

8) Delivering the message: In delivering an important message, Pacific People consider the way the message is delivered far more important than the message itself. This is because the protocols involved not only explain the message but can also bring a successful resolution to the issues. By following the protocols, barriers can be removed and cooperation improved.

9) Food: Food is important in Pacific cultures. Food brings people together; sharing of food symbolises stability, unity, agreements and decision.



SECTION 03

building a relationship

Guiding principles

Mahi oranga

Whanaungatanga

Pacific Peoples – building a relationship

guiding principles

Engagement

Assessment and intervention will be more easily achieved and time will be saved later if sufficient time is taken early in the contact with the young person and their family to establish a relationship and provide them with stability where possible.

Rapport-building

Identify and understand the cultural identity, context and needs of the young person and their family/whānau.

Care should be taken not to make any assumptions. The language and processes may be adapted (within the principles and intent of this guide) to be appropriate to the young person (see Section 2: Cultural considerations).

What is the current state of the young person?

An assessment will not produce useful or accurate information when the young person is agitated, high on drugs or alcohol, injured, uncooperative or unable to understand what is going on. In such circumstances care should be taken to assess suicidal risk as best as possible and keep the young person closely monitored until a fuller assessment can take place.

Talk compassionately and persistently with the young person about their feelings, fears and thoughts, and with those who are closest to them.

Vulnerability of the client

These young people are at their most vulnerable and highest risk at the point they come into first contact with authorities. If there are any suicidal thoughts, this

is a time when they are most likely to be actioned. This is highly likely if there is also a breakdown in significant supportive relationships, the likelihood of criminal proceedings (especially being locked up) and issues of shame particularly in relation to religious, spiritual and/or family/whānau expectations.

Confidentiality

This is an important issue when working with young people. Many young people will ask for a promise of secrecy before they make a disclosure.

This should be avoided and every effort made to encourage the young person to share their concerns and plans without any promise of confidentiality.

If a young person is at risk of suicide, the social workers must do everything in their power to ensure the young person's safety.

guiding principles

Trust your intuition

The identification of mental health disorders, especially any suicidal thoughts and behaviours, will depend upon the intuition, knowledge, experience and training of the social worker. Most young people can be expected to act differently when they first meet a social worker, not readily indicating how they really feel or think. Therefore, they may exhibit few and fleeting indications of how they are. As the indications of a mental health disorder, especially depression, are often the absence of normal behaviours and reactions, care needs to be taken to distinguish reserve from disorder. This will depend upon the young person's culture and personality, and what is normal for the young person should be checked with an independent source.

Check your assumptions

Check your assumptions and be prepared to respectfully, but persistently, inquire about matters that do not appear to be what they are. If there is a concern about the person's immediate safety, efforts to establish a relationship should be secondary to obtaining the information necessary to respond to keep the young person safe. In such cases, only the screening for suicide should be completed and then any necessary emergency action taken (refer Section 6). Assessment for mental health disorders and well-being assessment can take place at a later stage.

Sharing information

Share and discuss information with the young person's family/whānau taking into account that they may have a tendency to over-estimate the young person's problems when there are behavioural disturbances, and may under-estimate the severity of the problems when there is a depressive disorder.

Gathering information

Details will come to light that will be essential information for the screens and assessments that follow. Gather and note this information, but do not make a judgement about its significance until a considered assessment can be made using the tools for guidance.

During this stage, you should take time to explain:

- ⋮ *the assessment process*
- ⋮ *the social worker's role and responsibilities and the processes and procedures that are likely to be involved*
- ⋮ *the length of time these processes are likely to take*
- ⋮ *the nature of the support that may be available and other relevant information (refer to Appendix 1: Resource Contacts).*

The research clearly shows that the offender group has the highest rates of mental disorder of any group accessing Child, Youth and Family services.

mahi oranga

towards well-being

The social worker needs to adopt a systematic, holistic approach to rangatahi responsibility, health and well-being.

It is our goal to provide a framework that will assist in highlighting imbalances that rangatahi/whānau may present with.

This will be in line with procedures and practices already formulated and determined by Child, Youth and Family. These include the screening and assessment tools:

- ⋮ *Cage*
- ⋮ *Kessler*
- ⋮ *Suicide*
- ⋮ *Suicide-risk assessment*
- ⋮ *Well-being assessment.*

Comment:

To assist with working with this framework, the following headings will be used:

- ⋮ *knowledge required*
- ⋮ *skill*
- ⋮ *attitude.*

Mihi

When working with whānau and rangatahi, it will be helpful if the social worker first determines the nature and context of the relationship between the rangatahi, the whānau and their community.

There is a need to clarify how the rangatahi or whānau identify themselves. Do they describe themselves as Māori or non-Māori? Do they link to a particular tribal group? How do they describe the combination of ethnic and/or cultural groupings to which they belong?

1. Knowledge required

- ⋮ *names of waka in your working area*
- ⋮ *names of main tribal groups in your area*
- ⋮ *if urban, names of representing groups.*

2. Skill

- ⋮ *ability to acknowledge where the rangatahi and their whānau is from, to whom they belong and what the reason is for them coming together.*

3. Attitude

- ⋮ *an acceptance that there is a Māori world view*
- ⋮ *an acceptance that this world view is not better nor worse than any other, just different*
- ⋮ *an acceptance that because of their relationship with the rangatahi and their whānau, the social worker will be affected by this world view.*

Whanaungatanga

Whanaungatanga is an inclusive process that has as its central theme the strengthening of the whānau.

Whanaungatanga allows all involved to declare the nature and quality of their relationships, one with another.

Whanaungatanga creates opportunity for all concerned to share their commonality through kinship, shared experiences, and similar difficulties.

Whanaungatanga implies respect, one for another, and the willingness to resolve and reconcile.

Whanaungatanga insists that the integral essence of a person, be they rangatahi, mokopuna, matua, kuia, koroua or pakeke, is maintained and upheld.

Knowledge required

- ⋮ *what is meant by the terms whānau, hapū and iwi*
- ⋮ *what is meant by the terms mokopuna, tamaiti, and rangatahi*
- ⋮ *what status is accorded to mokopuna, tamaiti, and rangatahi, within the context of the whānau*
- ⋮ *what is meant by the terms awhi, aroha, and manaaki.*

Skill

- ⋮ *the ability to greet the whānau in the appropriate language*
- ⋮ *the ability to begin proceedings with prayer*
- ⋮ *the ability to acknowledge one's own antecedents.*

Attitude

- ⋮ *that whānau are an intrinsic part of the process*
- ⋮ *that rangatahi can determine what is valuable for them*
- ⋮ *that rangatahi are mokopuna, and therefore treasures.*

pacific peoples

building a relationship

Building and maintaining rapport is an on-going process that must be an integral part of the use of the assessment tools, and continued throughout their application.

Building rapport is an important matter to Pacific Peoples because, done properly, it not only acknowledges people's mana and dignity, but it also encourages commitment and participation. It acknowledges people as equals and recognises their ability to provide their own solutions.

Building rapport should include the following:

1. Having knowledge of the young person and his/her families in terms of the family status, where they are from, family connections and the type of family. In a Samoan family, for example, the family name can provide information about the family status and standing in the community. It is also important to know something about the young person's religious affiliation in case we need to acknowledge this.

2. When building rapport with Pacific young people, it is important to acknowledge the young person by allowing them to talk about their family in relation to status, where the family is from, the type of family, and family connections. It is also important to acknowledge the young person's ability to contribute to resolving their situation.

3. If family is involved, it is important to acknowledge those present, the status of the family, the roles of those present, the issues and the effects on the family. It is also important to acknowledge the role and contribution that the family can make to the process.

4. The language to be used must fit the situation. For young people, it is important to use language that is respectful and also helps them understand the purpose of the screening and assessment and their responsibilities in the process.

5. Food must be provided. Start with a cup of tea and, if possible, provide something to eat at the end of the assessment. Share it with the young person and the family if possible.



SECTION 04

concepts for practice

Motivation to change

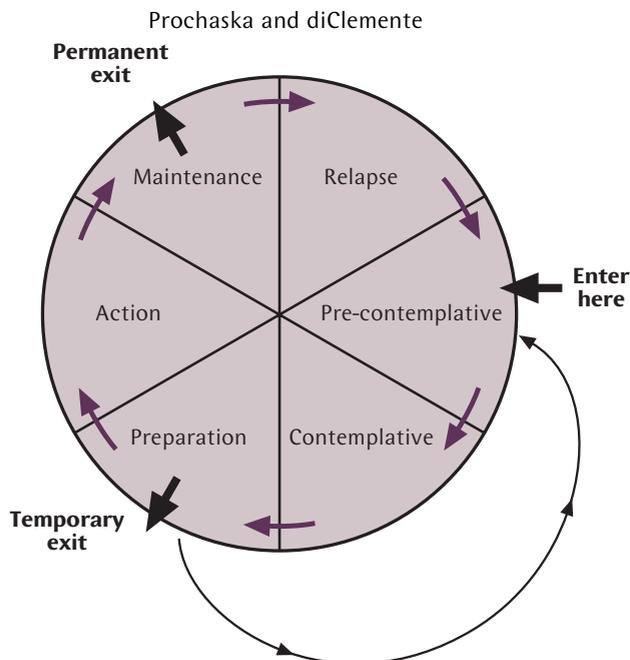
A Māori perspective

A Pacific Peoples' perspective

motivation to change

When assessing the needs and strengths of a young person, it is important to identify not only their needs but also their motivation to do something about those needs. When making recommendations on actions to address needs or strengths, the social worker should take account of the young person's motivation. The following diagram outlines the stages of the process of change and some suggested strategies to use with each stage.

A stage model of the process of change



Client stage	Social worker's motivational tasks
Pre-contemplative <ul style="list-style-type: none"> unaware of symptoms no readiness to change 	Raise doubts – increase the client's perception of risks and problems with current behaviour
Contemplative <ul style="list-style-type: none"> Some recognition but no action 	Tip the balance – evoke reasons to change risks of not changing; strengthen the client's self-efficacy for change
Preparation <ul style="list-style-type: none"> recognition open to change 	Help client determine the best course of action to take in seeking change
Action <ul style="list-style-type: none"> actively involved in treatment recognise that change must be maintained 	Help the client take steps towards change
Maintenance <ul style="list-style-type: none"> prevent relapse 	Help the client identify and use strategies to prevent relapse
Relapse <ul style="list-style-type: none"> guilt and a sense of failure 	Help the client to renew the processes of contemplation, determination and action without becoming stuck or demoralised because of relapse

motivation to change

The most important factor in determining what treatment is appropriate is whether or not, and to what extent, the young person wants to change their use of substances. The diagram on page 25 describes a model of readiness to change. Confrontation or acceptance of poor motivation leads to the young person becoming resistant to treatment. Motivation is enhanced by the social worker adjusting their intervention to the stage of readiness of the young person.

Drug abuse

The majority of young people aged 14 – 16 years are likely to use alcohol or drugs³. Those who have significant life difficulties are the most likely to use such substances in a manner that is harmful to their health and relationships. Most will also have another mental health problem (including conduct/oppositional disorder). The current best practice is to attempt to address the harmful drug-use first and then address any residual mental health problems. This is especially the case if the person has a concurrent depressive or anxiety disorder.

Very few young people of this age will be consuming drugs to a degree and in a manner that they are dependent on the drugs. However, the consumption

of drugs is very likely to be part of a pattern of behaviours destructive to their physical, emotional, social and spiritual well-being. Drug use can also be an attempt at self-medication to reduce the distress and pain they are experiencing. This will require a focus on the underlying reasons as to why they are using drugs in this way. Use of drugs should be reduced to the least possible, especially if the young person has a mental health disorder and/or is suicidal.

Mental health

Mental health disorders are common and affect every area of the life of a person who suffers from them. The disorders are usually episodic, lasting for a period but likely to reoccur, especially if the underlying risk factors have not been addressed adequately.

Frequently, a young person will suffer from two or more mental health disorders at one time, or following each other but reflecting the same underlying distress. This is sometimes referred to as comorbid disorders. The most important consequence is that the trauma and disability associated with these disorders will be significantly greater than when the disorders occur singularly.

³ Generically referred to as 'drugs', because in New Zealand most young people who abuse use a variety of substances including alcohol.

Suicide

The likelihood of young people referred to Child, Youth and Family thinking about attempting suicide is very high relative to other young people in the community. It is estimated that about 35% of young people in contact with Child, Youth and Family will seriously contemplate suicide and about 13%⁴ will make an attempt.

Young people who have a history of offending have the highest risk of attempting suicide with about 20% having made an attempt⁵.

In 1995/6 throughout New Zealand, 21 young people aged 14 – 16 suicided and a further 46 were hospitalised following a serious attempt. Of the 21 who suicided, nine were known to have had recent contact with Child, Youth and Family. During the period from 1994 to 1999, on average, between five and six young people aged 14 to 16 years who have had recent contact with Child, Youth and Family have suicided.

In the general population, slightly more males than females suicided and about four times as many young females than males were hospitalised. However, amongst those young people (aged 14 – 16 years) in contact with Child, Youth and Family, females are almost twice as likely to suicide as males.

There are few serious suicide attempts (requiring hospitalisation) by young people under 14 years in the general or Child, Youth and Family populations. By 15 years of age the rate of serious attempts for young women has reached its peak, and by 17 years their rate of completed suicides has reached its peak. For young

men, the rate of suicide attempts and completed suicides increases until the early 20s, with about two thirds of the serious attempts and half the completed suicides by age 17. However, most serious attempts at suicide occur after 17 years.

Detection of suicidal thoughts and actions and the risk factors (depression, substance abuse and accumulated disadvantage) at 14 – 16 will, if addressed, be an important early intervention that may prevent many of these later suicidal behaviours.

The major risk factors of suicidal behaviours are:

- ∴ *depression*
- ∴ *acts of deliberate self harm*
- ∴ *past suicide attempts*
- ∴ *substance abuse*
- ∴ *recent loss, situational crisis, family history of suicidal behaviour (especially hanging)*
- ∴ *antisocial/aggressive behaviour, having a firearm.*

Behaviours which may be associated with an increased risk are:

- ∴ *numerous accidents*
- ∴ *dangerous and high-risk behaviours*
- ∴ *discussing or writing about death and morbid themes*
- ∴ *giving away favourite possessions.*

⁴ About 5% of all young people will attempt suicide at some stage during their life.

⁵ Estimated from the sub-populations in the Christchurch Health and Development study.

a māori perspective

Note: Although these statements may apply elsewhere, they are specifically written from the focus group findings arising from the initial consultation with kaimahi on the development of the Youth Services practice tools.

Belief statements

- ‡ *rangatahi is the term most commonly used to describe a young person. Some areas use tama or taitama, hine or tamāhine*
- ‡ *rangatahi are neither children nor adults*
- ‡ *rangatahi is a major transition time in the life of a person*
- ‡ *rangatahi deserve special attention*
- ‡ *rangatahi are good indicators of the health of a community at any given time*
- ‡ *rangatahi have capacity*
- ‡ *rangatahi are capable of making good decisions.*

Our vision is:

- ‡ *rangatahi who can create more meaningful relationships with others, whānau and their environment*
- ‡ *rangatahi who are able to give and receive complete respect.*

Our beliefs and visions are based on our own experiences as rangatahi which include being misunderstood, patronised, controlled, oppressed, put down, encouraged, supported, given permission, loved.

Often we reflected our parents' and elders' greatest fears.

Barriers to effective service delivery

- ‡ *statutory processes sometimes work against the establishment of a relationship with parents and whānau. In some cases, this may be unavoidable*
- ‡ *Department and court processes sometimes take away the responsibilities of the parents and whānau*
- ‡ *some staff who work with rangatahi do not understand Māori values*
- ‡ *Māori have a different world view: not better, just different.*

a pacific peoples' perspective

To show and maintain respect, dignity and the willingness to share responsibility, it is important to explain the whole screening process to the family and/or young person. To contribute effectively to the process, the family and/or young person must understand the purpose of the screening and what it will involve. It is also important to explain the process that will be used.

Although the screening process is a necessity, it is courteous and respectful to ask the family to excuse any inconvenience that the exercise may cause, and explain why it is important to get screening completed.

Pacific Peoples need to be clear of their roles, and that of the assessor, in order to understand what they need to do; otherwise they may participate in the process to please the assessor but not to help themselves. It is important to show humility but maintain control of the process. The assessor must be seen as a good service provider and a good messenger. Pacific Peoples respond well to those who are skillful in these areas.

These people also speak with their bodies, but it is important that the social worker ensures that they interpret the body language correctly. For example, silence could mean an agreement or it could also mean anger or a refusal. Some Pacific Peoples regard their personal space as sacred and it is disrespectful to invade it.

Suicide is considered taboo and/or shameful in Pacific cultures, therefore it is not discussed readily. It is very

important to be aware of this and to be sensitive when discussing suicide with the family and/or young person.

Concepts of mental health

There may be a difference in the beliefs and views about the causes of mental health between the Island-born and the New Zealand-born Pacific people. Island-born people may continue to attribute mental health disorders to the malevolence of ancestral spirits who need to be placated. They believe in traditional treatment, whereas Pacific people born in New Zealand are more likely to have a less traditional understanding of the causes of mental health and view mental health disorders and their treatment as a matter for health professionals.

Samoa

Samoans generally consider mental health disorders as being caused by a violation of certain Samoan laws and customs. The following terms are used within the context of mental health in Samoan.

a pacific peoples' perspective

These terms are used to generally describe mental health.

'saogalemu o le mafau -

Calmness of the mind.

'ma'i aitu -

Possession by spirits manifesting in out-of-character behaviour and foul language.

ma'i fasia —

Being stricken by a spirit guardian as a violation of the local laws watched over by a spirit guardian e.g., the village of Falelima in Samoa is guarded by the Nifo.

Ma'i valea

'Emotional sickness' resulting in out-of-character behaviour.

Malaaumatua -

Sickness resulting from breaching of tapu and sa within the aiga (family).

Malaaunu'ua -

Breaching of tapu or sa placed by the village elders.

Mavaega -

Sickness resulting from a failure of a person to fulfil a dying person's final wishes.

Samoaans believe that an individual's well-being can be affected by events both within the family and spiritual spheres. When there is disruption or disharmony within the family, through death, severe illness, shame or

feelings of injustice, 'fa'anoanoa' (or unhappiness) results. When a person is 'fa'anoanoa', he is moved by the belief that no-one loves him. Thereby he feels compelled to isolate himself, seldom communicates and becomes generally unkempt. In its extreme form, 'fa'anoanoa' evokes bad thoughts, which can be manifested in undirected violence, murder or suicide.

Tonga

There is a scarcity of written material on Tongan dimensions of mental health.

The following terms are used to describe mental health problems from a Tongan perspective.

Puke fakatevolo, 'Avanga, Avea, Fa'ahikeke and Fakamahaki

These are similar conditions, in that they are believed to be supernaturally-induced ailments. The person is believed to have been possessed by a spirit, which causes a sickness that cannot be treated through conventional medicine. The physical symptoms usually include:

: *the affected person shouting and talking to unseen deceased people*

: *the affected person talking to him or herself as if he or she is conversing with someone invisible.*

Faka'ilonga tevolo

This describes bizarre behaviour with overtones of mental illness.

For example;

: *a person conversing with an unseen person*

: *an afflicted person showing incredible strength when attempts are made to subdue him or her.*

In a western context this can be interpreted as psychosis, or schizophrenia.

Fafanga fakatevolo

A spirit-induced dream where an affected person is 'fed' by a spirit. The affected person usually 'sees' his or her deceased relatives bringing food and feeding him or her. When the person wakes up, he or she feels full and does not eat. This condition can lead to death.

Akafia

A type of severe headache that cannot be treated through normal medicine. The headache is thought to be caused by the growth of tree roots in the skull of a deceased relative within their grave. The cure is usually to exhume and carefully rebury the bones of the dead person. This ailment usually only affects females.

Sausua

A type of mental disorder whereby a patient is either delirious or cannot move his/her limbs. It is believed that this condition can be brought about by someone unlawfully taking fruit from a tree that has a small bundle of leaves attached to or buried near it. This condition is similar to catatonia.

Fesi'ia

A type of spirit infliction with reported symptoms such as muscular weakness or the inability to straighten out one's limbs. Fesi'ia is said to be caused by someone breaking a tapu, through inappropriate behaviour within a cemetery.

The words '*fakasesele*', '*angaangaua*' and '*te'ia*' are terms used in a derogative manner to describe mental illness.

Cook Islands

Little has been written on mental illness in the Cook Islands, partly because of the stigma attached to such illness. Despite a degree of denial that such problems can be found among the people, oral knowledge certainly exists.

The Cook Islands people take a holistic approach when working with clients with mental health problems. Therefore, when working with Cook Islands people, the social worker must take into account the young person's personality, history, family, extended family/community, culture and customs, religion, social and economic situation, educational background, and physical and mental condition. Some of these factors may be contributing towards the person's state of ill-health, while attention to others may help the healing process.

The following terms are used in the Cook Islands to describe mental illness.

Pana

Commonly used to describe mentally ill people. Pana means jumpy.

Pana marama

Mental illness.

Maki tupapaku

Refers to a spiritual illness. Tupapaku means a ghost, therefore maki tupapaku describes a person possessed by a ghost.

a pacific peoples' perspective

Maki enua, maki tapiri, maki Māori

An illness of the Māori people or an illness of the people of the land. Cook Islands people refer to themselves as the Māori people and only as Cook Islanders after they have left the islands.

Cook Islanders believe that culture and customs can be contributing factors in mental illness, particularly in situations where children of Island-born parents are born and raised in New Zealand. This is because there is usually a difference, and therefore a clash, between the parents' and the children's perceptions and knowledge of culture and customs. The parents will see life from a different perspective to that of their children, because of the different environment in which they were raised. The physical, cultural and economic situation, factors which strongly influence the values and customs of any culture, are vastly different in New Zealand than those in the Cook Islands. It becomes difficult at times for parents to maintain the Cook Islands culture and customs in New Zealand, while the children are faced with values that conflict with those of their parents. This leads to miscommunication between the parents and the children.

Other contributing factors in mental illness are stress and depression, which arise out of the inability of people to cope with social and economic issues within their communities. These problems are also found when parents and children are not able to communicate. The traditional Island belief that children should listen and not speak can

block communication. When they have problems the children are not able to turn to their parents.

Niue

There was initially no concept of mental illness in Niue but there were beliefs Niueans hold regarding people becoming mentally and physically unwell. It seems that there is a general but reluctant acceptance of the term mental illness. Mental illness is known in Niuean as Ai maopoopo mitaki e manamanatuaga.

Niueans believe that a person becomes unwell when:

- ∴ *the harmony and balance within a person's spiritual, mental/emotional and physical life is disturbed*
- ∴ *a person's relationship with the gods, land and family, including extended family is disturbed and unbalanced.*

There are various beliefs about the causes of being unwell or mental illness in Niue. The causes of mental illness include:

- ∴ *the upsetting of the spiritual forces*
- ∴ *the violation of a tapu that had been put in place for a reason*
- ∴ *being cursed. The curse can last through generations and can only be uplifted by the person who had put the curse in the first place.*

Postnatal depression is also seen as a mental illness if it is treated.

The following terms are used by Niueans:

- ∴ *Holifono – violation of tapu*
- ∴ *Malaia – being cursed for wrongful and malicious actions*
- ∴ *Huaitu – possessed by the spirits*
- ∴ *Fiva fanau – occurs when a new mother neglects to look after herself or when there is a lack of family support for the new mother*

‡ *Ulu heketia – mental illness*

There are also derogatory and negative terms describing mental illness and these include *goagoa* and *heketia*.

Factors in general

The older people know more about the traditional mental health disorders and their treatment. The young person's knowledge of their ethnic language and their attachment to traditional values may not be as strong as their parents' knowledge and attachment. So when a young person is being screened or assessed for mental health issues, it is important to keep this in mind.

Extreme forms of behaviour are usually caused by familial and social difficulties. Suicide is one of these behaviours. Suicide may be resorted to in an effort to atone for seriously failing the family. Much of the literature on suicide has focused on the Samoan population because of the high rate of suicide in Samoa.

Factors that seem to prompt suicide by Pacific Island young people living in New Zealand are:

- ‡ *unresolved family conflicts*
- ‡ *inability to meet family, church and social obligations*
- ‡ *shame resulting from misdeeds*
- ‡ *sexuality and sexual conduct*
- ‡ *failure to meet unrealistic expectations*
- ‡ *low self-esteem*
- ‡ *abuse*
- ‡ *conflict between traditional and new ways.*

It also seems that the use of alcohol may result in behaviour for which the person is remorseful. For some young people who suicide, the trigger may have been depression following a bout of drinking.

The family and/or young person must be informed of why it is important to complete this assessment. In some situations, this may be better explained with the use of illustrations or pictures. The use of qualified interpreters must be considered if English is not the family's and/or young person's first language.

Because this assessment will involve asking a lot of questions, it is important to phrase these questions carefully to avoid putting the family and/or young person under pressure but to encourage them to tell their story. The important thing is to make the family and/or young person feel in control and have ownership of what they are disclosing.

In some situations, it is appropriate to talk with the family and the young person separately and encourage them to talk with one another at a later time. Sometimes, the spiritual aspect of Pacific culture can be used in situations like this. The use of prayer can do wonders in bringing Pacific families together in time of distress.

Knowledge of cultural reasons for behaviour is important. Pacific cultural and language skills are also critical in clarifying any concerns and restoring the integrity and mana of the family and/or young person. Careful attention must be given to the necessary and appropriate processes and protocols as this would ensure the safety of the young person and their families.

SECTION 05

the assessment process

5

Overview of the process

Advice for the use of the
screening tools

Outcome of the screenings

Guide to decision-making

overview of the process

The practice tools used during the process consist of:

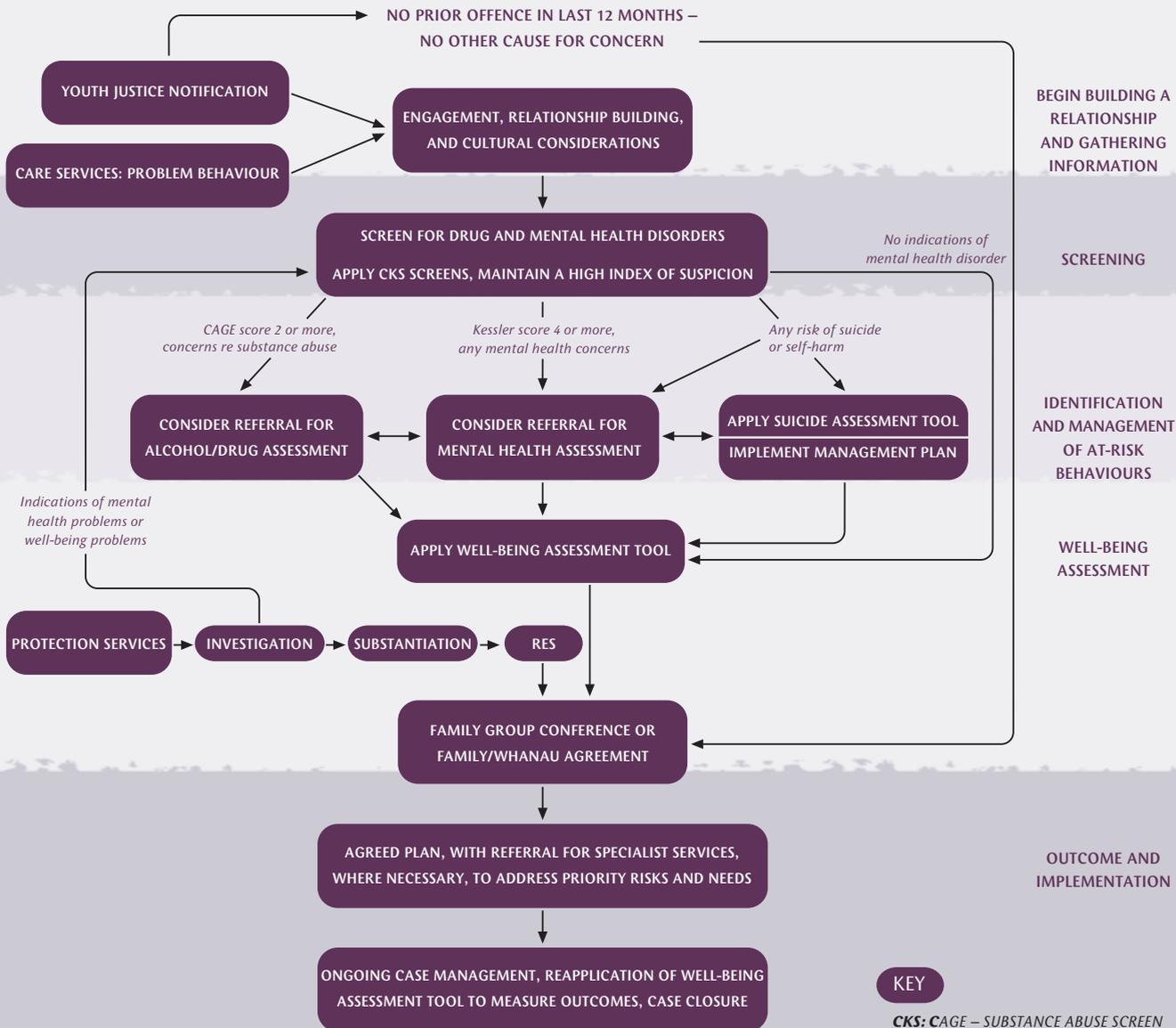
Three screening tools:

- ⋮ for alcohol or drug abuse,
- ⋮ for psychological distress,
- ⋮ for risk of suicide.

Two assessment frameworks:

- ⋮ to assess and manage suicidal behaviour, and
- ⋮ to assess well-being.

The gathering of information for the screens and assessments must be carried out throughout the whole process (beginning at the relationship building stage.) However, the process for assessing this information must be carried out as set out over the page.



KEY

CKS: CAGE – SUBSTANCE ABUSE SCREEN
 KESSLER – MENTAL HEALTH SCREEN
 SUICIDE SCREEN

RES: RISK ESTIMATION SYSTEM –
 ABUSE/NEGLECT ASSESSMENT TOOL

advice for the use of the screening tools

Social workers should expect that a young person referred to Child, Youth and Family, especially one who has offended, is likely to have one or more mental health disorders and many will be in need of some specialist assistance⁶. However, not every disorder will always be severe and disabling; its nature and severity will vary from time-to-time and will not always need the same level of treatment. Most disorders, appropriately treated, will improve and the chances of a relapse, or worsening, will decrease.

Young people in contact with Child, Youth and Family are, as a group, at the highest risk of self-harm. This can include participation in high-risk behaviours – e.g. driving at speed and driving while intoxicated, having unsafe sex – through to thinking about and attempting suicide. Young people who have a history of offending, who have little regard for themselves and who are inclined to be impulsive, are particularly at risk. Any indications of high-risk behaviours should be treated seriously, especially any suicidal behaviours. An assessment should be made, the details passed on to the supervisor and, where necessary a referral made to the appropriate person or agency. Any such referral should be made, or followed up, in writing and a check made to determine that there was a successful transfer of the responsibility for care.

While this Guide outlines technical information and methods of assessment, these should not replace workers' intuitions about whether a young person is at risk. People of all ages can cover up their intentions or may not be fully aware of their thoughts or intentions.

It is most critical to identify when a young person is psychologically distressed (that is, to a degree and in a way that is beyond what is considered normal). For some young people, this will involve acting out and displaying emotions. For others, it will be the absence of showing normal emotions.

The abuse of substances, such as alcohol, cannabis or other drugs (frequently in combination) will invariably aggravate any concurrent mental health disorder and increase the risk of suicidal behaviours.

⁶ Data from the Christchurch Child Health and Development study indicate that about half will have two or more mental health disorders and of those who offend about 70% will have two or more such disorders.

advice for the use of the screening tools

The screening questionnaire is referred to as CKS where C is CAGE (screen for alcohol or drug abuse), K is Kessler (screen for psychological distress), and S is the screen for recognition of any risk of suicide. The CKS consists of between seven and fifteen questions that have been shown to be sensitive to the presence of psychological distress and abuse of substances.

Screening using the CKS tools will occur for all cases of problem behaviour, some protection services cases where there are indications of mental health problems, and all repeat and serious offenders (with discretion for youth justice coordinators not to assess first offenders with minor offences where there are no indications of concern). There is provision for screening young people under 14 years of age, although there is less benefit for youth under 14 years, and probably no advantage for youth under 12 years.

While the Youth Services Strategy is primarily focused on 14 – 16 year-olds it is recognised that there are many 12 and 13 year-olds facing multiple risks and with many needs beyond their chronological age.

It is expected that the screening and assessment tools programme and services in the Youth Services Strategy will be available to high-risk 12 and 13 year-olds.

The screening tests should be administered verbally with the young person and their family where appropriate. Time should be taken to establish a rapport and ensure the young person is likely to be forthcoming with the information required. Each question should be asked in a normal tone and within the context of a conversation. At the end of the process it can be useful to review the information gained with the young person.

As with all screening tools, a negative result (the scores being below the cut-off) indicates that the young person is most likely not to have a problem. A positive result indicates they may have a problem and that there should be further assessment to determine if this is the case and what the problem is.

It should be noted that a positive result is intentionally over inclusive, i.e. identifying young people who will later be found not to have a mental health disorder or an alcohol/drug problem. This is appropriate for a screening tool, provided that there is subsequently a more in-depth assessment. These screens are designed to take account of a degree of minimisation and under-reporting. However, obvious non-compliance and untruthful responses need to be addressed. Care should be taken to identify any young people who are considered to be exaggerating or minimising their responses to both scales. If there is any doubt, request a full assessment. A negative result will allow you to proceed with confidence that the young person is not at risk. A positive result must be followed up by an in-depth assessment.

C: CAGE screen for alcohol or drug abuse

A modified version of the CAGE questionnaire (Ewing, 1984). The standard CAGE has been found to be sensitive and accurate in identifying alcohol abuse in clinical populations, although not for the general population (Bisson, Nadeau and Demers, 1999). The CAGE was modified to include an entry question that asks which drugs (including alcohol) the young person has recently used (with a list of terms for drugs in current use in New Zealand) and then the standard four questions (for both alcohol and drug use).

I want to ask you some questions about your use of alcohol or other drugs. First, have you used alcohol or any other drug recently? (prompt: In the last month) **DO NOT SHOW THE LIST BELOW.**

If the answer is definitely “none” then discontinue.

Ask: **What drugs do you regularly use?** (circle the drug – e.g. ‘beer’)

⋮ **tobacco**

⋮ **alcohol** (types: beer, wine, meths, alcopops, spirits)

⋮ **cannabis** (names: dak, green, herb, huna, buds, smoke, cabbage, weed, joint, tinnie, marleys, electric puha, oh zee, roaches, shotty, stone, bong, sniffballs)

⋮ **cannabis oil** (names: caps, spotting)

⋮ **psychedelics** (names: LSD (acid, holidays, limited slip diffs, lollies, luckies, spots, trips, tickets), mushrooms (blue meanies, smurf tops, gold caps)

⋮ **solvents** (types: glue, petrol, spray paint)

⋮ **opiates** (types: heroin – H, morphine, mistys, methadone)

⋮ **other** (types: codeine (panadeine), kava, sleeping pills, ecstasy (E, M and M, XTC), speed (Chaos, K) cocaine (coke, crack))

Ask: **And which have you used in the past two weeks?**

(check for each group (e.g. ‘alcohol’) in the above list – tick groups used).

1	Have you ever felt you ought to <u>cut down</u> on your drinking alcohol or doing drugs?	YES/NO
2	Have people ever annoyed you by <u>criticising</u> your drinking alcohol or doing drugs?	YES/NO
3	Have you ever <u>felt bad or guilty</u> about your drinking alcohol or doing drugs?	YES/NO
4	Have you ever had a <u>drink or drugs when you first wake up</u> to steady your nerves or get rid of a hangover or coming off a high?	YES/NO
	<i>(key elements are underlined)</i>	TOTAL YES

If the young person answers YES to two or more questions for the **CAGE** and is currently using alcohol and/or drugs, then it is very likely that they have a substance abuse problem and should be assessed more fully.

Working with rangatahi/whānau

Mate haurangi:

Most Māori understand ‘*haurangi*’ to mean ‘*drunk*’.

By inference, ‘*mate haurangi*’ means ‘*made ill by drunkenness*’.

Within the concept of ‘*haurangi*’ there is a notion of control.

It affects the puku and the wairua.

It creates a restlessness that needs attention.

The action most associated with this state is ‘*hurori*’.

The phrase ‘*mate haurangi*’ now includes use of any psychoactive substance.

To assist in understanding the phenomena of ‘*mate haurangi*’, imagine the effect of the wind on your face and body. You cannot see what it is but you can feel it, e.g. *hauangi* – a gentle breeze; *hau pūkeri* – a raging gale. There is an external force at work.

Handy hints	Warning bells
<p>Use the ‘language of the day’</p> <p><i>E.g. “Do you do drugs?”</i> <i>“Do you smoke?”</i> <i>“What do you use to get out of it?”</i></p>	<p><i>Most rangatahi will answer your questions honestly; therefore, if you sense they are lying, check further.</i></p>
<p>Assume that the rangatahi you are working with has tried or is using drugs.</p>	<p><i>Rangatahi display hypersensitivity and extreme suspiciousness.</i></p> <p><i>Rangatahi boast ‘about how much they are using’.</i></p>
<p>Know that you will be tested about your drug knowledge.</p>	<p><i>Signs of intoxication</i></p>
<p>Drugs of choice: <i>Rural</i> – Cannabis and alcohol <i>Urban</i> – Cannabis, alcohol, speed, tablets, solvents.</p>	<p><i>Rangatahi report as not having had these drugs offered to them.</i></p>
<p>All have street names.</p>	<p><i>When rangatahi say they don’t know the language around drugs.</i></p>
<p>Most drug use for rangatahi is about hazardous use and intoxication.</p>	<p><i>Whānau has a history of excessive and abusive use of alcohol and drugs.</i></p>

K: Kessler screen for psychological distress

This is the six-item version of the Kessler screen for psychological distress (Kessler and Mroczek, 1994). This screen is relatively new and is currently being tested. It was selected because it was developed from the National Comorbidity Research Programme (Kessler et al, 1994). A New Zealand study on a student population (Westwater, 1998) and feedback from the Australian Health Survey (Korten, 1999) both indicate it is an accurate and brief screen for mental health disorders.

<i>In the last two weeks, about how often did you feel...</i>	<i>Rating (0 – 4)</i>
<i>...so sad nothing could cheer you up</i>	
<i>...worried or frightened</i>	
<i>...restless or stressed</i>	
<i>...hopeless</i>	
<i>...that everything was an effort</i>	
<i>...worthless</i>	
TOTAL SCORE	

Rating Scale

- 0 = **None** of the time
- 1 = **A little** of the time
- 2 = **Some** of the time
- 3 = **Most** of the time
- 4 = **All** of the time

If the **Kessler Total Score** is four or more then the young person is likely to require further assessment to determine whether they are suffering from a mental health disorder.

Working with rangatahi/whānau

Mate ira hinengaro:

Most Māori understand 'hinengaro' to mean 'mind' and 'ira' 'life principle'.

By inference, 'mate ira hinengaro' means 'affliction of the essence of one's thinking'.

Within the concept of 'mate ira hinengaro' there is a notion of being disconnected.

It affects the roro and the wairua.

It creates a panic to be free of something.

The action most associated with this state is 'keka'.

The phrase 'mate ira hinengaro' is most often used in assessment.

To assist in understanding the phenomena of 'mate ira hinengaro', imagine you are in a cage that allows you limited movement. You have a feeling of being spied on. It seems as if the cage is getting smaller and no one can hear you.

Handy Hints	Warning Bells
The most common indicator for rangatahi presenting with psychological distress is heightened paranoia.	<i>Rangatahi speak of 'tūpuna' telling them to do things that are not consistent with their beliefs and values. Check out that by 'tūpuna' they are referring to deceased persons, not living relatives.</i>
Ensure that interviews are conducted in spacious surroundings and that exits are easily accessed.	<i>Jealousy and rage attacks. Strong anxiety, heightened fears and observable phobias.</i>
Hallucinations and delusional thinking will often feature in the dialogue. Stay calm and just receive the kōrero.	<i>Depression and low self-image.</i>
Delusions of grandeur will often manifest with rangatahi being 'toa' and using traditional weapons e.g. mere. Ask where the weapons have come from?	<i>Assault and other violent offences. 'Out of the ordinary' behaviours.</i>
In many instances, rangatahi will present with drug-induced psychosis.	<i>Not sleeping, not eating.</i>
Sadness will often be accompanied by: tamātāne - – 'air of bravado' tamāhine - – attitude of 'I don't care'.	<i>Feeling as if your energy is being sucked from you.</i>

screen for recognition of S: any risk of suicide

This is an initial assessment of whether there are any indications that suggest to the social worker that the young person may be contemplating suicide. It is primarily a clinical judgement aided by three prompts for the social worker to ask the young person if they are unsure that there is any risk of suicide. If there is any indication of suicidal thoughts and behaviours, then a second in-depth assessment must be completed by a trained social worker.

If there is any indication that the young person is thinking about suicide or significant self-harm, then:

- : *take immediate steps to ensure the safety of the young person, and*
- : **proceed immediately** to refer for specialist assessment, or complete a full assessment of the suicide risk (see page 49 – Suicide Risk Assessment).

If in doubt about whether there is a risk, the following questions may be useful to determine the nature and extent of the risk:

- : *“How do you see the future?”*
- : *“Do you ever feel that life is not worth living?”*
- : *“Have you ever thought you would like to end it all?”*

Working with rangatahi/whānau

Whakamomori

Many traditional Māori understand ‘whakamomori’ to mean ‘sulk or pine’ and refers to a partner not wanting to carry on without the one who has died.

It is now taken to mean death by one’s own hand and an act of desperation.

It affects the ngākau and the mauri.

It creates a desire to be at peace and to be free.

The action most associated with this state is ‘toitū’.

The phrase ‘whakamomori’ is becoming an acceptable word for describing suicide.

To assist in understanding the phenomenon of ‘whakamomori’, imagine you have lost the most important person in your life and there is a big hole in your heart where they used to live. You don’t know how to fill up the hole.

If the youth services worker believes that the language used in the screens will not be understood by the young person or it is inappropriate, then the language may be adapted to be appropriate to the young person. Any adaptation must keep within the principles and intent of the original questions.

outcome of the • screenings

If either the Kessler or CAGE indicate the possibility of a mental health or alcohol and drug use disorder, or the social worker has any suspicion that there is suicidal ideation, they should assess for suicidality using the Suicide Risk Assessment (see page 49).

Outcome of the screenings

If the young person scores three or less on the Kessler, less than two on the CAGE and the social worker is satisfied that there are no suicidal thoughts or behaviour, they should proceed directly to the well-being assessment.

If the Kessler or CAGE indicate that there is a mental health and/or alcohol and drug problem, but there are no concerns of suicidal ideation, a referral should be made to a medical centre or mental health professional to complete an assessment and provide advice on the treatment(s) that are necessary.

If a referral is made, it should be made clear that the indications of a problem are based on a screening test that is intentionally over inclusive. Do not be surprised if the later diagnosis is not confirmed – it is intended to err towards ensuring safety at the expense of accuracy. If a diagnosis is not confirmed, you should still monitor the young person to check in case their mental state does deteriorate. While the problems were not severe enough to warrant a diagnosis, they may continue to be a significant issue for the young person and their family/whānau.

guide to decision-making

If the disorder is thought to be severe and/or there is a risk that the person has a moderate to high risk of suicide, a referral should be made directly to a specialist youth mental health service for assessment and the necessary emergency interventions. If there is any risk of suicide the young person should be accompanied by a family member or social worker to the appointment and not be left unsupervised. (Any difficulties in accessing the required service should be discussed with your supervisor.)

If there is a suspected mental health disorder and/or risk of suicidal behaviours, youth service workers must ensure that assessment and consequent treatment is provided and monitored – Child, Youth and Family continues to have a responsibility to ensure the care and protection of the young person.

If a referral is made, it should be made clear that the indications that there is a problem are based on a screening test which is intentionally 'over inclusive'. Do not be surprised if the later diagnosis is not confirmed – it is intended to err towards ensuring safety at the expense of accuracy. If a diagnosis is not confirmed, you should still monitor the young person to check in case their mental state does deteriorate. While the problems were not severe enough to warrant a diagnosis, they may continue to be a significant issue for the young person and their family/whānau.

SECTION 06

identification and management of suicidal behaviour

6

Assessment of the risk of suicidal behaviour

Management of young people at risk
of suicide

Guide to decision-making

Developing and recording the
suicide risk management plan

Suicide risk management plan

management of young people at risk of suicide

When a social worker assesses a young person as being at risk of suicide, they must inform their supervisor regardless of the severity of the risk, and address any immediate safety issues.

A plan to manage the young person's risk of suicide will develop as the guidelines are followed (see pages 54 – 59). The social worker needs to be familiar with these. They must pay particular attention to the actions to be taken when a young person is assessed at a moderate or high risk of suicide (see the assessment process on pages 49 and 51).

If the severity of the risk has been determined as moderate or high, the social worker must inform other staff and agencies involved with the case of the significance of the level of risk and the proposed management plan.

Where the possibility of suicide is a concern, it is important to speak with the family/whānau and caregivers at the earliest opportunity. The development and maintenance of a good relationship between the young person, the social worker, their family/whānau, and their social network will be an important factor contributing to safety in the short term.

The young person should always be informed of the steps that need to be taken for their safety. Contact with their family/whānau should also take into account the likely impact this will have on current and future relationships. It may be appropriate in the short term for another member of the team to be available to the family/whānau to try and assist with issues of concern to them⁷.

Staff should take time to explain the nature of the support that will be provided and respond to other relevant information sought by the young person and their family/whānau. For instance, an explanation of the length of time that the supports will be in place,

emphasising both the expected outcome and the need to persist, may also help.

The development of a good relationship between the key staff member, any health professional involved and both the young person and their social network will be an important factor contributing to safety and a positive outcome.

Working with rangatahi/whānau

Mahi arataki (traditionally this was an area given over to tohunga):

Areas to consider:

- ⋮ **karakia** is an important element in ensuring that the social worker is grounded and free from their fears
- ⋮ **mahi āwhina** is necessary for the spiritual and emotional well-being of the social worker
- ⋮ **mahi atawhai** requires the assistance of an elder experienced in reconciling the relationship between life and death
- ⋮ **whakawātea** frees the social worker from the emotional intensity of the experience.

⁷ Parents in prison can be accessed in emergencies through PARS (in local telephone directory).

guide to decision-making

If the disorder is thought to be severe and/or there is a risk that the person has moderate to high risk of suicide, a referral should be made directly to a specialist youth mental health service for assessment and the necessary emergency interventions. If there is any risk of suicide the young person should be accompanied by a family member or social worker to the appointment and not be left unsupervised.

If there is a suspected mental health disorder and/or risk of suicidal behaviours, youth service workers must ensure that assessment and consequent treatment is provided and monitored – Child, Youth and Family continues to have a responsibility to ensure the care and protection of the young person.

If a referral is made, it should be made clear that the indications that there is a problem are based on a screening test which is intentionally 'over inclusive'. Do not be surprised if the later diagnosis is not confirmed – it is intended to err towards ensuring safety at the expense of accuracy. If a diagnosis is not confirmed, you should still monitor the young person to check in case their mental state does deteriorate. While the problems were not severe enough to warrant a diagnosis, they may continue to be a significant issue for the young person and their family/whānau.

Any assessment of whether the young person is depressed, has a substance use disorder or has an anxiety disorder, and consequent treatment, should be of a manner and standard consistent with the National Health Committee's guidelines for primary health professionals⁸:

- ∴ *Guidelines for the treatment and management of depression by primary healthcare professionals (1996)*
- ∴ *Guidelines for assessing and treating anxiety disorders (1998)*
- ∴ *Guidelines for the assessment and treatment of substance abuse (July 1999).*

⁸ These guidelines may be obtained from the National Health Committee, Ministry of Health, PO Box 5013, Wellington. Phone (04) 496 2296; Fax (04) 496 2050.

developing and recording the suicide risk management plan

As the social worker commences the process of addressing the safety needs of the young person and consults with the supervisor, family and others involved with the young person, the suicide risk management plan will begin to take shape.

The three charts (pages 55-58) provide a basic outline of the steps that need to be taken in developing the plan. Use the chart that corresponds to the level of assessed risk: Low, Moderate or High.

Important note: address any immediate safety issues before commencing to write up the plan.

The following issues should be considered in developing the plan:

- ⋮ *How can the plan create an effective safety net for this young person?*
- ⋮ *How can the lines of responsibility and communication be made clear?*
- ⋮ *How can the young person's cultural needs be addressed?*
- ⋮ *Does the placement need to be made safe? How?*
- ⋮ *How can monitoring of the young person's safety best be achieved?*
- ⋮ *Who will people report concerns to?*
- ⋮ *How can any improvement or deterioration in the young person's condition best be monitored?*
- ⋮ *How can the young person be better supported in the future?*

- ⋮ *Have I involved everyone who should be involved in developing this plan?*
- ⋮ *How will the plan be reviewed?*

Recording the plan:

1. *Make sure your language is concise and easily understood by everyone concerned.*
2. *Each task must be achievable and realistic.*
3. *Consult all those involved in the plan to ensure they are aware of their roles and responsibilities.*
4. *The lines of communication must be clear and open.*
5. *The plan must state how and when it will be reviewed.*
6. *All those involved in the plan should receive a copy.*

The form on page 59 provides the format of how the social worker will record the plan details.

Working with rangatahi/whānau

Areas to consider:

In working with whakamomori, its effects and after-effects, the following headings will be helpful:

∴ **roles** – these are best described by the phrase ‘awhi mai, awhi atu’ where the emotional roles are very clearly defined

∴ **responsibilities** – these are best described by the phrase ‘aroha ki te tangata’ where the responsibilities are accepted by all participants

∴ **relationships** – these are best described by the notion of ‘whanaungatanga’, where the nature and quality of the relationship is apparent to all.

Handy hints Three factors that initiate suicide thinking are: ∴ <i>absolute loss</i> ∴ <i>alienation</i> ∴ <i>traumatic incidents</i> Check these out! Be purposeful.	Warning bells <i>Diminished interest in sex.</i> <i>Sleeplessness, fatigue, tired, no energy.</i>
Ask rangatahi, “What is a good way to die?” “What is a bad way to die?” “Have you thought about killing yourself?” Check out the answers! Be direct.	<i>Paranoia and thoughts of death or killing.</i> <i>Whānau history of completed suicides and suicide attempts.</i>
Where is your wairua right now? Is it strong, weak, light, dark, heavy, soft? Check out the feelings! Be gentle.	<i>Reinforcement of thoughts of worthlessness and powerlessness, e.g. verbal, physical and spiritual abuse.</i>
Death reminds us of how powerless we are. We need a ritual to deal with this powerlessness. Māori logic tells us to distribute the mamae throughout the hapū and iwi. Don’t let rangatahi carry the pain by themselves. Check out your responses! Be there.	<i>Preoccupations with ancestors and family members who have passed on.</i> <i>High incidence of risk-taking behaviour, e.g. flirting with death.</i>
Where whānau is chaotic, rigid, inflexible and prone to conflict there is a higher risk of suicide ideation in rangatahi. Check it out! Remember whanaungatanga.	<i>When whānau wairua is non-existent, rangatahi are at risk.</i>
Where rangatahi are in systems that see them as unimportant and having secondary roles, suicidal ideation may be more prevalent. Check it out! Remember your own growing up.	<i>Rangatahi displaying ‘Whiro and Rongo’ characteristics. Rangatahi who are overwhelmed by the world of sense perception.</i>
Where rangatahi emotional and spiritual needs are met last there is greater risk of suicidal ideation. Check out their tinana korero! Listen to your wairua.	<i>Rangatahi whose wairua is ambushed or in limbo.</i>
Isolating rangatahi from peers makes them more vulnerable. When rangatahi have something to fight for and to love for, they don’t commit suicide. Where possible, include their significant peers.	<i>Rangatahi who don’t want anybody around, want to be by themselves.</i>

developing and recording the suicide management plan

Low risk

Immediate Intervention	Referral	Consultation/Case Management	Follow-up
<ul style="list-style-type: none"> ∴ consult with your supervisor. ∴ inform the family/whānau and caregivers. ∴ ensure case history checked and made available as appropriate. ∴ check available supports and involve them. ∴ establish and confirm an appropriate plan to monitor the young person's suicide risk. 	<p>Provide information to the young person and their family/whānau and caregivers on resources available and assist them in accessing these within seven days.</p>	<ul style="list-style-type: none"> ∴ check if other services are involved (e.g. GP, mental health services, school, SES, counselling). ∴ confirm plan with your supervisor. ∴ ensure that there is a monitoring plan in place and all incidents of concern are reported to a key person. ∴ consult with the young person about the management plan, maximising supportive and protective factors and seeking the young person's ownership and participation. 	<ul style="list-style-type: none"> ∴ ensure regular review of the young person to identify any changes in risk. ∴ if there has been no improvement in 4-6 weeks, then treat as if the risk were moderate and seek additional assistance. ∴ on any increase in risk, consult with supervisor and review management plan (same day plus one).

Moderate risk

Immediate Intervention	Referral	Consultation/Case Management	Follow-up
<ul style="list-style-type: none"> ∴ <i>consult with your supervisor immediately.</i> ∴ <i>inform the parents/whānau and caregivers and discuss strategies appropriate to the level of risk.</i> ∴ <i>ensure that the current placement is safe for the young person – take action as required.</i> ∴ <i>ensure case history is checked and made available as appropriate.</i> ∴ <i>check that the safety of the young person is addressed while at school and other activities.</i> ∴ <i>establish and confirm an appropriate plan to monitor the young person's suicide risk.</i> ∴ <i>check if other services (other Department staff, GP, mental health services, school, SES, counselling) are involved, advise them of your assessment of risk and request relevant information and support.</i> ∴ <i>prepare interagency case coordination.</i> 	<ul style="list-style-type: none"> ∴ <i>recommend to the family/whānau appropriate agencies or other resources, and assist them to access the appropriate assessment, treatment, counselling services within same day plus one.</i> ∴ <i>ensure that a supportive adult attends initial session(s).</i> 	<ul style="list-style-type: none"> ∴ <i>check if other services are involved and are coordinated.</i> ∴ <i>consult with the young person about the management plan, maximising supportive and protective factors and seeking the young person's ownership and participation.</i> ∴ <i>consult with cultural consultant/pastor as necessary.</i> ∴ <i>consult with relevant professionals (e.g. GP, mental health services, school, SES, counselling) about the management plan and their part in it.</i> ∴ <i>ensure all people involved with the young person report all incidents which cause concern. As necessary, ensure the management plan is reviewed.</i> 	<ul style="list-style-type: none"> ∴ <i>check outcome of any referral with the young person, health professional and family/whānau. If no improvement in 4-6 weeks, then refer to specialist mental health services.</i> ∴ <i>prior to any return to school or other activities, liaise with other agencies involved to plan reintegration and ensure the necessary monitoring and support systems.</i> ∴ <i>address any increase in risk the same day.</i>

High risk

Immediate Intervention	Referral	Consultation/Case Management	Follow-up
<ul style="list-style-type: none"> ∴ consult with your supervisor immediately. ∴ make an urgent, same day referral to an appropriate health professional (GP, mental health service) for further assessment and primary case management. ∴ inform the parents/whānau and caregivers of the risk, safety precautions and support available, the need for an urgent referral to a health professional (GP, mental health services) and any proposed interagency involvement. ∴ ensure case history checked and made available as appropriate. ∴ establish and confirm an appropriate plan to monitor the young person's suicide risk. ∴ supervise the young person until you hand over responsibility to parents/whānau or a health professional. Ensure the young person is accompanied at all times. ∴ inform the school, or other day-activity programmes that the young person is involved in, of the actions taken. 	<ul style="list-style-type: none"> ∴ ensure the urgent referral (over) has been actioned and that a lead health professional with responsibility for case management is identified. ∴ check the outcome of the assessment and if there is significant disagreement on the level of risk, consider requesting or obtaining a second opinion. 	<ul style="list-style-type: none"> ∴ identify and confirm that a safe placement is available for the young person (i.e. removal of the means of suicide and close appropriate monitoring and support available). ∴ ensure professionals involved know the current level of risk and report all incidents which cause concern. <p>Risk factors:</p> <ul style="list-style-type: none"> ∴ an unexpected reduction in academic performance; ∴ ideas and themes of depression, death and suicide; ∴ changes in mood: 'shame', grief, withdrawal; ∴ physical symptoms; ∴ high risk behaviours (including increased use of alcohol and drugs and unsafe sexual activity); ∴ giving away prized possessions; financial troubles; ∴ problems with Police. <p>Address increases in risk urgently.</p> <ul style="list-style-type: none"> ∴ consult with other welfare, health and educational professionals as necessary to ensure optimum engagement. 	<ul style="list-style-type: none"> ∴ continue contact (at least weekly) with the young person and their family/whānau and caregivers to ensure that the required level of service is being provided and there is an ongoing assessment of risk. ∴ if there is no improvement in 2-4 weeks, consult with specialist mental health services to request a review of the treatment. ∴ prior to any return to school or other activities, liaise with other agencies involved to plan reintegration and to ensure the necessary monitoring and support systems.

suicide risk
**management
plan**

Client name: _____

SWis no: -

Level of assessed risk High, Medium, Low: _____

Date: _____ People/agencies responsible for implementing this plan: _____

Immediate intervention:

Action	By whom?	When?	Completed ✓

Referral:

Action	By whom?	When?	Completed ✓

Consultation/case management:

Action	By whom?	When?	Completed ✓

Follow-up:

Action	By whom?	When?	Completed ✓

Notes: _____

Social Worker: _____ Date plan completed: _____

Supervisor's comments: _____

Supervisor's sign-off: _____ Date: _____

SECTION 07

the well-being assessment

Guidelines on the well-being assessment

Advice for the well-being assessment of
Māori young people

Advice for the well-being assessment of
Pacific young people

Guidelines for recording the well-being
assessment

Well-being assessment

Well-being assessment intervention plan

guidelines on the well-being assessment

The purpose of the well-being assessment is to identify factors that are impacting on the young person's life which may be contributing to, or influencing, their criminal or problem behaviour. The aim is to identify these factors and thereby assist in the targeting of services and programmes to help the young person. The well-being assessment is simply an aid to structure an assessment of the needs and strengths of the young person and their family/whānau and assist planning and decision-making.

It is important that, from the initial contact with the young person, the social worker takes into account their overall well-being.

The well-being assessment tool is to be used with young people after they have undergone a screening assessment for depression, substance abuse and suicide (CKS). The information gathered from this assessment will be made available to the coordinator of the FGC or family/whānau hui to assist in making a plan.

The assessment covers eight domains:

- : *pattern of offending*
- : *family/whānau environment*
- : *educational/employment*
- : *physical well-being*
- : *emotional well-being*
- : *attitudes*
- : *social interactions and peer relationships*
- : *spiritual/cultural identity.*

Under each of these domains, there are a number of assessment areas seeking greater detail (see pages 70 – 75). The assessment domains and items are based on New Zealand and overseas studies that have identified the most common factors associated with recidivism and poor life outcomes.

guidelines on the well-being assessment

Professional judgement

This is not a predictive tool for assessing risk, but rather a process for assessing the needs and strengths of young people to assist planning.

Many of the assessment items call for a high degree of judgement. The assumption underlying the assessment is that the social worker, in conjunction with those that know the young person, will form a judgement about the young person's strengths and needs. To assist with this judgement, you should consult with as many people as possible who know the young person. However, in the final analysis the effective use of the assessment depends on your exercise of professional judgement.

The procedure

For each assessment item, you are asked to indicate with a tick if this is an area where the young person has a need, or a strength, or the situation is satisfactory (i.e. does not require any action). To assist the accuracy of responses the assessment is best carried out when a relationship or rapport is created between the young person and the social worker (see Section 3). The assessment should take place in circumstances where the young person is willing and able to cooperate and made to feel comfortable. Arrange for this to happen with trusted family/whānau members present whenever possible.

It is also important that the reason for the assessment is explained to the young person and their family/whānau and they have the opportunity to provide their views.

An assessment will not produce useful or accurate information when the young person is agitated, high on drugs or alcohol, injured, uncooperative, or unable to comprehend what is going on.

The tool is designed to prompt the social worker to investigate areas of the young person's life that are likely to impact on their offending or problem behaviour. It is not intended that the items be used as direct questions. They are a guide to the areas of information that need to be covered to assist in assessment and planning. The order in which the information is gathered is not important but all areas must be considered. The young person and their family/whānau should also be asked to identify any other information they think is important that has not been included in the assessment.

guidelines on the well-being assessment

Sources of information

To complete the assessment, it is likely that information will need to be gathered from a number of sources and from more than one contact with the young person. Information gathered when building a relationship with the young person is important for informing the overall assessment.

Under ideal conditions, a social worker would have access to a wide range of sources of information to complete the assessment. The general rule is that the assessment should be completed on the basis of the best information available. There is space at the end of each section for comments, and the social worker should note in this where information is limited or unreliable.

Action required

The purpose of the tool is to assist in structuring information for the Family Group Conference or family/whānau hui for planning and targeting services. To achieve this, it will be necessary to identify areas where strengths or needs exist that can be influenced or built on with programmes or services.

For each item, there is space to record whether the area represents a strength or a need for the young person, and space is made for comments. It is important to identify factors that can be built on, as well as negative factors, which must be addressed. Strength factors are those that enable a young person to overcome or be resilient to negative influences or risk factors in their lives. It is important to note that the absence of a need does not mean that the young person has a strength in this area.

At the end of each section, the social worker is asked to consider the strengths and needs identified for each area and determine if some action is required. These factors are not weighted and therefore cannot be assessed just on the number of needs versus strengths. That is, one need in an area may outweigh a number of strengths.

There is space at the end of the template for the social worker to record any other information they think is relevant to the young person's situation that has not been captured in the information in the other sections.

This is followed by a summary box to record the areas identified where action is required.

guidelines on the well-being assessment

Analysing the information

Once you have summarised the information gathered during the assessment, areas of strengths and needs should become apparent. Even though the young person may have five out of the six prompts ticked under the education/intellectual area, this may not be as important in terms of their problem behaviour as the one tick they have under whānau relationships (e.g. abuse within the family). As a general guide, areas with greater concentrations of problems should be targeted for services.

Where strengths have been identified, these should be recorded with suggestions for building on them. Strength factors may reduce the impact of some areas of need but they do not always cancel out needs. Therefore a plan should identify ways to build on and enhance the strength factors, while also incorporating services to reduce need factors.

When making recommendations for action, the following considerations should be taken into account:

- : Are the actions related to the areas of needs and strengths identified in the assessment?*
- : Do they cover areas that can be altered by intervention?*
- : Do they take into account what will work for the particular characteristics of the young person?*
- : Are they realistic and attainable?*

: Are they specific and concrete?

: Are they understood by the young person and their family?

: Can the recommendations be reviewed to see if they were achieved?

Outcomes assessment

The tool has been designed to be reapplied before case-closure to determine outcomes. Improved life outcomes will be apparent from a reduction in needs and/or an increase in strengths or items assessed as satisfactory.

advice for the well-being assessment of māori young people

Working with rangatahi/whānau

Ariari ki te oranga:

Most people in Aotearoa understand 'kia ora' to mean 'hello', or 'greetings'. Within the Māori world view, 'ora' means 'life', so 'kia ora' simply means 'to life'. By inference 'ariari ki te oranga' means 'movement towards life and well-being'. It affects 'te whare tapa whā', better known as taha tinana, taha wairua, taha whānau, and taha hinengaro. It generates energy to create. The action most associated with this state is 'te haka a Tāne Rore'.

The phrase 'ariari ki te oranga' is fairly recently coined, and is heard mostly in the area of mental health.

To assist in understanding the phenomena of 'ariari ki te oranga', imagine you are dancing on a moonbeam to your favourite song.

Checklist for reviewing the intervention plan:

- ⋮ *Has the rangatahi and their whānau moved from finite outcomes to infinite possibilities?*
- ⋮ *Has the rangatahi moved from an 'I' role to a 'we' role?*
- ⋮ *Has the rangatahi and their whānau moved from a state of dependence to interdependence?*

advice for the well-being assessment of māori young people

Handy hints

Te whare tapa whā

As this framework is the most well known in the helping professions, it would be okay to use it in developing an oranga plan with the rangatahi you are working with.

Taha tinana:

- ‡ *something your tinana does really well*
- ‡ *something you would like your tinana to experience in the future*
- ‡ *something about your tinana that doesn't feel right.*

Taha whānau:

- ‡ *something your whānau does really well*
- ‡ *something you wish your whānau would do more often*
- ‡ *something your whānau doesn't handle very well.*

Taha hinengaro:

- ‡ *something you know about yourself that keeps you safe*
- ‡ *something you would like to find out that would help you get out of the present mess*
- ‡ *something you keep remembering that blocks things.*

Taha wairua

- ‡ *something that makes you feel good, apart from drugs*
- ‡ *something that would help you feel good in the future, apart from drugs*
- ‡ *something that stops you from feeling anything good, apart from drugs.*

advice for the well-being assessment of pacific young people

When assessing Pacific Peoples' well-being, it is important to remember that it is usually considered in the collective sense. The belief is that the well-being of the family is an indicator of the well-being of its members. The family is responsible for taking care of its members' well-being, sharing resources and looking after each other.

However, the environment in New Zealand and changes that have been impacting on Pacific Peoples' traditional support systems make it vitally important to also consider individual family members' well-being. This is because some of the cultural and familial expectations can put pressures on the emotional well-being of particular family members.

The cultural considerations described in Section 2 inform the process for this assessment.

In understanding some of the concepts from a Pacific Peoples' perspective, the following are suggested:

∴ **Education/intelligence:** *Pacific people have cultural intellect, which is as important for them as educational intellect.*

Their relationships with school peers and teachers are usually determined by cultural upbringing of respecting elders and not associating with people other than family and community members.

Sometimes Pacific people are regarded as having learning disabilities when they can't read or write in English but can only read and write in their first language.

∴ **Physical well-being:** *Pacific people normally have more than one family in the household because of collective responsibility. Some of them may not be in paid employment but, because of the collective nature of their cultures, this doesn't necessarily mean that they have financial problems.*

In some Pacific cultures, discussing sexuality within the family is not appropriate. Be aware of this and be sensitive in such discussions.

∴ **Whānau relations:** *The concept of 'attachment' is communal for Pacific people, because Pacific children are usually brought up by the extended family, not just the parents.*

The concept of managing a young person's behaviour may also be different for Pacific people because of parental authority and beliefs about the relationship between parents and children.

advice for well-being assessment of pacific young people

- ⋮ **Attitude:** Pacific young people are not always encouraged to plan for the future, because some of these decisions are made by their parents.
- ⋮ **Social interaction:** Pacific young people are expected to be obedient, and this is sometimes misinterpreted as having poor social interaction abilities.
- ⋮ **Emotional well-being:** Pacific young people may be perceived as having low self-esteem, whereas being assertive and promoting one's self is considered inappropriate behaviour.
- ⋮ **Spiritual and cultural well-being:** It is important to consider the young person's family history, as this provides the avenue for identity and making family connections.

Also refer to Section 2: Cultural Consideration for Pacific Peoples.

guidelines for recording the well-being assessment

The assessment, as on pages 70 – 75, covers eight domains: patterns of offending; educational/employment; physical well-being, family/whānau environment; attitudes; social interactions and peer relationships; emotional well-being, and spiritual/cultural identity.

The social worker records details about the young person and the assessment, as well as the sources of the information used to make the assessment. Each domain covers aspects of the circumstances and behaviour of the young person and their life situation. Tick the boxes that best describe the situation and behaviour at the present time.

In the text area below each domain, note any other relevant information.

Well-being assessment intervention plan

Consider the information above and weigh the relative significance of the strengths and needs identified in each domain. List the needs, any action required to address those needs, and identify who is responsible for carrying out those actions. Similarly, list the areas of strength, any actions to enhance those strengths and who will carry out those actions.

Case closure

The process of assessment and planning should be repeated when consideration is being given to closing the case. The purpose of this is to re-evaluate the needs and strengths and to decide whether the identified needs have been addressed sufficiently to allow for closure.

well-being assessment

Name of young person: _____ SWis No: –

Status: _____

Date of assessment: _____ Social Worker: _____

1. Pattern of offending

Offences in last 12 months (enter number)

Age of first admitted or proven offence (enter age)

An offence: a charge that has been admitted by the young person or that has been proven in the Youth Court. In this section the social worker should identify any pattern of offending. Describe the pattern, including the severity, frequency, when the offending is being committed and who the young person is with when offences occur:

2. Family/whānau environment

Strength	Satisfactory	Need
<input type="checkbox"/> Strong family/whānau attachment	<input type="checkbox"/> Family/whānau attachment is satisfactory	<input type="checkbox"/> Lack of attachment with parents or other adults in the family/whānau
<input type="checkbox"/> Young person accepts boundaries and operates within them	<input type="checkbox"/> No major difficulties in controlling behaviour	<input type="checkbox"/> Young person is out of control/parents have difficulty controlling him/her
<input type="checkbox"/> Cooperative atmosphere exists in the home	<input type="checkbox"/> Disciplining of young person is non-violent and reasonable	<input type="checkbox"/> Violent, excessive or abusive disciplining of the young person
	<input type="checkbox"/> No history of abuse within the family/whānau <input type="checkbox"/> No history, nor indications, of abuse of the young person. <input type="checkbox"/> No current parental substance abuse problem	<input type="checkbox"/> History of abuse and neglect within family/whānau <input type="checkbox"/> History of abuse of the young person (verified by RES assessment) <input type="checkbox"/> Parents currently abuse substances
<input type="checkbox"/> No tolerance of criminal activities within the family/whānau	<input type="checkbox"/> No history, or recent cases, of criminal activity in the family/whānau	<input type="checkbox"/> Members of immediate family/whānau are engaged in or tolerate criminal activities
<input type="checkbox"/> Strong bond between parents/caregivers	<input type="checkbox"/> Infrequent conflict between parents/caregivers	<input type="checkbox"/> Frequent and/or significant conflict and tension between parents/caregivers
<input type="checkbox"/> Parents/caregivers take steps to ensure safety of young person	<input type="checkbox"/> Parents/caregivers generally aware of whereabouts or activities	<input type="checkbox"/> Young person left unattended or parents/caregivers unaware of whereabouts or activities
<input type="checkbox"/> Family/whānau active participants within their community	<input type="checkbox"/> Family/whānau involvement in community is satisfactory	<input type="checkbox"/> Family/whānau isolated from their community by choice or circumstance

Other relevant information: _____

3. Education/employment

Strength	Satisfactory	Need
<input type="checkbox"/> Actively involved in, or enjoys school or other educational activities (e.g. church group, cultural group, training) or employment	<input type="checkbox"/> Attending school, other educational activities or employment	<input type="checkbox"/> Young person is not attending school, other educational activities or employment
<input type="checkbox"/> Young person has a positive input at school other educational activity or employment	<input type="checkbox"/> Few, or no problems at school, other educational activity or employment	<input type="checkbox"/> Consistently disruptive at school, other educational activities or employment
<input type="checkbox"/> Advanced attainment at school or in other areas of learning	<input type="checkbox"/> Achieving within normal academic range at school or in other areas of learning	<input type="checkbox"/> Failing at school or in other educational areas
<input type="checkbox"/> Has strong relations with groups of friends at school, other educational activity or employment	<input type="checkbox"/> Relations with classmates/workmates are not causing a problem	<input type="checkbox"/> Poor relations with classmates/workmates, very few friends or strong attachments
<input type="checkbox"/> Experiences work or training as positive and demonstrates on-going commitment	<input type="checkbox"/> Is employed or in training for employment	<input type="checkbox"/> Has left school and is in neither employment nor training
<input type="checkbox"/> Has positive relations with adults at school, other educational activities or employment	<input type="checkbox"/> Has adequate relations with adults at school, other educational activities or employment	<input type="checkbox"/> Poor relations with adults at school, other educational activities or employment

Other relevant information: _____

4. Physical well-being

Strength	Satisfactory	Need
<input type="checkbox"/> Stable and safe accommodation <input type="checkbox"/> Family/whānau or young person manages financial situation	<input type="checkbox"/> Safe accommodation <input type="checkbox"/> Family/whānau or young person's financial situation is not causing stress	<input type="checkbox"/> Inappropriate/unsafe accommodation (e.g. living on streets) <input type="checkbox"/> Family/whānau or young person's financial situation is causing stress
<input type="checkbox"/> Positive and responsible attitude towards sexuality	<input type="checkbox"/> No sexual activities or practising safe sex	<input type="checkbox"/> Young person engages in unsafe sexual activities (e.g. illegal or unprotected sex)
<input type="checkbox"/> Functioning well physically	<input type="checkbox"/> No major physical problems	<input type="checkbox"/> Physical condition or disability which impairs functioning and must be managed

Other relevant information: _____

5. Emotional well-being

Strength	Satisfactory	Need
<input type="checkbox"/> Self-esteem is positive and realistic	<input type="checkbox"/> Self-esteem is satisfactory	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Defuses angry and aggressive situations non-violently and responsibly	<input type="checkbox"/> Management of anger and aggression is non-violent	<input type="checkbox"/> Physically aggressive/often in fights
	<input type="checkbox"/> No signs of depression (as indicated by Kessler screen)	<input type="checkbox"/> Signs of depression (as indicated by Kessler screen)
	<input type="checkbox"/> No/low risk of suicide	<input type="checkbox"/> Risk of suicide (as indicated by suicide screen and management)
	<input type="checkbox"/> No substance use or limited use	<input type="checkbox"/> Abuses substances (as indicated by CAGE screen)

Other relevant information: _____

6. Attitudes

Strength	Satisfactory	Need
<input type="checkbox"/> Positive relationship(s) with authority figures	<input type="checkbox"/> Accepts authority	<input type="checkbox"/> Defies authority
<input type="checkbox"/> Pro-social attitudes – supports non-criminal lifestyle, institutions, values etc.	<input type="checkbox"/> Neutral attitude to crime	<input type="checkbox"/> Pro-criminal attitudes e.g. supports, or is tolerant of, criminal activities or drug use
<input type="checkbox"/> Accepts responsibility for actions/behaviours and wants to change them	<input type="checkbox"/> Accepts responsibility for actions/behaviours	<input type="checkbox"/> Denial of responsibility for offending or problem behaviours/blames others
<input type="checkbox"/> Young person has a positive view of the future	<input type="checkbox"/> Young person not negative about their future	<input type="checkbox"/> Negative or pessimistic about the future

Other relevant information: _____

7. Social interactions and peer relationships

Strength	Satisfactory	Need
<input type="checkbox"/> Associates with positive group of friends	<input type="checkbox"/> Associates with a mix of peers	<input type="checkbox"/> Associates with peers with similar or worse problems e.g. other offenders
<input type="checkbox"/> Able to make friends easily and is comfortable in social settings	<input type="checkbox"/> Relationships with peers is not of concern	<input type="checkbox"/> Poor social interactions/difficulty in making and holding relationships
<input type="checkbox"/> Actively involved/enjoys organised activity	<input type="checkbox"/> Takes part in some organised activity	<input type="checkbox"/> Not involved in organised activities nor shows any interest

Other relevant information: _____

8. Spiritual/cultural identity

Strength	Satisfactory	Need
<input type="checkbox"/> Positively aware of, and draws strength from his/her culture	<input type="checkbox"/> Aware of cultural identity	<input type="checkbox"/> Lack of cultural identity or negative about his/her culture
<input type="checkbox"/> Strong, positive personal and spiritual beliefs	<input type="checkbox"/> Cultural connection and spirituality is satisfactory	<input type="checkbox"/> Feelings of alienation, lack of purpose, spiritual connection absent or negative
<input type="checkbox"/> Involved and supported in community, church or cultural group	<input type="checkbox"/> No significant alienation from community, cultural, church or similar group	<input type="checkbox"/> Negative influence or isolated from, community, cultural, church or similar group

Other relevant information: _____

well-being assessment intervention plan

Name of young person: _____ SWis No: -

Status: _____

Date of assessment: _____ Social Worker: _____

Consider the information you have collected in the well-being assessment and evaluate the relative importance of the strengths and needs in each domain. List the needs that arise from the evaluation, any actions required to address those needs and who is responsible for carrying out the actions.

Priority*	Needs	Actions	By whom?

*Priority: 1 – Highest: requires immediate action

2 – Medium: requires action prior to case closure

3 – Lowest: does not require action at present

Now list the areas of strength, any actions to enhance those strengths and who will carry out those actions.

Strengths	Actions to enhance strengths	By whom?

Comments: _____

Supervisor's comments: _____

Supervisor's sign-off: _____ Date: _____



SECTION 08

appendices

Appendix one:
Resource contacts

Appendix two:
Origin of the CAGE and Kessler
screening tools

Origins of the well-being assessment

Other resources

APPENDIX ONE

resource contacts

Details of your local resource professionals and agencies.

This template should be completed during training or whenever a social worker moves to a new locality. It should be regularly up-dated.

Local Medical Centre(s)

1:	Phone
Contact person:	
Other(s)	
After hours:	
Address:	
Fax	
email:	
2:	Phone
Contact person:	
Other(s)	
After hours:	
Address:	
Fax	
email:	

Mental Health Services – Acute Assessment Team

Phone
Contact person(s) (including Duly Authorised Officers)
After Hours:
Address:
Fax
email:

resource contacts

Youth Mental Health Services

Phone
Contact person(s):
After hours:
Address:
Fax
email:

Child and Family Services

Contact person(s):	
After hours:	
Address:	
email:	Fax
Contact person(s):	
After hours:	
Address:	
email:	Fax

Cultural advisors and support people: Māori

Contact person(s):	
Phone	
After hours:	
Address:	
email:	Fax
Contact person(s):	
After hours:	
Address:	
email:	Fax
Contact person(s):	
After hours:	
Address:	
email:	Fax

resource contacts

Other cultures

Contact person(s):
After hours:
Address:
email: Fax
Contact person(s):
After hours:
Address:
email: Fax
Contact person(s):
After hours:
Address:
email: Fax
Contact person(s):
After hours:
Address:
email: Fax

Public Health resource people (e.g. Nurse)

Contact person(s):
After hours:
Address:
email: Fax
Contact person(s):
After hours:
Address:
email: Fax

resource contacts

School:
Contact person(s):
Phone:
After hours:
Address:
email: Fax
School:
Contact person(s):
Phone:
After hours:
Address:
email: Fax
School:
Contact person(s):
Phone:
After hours:
Address:
email: Fax
School:
Contact person(s):
Phone:
After hours:
Address:
email: Fax

Special interest groups

Contact person(s):
After hours:
Address:
email: Fax
Contact person(s):
After hours:
Address:
email: Fax

origin of the CAGE and Kessler screening tools

CAGE Screening Tool

The CAGE was developed in the 1970s as a short screen for alcohol and drug use problems. Its advantage over other similar screening tools is that it is shorter, has simple scoring and focuses on the negative effects of any use rather than the volume of use. The acronym CAGE stands for the key behaviours targeted in each of the four questions (Cut down, Annoyed, Guilty, Early morning consumption).

A majority of studies have confirmed it as a valid screening instrument for alcoholism in populations in which there is likely to be a high proportion of people with drug (including alcohol) and mental health problems⁹. Given estimates that 50-70% of young people who are in contact with Child, Youth and Family have, or have had, a mental health disorder (including alcohol and drug use disorders), it is a valid screening tool for the Department's population. There is recent evidence that it should not be used in the general population.

The current version of the CAGE has been modified to include all drug use and has an additional section asking about regular and recent use of drugs (including a checklist of common names for the most common drugs used currently in New Zealand).

Kessler screening tool for psychological distress

The six-item Kessler is the shorter of two tools developed by Professor Ron Kessler, Harvard University, for use as an initial screen for psychological disorder. The screen is developed from the 'stem questions' (those questions indicating that there is likely to be a disorder and the interview should progress further) of the CIDI (a DSM-IV based questionnaire).

The six and 10 item Kessler has been investigated in a pilot study in Wellington, New Zealand in 1998 and found to be a valid screening instrument in comparison with other commonly used (and longer) screening tools and the DSM-IV (Westwater, H.M.. MA thesis, Department of Psychology, Victoria University). The Kessler has also been used in a study of the mental health of 10,000 people in Australia, which is presently being analysed. Future normative data and 'cut-off' scores may be available from

⁹Bisson, J.; Nadeau, L.; Demers, A. *Addiction* (1999), 94(5), 715-722.

origin of CAGE and Kessler

this study. The Kessler is also expected to be used in a New Zealand mental health survey planned for 2001.

Two items in the present version have been modified to include words more easily understood by New Zealand youth.

CAUTION

Both screening tools are intended to rule out young people who do not need further investigation about their drug use – a ‘positive’ score must be followed up with further investigation before any decision can be made about whether there is a ‘problem’.

Both tools are being used in an age group outside of the published normative data, but are the best available for screening at this time. Ideally, there is a need for research to confirm the validity, normative data and ‘cut-off’ scores for the youth services population (14–17 years). Data is expected for the Kessler for the 15-17 age group from the Australian study currently being analysed.

Care should be taken to identify any young people who are considered to be exaggerating or minimising their responses to both scales. If there is any doubt request a full assessment.

While the Youth Services Strategy is primarily focused on 14 – 16 year-olds it is recognised that there are many 12 and 13 year-olds facing multiple risks and with many needs beyond their chronological age.

It is expected that the screening and assessment tools programme and services in the Youth Services Strategy will be available to high-risk 12 and 13 year-olds.

origins of the well-being assessment

During the 1970s, research in the United States suggested that, when it comes to using rehabilitation programmes to prevent re-offending, there was no supporting evidence that these programmes made any difference¹⁰. The ‘nothing’ view led to support for limiting interventions with offenders and reliance on increasing custodial sentences and sanctions as the most effective response to deter offenders and discourage re-offending.

A re-visiting of this earlier work and the use of more sophisticated research techniques led to a challenge of the nothing-works doctrine. A growing body of international research has demonstrated that programmes and services for persistent recidivists can make a difference to their chances of re-offending¹¹. However, the effectiveness of programmes is dependent upon what is delivered and for whom.

Programmes that have been shown to be successful at reducing re-offending include those that:

- : *provide intensive services targeted at the highest risk youth*
- : *target dynamic risk factors of the young person (referred to as criminogenic needs)*
- : *take account of their learning skills and characteristics; and*
- : *aim to improve the young person’s reasoning skills and social behaviours (cognitive behavioural therapy)*¹².

The identification of predictive risk factors using assessment tools has reached an advanced stage whereby static and dynamic risk factors can be assessed. Static risk factors are used to identify the level of risk of future offending while dynamic risk factors are used to identify underlying needs that can be targeted by rehabilitation programmes.

Bonta (1996) describes these risk/needs assessment tools that look at underlying needs as third generation assessments. First generation assessments involve collecting information on offenders and their situations and then interpreting this information based on practitioner knowledge and experience. These assessments are subjective and therefore variable and not open to observation, and always perform poorly in prediction studies. Second generation assessments involve the use of objective, empirically based, offender risk assessments (static risk factors). In such assessments, weights are assigned to various historic or static indicators (e.g. age, gender, criminal history, family factors such as parental and

¹⁰ Martison, R. What works? Questions and answers about prison reform. *The Public Interest* 35, pp22-54. 1974.

¹¹ Lipsey, M. ‘Juvenile delinquency treatments: A meta-analytic inquiry into the variability of effects’ in Cook, T. et al. (eds), *Meta-analysis for explanation: A casebook*, New York 1992. Andrews, A.; Zinger, I.; Hoge, R.; Bonta, J.; Gendreau, P.; Cullen, F. ‘Does correctional treatment work?’.

A clinically relevant and psychologically informed meta-analysis. *Criminology*, Vol 28, Number 3, pp 369 – 403 1990.

¹² Andrews, D.; Bonta, J. *The Psychology of Criminal Conduct*. Anderson Publishing Co. Cincinnati 1994.

origins of the well-being assessment

family criminality). These scales perform better than subjective approaches, but provide little guidance on treatment services. Third generation assessments go beyond a statistical risk prediction and recognise the need to deliver rehabilitation services if risk is to be managed effectively. To do this, assessment tools need to identify dynamic risk predictors (i.e. factors that can be influenced) that are associated with changes in recidivism.

Bonta and Andrews and Hoge have described the principles characteristic of successful third generation programmes:

- ⋮ *RISK PRINCIPLE*
- ⋮ *NEEDS PRINCIPLE*
- ⋮ *RESPONSIVITY PRINCIPLE*
- ⋮ *PROFESSIONAL DISCRETION*¹³

Risk principle

The level of treatment should match the risk level of the offender. Intensive services should be reserved for higher risk cases because they respond better to intensive

service than to less intensive service, while lower risk cases do well or better with minimal as opposed to more intensive service.

Needs principle

Targets of service should be matched with the criminogenic needs of offenders. Criminogenic needs are the offender needs that, when changed, are associated with changes in recidivism. For example, substance abuse and employment problems are criminogenic needs. They may serve as treatment goals that, if successfully addressed, may reduce recidivism. Anxiety and self-esteem are examples of non-criminogenic needs. Decreasing anxiety or increasing self-esteem is unlikely to impact on future criminal behaviour (Bonta 1997).

Other categories of criminogenic and non-criminogenic needs are shown here:

Criminogenic	Non-criminogenic
<i>Pro-criminal attitudes</i>	<i>Low self-esteem</i>
<i>Criminal associates</i>	<i>Anxiety</i>
<i>Substance Abuse</i>	<i>Feelings of alienation</i>
<i>Anti-social behaviour</i>	<i>Psychological discomfort</i>
<i>Lack of problem-solving skills</i>	<i>Group cohesion</i>
<i>Hostility-anger improvement</i>	<i>Neighbourhood</i>

¹³ Andrews, D.A.; Bonta J.; Hoge R.D. 'Classification for effective rehabilitation: Rediscovering psychology.' *Criminal justice and Behaviour*, 17 pp 19-52, 1995.

¹⁴ Cognitive behaviourism is a term given to a range of interventions, derived from an integration of behaviourism, cognitive and social learning theories, which seek to modify patterns of thinking and behaviour. (See Vennard, Sugg and Hedderman 1997.)

¹⁵ Bonta, J. *Offender Rehabilitation: From research to practice*. Public Works and Government Services Canada, 1997.

Vennard, J.; Sugg, D.; Hedderman, C. 'Changing offenders' attitudes and behaviour: what works'.

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origins of the well-being assessment

Responsivity principle

Styles and modes of services should be matched to the learning styles and abilities of offenders. In general the research shows that programmes that seek to modify offenders' patterns of thinking and behaviour (cognitive-behavioural treatments¹⁴) are generally more successful in reducing re-offending than other techniques. But their impact is enhanced by targeting factors that contribute to offending behaviour, and match the intensity and duration of intervention to the risk of re-offending¹⁵.

Professional discretion

Instruments should be designed to aid judgement; they should not be used to replace judgement. Final decisions about clients should rest with the judgement of the individual(s) responsible for the client's welfare.

The assessment tool

A third generation tool, incorporating all four principles described over, has been developed in Canada. Widely used there, it is called the Youth Level of Service/Case Management Inventory¹⁶. This tool was developed out of the original Level of Supervision Inventory, which has subsequently been revised¹⁷ (LSI-R Andrews and Bonta, 1995). The LSI-R is used widely throughout Canada and the USA and a version is being piloted for national usage within the probation service within the UK. The Department of Corrections in New Zealand is also piloting the system.

Evidence in support of the reliability of the items assessed by the LSI and its youth version have been presented by Andrews et. al (1986), Hoge and Andrews (1996), and Shields and Simourd (1991)¹⁸.

The risk and needs items from these tools have informed the well-being assessment used in this Child, Youth and Family guide, *Towards Well-being*. Modifications have been made to reflect the New Zealand context and cultural considerations. Strength factors have also been incorporated to provide a balanced view of the young person and a more holistic assessment from which to identify needs for targeting of services. At present, a weighting system has not been incorporated into the well-being assessment. This is because data on the relative importance of the different factors to offending behaviour has not been gathered for young people notified to the Department. A predictive tool based on data for the Department's client group is planned for future development.

¹⁶ Hoge, D; Andrews, D.A. The Youth Level of Service/Case Management Inventory – Intake Manual and Items Scoring Key (Revised 1996). Multi-health Systems New York 1996.

¹⁷ Andrews, D.; Bonta, J. Level of Service Inventory – Revised, Toronto, Multi-Health Systems 1995.

¹⁸ Andrews, D.; Robinson, D.; Balla, M. 'Risk principle of case classification and the prevention of residential placements: An outcome evaluation of the Share the Parenting program.' Journal of consulting and clinical psychology, 54, 1986.

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Guidelines for the treatment and management of depression by primary healthcare professionals.

National Health Committee, Wellington, New Zealand. September 1996.

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National Health Committee, Wellington, New Zealand. November 1998.

Further reference material is available in Social Work Now:

Issue 13, 1999 New approach for hard-core and high-risk kids, Lisa Hema.

Issue 14, 2000 Identifying young people at risk of suicide, Don Smith and Annette Beautrais.

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