PAE WHAKATUPURANGA | FFT-CG

IMPACT EVALUATION

WAVE 4 REPORT

Family Centre Social Policy
Research Unit

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A Report by the Family Centre Social Policy Research Unit for Oranga Tamariki—Ministry for Children

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Foreword

E mihi maioha ana mātou o Family Centre ki ngā tangata huhua, nā koutou i tuku mai i te hohonutanga me te whānuitanga a ōu koutou mātauranga e pā ana ki te kaupapa e kiia nei Te Pae Whakatupuranga, arā, Functional Family Therapy Cross Generations Impact Evaluation Report Wave

Ko te hāngai pū o te wāhanga whā o te kaupapa nei kia āta tirohia i tutuki pēhea ake ngā whāinga oranga matua me ērā atu whāinga whānui mō te hunga rangatahi me ō rātou whānau tae rawa mai ki te tōpitotanga o te tau tuatoru.

E mihi kau ake ana ki ngā whānau i whai wāhi mai i roto i te kaupapa nei, ā, ka mihi hoki ki ngā kaumātua, ngā tohunga tikanga ā moutere, te Rōpū Tohutohu me ngā kaimahi katoa o Kia Puāwai.

Hei whakamutu ake me mihi ka tika hoki ki Te Pūtahitanga Rangahau a Oranga Tamariki mō te āta tātari i ngā tuhinga hukihuki o tēnei rīpoata.

Tēnā rawa koutou katoa i ō koutou tautoko mai i tēnei o ngā kaupapa rangahau.

The Family Centre Social Policy Research Unit wishes to thank all those who generously shared their knowledge and experience of the development of Pae Whakatupuranga: Functional Family Therapy Cross Generations Impact Evaluation Report Wave 4.

The primary focus of this wave is on understanding the extent to which the Pae Whakatupuranga I FFT-CG service has achieved its wellbeing and other planned outcomes for young people and their whānau by the end of its three-year pilot operation.

We firstly acknowledge the families who generously shared their stories and experience of the programme. We acknowledge the Kia Puāwai Kaumātua and cultural supervisor, the Pasefika cultural leaders, members of the Steering Committee and the therapists and managers at Kia Puāwai.

We also wish to acknowledge the Oranga Tamariki Evidence Centre for their review of drafts of this impact evaluation report.

Our thanks to all of you who supported this research evaluation project.

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EXECUTIVE SUMMARY

Please note the executive summary provides a reduced summary of the report. The details that fill out and explain the text can be found in the body of the report.

Report context

Pae Whakatupuranga I Functional Family Therapy - Cross Generations (FFT-CG) is a pilot programme aimed at breaking the intergenerational cycle of justice involvement for rangatahi/young people and improving wellbeing for them and their whānau/aiga/families. This happens through the facilitation of positive change in family systems. This programme is an adaptation of the original Functional Family Therapy (FFT) model (referred to as FFT Standard), which is designed and owned by US based FFT-LLC, but has been adapted in order to be culturally appropriate for the Aotearoa context.

Pae Whakatupuranga I FFT-CG aims to weave together three distinct approaches in a model designed to increase cultural understanding and skills for family therapists working with whānau/aiga/families. The three approaches are:

Pae Whakatupuranga is an adaptation of:

- FFT Standard which focused on the young person in the presence of a largely stable family unit;
- FFT-CW which built on that and focused on the family unit where there were reports of concern around parenting; and
- FFT CIA which focused on older young people moving into independence.

There are two cultural frameworks that are woven though the clinical model and they are:

- Whaitake Whakaoranga Whānau[1], whose purpose is to ensure that whānau experience therapy that is respectful of and consistent with Māori values, processes, and culture

[1] Whaitake Whakaoranga Whānau' loosely translates as 'To pursue whānau wellbeing'. The model originates in the sacred knowledge of Māori that is transferred from generation to generation to provide protection and care for whānau. This knowledge is not developed by nor does it belong to a single person. It is the indigenous worldview that is instilled in Māori to ensure their wellbeing, whether it is their perception of the way things work, their surrounding world, or their own whānau safety and prosperity. In putting together this framework, Kaumātua and kaitiaki act as guardians of and guides for the sacred knowledge to make sure that they are appropriately understood and used in promoting Māori wellbeing.

- Uputāua Pan-Pacific Cultural Framework (Uputāua)[2], a Pasefika[3] framework that recognises many of the cultural and spiritual protocols that are central to Pacific communities.

Pae Whakatupuranga I FFT-CG is funded by Oranga Tamariki under its Reducing Youth Offending programme of work. The service involves two other agency partners – the Department of Corrections (Corrections) and New Zealand Police (Police). Kia Puāwai (was Youth Horizons but changed its name after the pilot period was completed)[4], a contracted third-party provider of the Pae Whakatupuranga I FFT-CG service, has been implementing the pilot in Auckland since July 2019.

The Family Centre Social Policy Research Unit (FCSPRU) has undertaken a multi-year evaluation of the Pae Whakatupuranga I FFT-CG pilot programme (July 2019 to June 2022). The evaluation has three overall high-level objectives:

- To assess how well Pae Whakatupuranga I FFT-CG is being implemented, including its cultural appropriateness in the Aotearoa/New Zealand context, and identify any areas for improvement
- To understand the service's early effect on the wellbeing of young people and their whānau
- To identify key requirements for implementing the service well in other locations (if it is deemed effective).

The desired wellbeing outcomes of Pae Whakatupuranga | FFT-CG are:

- improving the way family members interact and communicate with each other
- strengthening family relationships
- improving family wellbeing by reducing conflict and aggression in the home
- helping young people to stay at home or transition successfully to independent living
- helping young people either stay in school or return to school, training, or employment.

[2] The Uputāua Pan-Pacific Cultural Framework (Uputāua) originated from Samoan foundations. It is premised on shared conceptual elements across Pasefika indigenous cultures and centralises the importance of spirituality, intergenerational relationships, and boundaries, roles, and responsibilities for the wellbeing of the collective. Uputāua was created as the approach to working in respectful ways with Pasefika aiga. Uputāua has brought Pasefika spirituality and the importance of intergenerational aiga relationships explicitly into the practice of Pae Whakatupuranga I FFT-CG for the first time.

[3] Various spellings of Pasefika are used to describe Pacific peoples. The Pasefika authors within the overall group of authors of this report are Samoan. It has thus been considered appropriate for this publication to use the Samoan spelling Pasefika.

[4] Youth Horizons changed their name to Kia Puāwai in November 2002. Kia Puāwai will be the term used for this service throughout the report

The desired pilot infrastructure outcomes[5] are:

- collaboration across partner agencies
- the establishment of a culturally appropriate FFT-CG therapeutic manual and process, resulting in an adaptive service that weaves together Te Ao Māori, Tafa o le Pasefika, and Western approaches
- therapists and referrers perceive FFT-CG as having a positive effect on the lives of clients, referred people and their whānau, so continue to practice FFT-CG.

This evaluation report is the final evaluation of the pilot programme after the two initial formative evaluations and the first impact evaluation[6]. It constitutes wave four and the second impact evaluation.

The primary evaluation question for this impact evaluation is: *To what extent has the programme achieved its wellbeing and pilot infrastructure outcomes, by mid-2022?*

Six sub-questions consider specific dimensions of progress towards the outcomes:

1. How well did the programme achieve outcomes for Māori and Pacific Peoples, including the outcomes they wanted to achieve for their whānau/family through FFT-CG?
2. What helped or hindered the programme from achieving its outcomes?
3. What are the unintended consequences of the programme?
4. What has been learned that can improve the effectiveness of the programme in the future?
5. How have COVID-19 Alert Levels affected the delivery and uptake of the programme, and the programme's intended outcomes?
6. What lessons have been learned about making the programme sustainable?

[5] The term 'pilot infrastructure outcomes' refers to the new partnering model and practice manual (Kia Puāwai & Functional Family Therapy LLC. (2020). *Pae Whakatupuranga: Te Huarahi o Te Ranagatahi.* Waikato-Tainui College of Research and Development at Hopuhopu) that underpin the operation of the pilot.

[6] The three previous evaluations are available on the Oranga Tamariki website www.orangatamariki.govt.nz/about-us/research/our-research/fft-evaluations/

Methodology

This evaluation employed a mixed-method approach of both qualitative and quantitative analyses. The qualitative analysis draws on 20 interviews in total, ten of which were with youth, whānau, aiga and families who have used Pae Whakatupuranga I FFT-CG services, and two were with therapists in focus groups. The remaining interviews consisted of: the Kia Puāwai Kaumātua; Kia Puāwai management (including the Operations Manager, the Practice Lead and the Intake Specialist); the Programme Manager (Oranga Tamariki); and referrers (Police and Corrections).

The interviews were conducted between 4 April and 8 October 2022. The ten interviews with client families were conducted with three Māori whānau, three Pasefika aiga, and four Pākehā families remotely via zoom or telephone. They represent the three largest client bases of Pae Whakatupuranga | FFT-CG. Remote interviewing was used as a health safety measure because of the ongoing impacts of the COVID-19 pandemic.

Interviewers and interviewees were matched culturally for the interviews with whānau, aiga and families (Māori, Pasefika, Pākehā). Interviews with management, therapists, the kaumātua and stakeholders were also conducted by Zoom or phone.

The quantitative analysis interrogated the data stored in the: FFT-LLC database (CSS); Kia Puāwai database (HCC); Outcome Questionnaire website; and in a separate spreadsheet with data from the Cultural Satisfaction form. Tabular analysis was employed to analyse the extent of engagement and equity of outcomes across ethnicity, gender and referral sources.

The outcome data are measured by responses to OQ (Outcomes Questionnaire), the YOQ (Youth Outcomes questionnaire) and the YOQ-SR (Youth Self Report) before and after treatment, and responses to COM-A (Client Outcome Measure (Adolescent)), COM-P (Client Outcome Measure (parent)), and Cultural Satisfaction form at discharge. We use tables and graphs instead of t-tests to evaluate the differences in measured outcomes before and after treatment when sample size is small.

Findings

Snapshot of progress as at 30 June 2022:

The numbers	119 families have started Pae Whakatupuranga I FFT-CG: **22** are active **42** completed the programme **55** exited early.
Working well	• Improved family communication and dynamics enabling better conversations between young people and their whānau/aiga/families. • The Pae Whakatupuranga interweaving of the Māori and Pasefika frameworks with FFT international is now well established. • The cultural approach to therapy is greatly appreciated by all clients, including Pākehā. • The ongoing cultural training and supervision has developed confidence and skills among the therapists. • Despite difficulties, the programme managed the COVID-19 pandemic isolation period well.
Challenges	• Need to increase frequency and regularity of Pasefika cultural supervision for therapists to better address higher drop out and lower completion rates. • Need to acquire evidential data on very high numbers of 'never began' referrals and on the reduction in referrals during the pilot and increase since.
	MINISTRY UPDATE: As at March 2023 60 people have completed the programme and 61 have exited early[7]*.*

A summary of findings in relation to the six key evaluation questions is set out below.

How well did the programme achieve outcomes for Māori and Pacific Peoples

Over the course of the pilot, 97 cases were closed (i.e., not including the currently active cases because their outcomes are not yet determined). Māori and Pasefika had lower completion rates than Pākehā, being 40% and 31% respectively, while 64% of Pākehā completed by comparison.

The therapeutic course has five stages of treatment: Engagement; Motivation; Relational assessment; Behaviour change; and Generalisation. If we add those who reached the final generalisation stages of the course to those who fully completed, then the Māori rate increases to 50%, the Pasefika to 38%, and Pākehā to 71%.

It should be borne in mind though, that the client base is drawing upon households experiencing serious social, legal and economic difficulties for whom the programme was

[7] Note that exits can be split into two categories: treatment failure (41 exits) applies to whānau who have withdrawn from treatment or had things go wrong during treatment that have led to them not finishing. Exits outside therapist control (20 exits) refers to whānau who have not completed treatment for reasons like moving towns or placed under a custodial sentence.

designed. Furthermore, the Māori and Pasefika referrals are more than two and a half times more likely to be referred for delinquent behaviour than the Pākehā referrals.

Māori and Pasefika whānau and aiga who were interviewed consistently spoke of how the therapy had improved their communication and family dynamics. They referred to finding new ways of talking with each other about their feelings and resolving conflicts. They also spoke of learning ways to discuss hard issues in a safe manner so that the matters did not escalate. The quantitative data showed that many clients began treatment with high levels of distress which were subsequently reduced, particularly for those under 18 years.

The distinctive cultural achievement of the entire programme is demonstrated in the cultural approach to therapy. The Pae Whakatupuranga interweaving of the Māori and Pasefika cultural frameworks with FFT enables the therapists to fully engage in the cultural worldviews, while also drawing on the developed wisdom and experience of the international FFT organisation. Māori and Pasefika clients registered high cultural satisfaction scores and said they felt comfortable and that their cultural values were respected because the therapists understood their ways of doing things.

There is a need to develop more frequent and regular Pasefika cultural training and supervision. As with the Māori cultural supervision, it is appreciated and very helpful for therapists. The proportionally higher drop out and lower completion rates for Pasefika clients indicate the need to increase cultural competence and confidence among the therapists.

Overall, the psychological, social and behavioural outcome measures showed that for 10 to 17 year-olds, 76 percent of parents and caregivers, and 74 percent of the young people reported improvement scores as a result of treatment. For 18 to 25 year-olds, 67 percent of parents and caregivers reported improvements, but only 37 percent of the young people did[8]. On an outcome scale filled in just before discharge, the results also noted improvements. On a scale of 0 to 5 where 0 registers things are worse, 1 registers no change, and 5 registers most things changed successfully, the family dynamic and behavioural change scores of parents and caregivers and the young people ranged between 3.67 and 4.00 (three indicated things were somewhat better, and four that things were a lot better).

Here are the links to the outcome summary tables: Table 5 and Table 6.

What helped or hindered the programme

Things that have helped the achievement of good outcomes are:

1. Improved family communication has enabled better conversations between young people and their whānau/aiga/families around key independence issues of leaving home and participation in education, employment, and training (EET).
2. The culturally interwoven approach has improved therapy for Pākehā and other ethnicities as well as for Māori and Pasefika clients.

[8] Data was only available for eight young people, whereas 27 parents and caregivers reported results.

3. The key attributes of the approach that families identified helped them were:
    i. The focus on the holistic dynamics of whānau/aiga/families rather than just the index client[9]
    ii. The emphasis on minimising blame and using a positive focus that enhances the mana of all people
    iii. The humble approach of the therapists who place themselves alongside whānau/aiga/families without judging
    iv. The commitment and persistence of the therapists to achieve good outcomes for the clients.
4. Teamwork and support from managers have been key to meeting new challenges.

Things that have hindered the achievement of good outcomes are:

1. The referral process and lower caseload, part of which is outside Kia Puāwai control, have under-supplied client families who could have benefitted from the demonstrated success of the programme.
2. Although very good cultural support is available, the less frequent and regular Pasefika cultural training and supervision has somewhat reduced the early momentum of Pasefika cultural learning and engagement with the therapists and Pasefika clients.

Improving the effectiveness of the programme

Consolidating the three matters that helped the programme addressed above will continue to improve effectiveness.

There are two other improvements interviewees suggested that could increase the programme's effectiveness that are worthy of consideration:

1. Developing a post-treatment procedure for young people and whānau/aiga/families who would appreciate it.
2. Matching referrals more with what Kia Puāwai does best. The quantitative data indicates more success with clients under 18 years old. Schools could be looked to as a referral source where young people are either offending or at risk of offending. This is an addition, not a suggestion of neglecting those 18 years and over.

The effect of COVID-19 alert levels on the delivery and uptake of the programme

The COVID-19 pandemic and isolation requirements affected the delivery and uptake of the programme in the following ways:

1. COVID-19 reduced referrals and subsequently caseloads
2. COVID-19 reduced a number of training opportunities for therapists

[9] The term 'index client' refers to the young person referred to the service.

3. The largest impact of the COVID-19 pandemic was on the reduced effectiveness in session delivery. Families often found it difficult to talk about deep personal matters and hold the attention of young clients online or by phone, and the therapists were not able to practice all of the aspects of the manaakitanga they were taught.
4. COVID-19 undermined the flow of information to and from stakeholders, particularly those in agencies who refer clients to the service because of the disruption to their organisations and the service.

Lessons learned about making the programme sustainable

Three key lessons have been learned about making the programme sustainable. These are:

1. Recognising the cultural integrity and subsequent training and supervision that reflects the Pae Whakatupuranga interweaving process is key to programme expansion.
2. The need to study the referral process of the 'never began' treatment category and monitor increases and reductions in referrals to help develop a more targeted and efficient referral system.
3. The data recording and tracking process is unnecessarily complicated because the CSS system used by FFT international is not linked to the HCC system used locally by Kia Puāwai. The CSS system does not record New Zealand ethnicities accurately, nor the sources of referral for participants. There are also other incongruent entries between the systems. It is important that matching data is used on both systems that allows speedy and up-to-date retrieval, and a current dashboard that is congruent with both systems.

Recommendations

Our previous evaluations have made numbers of recommendations, many of which have been taken up by the programme. Given the emerging early maturity of the service and its comparative success, we put forward the following four recommendations.

Prioritising Pasefika cultural training and supervision

The Pasefika cultural leaders have, and continue to contribute a lot to the overall programme. There is a current need to increase the momentum of Pasefika cultural training and supervision for therapists to enhance their cultural capacity and build confidence. An investment of resources and time that prioritises frequent and regular training and supervision at least once a month would enable therapists to work more confidently and effectively in the early interviews in particular. The data shows higher drop out and lower completion rates for Pasefika aiga. Therapists have appreciated the Pasefika training and supervision and would be responsive to further support.

> *MINISTRY UPDATE: Monthly Pasefika cultural sessions are now occurring which is enabling therapists to work more confidently with Pasefika aiga. Access to cultural leadership has grown with the inception of the Matua Council which has provided significant support to the team.*

Study the referral process and diversify strategies with referrers

More than half the referrals are categorised 'never began' because they don't reach the point of a first interview with the service. There are mitigating reasons for at least some of them because their status may change between the referral and contact with Kia Puāwai. However, the number is large and may also relate to uninformed or unsupported referrals. There is a need to gain information on the referral pathways to provide solid evidence on what is happening and how the situation can be improved.

There was also a substantial reduction in referrals during the last year of the pilot, even though they were higher during the main period of the COVID lockdown requirements. We are informed they have increased again since the pilot and this research was completed. There is a need to acquire solid evidence about what is working and what doesn't work in the referral space, so that the process can be more streamlined.

Various innovative strategies have been tried to streamline the referrals and the service will benefit from further work in this area. It could include: liaising with referrers to find suitable programmes and processes within each referring agency to promote the programme and skills of Pae Whakatupuranga | FFT-CG; pointing out to referrers the high level of 'never began' categories and highlighting appropriate referrals; continuing to engage appropriately with referred whānau/aiga/families before starting treatment; ensuring therapists liaise appropriately with referrers about the progress or otherwise of the referred clients; and developing face-to-face and social media communication processes that will enthuse referrers and target appropriate referrals to the programme.

Consideration could also be given to widening the referral network to include schools and the possibility of self-referrals by whānau/aiga/families where young people have offended or are at risk of offending.

> *MINISTRY UPDATE: The number of referrals has recently increased. Kia Puāwai will continue to monitor the 'never began' referrals and provide feedback to their referrers. Some referrals may become inappropriate because the family's situation changes (e.g., the young person absconds). Such changes cannot be anticipated by partner organisations.*

Develop matching data processes between the CSS and HCC systems and comprehensive data entry training for therapists

The current data systems are unnecessarily complicated and not matched which makes the retrieval of monitoring data difficult.

It is recommended that:

a. Outcome data measured by FFT procedures are matched with the correct progress stages (before/after treatment, at completion of treatment), and with the correct client groups (age group), ethnicities, living situations and education as used in New Zealand with consistent entry categories.

b. Matching data is used on both systems to allow speedy and up-to-date retrieval, enabling a current dashboard that is congruent with both systems.

c. Continue to develop comprehensive data entry training providing an understanding of both systems for therapists. This would help ensure that data entry is neither fragmented nor incomplete {with missing values} so that the systems are comprehensive and information is transparent.

MINISTRY RESPONSE: We do not think that the inability to link the CCS system used by FFT to the HCC system used by Kia Puāwai makes the programme less sustainable. Nor do we believe that it impacts our ability to report back on outcomes or other data. This is an issue experienced by many other agencies delivering FFT globally.

Consider developing a post-treatment procedure for young people and whānau/aiga/families who would like it

As numbers of client whānau/aiga/families have suggested, a post-treatment, or various post-treatment, arrangements could be developed. They could take the form of a checking-in process, developing a network of parents or young people, or creating useful activities like those used by FFT therapists that families enjoy. They could provide support for those who have slipped back, and may also offer young people, who would be willing to help others, the opportunity to develop a buddy system.

MINISTRY RESPONSE: The current model allows for booster sessions to be made available to all FFT families for this purpose.

1. WELLBEING AND PILOT INFRASTRUCTURE OUTCOMES

Context

Functional Family Therapy (FFT) is a family-based treatment designed to address young people's behavioural problems and the family context within which they occur. Pae Whakatupuranga | Functional Family Therapy–Cross Generations (Pae Whakatupuranga | FFT-CG) is an adaptation of the original FFT model, which is designed and owned by FFT LLC, a US-based organisation that certifies locations around the world to use the programme.

The Pae Whakatupuranga | FFT-CG therapeutic approach has been co-designed by FFT-LCC and Kia Puāwai, Oranga Tamariki, New Zealand Police and Ara Poutama Aotearoa – Department of Corrections. The programme includes cultural responsiveness to Māori and Pacific Peoples in recognition of the ethnic composition of the target group and in order to weave relevance of Pae Whakatupuranga | FFT-CG in an Aotearoa context. The Steering Group consists of Kia Puāwai and the three referring partner agencies in the programme: Oranga Tamariki; New Zealand Police; and Department of Corrections.

Kia Puāwai are piloting Pae Whakatupuranga | FFT-CG in the Greater Auckland region (including Franklin to the south, Waiheke Island and Wellsford to the north). The pilot has run for three years, from 1 July 2019 to 30 June 2022. It is governed by the Steering Group.

Desired outcomes of the Pae Whakatupuranga | FFT-CG therapeutic intervention include:

- reducing risk of re-offending
- strengthening family relationships
- improving the way family members interact and communicate with each other
- improving family wellbeing by reducing conflict and aggression in the home
- helping young people to stay at home or transition successfully to independent living
- helping young people either stay in school or return to school for education, training or employment (EET).

This evaluation

The Family Centre Social Policy Research Unit (FCSPRU) was contracted by Oranga Tamariki to deliver a high quality, multi-year evaluation (July 2019-June 2022 – extended by eight months because of the impact of the COVID-19 pandemic and the difficulties the provider (Kia Puāwai) had recruiting clients with multiple social and economic challenges) of the Pae Whakatupuranga | FFT-CG programme. This is the final evaluation of the pilot program after the two initial formative evaluations and the first impact evaluation[10].

This evaluation is expected to address three high-level objectives:

(i) To assess how well Pae Whakatupuranga | FFT-CG is being implemented, including its cultural appropriateness in the Aotearoa/New Zealand context, and identify any areas for improvement

(ii) To understand the service's early effect on the wellbeing of young people and their whānau

(iii) To identify key requirements for implementing the service well in other locations (if it is deemed effective).

The primary question for this impact evaluation is: *To what extent has the programme achieved its wellbeing and pilot infrastructure outcomes, by mid-2022?*

Six sub-questions consider specific dimensions of progress towards the outcomes:

1. How well did the programme achieve outcomes for Māori and Pacific Peoples, including the outcomes they wanted to achieve for their whānau/family through FFT-CG?
2. What helped or hindered the programme from achieving its outcomes?
3. What are the unintended consequences of the programme?
4. What has been learned that can improve the effectiveness of the programme in the future?
5. How have COVID-19 alert levels affected the delivery and uptake of the programme, and the programme's intended outcomes?
6. What lessons have been learned about making the programme sustainable?

Of these six questions, number five was added to account for the unexpected (in 2019) COVID-19 pandemic that has had an impact on the overall delivery and achievements of the programme.

[10] The three previous evaluations are available on the Oranga Tamariki website: www.orangatamariki.govt.nz/about-us/research/our-research/fft-evaluations/

Both qualitative and quantitative data and information sources have been used to provide the material for our analysis.

Methodology

This evaluation, the final in a series of four evaluations, employed a mixed-method evaluation strategy comprising both qualitative and quantitative analyses.

The qualitative analysis draws on 20 interviews in total, ten of which were with youth, whānau, aiga and families who have used Pae Whakatupuranga I FFT-CG services, and two were with therapists in focus groups. The remaining interviews consisted of: the Kia Puāwai Kaumātua; Kia Puāwai management (including the Operations Manager, the Practice Lead and the Intake Specialist); the Programme Manager (Oranga Tamariki); and referrers (Police and Corrections) as set out in Table 1.

Table 1. Sample for Wave 4 impact evaluation qualitative analysis

	Type of interview	Number of interviews	Number of persons
Kia Puāwai Kaumātua	Individual	1	1
Kia Puāwai Management	Individual	3	3
Programme Manager (Oranga Tamariki)	Individual	1	1
Therapists	Focus group	2	5
Young people/whānau/family	Family	10*	18
Stakeholder – Police	Individual	1	1
Stakeholder – Corrections	Individual	2	2
Total		**20**	**31**

* 3 Māori, 3 Pasefika and 4 Pākehā

The interviews were conducted between 4 April and 8 October 2022. The ten interviews with client families were conducted with three Māori whānau, three Pasefika aiga, and four Pākehā families remotely via Zoom or telephone. They represent the three largest client bases of Pae Whakatupuranga | FFT-CG. Remote interviewing was used as a health safety measure because of the ongoing impacts of the COVID-19 pandemic.

Interviewers and interviewees were matched culturally for the interviews with whānau, aiga and families. Interviews with management, therapists, the kaumātua and stakeholders were also conducted by Zoom or phone.

The provider (Kia Puāwai) recruited as many clients as they could engage for interviewing. However, the resource and housing pressures on many of the clients, and the difficulties low-income households often have in affording and accessing online technologies, prevented numbers of families from engaging with the evaluation. This also explains why the interviews took place over an extended six-month period, in order to maximise the number of participants.

The quantitative analysis interrogated the data stored in the FFT- LLC database (CSS), Kia Puāwai database (HCC), Outcome Questionnaire website, and in a separate spreadsheet containing data from the Cultural Satisfaction form. Tabular analysis was employed to analyse the extent of engagement and equity of outcomes across ethnicity, gender and referral sources. Results are illustrated by graphs and tables in this report.

The sample of clients for whom quantitative data is available has increased from 66 in the previous evaluations to 119 client whānau, aiga or families. While still a modest sample over the three-year period of the evaluation, it should be borne in mind that the programme was designed for clients and households experiencing serious social, legal and economic difficulties. Furthermore, the COVID-19 pandemic which began around eight months into the programme, impacted clients' ability and willingness to engage in online or phone therapy sessions. The sample size limits the generalisability of the results, but is sufficient to provide an indicative analysis.

The outcome data are measured by responses to the OQ (Outcomes Questionnaire), the YOQ (Youth Outcomes questionnaire) and the YOQ-SR (Youth Self Report) before and after treatment, and responses to COM-A (Client Outcome Measure (Adolescent)), COM-P (Client Outcome Measure (parent)), and Cultural Satisfaction form at discharge. We use tables and graphs instead of t-tests to evaluate the differences in measured outcomes before and after treatment when sample size is small. Appendix 1 provides details about our data sources, analytic methods and examples of the questionnaires and forms listed above. Below is the programme's impact in each of the areas for outcome investigation (outcomes for Māori and Pasefika, what helped or hindered progress, unintended consequences of the programme, improving programme's effectiveness, COVID-19 impacts, and lessons learned).

Overview of findings

The findings of this evaluation are set out systematically to respond to, and answer, to the extent possible, the six key evaluation questions, which together answer the primary question for this impact evaluation which is:

To what extent has the programme achieved its wellbeing and pilot infrastructure outcomes, by mid-2022?

1.1 The overall summary of referrals, engagement, ethnicity, participation and continuity within the Pae Whakatupuranga I FFT-CG programme

1.2 Outcomes for Māori and Pasefika: Communication and whānau dynamics

1.3 Outcomes for Māori and Pasefika: Conflicts and family relationships

1.4 The cultural approach to therapy

1.5 Young people's living situation and their education or employment

1.6 What helped or hindered the programme from achieving its outcomes?

1.7 COVID-19 and its impact on delivery and uptake of the programme and intended outcomes

1.8 Unintended consequences of the current programme implementation

1.9 Improving programme effectiveness.

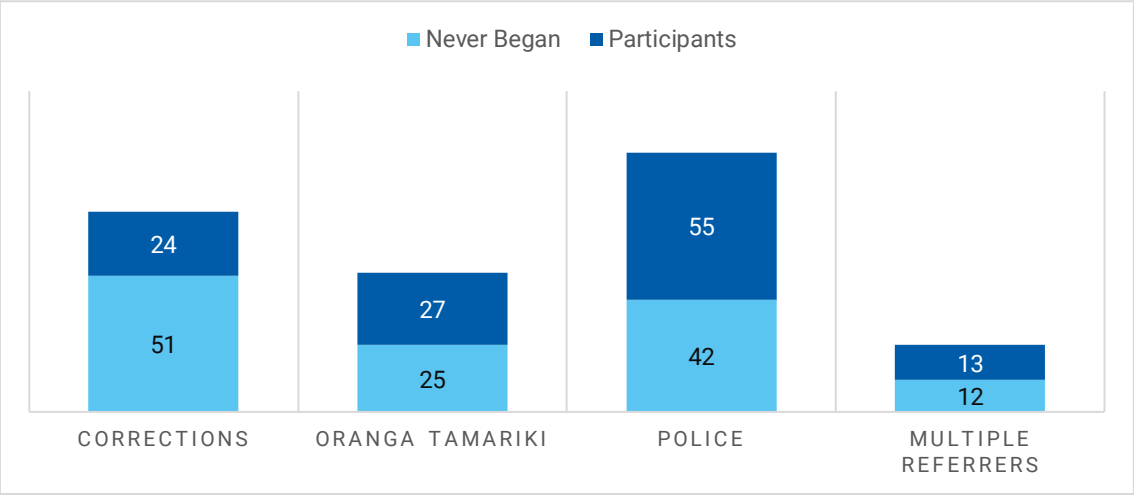
1.1 Referred and participating clients

Referral process

In total 249 referrals were made during the pilot, but only 119 participated in the programme. (Caution should be used when assessing the high non-participation rate. It stems from the US CSS monitoring system that may have a different application in New Zealand, as Table 2 later in this section illustrates). Figure 1 divides the total referred clients into the number of participants in the programme and those who did not commence the programme ('Never Began') during the pilot period.

The Police provided the largest source of referrals and had the highest participation rate (55 out of 97 cases or 57%). Corrections referred more cases than Oranga Tamariki (75 cases and 52 cases respectively) but had a lower participation rate than Oranga Tamariki (32% and 52% respectively). Recently, multiple referrers also contributed to the sources of referral for the pilot programme.

Figure 1. Sources of referrals and number of never began cases versus participating cases

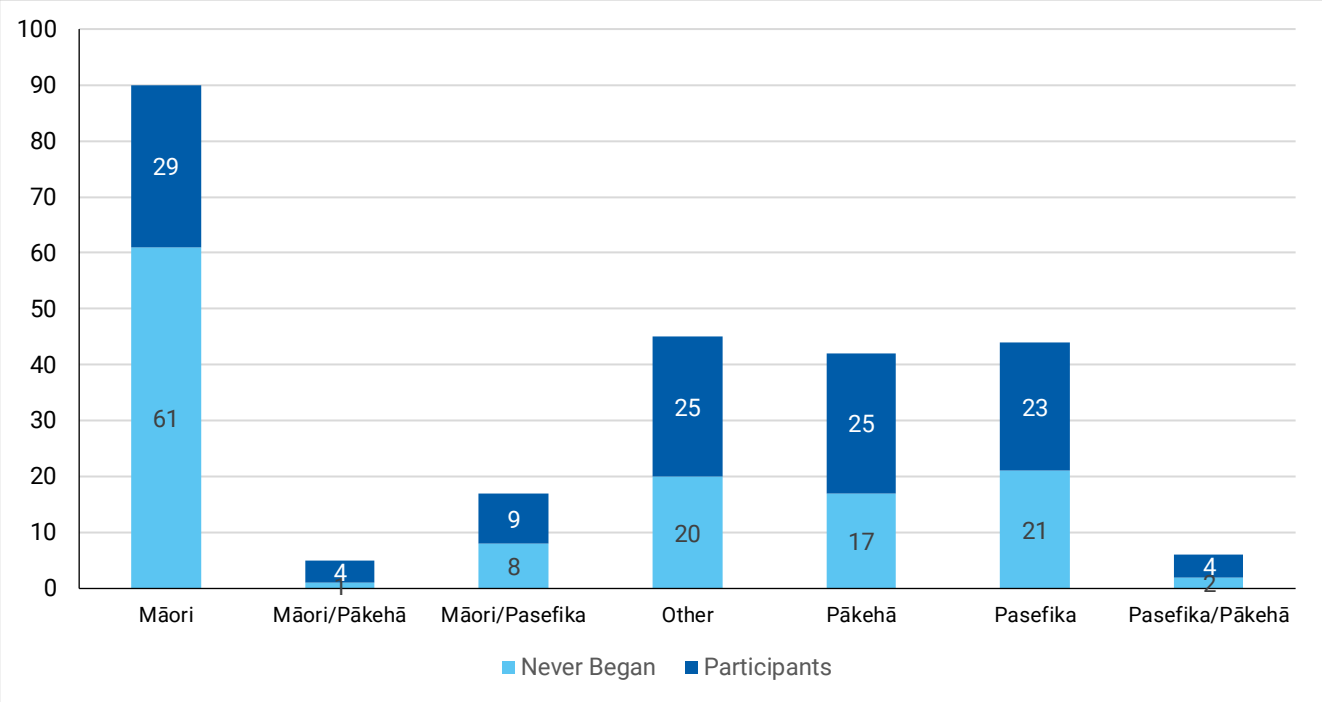


Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

In this evaluation, in addition to the three cultural groups of Māori, Pasefika and Pākehā identities, we considered those with dual cultural identities. Māori clients were the largest cultural group in the referring process (Figure 2). The total number of referred Māori clients was 90 when single identity is considered, and 112 when dual identities are considered. Pasefika clients were the next largest group, totalling 44 when single identity is considered and 67 when dual identities are considered. Pākehā clients made up the third largest group referred to the programme, totalling 42 when single identity is considered and 57 when dual identities are considered.

However, the participation rates were not the same for the three groups. The Māori group had the lowest participation rate of 32% when single identity is considered, and 38% when dual identities are considered. The participation rates for the Pasefika group were higher, at 52% and 54% respectively. Pākehā had the highest participation rates of 60% when single identity is considered and 58% when dual identities were considered.

Figure 2. Ethnicity of referred clients and number of never began cases versus participating cases



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Table 2 sets out the most common reasons for not participating in the programme. The results suggest the referral criteria are not well understood by the referring agencies because for 22% of referrals, the criteria for acceptance into the programme were not met and they were triaged elsewhere. A further 38% of potential clients were either referred to different services or withdrawn from the programme. The combination of these two categories means 60% of potential clients did not begin treatment. However, in the New Zealand context these people, and the 12% who were not able to be contacted, would not normally be counted as potential clients who failed to engage in treatment. As noted above, this suggests the US CSS monitoring system may have a different application in the US context than it does in New Zealand.

The other substantial reason for potential clients not beginning treatment was because they declined the services (19%). This reason would be counted as failure to engage in the New Zealand context.

Table 2. Reasons for clients never beginning treatment

	Corrections	Multiple referrers	Oranga Tamariki	Police	Total 'Never Began'	(%)
Criteria not met	13	2	5	9	29	22
Declined services	6	4	1	14	25	19
Placement into youth justice system	1				1	1
Not able to contact	7	3	2	3	15	12
Moved out of service area	1	1		1	3	2
Withdrawn referrals/Referred to different services	23	1	14	11	49	38
COVID-19 related			1		1	1
Others		1	2	4	7	5
Total					**130**	**100**

Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

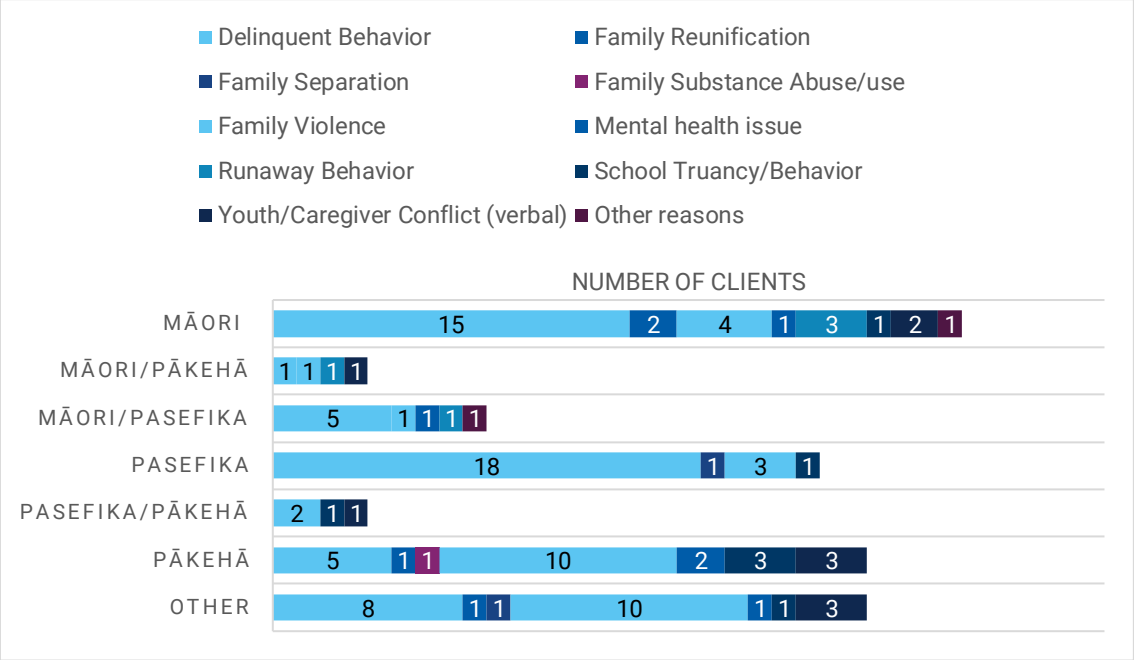
Participation process

As of 31 July 2022, 119 clients and their whānau/aiga/family had participated in the programme. Figure 3 gives information on the ethnicity of the clients referred to Pae Whakatupuranga I FFT-CG and their reasons for using the service. Clients with more than one identity were recognised by their indication of two of the three major ethnic groups: Māori, Pasefika and Pākehā.

Compared to the previous impact evaluation, among those who have only one identity, the proportion has changed to reflect a slight reduction in Pasefika participation with 23 participants (19 percent) and a corresponding slight increase in Pākehā participation with 25 participants (21 percent). Those identified as Māori only remain the largest group with 29 participants (24 percent). Nine clients identified themselves as both Māori and Pasefika; four as both Māori and Pākehā and four as both Pasefika and Pākehā.

When dual identities are considered, Māori and Pasefika peoples are the two largest groups of the programme's client base, with Māori accounting for 35 percent and Pasefika 30 percent. Pākehā comprised the third largest group, with 28 percent. There were 25 families who were not identified with Māori, Pasefika or Pākehā cultural heritage and they were classified as other ethnicities. These clients include three Asian families, two African families and 20 other families.

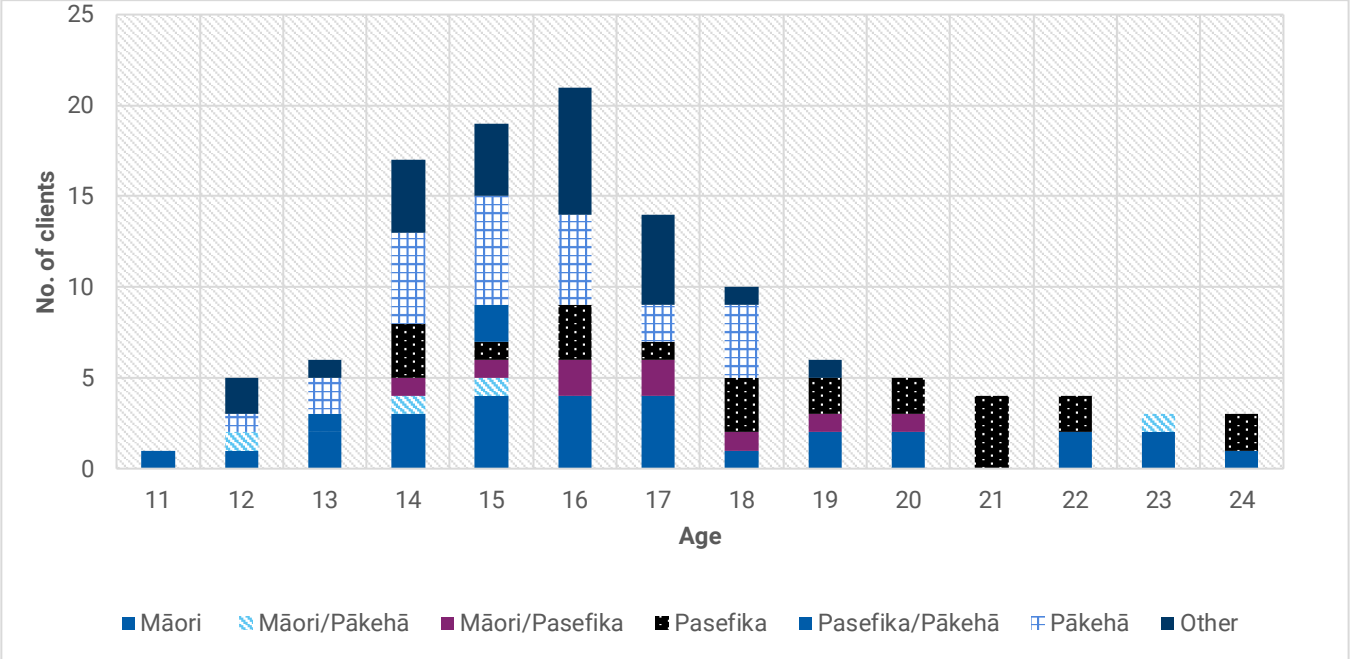
Figure 3. Reasons for being referred to the service by ethnicity



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Overall, the majority (70 of 119) of clients referred to the programme were under 18 years old. Figure 4 shows that Māori and Pasefika clients are between 11 and 25 years old. In contrast, Pākehā are mostly under 18 years old

Figure 4. Age and ethnicity of clients referred to the programme



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Table 3 shows clients' progress at the end of the pilot Pae Whakatupuranga I FFT-CG. As of 31 July 2022, 42 whānau/aiga/family had completed cases, 19 cases are still receiving treatment (Active)[11] and 55 did not complete their treatment programme (Dropped out). This table excludes those who never engaged (never began cases).

Table 3. Ethnicity and treatment status of clients as of 31 July 2022

	Completed	Dropped out	Active	Total number	Completed %	Dropped out %	Active %
Māori	11	15	3	29	38%	52%	10%
Māori/ Pākehā	1	2	1	4	25%	50%	25%
Māori/ Pasefika	3	4	2	9	33%	44%	22%
Pasefika	5	15	3	23	22%	65%	13%
Pasefika/ Pākehā	1	1	2	4	25%	25%	50%
Pākehā	16	7	2	25	64%	28%	8%
Other	5	11	9	25	20%	44%	36%
Total number	**42**	**55**	**22**	**119**			
Total (%)	**35%**	**46%**	**18%**				

Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

MINISTRY UPDATE: As at March 2023 60 people have completed the programme and 61 have exited early[12].

The Pākehā group had the highest completion rate of 64%, much higher than any other ethnic groups when single identity is considered. The two targeted client groups of Māori whānau and Pasefika aiga showed lower completion rates of 38% and 22% respectively.

When dual identities are accounted for and the active cases are excluded (because there is not yet a final outcome for them), those with at least one identity as Pākehā still achieved the high completion rate of 64%, followed by those identified as Māori of 42%, and those with at least one identity as Pasefika of 31%.

Overall, less than half the participants in the programme did not complete their treatment. 43% (42 of the 97 finished non-active cases) had completed at the end of the pilot programme. These numbers need to be understood in the context of a pilot programme tackling one of the most challenging social issues in Aotearoa, that of youth offending and the disproportionate sentencing and incarceration of young Māori.

Table 4 lists the reasons why clients did not complete their treatment, disaggregated by ethnicity. The most common reason was due to clients not engaging with therapists after attending one to several sessions (32 out of 55 cases). The proportion of clients making this choice was higher for Pākehā groups (7 out of 10 cases) and Pasefika group (11 out of 16

[11] Three active cases were near completion, pending administrative closure.

[12] Note that exits can be split into two categories: treatment failure (41 exits) applies to whānau who have withdrawn from treatment or had things go wrong during treatment that have led to them not finishing. Exits outside therapist control (20 exits) refers to whānau who have not completed treatment for reasons like moving towns or placed under a custodial sentence.

cases) when dual ethnic identities were considered. By comparison only 11 out of 21 Māori clients made this choice when dual ethnic identities were considered.

The next two most common reasons were not the client's choice, but the recognition that another programme would be more suitable (9 out of 55 cases), and the fact that clients moved and could not be contacted (7 out of 55 cases). In the event of COVID-19 it is interesting to note that only three Māori whānau stopped treatment because they did not want to participate in a virtual mode. Other reasons were due to the living condition of the young person that prevented therapists from organising family therapy (two clients ran away from home and two were placed into different care systems).

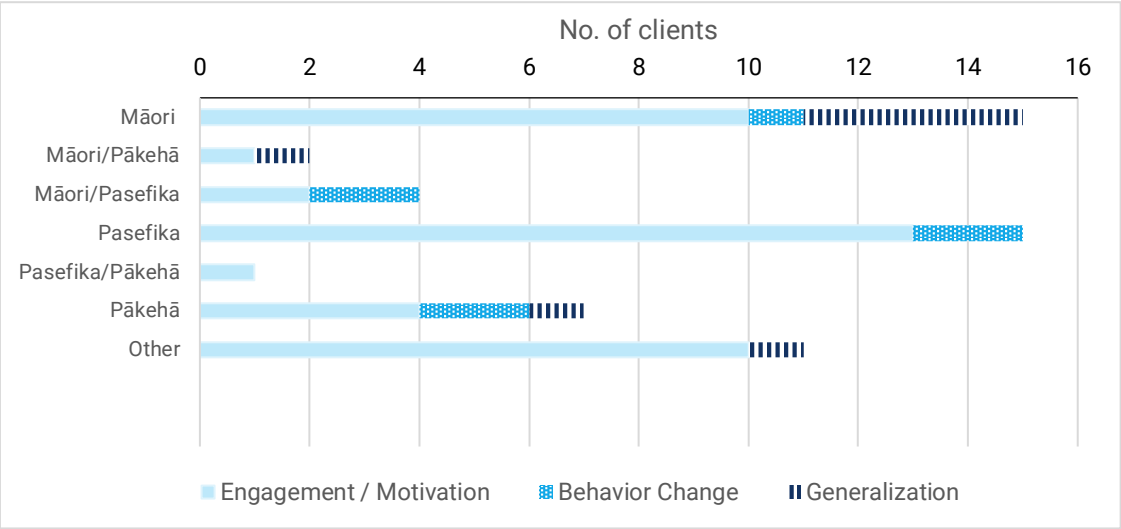
Table 4. Ethnicity and reasons for dropping out

	Extended period of youth running away from home	Moved out of service area	Placement into justice system or other care system like foster care	Quit after attending one or more sessions	Youth referred to more appropriate services after participation	Refused tele-session	Total
Māori	1	3		7	1	3	15
Māori/ Pākehā				2			2
Māori/ Pasefika		1	1	2			4
Other		1	1	6	3		11
Pākehā		1		4	2		7
Pasefika	1	1		10	3		15
Pasefika/ Pākehā				1			1
Total	**2**	**7**	**2**	**32**	**9**	**3**	**55**

Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Figure 5 compares the number of dropped-out clients who reached different treatment stages across different ethnic groups. Seven of them reached the final generalisation stage (four Māori, one Māori/Pākehā, one Pākehā and one other). The majority who quit were still in the engagement/motivation/relational assessment stages (41 out of 55 cases). It is however worth noting that for the seven families who reached the behaviour change stage and the further seven who reached the generalisation stage in particular, they may have been helped such that they considered they could manage on their own.

Figure 5: Completion stages for those who did not complete treatment (dropped out)



Source: CSS data (1 Jun 2019- 31 Jul 2022). Accessed 04 Aug 2022.

1.2 Outcomes for Māori and Pasefika: Communication and whānau dynamics

As identified in the previous impact evaluation, the most evident outcome for Māori whānau and Pasefika aiga was the distinct improvement in communication among the members. Qualitative interviews revealed turning points for resolving conflicts by having family members talk to each other about how they felt during therapeutic sessions, which subsequently enabled achievements of perception and behavioural changes that are conducive to the programme's intended outcomes. This outcome is also the most frequently expected by interviewed whānau/aiga.

Māori whānau

One Māori mum described how much she enjoyed having her children get together and go over how things were for them during the day. The sessions amazed her in hearing how her kids were feeling proud of her, and brought her peace in knowing that her son – the index client –could finally open up himself.

> *I didn't realise how proud my kids were of me. I didn't realise that they really do look up to me, but they were proud of me for my achievements and how far we have come.*
>
> *I think just the way [the therapist] got us to open up and talk about the things that we didn't usually talk about and got everybody's thoughts and insights about how we felt about it. We were all saddened and shocked and all affected by the incident. For me, it gave me closure and gave me peace of mind that [son] had to struggle with it mentally and to know that he knew that he did make a mistake. It wasn't an intentional thing for him to go out and hurt somebody that day. It helped us to talk openly about it and accept it.*

I love having therapy sessions, all of it. I expressed how fortunate and blessed I felt to have us all together and how I like knowing what was on their minds and how they felt. (IEW2 Mā #1)

I learn how to, try to learn how to talk about or speak about how I'm feeling and stuff like that and. I don't know. I'm still learning a few things on the way (IEW2 Mā #1 Son)

Another whānau confirmed improvement in their young person's behaviours.

Interviewer: so what in particular do you think has been sorted out?

Mum: Well. Attitude and behaviour.

Interviewer: like, was he getting negative or defiant to you previously?

Mum: Yeah

Interviewer: And is it improved?

Mum: Yes, it has. She [therapist] did an excellent job (IEW2 Mā #2)

Pasefika aiga

Pasefika aiga also described how they expected to improve their communication and how they have achieved it through the programme. One Pasefika aiga entered the programme with a lot of positive hopes. They were keen to seek help, they "wanted everything to work out right". They accepted the strategies and the methods that would help them to communicate better both as a couple and as a wider family group. The dad wanted his son, who is now a young parent, to get help with some skills needed in order to form a safer communicative partnership and to ensure the children were going to live in a more stable home.

We wanted everything to work out right, to get better communication with each other, and it has. We got all the supports, and everything came together, everyone took it seriously. All the hopes have worked out for us (IEW2 Pas #2)

Another interviewed aiga also felt great achievements in improving relationships after participating in the programme. This aiga developed a strong bond with the therapist, and her support and guidance enabled members to face each other and to work things out together.

We came in open minded and was surprised with what was achieved. It was all good. I could not have achieved so much without [therapist]. My son and I bonded more having her there. She made us feel comfortable and that helped us to relax and open up more (IEW2 Pas #3)

Another aiga however did not respond with as much positivity. They did acknowledge the definite improvement in communication.

Definitely communications have been improved, we went from fighting hard out to communication being a lot better now. (IEW2 Pas #1)

This Pasefika aiga, however, had other expectations and felt that the programme could not help with mental health issues that her daughter was experiencing. Their issues were not resolved.

> *Things have gotten better with us in our relationship but there are mental health issues that therapy can't fix.*
>
> *My relationship with my daughter was so complex and there were times I wanted to bail out from Kia Puāwai because it was mixed with mental health needs, so it was hard to explain because they focused on behavioural change, but from my perspective it required a more complex and sophisticated skill level. My mental health started going down because of the situation.* (IEW2 Pas #1)

Managers' perspectives

The managers at Kia Puāwai confirmed the general feedback from whānau/aiga about improving interaction and communication among members.

> *The outcomes have been significant. There has consistently been a shift in the right direction. Families are just able to talk about the hard things and without escalation. They can actually hear and understand each other's perspectives a little bit better. There's less negativity and there's more of a relational focus. They are holding each other rather than blaming each other.* (IEW2 Management 3)
>
> *I heard some comments from families saying that they've really enjoyed it. I think it was one comment to me from a Pākehā dad who had a Māori son saying they've really enjoyed it and they've started to connect a little bit with whānau through tikanga.* (IEW2 kaumātua)

As participants in the programme tend to be living in whānau/aiga who were experiencing serious problems in communicating, these reports from families and staff indicate the programme is working effectively for them. One of the managers highlighted the difficulties many of the whānau face and how profound she considered the therapy was in its ability to turn the dynamics around for traumatised clients.

> *I would say [the programme is] very effective. The cohort we were engaging was the most complicated. We weren't looking for the easy whānau who connect to each other, who communicate well. We were looking for the ones who were the most complicated, who struggled the most to make the right choices. And for those ones, it's made profound differences. Those therapists have made really significant differences when they start talking to us about different cases and different people that they had seen and how their family is now working differently. And, you know, they would call and ask the therapist to come. People keep connecting and be a part of them. So once they created that relationship, whānau, didn't want to let it go.* (IEW2 Management 2)

The view that the families being referred to Kia Puāwai in this programme were very challenging was shared by stakeholders from Police and Corrections. The stakeholders described how the clients referred to Pae Whakatupuranga | FFT-CG often had been

traumatised by social and economic circumstances that prevented them from engaging in the therapeutic intervention programme.

> *The family would have been the biggest barrier to taking on board. They are at the high risk extreme – all of the kids are in courts. The family just weren't ready to receive the help in family dynamics or communication. They didn't really place the programme a high priority compared to trying to find a stable accommodation, finding a proper home with furniture and all the family home jobs that were happening at their house.* (IEW2 Stakeholder 1 Police)

> *The kind of client base that we would have would be at the far end. They come to us in the most traumatised, damaged, disengaged form and are harder to reach or harder to work with.* (IEW2 Stakeholder 2 Corrections)

Given this special characteristic of the Pae Whakatupuranga | FFT-CG another manager placed this programme high in terms of achieving outcomes for whānau/aiga.

> *Although their completion rates aren't as high as some other FFT teams they're working with more complex whānau and when they do complete, they are getting those outcomes that they should be getting. So I do find FFT-CG to be one of our most effective therapeutic interventions.* (IEW2 Management 1)

1.3 Outcomes for Māori and Pasefika: Conflicts and family relationships

Conflicts have been reduced and family relationships have improved

With improved communication, both therapists and whānau/aiga acknowledge the reduction in conflicts and the strengthening of relationships between members. Therapists described how whānau/aiga started coming together, especially when they talked about hard issues. Whānau/aiga members realised they now could talk about these matters in a safe way so that things would not escalate. They now 'had each other's back' and could all effectively work on these challenges.

> *Feedback has been lowering reoffending and lowering conflict and whānau are much better able to come together and talk about the hard stuff so things don't escalate. They know they have each other's back so they gain confidence about working through things together.* (IEW2 Therapist #1)

Māori whānau

One whānau Mum described how the mutual trusting relationship was developed between her and her children during the sessions.

> *And the family sharing time helped them a lot. It gave them an open room to discuss anything that they didn't share much before. They know that it's a safe place to come to if they ever needed to talk. I was there, seeing them get that information, knowing that they know that, it helped a lot.* (IEW2 Ma #1)

Pasefika aiga

Similarly, two out of three Pasefika aiga reported great improvements in reducing conflicts and improving relationships among aiga members.

> *Our relationship with my son was able to be built. We made it a family thing, and we don't often have that because we don't have the time and it turned out to be a good time for us and we had a lot of laughs which we don't often have.* (IEW2 Pas #3)

> *Issues in the relationship have been really sorted out. [Young person] is not playing games all the time any more.* (IEW2 Pas #2)

One Pasefika aiga however, did not consider their main problem was resolved. The mother felt her daughter was still prone to violent outbursts, destructive behaviours as well as abusive language towards her. She thought these were mental health matters that the therapist did not deal with.

> *[Young person] drove me nuts. I didn't feel listened to. At times I felt I was being tag teamed by [therapist] and my daughter. Sometimes teenagers can be manipulative…and there were times my daughter would say stuff that wasn't true*. (IEW2 Pas #1)

She considered the therapy only dealt with the superficial problems between her and her daughter.

The quantitative report data

In general, the quantitative data provides support for this qualitative feedback. Outcome data for all ethnicities measured by YOQ (Youth Outcomes Questionnaire), YOQ-SR (self-report Youth Outcomes Questionnaire), COM-A (Client Outcome Measure – Adolescent) and COM-P (Client Outcome Measure – Parent) give positive feedback on youth behaviours from their parents and from their own reflection. In this quantitative analysis we present outcome data of Pākehā and other ethnicity groups to compare with Māori and Pasefika groups. Appendix 1 provides details of the questionnaires used in these outcome measures.

Figure 6 gives the data on YOQ total scores, reported by parents and caregivers about the behaviour of their children. This only includes parents and caregivers of children in the 10- to 17-year-old age range. In total we have 34 data points of YOQ total scores for the 24 completed cases that have both pre-treatment scores (horizontal axis) and post-treatment scores (vertical axis). They are five Māori, one Māori/Pākehā, two Māori/Pasefika, one Pasefika, eleven Pākehā, and four other ethnicities. Data for Pākehā and other ethnicities are presented here for comparison.

To ease understanding, the following figures 6 to 9 firstly set out the scores for all responses, and then follow with the ethnic scores within the total sample in the following order Māori, Pasefika, Pākehā, and (where applicable) Other. Where there is dual identity, both are recorded.

The data points are larger than the completed number of clients because some clients had feedback from both of their carers/parents. Graphs for each ethnic group are presented to

avoid having scatter dots with more than one response on the same score point, making it difficult to see ethnic differences on the same graph.

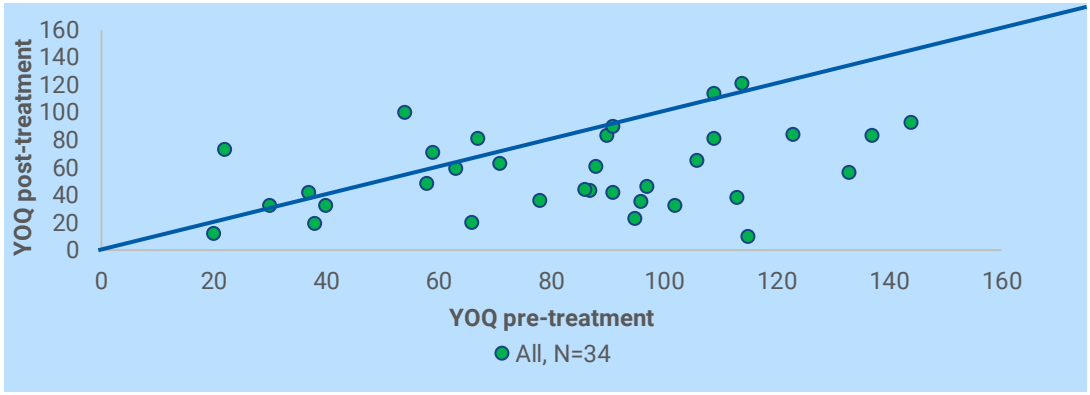
In Figure 6, the diagonal line divides the graph into the area where there is improvement (below the line) and the area where there is deterioration (above the line). The diagonal line in each graph corresponds to the data point where post-treatment scores would be the same as pre-treatment scores and no change would have occurred.

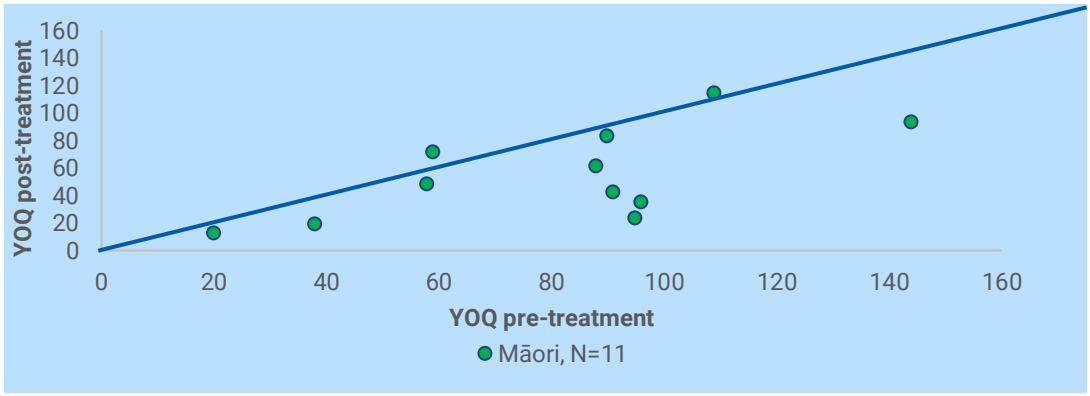
The YOQ total score is the sum of six sub-scores in the YOQ-SR: critical items (those that may necessitate clinical follow-up); intrapersonal distress; physical and/or somatic concerns; interpersonal difficulty; social behaviour; and behavioural dysfunction.

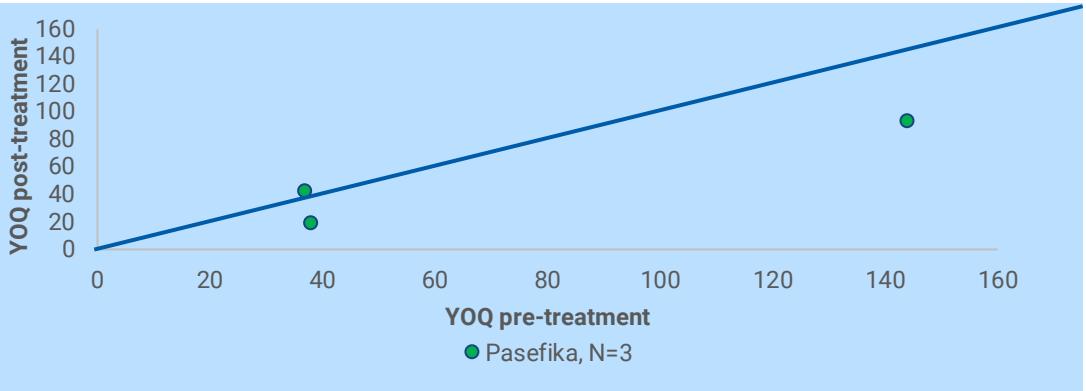
The higher the total score, the more critical the situation. The levels of distress for the YOQ are described as follows: high is a score greater than 99; moderately high is a score between 80 and 99; moderate is a score between 48 and 79; and low is a score less than 48. The cut-off point for the total YOQ score is 48. Total scores of 48 or higher are considered to be clinically significant: they reflect the parent or caregiver's perception that their child is experiencing a significant level of distress.

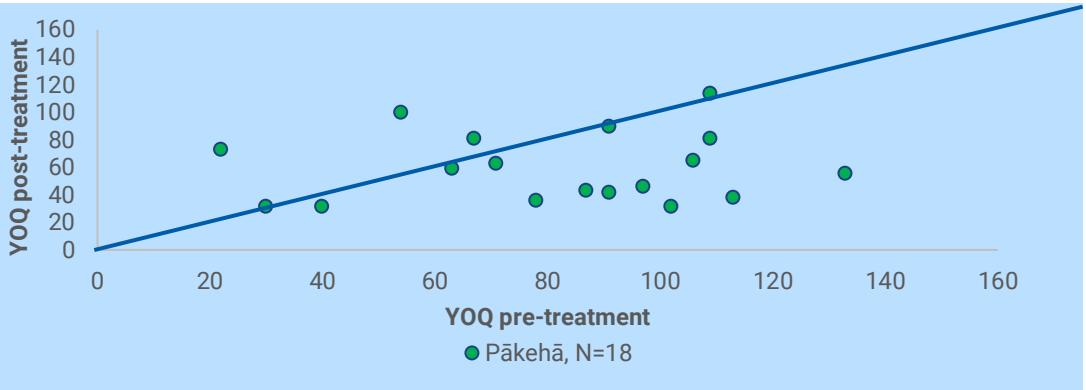
The pre-treatment YOQ total score distribution (the place on the horizontal axis immediately below each dot in figure 4) is high with 28 out of 34 observations above the cut-off score of 48. This highlights the challenging circumstances and experiences of the programme's clients, as was noted in the qualitative analysis.

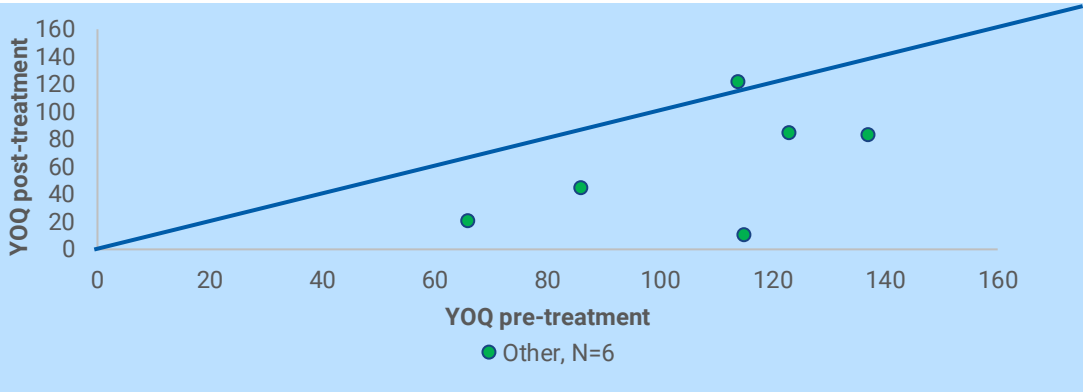
Figure 6. YOQ total scores before and after treatment (N=34)











Source: OQ analyst website (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Although there are cases where the after-treatment scores are higher than pre-treatment scores (those lying above the diagonal line), the majority of the data points lie below the diagonal line, implying an overall improvement in the young person's situations after participating in the programme. 76 percent of parents and caregivers reported improvement. Further, we performed a t-test of the 34 data points and found a highly significant decrease in the average treatment scores from 83.21 before to 56.82 after, with t-stat = 0.0001.

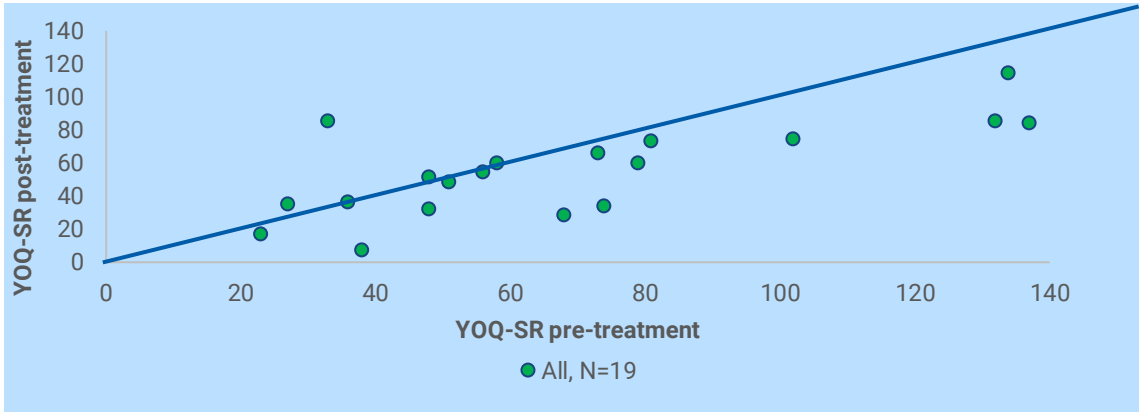
Figure 7 shows the scatter plot of YOQ-SR total scores of 19 completed cases that have both pre-treatment scores (horizontal axis) and post-treatment scores (vertical axis). They show the self-report scores of youth in the 10- to 17-year-old age range. The responses were provided by five Māori, one Māori/Pākehā, one Māori/Pasefika, one Pasefika/Pākehā, eight Pākehā, and three other ethnicities. As with Figure 6, where there is dual identity, both ethnicities are recorded.

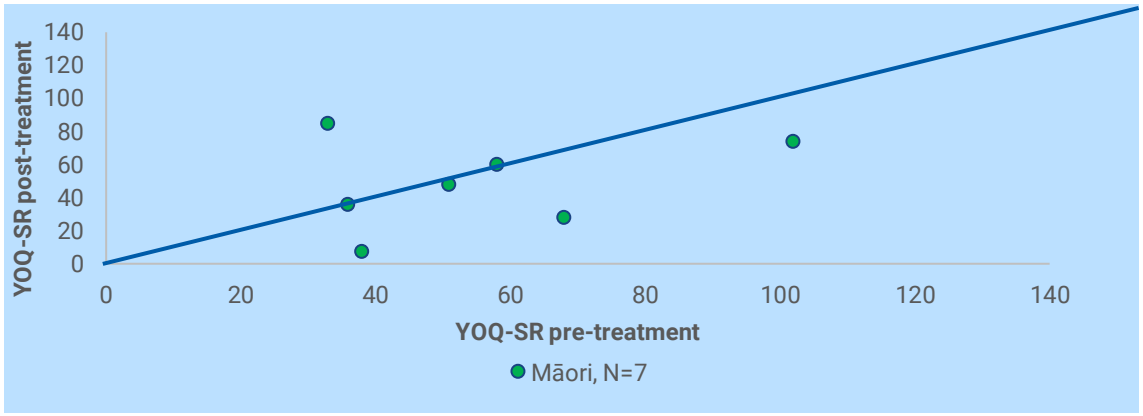
The design of Figure 7 is the same as Figure 6, with graphs for different ethnic groups. The YOQ–SR total scores were calculated using the YOQ-SR questionnaires completed by the young people who are under 18 years old about themselves. The total score is the sum of six sub-scores: critical items (those that may necessitate clinical follow-up); intrapersonal distress; physical and/or somatic concerns; interpersonal difficulty with parents, caregivers, adults, and/or peers; social behaviour that violates norms; and behavioural dysfunction (difficulty with attention, concentration, or management of impulsive behaviour).

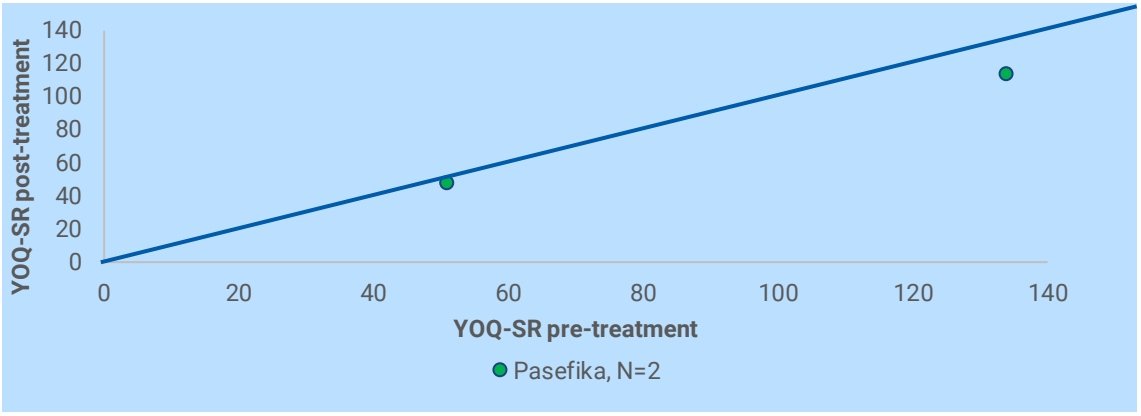
The higher the total score, the more critical the situation. The levels of distress are described as follows: moderately high is a score greater than 67; moderate is a score between 67 and 48; and low is a score less than 48. As with YOQ, the cut-off point for clinically significant distress is a total score of 48. Total scores of 48 or higher are clinically significant: they indicate that the adolescent is experiencing a significant level of distress.

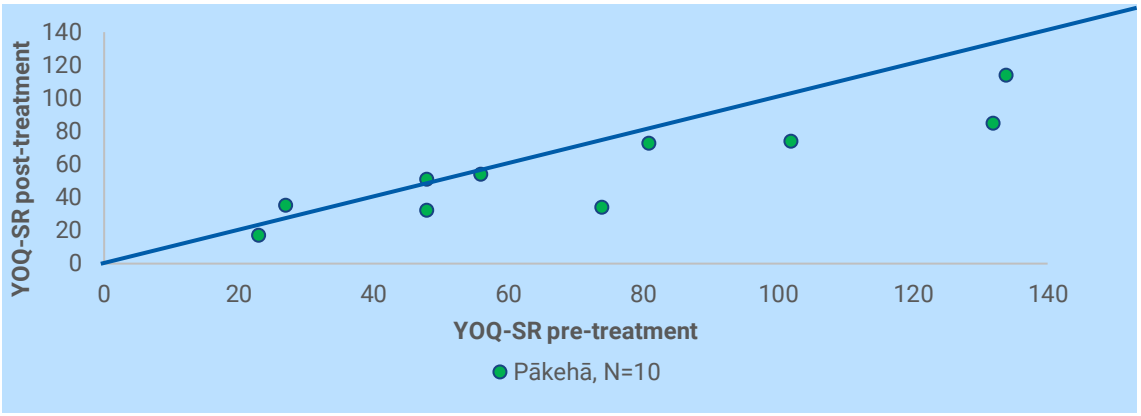
Given the cut-off of 48, the majority of the pre-treatment score observations (14 of 19) have moderate levels of distress that were considered to be clinically significant. The pre-treatment score data highlights the challenging circumstances and experiences of the programme's clients as noted earlier.

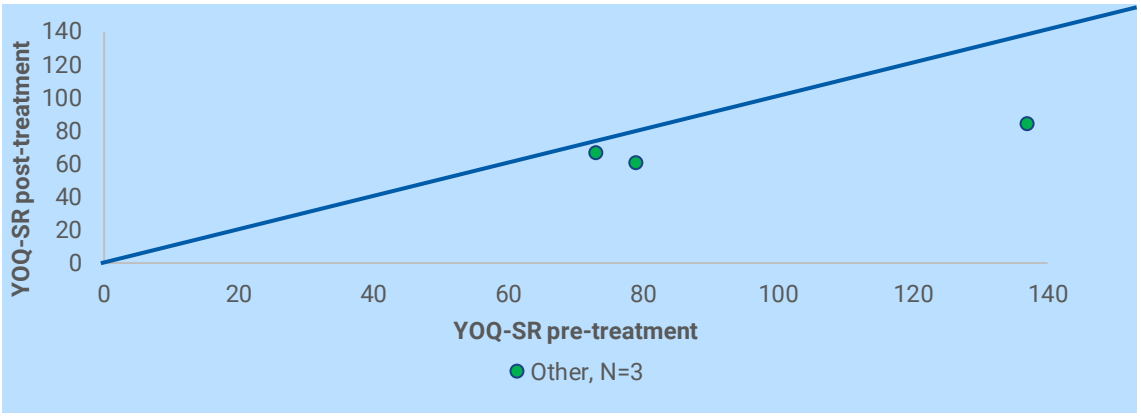
Figure 7. YOQ-SR before and after treatment (N=19)











Source: OQ analyst website (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Similar to the parents' and caregivers' results, the majority of YOQ-SR scores are under the diagonal line except for one Māori case and one Pākehā case, indicating that the treatment had lowered distress levels among the index clients. 74 percent reported improvement. The lower the data points, the more distress levels have been reduced and the better the behavioural outcomes. It is difficult to establish differences between ethnic groups due to data size limitation.

It is noted that YOQ and YOQ-SR are for clients under 18 years old but several index clients were older than 17 at the time of test administration.

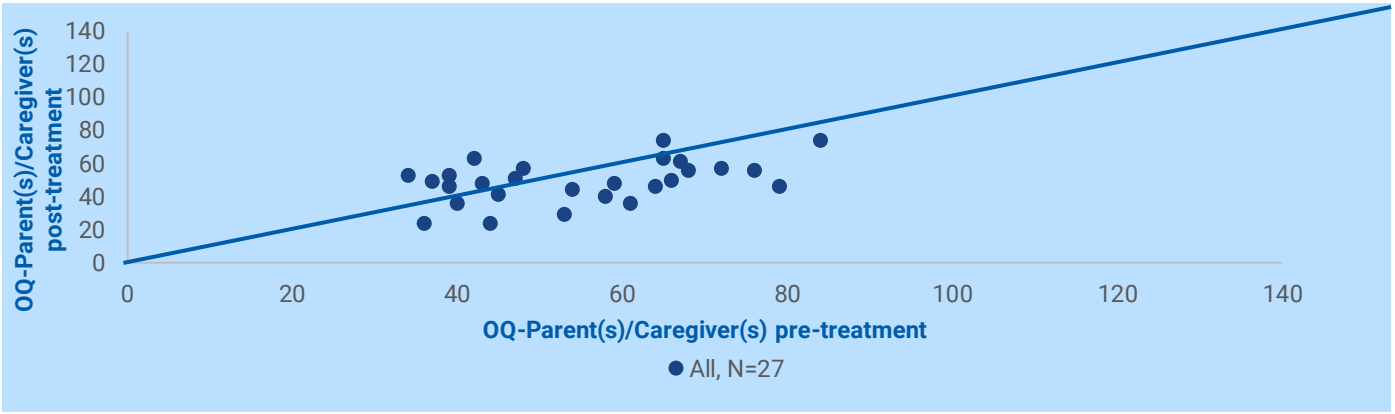
Figure 8 provides self-reported OQ scores of parents/caregivers whose children were over 17 years old at treatment completion and Figure 9 gives self-reported OQ scores by young people who are over 17 years old.

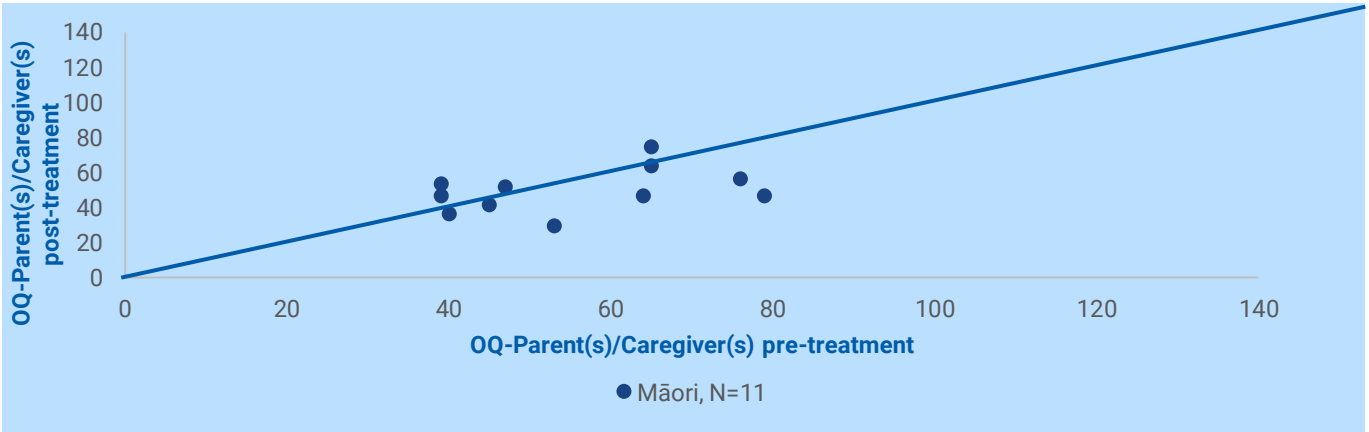
The total score is the sum of three sub-scores: Symptom Distress (discomfort related to intrapsychic symptoms of depression, stress, and anxiety); Interpersonal Relation (friction, conflict, inadequacy, and withdrawal in friendships, family, and partnerships) and Social Role (dissatisfaction, conflict, distress, and inadequacy in performance of tasks related to employment, school, family roles, and leisure life). The higher the total score, the more critical the situation. The levels of distress are described as follows: high is a score of 106 or higher, moderately high is a score between 83 and 105; moderate is a score between 64 and 82; and low is a score less than 64. The cut-off point for clinically significant distress is a total score of 64. Total scores of 64 or higher are clinically significant: they indicate that the adolescent is experiencing a high number of symptoms, interpersonal difficulties, and decreased satisfaction and quality of life. Similar to previous graphs, the further the scatter dots are under the diagonal line, the more improvements in total scored were recorded.

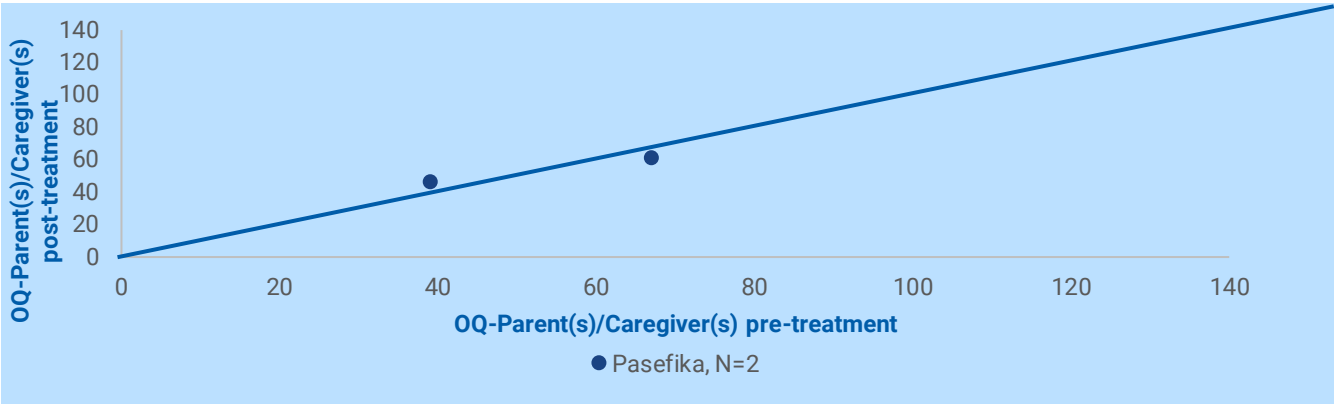
We have considerably more OQ data completed by parents and carergivers (n = 27) than we have for the young people (n = 8 set out in Figure 9). For the parents and caregivers, the decreases in scores are more pronounced than those assessed by the young people, with 18 out of 27 data points under the diagonal line (67 percent) indicating improvement as a result of treatment.

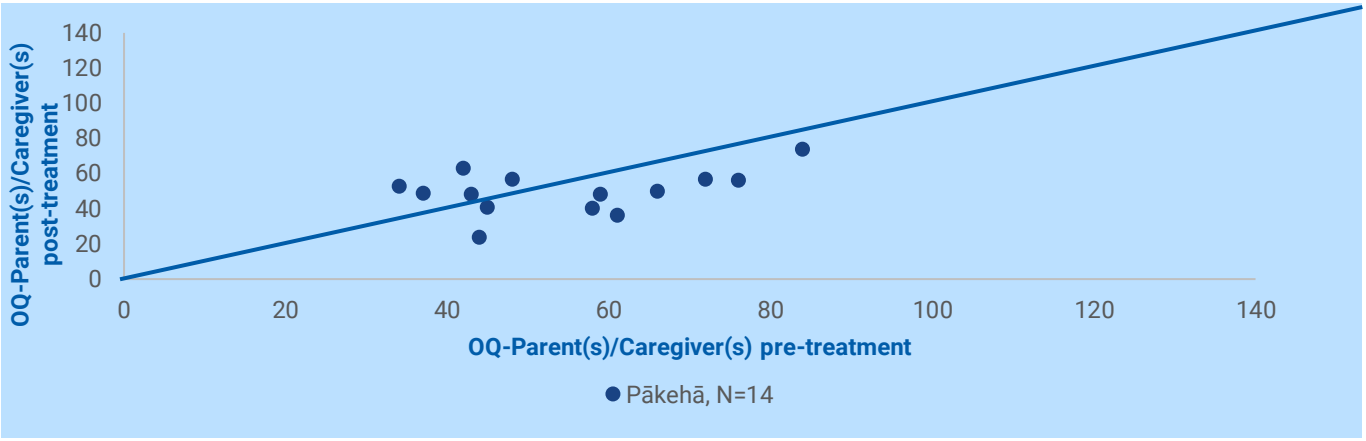
Because of the small sample of data for OQ, t-test for significant reduction in scores before and after treatment was not performed.

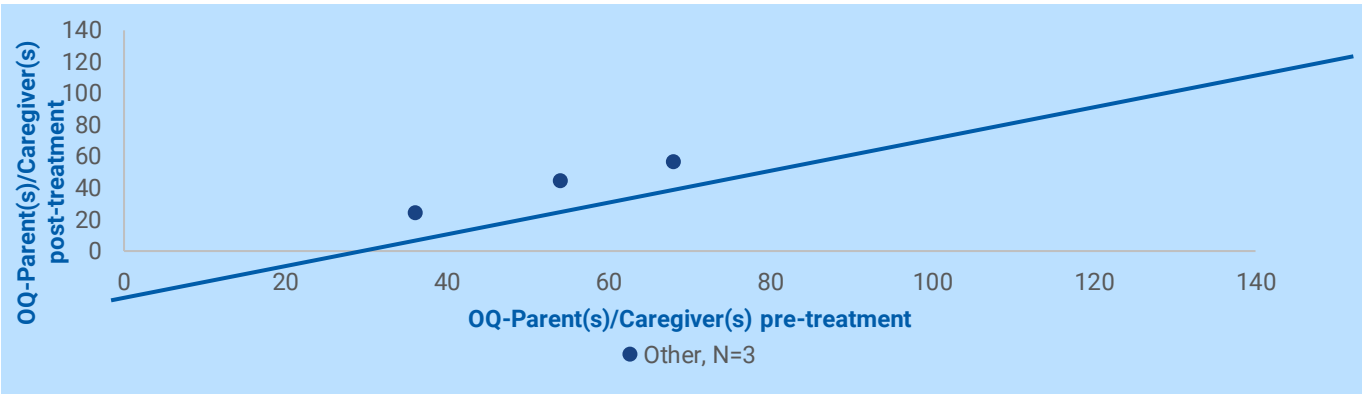
Figure 8. OQ self-reported by parent(s)/caregiver(s) before and after treatment (N=27)







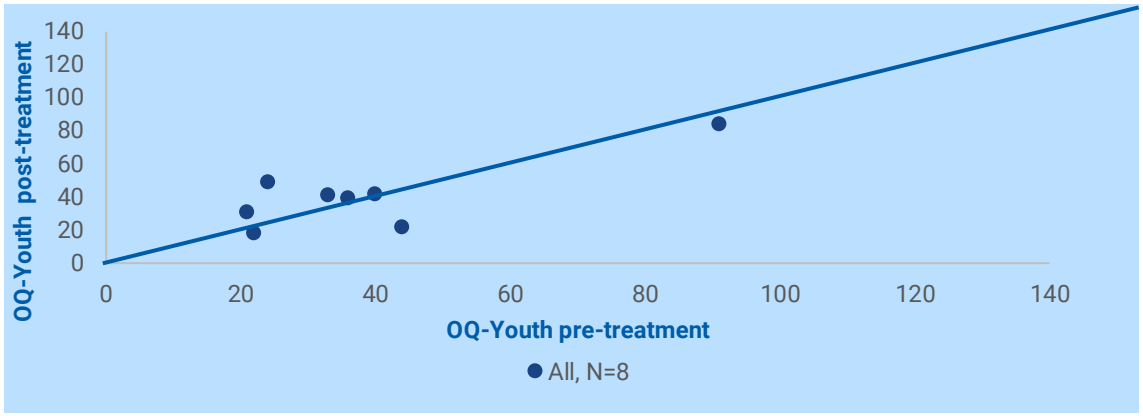


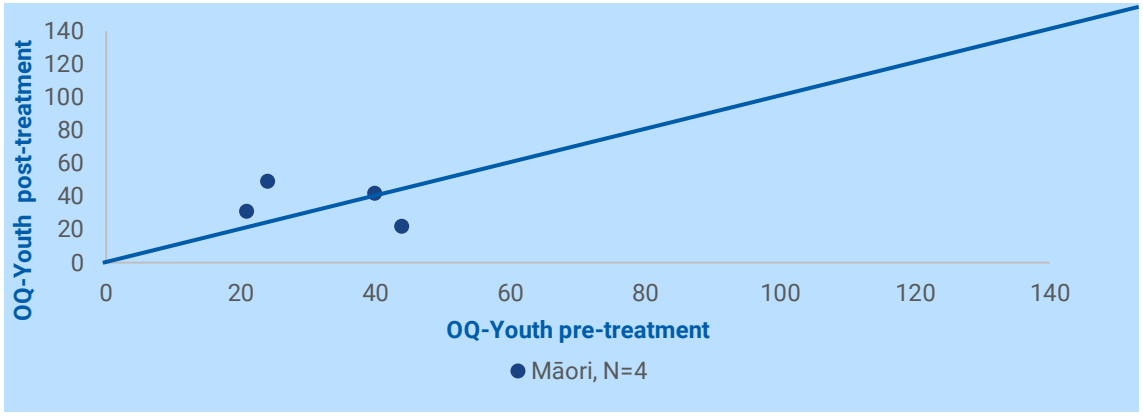


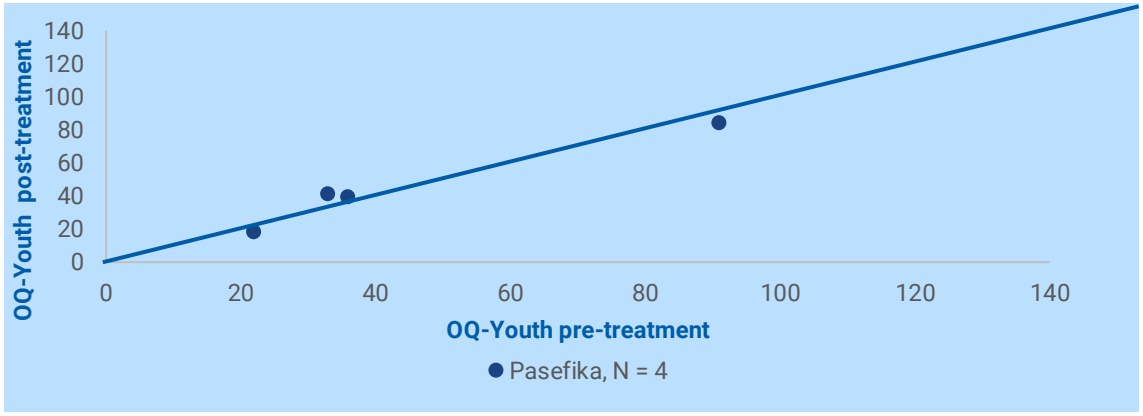
Source: OQ analyst website (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

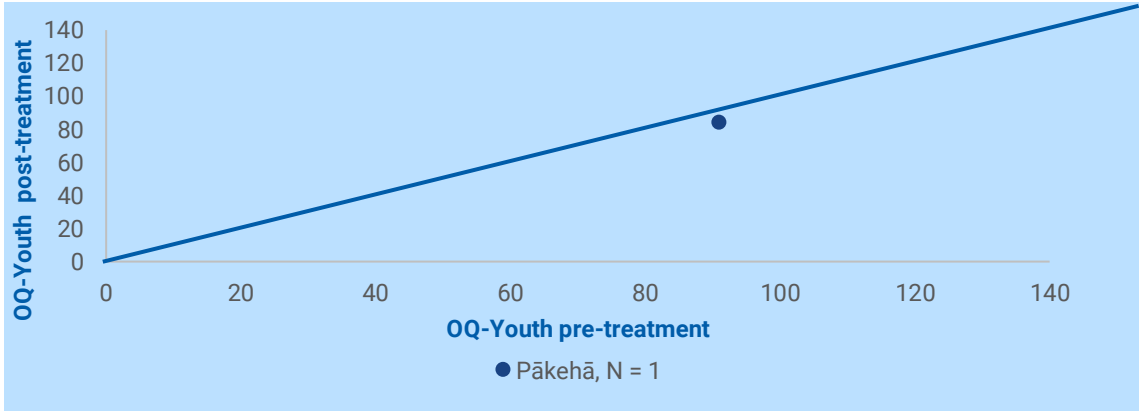
By contrast Figure 9 shows the OQ scores self-reported by the young persons aged 18 years old and over, which show considerably less assessed improvement. Their understanding of their own levels of distress after treatment suggest higher levels than their parents observe. There are only eight completed scores, which may have influenced this unexpected result. Three clients achieved modest decreases (37 percent) before and after treatment. The scores of the remaining six either stayed the same, or were higher after treatment, implying an increase in stress levels. This result also contrasted with those aged under 18 years old.

Figure 9. OQ self-reported by young person before and after treatment (N=8)









Source: OQ analyst website (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

A summary of the overall results of the outcome questionnaires is set out in Table 5.

Table 5. Outcome Questionnaire scores

Participant category		Improved	Regressed or no change	Assessed improvement
Parents and caregivers of 10 to 17 year-olds*		26	8	76%
10 to 17 year-olds self-report*		14	5	74%
Parents and caregivers of 18 to 25 year-olds**		18	9	67%
18 to 25 year-olds self-report**		3	5	37%

* 10 to 17 year-olds – The total score is the sum of six sub-scores: critical items (those that may necessitate clinical follow-up); intrapersonal distress; physical and/or somatic concerns; interpersonal difficulty; social behaviour; and behavioural dysfunction.

** 18 to 25 year olds – The total score is the sum of three sub-scores: symptom distress (discomfort related to intrapsychic symptoms of depression, stress, and anxiety); interpersonal relation (friction, conflict, inadequacy, and withdrawal in friendships, family, and partnerships) and social role (dissatisfaction, conflict, distress, and inadequacy in performance of tasks related to employment, school, family roles and leisure life).

Figure 10 gives the Client Outcome Measure – Adolescent (COM-A) scores for both the old platform (old CSS) and the new platform (new CSS). Since the previous evaluation, a new questionnaire has been developed with additional questions. The COM-A questionnaire is completed by the index client just before discharge, and provides an evaluation across six dimensions: family status; family communication skills; youth behaviour; caregiver or parenting skills; caregiver ability to supervise; and family conflict level. The responses range from 1 (things are no different) to 5 (very much better). The final COM-A is the average of all responses to the six dimensions.

In the new CSS platform, the equivalent of COM-A is COM-Y. This new set of questionnaires include those covered by COM-A, and additional questions concerning illegal behaviour, runaway behaviour, school attendance, school performance, alcohol use and drug use. The responses similarly range from 1 (things are no different) to 5 (very much better), with an additional score of 0 when things are worse. Clients will choose 'not applicable' (NA) if they do not exhibit the behaviour(s).

Because of the new information in COM-Y, we present three graphs in box plot format:

(i) data on the original six dimensions: family status; family communication skills; youth behaviour; caregiver or parenting skills; caregiver ability to supervise; and family conflict levels retrieved from COM-A and COM-Y

(ii) data on young people's behaviours are retrieved from COM-Y only

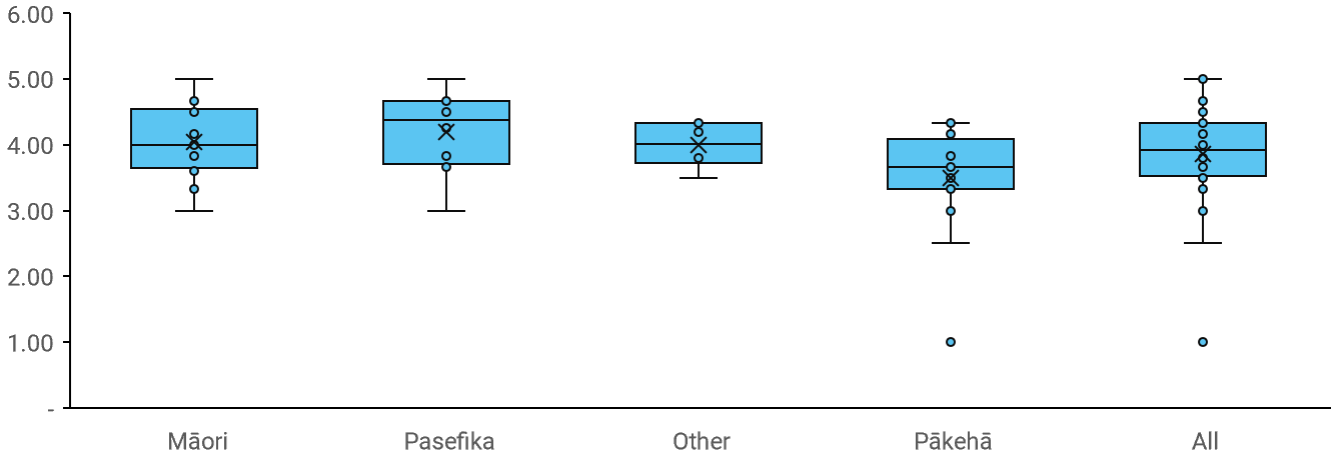
(iii) data on family dynamics and behaviour change from COM-Y only.

Where there is dual identity, both ethnicities are recorded.

The data shows good outcomes, with average responses ranging from higher than 3 (somewhat better) to higher than 4 (a lot better) at 3.86 for all ethnic groups applying the six original dimensions (Figure 10a). The differences across ethnicities are small, except for the Pākehā and Pasefika groups. The Pākehā clients have an overall average score for all 16 clients being smaller than those of other groups, approximately 3.49 (somewhat to a lot better), but with a wider range of data, with one client scoring as low as 1 on average (no change) and three clients scoring as high as 4.33 on average (a lot to very much better). The

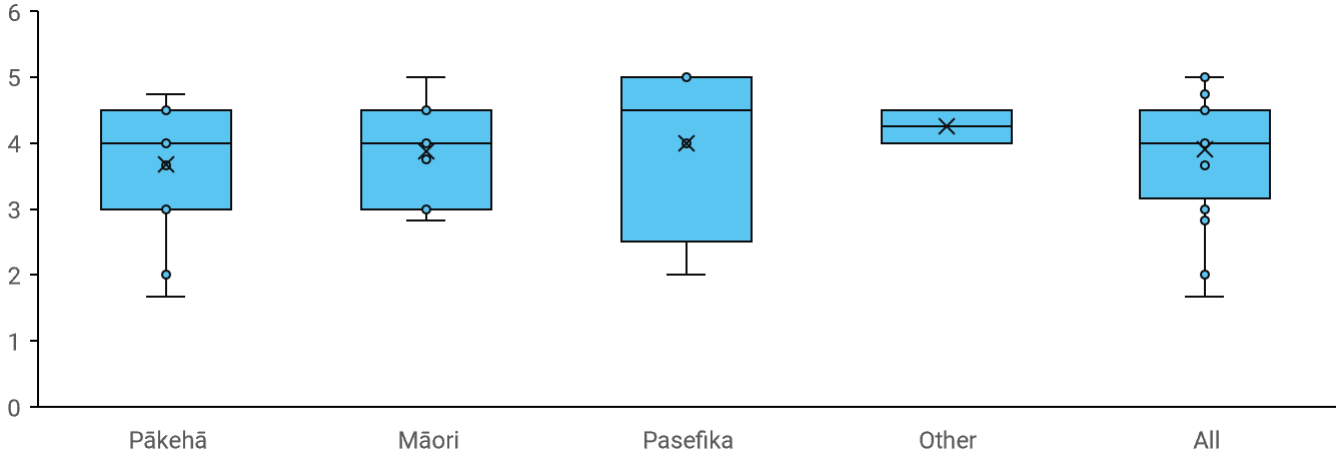
Pasefika group includes data for eight clients, but the range of data is also large with one client scoring as low as 3 on average (somewhat better) and one client scoring as high as 5 on average (a lot better). This group has the highest overall average score of 4.20 (a lot to very much better) for all clients. The Māori clients score on average 4.05 (a lot better) for all 14 clients, lower than the Pasefika group but higher than the Pākehā group. This group has the least difference in data range compared to the other two main groups of clients.

Figure 10a. Box plot of COM-A (COM-Y) average score on family dynamics (N=40) (old CSS 14, new CSS 26)



In Figure 10b we consider data for behavioural changes only, which were recorded via the new COM-Y questionnaire. The data sample is smaller for those who used COM-Y and only for clients with data available. Improvements in behaviours are noted for all ethnic groups, but there are differences within groups as well, especially for the Pasefika and Pākehā groups, as the box plot shows. The overall average score was 3.91.

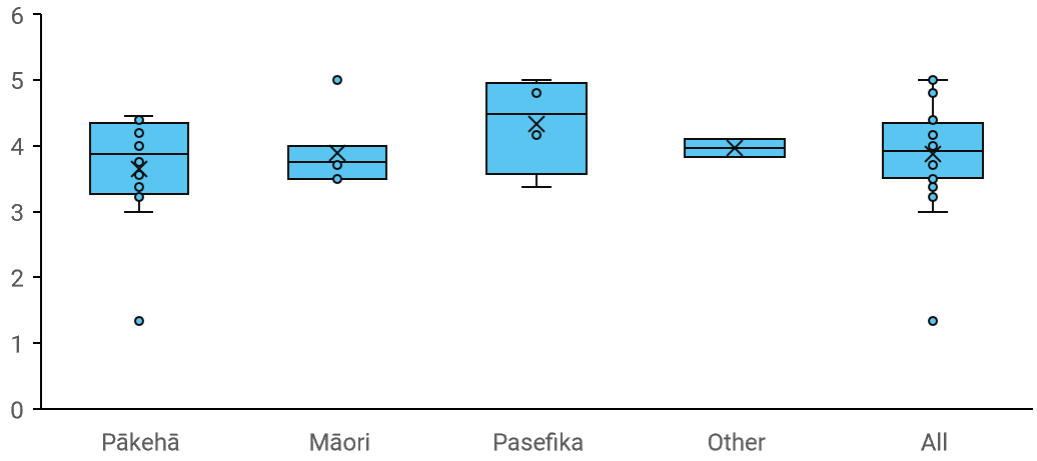
Figure 10b. Box plot of COM-Y behaviour change average score (N=24) (new CSS)



In Figure 10c we consider data for the six original dimensions of family dynamics and six additional dimensions of youth behaviours retrieved from COM-Y data. When young people do not have the behaviours that were asked in the COM-Y questionnaire, the data provides the average of six dimensions of family dynamics only. While all ethnic groups improved their situation with average scores between 3 (somewhat better) and 4 (a lot better) at 3.87,

the Pasefika group achieved the highest overall average score of 4.33, followed by Māori and Pākehā groups with 3.89 and 3.64 respectively for overall average scores. However, there were more differences among the 12 Pākehā clients than other ethnic groups.

Figure 10c. Box plot of COM-Y family dynamics and behaviour change average scores (N=24) (new CSS)



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Figure 11 gives the perception of the parents/caregivers about their family dynamics across the six similar original dimensions (COM-P) and the additional six behaviour change dimensions (COM-C). Again, we present three graphs corresponding to three sets of data:

(i) Average scores of six dimensions of family dynamics from both COM-P (old CSS) and COM-C (new CSS)

(ii) average scores of six dimensions of behavioural changes from COM-C (new CSS)

(iii) average scores of both family dynamics and behaviour changes from COM-C when data are available.

Where there is dual identity, both ethnicities are recorded.

Similar to Figure 10, the average scores are high, between 3 (somewhat better) and 4 (a lot better) for Māori, Pasefika, and Pākehā parents. They were 3.67, 4.00, and 3.75 respectively. However, there are differences within each ethnic groups as the box plots illustrate.

Figure 11a. Box plot of COM-P (COM-C) average scores on family dynamics (N=54, old CSS 20, new CSS 34, including both parents/carers for several index clients)

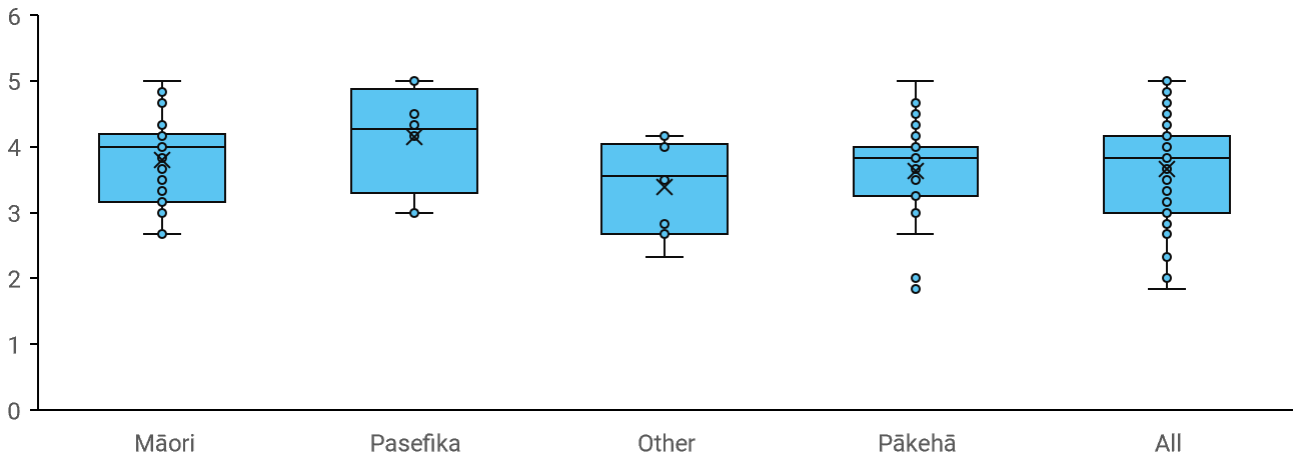


Figure 11b. Box plot of COM-C behavioural change average scores (N=31) (new CSS)

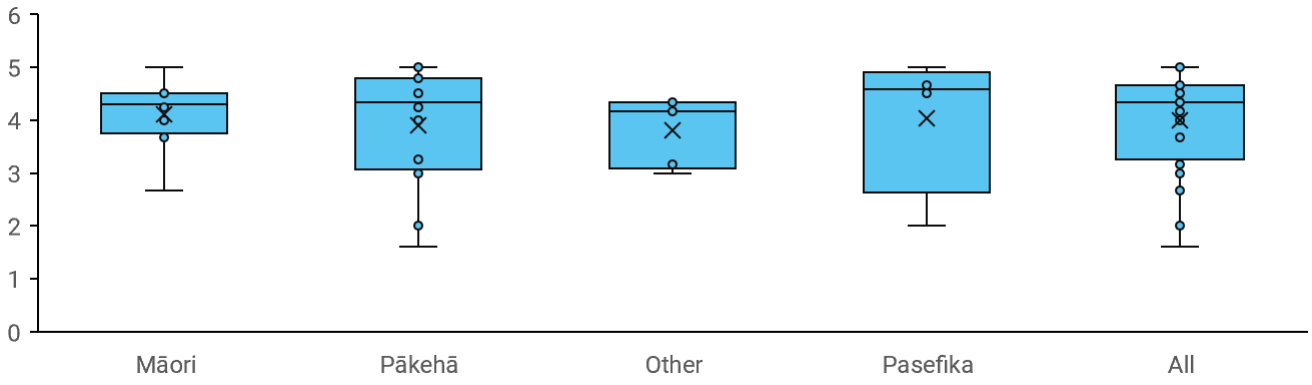
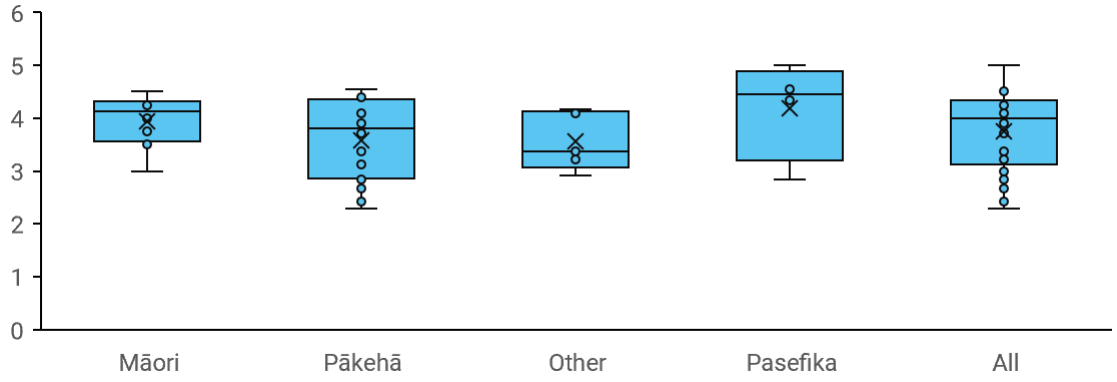


Figure 11c. Box plot of COM-C family dynamics and behavioural change average scores (N=31) (new CSS)



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

A summary of the overall averages of the client outcome measures is set out in Table 6.

Table 6. Client outcome measures just before discharge

(Scores between 3: Some better – things are somewhat better, and 4: A lot better – many things changed but not all, on a scale of 0 to 5)

Dimensions measured	Average score
Self-report - six dimensions of family dynamics*	3.86
Self-report – behaviour change from additional new questions**	3.91
Self-report – family dynamics and behaviour change from additional new questions**	3.87
Parents and caregivers – six dimensions of family dynamics*	3.67
Parents and caregivers – behaviour change from additional new questions**	4.00
Parents and caregivers – family dynamics and behaviour change from additional new questions**	3.75

Things are worse 0; No change 1; Little better (a few things have changed) 2; Some better (things are somewhat better) 3; A lot better (many things changed but not all) 4; Very much better (Most things changed successfully) 5.

* An evaluation across six dimensions: family status; family communication skills; youth behaviour; caregiver or parenting skills; caregiver ability to supervise; and family conflict level.
** Additional questions concerning illegal behaviour, runaway behaviour, school attendance, school performance, alcohol use and drug use.

Māori whānau have become more resilient with parents learning new skills

Even though the focus of Pae Whakatupuranga | FFT-CG is the young person (rangatahi), parent(s)/carer(s) have also benefitted from the programme during therapeutic sessions because of the cross-generation characteristic of family therapy.

A Māori mother understood her daughter's experiences and what she was going through which helped develop a finer appreciation of her circumstances.

> *My daughter probably didn't take as much as what I would have liked out of it. But I think with her being a teenager and going through her battles learning a few hard life lessons, getting into the court system and all that kind of stuff. I think my daughter did a lot of growing within herself and that also played a big part for where we are now. [Therapist] helped me learn and understand what I was dealing with.* (IEW2 Mā 3 Mother)

The parent(s)/carer(s) of all whānau/aiga/family learned new skills and strategies to be better prepared for future challenges faced by family members.

> *I got a lot out of the session like I opened my eyes to a few things. We had like a piece of paper [young person] would draw down her feelings her emotions. It was really helpful for understanding how [young person] would get to a certain point within herself and the same with me. It was helpful to learn what [young person] experiences when she's going through her emotions and when she's getting angry.* (IEW2 Mā 3 Mother)

Most, though not all, Pasefika aiga were helped with new parenting skills

Two interviewed parents of Pasefika aiga enjoyed activities that therapists organised during their sessions. They understood the purpose of these activities and continued to apply skills they learned after treatment was completed.

> *She got us to brainstorm what the good things our family had, and what we would like to have. We did posters that she laminated and to this day we have them on our fridge and we gave some to our other family members so they like them too.* (IEW2 Pas #2)

> *She gave us heaps of different strategies, like when you are really frustrated, she gave us some strategies before you say anything. They helped us to understand the other person's feelings about the situation. At the end of the day as a parent you want the best for your children, so it really worked out.* (IEW2 Pas #3)

The other Pasefika aiga suffered from not being able to practice their parenting skills. The strategies given by the therapist were helpful, but they were not strong enough to solve their problems which included a deep level of conflict and misunderstanding.

> *It was good for communication and for [young person] the charts helped but a lot of stuff that were going on couldn't be talked about. For 6 months my name was [swear word] so I couldn't speak about these things or my daughter would flip out once [therapist] left. I would have to constantly check so we stayed in the safe areas and not speak about specific areas so I would not be the target afterwards.*

> *I felt ganged up on and not listened to. [Therapist] believed it was my mental health that was the problem.* (IEW2 Pas #1)

Given that parent(s)/carer(s) are strong drivers of whānau/aiga/family dynamics, the skills and strategies acquired by parent(s)/carer(s) during therapeutic sessions are very important for achieving effective outcomes of the programme. Both therapists and whānau/aiga/family acknowledged that not all issues were resolved, however important skills and strategies have been learned and applied such that many, though not all, whānau/aiga/family have been enabled to de-escalate conflicts and better navigate the complex dynamics of relationships.

There was still an exceptional case in the qualitative interview where one Pasefika aiga expressed deep concern about the programme and how it did not meet her expectations. The main conflict between mother and daughter in this aiga was not solved and mental health treatment from a clinic was sought after treatment.

1.4 The cultural approach to therapy

The interweaving of Māori and Pasefika cultures into current FFT-CG methodology has turned Pae Whakatupuranga | FFT-CG into a unique programme that inherits the international characteristics of FFT-CG model and tailors these characteristics to fit into special context of New Zealand. The key context the programme focuses on is Māori and Pasefika cultural tikanga. Feedback from Kia Puāwai managers and therapists pointed to how the cultural trainings have helped them effectively apply FFT-CG in Aotearoa.

One manager explained why cultural knowledge is important and has become a big part of trainings for therapists.

> *Most of the training goes into how I sit, how I reframe, how I engage. That's the biggest chunk that they do. And then you need to work out with whānau, which is more*

> *of a journey. So that really encourages their engagement skills and being able to talk in a way that whānau understand and that resonates from their world view, because otherwise it sounds very western.* (IEW2 Management 1)

Both therapist group discussions described how Pae Whakatupuranga | FFT-CG, particularly the Māori cultural framework Whaitake Whakaoranga Whānau, has enabled them to explore avenues of contact with whānau and establish the connection needed for FFT-CG to work.

> *It is [the Pae Whakatupuranga] interpreting every practice of FFT that has made it successful, and I know that it's not something that you just learned, not something that sits on the side, it's something that has consistently been practiced all the time, and that is why it's successful.*
>
> *For Functional Family Therapy, you have balanced alliance and building hope, reducing blame etc. However, this is deeper than the typical Pākehā tick box like this is what we need to achieve through FFT. I think [the Pae Whakatupuranga] has deepened experiences. Whānau obviously don't really know what we're doing. It's not like we sit in a session and then say right now we're going to do Pae Whakatupuranga — they don't know that what we're doing, but it's the experience of coming in and being humble and allowing us to integrate those whakawhānaungatanga is what has made their experience better. (IEW2 Therapist 1)*
>
> *One kupu in the model, oranga whānau, really allows you to take care of everything about that whānau. So pretty much everything under FFT is covered under oranga whānau, and that is just one kupu. So there's a wide variety, a huge space to be able to work in, and yet it also has the ability to provide structure and keep you focused on what you need to do well in that space.* (IEW2 Therapist 2)

Pae Whakatupuranga

The reference to Pae Whakatupuranga illustrates how seriously the Kia Puāwai expression of FFT has taken the significance of authentic Māori and Pasefika cultural ways of being in their work with whānau and aiga. Pita Te Ngaru, the Kia Puāwai Kaumātua, notes that it refers to *'the action of weaving growth together in up-and-coming family generations'*[13]. When Kia Puāwai first decided to bring FFT to New Zealand in 2009, they worked with Pita Te Ngaru and Miriama Hiriaki, a functional family therapist, to explore the integration of clinical and cultural practice with a Māori world view. The outcome was the development of Whaitake Whakaoranga Whānau which is a process…

> *"framed within Te Ao Māori principles which is compatible with FFT … it offers a Māori centred approach that helps therapists to draw on their personal and cultural selves in a way that aligns with the FFT model."*[14]

Pita Te Ngaru continues in his role as Kia Puāwai Kaumātua.

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[13] Kia Puāwai & Functional Family Therapy LLC. (2020). *Pae Whakatupuranga: Te Ruatahi o Te Ranagatahi*. Waikato-Tainui College of Research and Development at Hopuhopu. p. 1.

[14] Ibid p. 8.

Sometime later in 2019, Dr Byron Seiuli, the developer of the Pasefika framework Uputāua, carried out the role of Pasifika cultural advisor. Uputāua provides:

> *"a guiding reference for cultural protocols and practices that are significant in the lives of Pacific people in Aotearoa. Importantly this cultural framework reminds therapists and referring professionals of their responsibility to teu le vā – to take care of the relational space with Pasifika families and the wider community in all facets of engagement."*[15]

The commitment to Māori and Pasefika ways of doing things and ensuring their role in the therapeutic process has been serious and ongoing.

During the interviews, examples were given from the beginning (Engagement stage) to the end (Generalisation stage). In the Engagement stage, FFT-CG gave the guiding principles, but Pae Whakatupuranga provided them the details of how to plan their engagement and initial contacts with whānau successfully. In some cases, therapists actually used the knowledge gained from cultural training instead of FFT-CG to approach their clients.

> *When we are planning, especially for those initial sessions with whānau, we think of what is important, and standard FFT doesn't tell us 'you've got to go in there and focus on whakatau or whakawhānaungatanga'. When I use this framework to plan, I decide I'll be focusing on an hour of whakawhānaungatanga before I even give time to what the actual model is and what the programme looks like.*
>
> *The framework has really allowed us to focus on these really important kupu before even giving into FFT. Being able to go in there and being humble and not saying 'I'm a functional family therapist, and this is what the programme looks like' but actually first and foremost focus on whakatau — how do we really connect and settle whānau before even getting into that, how do we just sit and have a conversation and allow them to know who we are. Because it's a real privilege for us to be able to go into whānau homes, just as much as we want to learn about them, they really want to know who we are, especially if we're going meet them every single week at their homes and Pae Whakatupuranga has really allowed us to do that in a natural way.* (IEW2 Therapist 1)

In the behavioural change stage, therapists need whānau to trust them in order for changes to happen. Again, Pae Whakatupuranga deepened the relationship between therapists and whānau such that the changes were more actively brought about by whānau. FFT alone would definitely bring about changes. However, it has become more effective for whānau when FFT was interwoven with Whaitake Whakaoranga Whānau into Pae Whakatupuranga and became a process of working with whānau.

> *We see more success with Māori whānau now because we spent the time and motivation building that foundation. When we go to behaviour change we ask them 'Look this isn't something that you normally do as a whānau, let's get together and do something different'. They were like 'okay I've got a relationship with this person I trust*

[15] Ibid p. 29.

this person'. I think that the framework interwoven with the standard FFT model has made it very effective, especially in terms of relationship building and keeping whānau engaged in the programme. (IEW2 Therapist 1)

Value of ongoing cultural training

The managers strongly advocated the cultural competency building among therapists, considering how effective it is in helping therapists deliver their sessions.

> *Therapists naturally love [the model], which is why we want to implement that model of working into all our FFT teams because it, it just brings their ability to engage to a whole new level. There's a richness to it that draws people in*. (IEW2 Management 1)

> *It's about a balancing act between bringing them on board, giving them a sense of competence and confidence and the therapeutic work within FFT, but not leaving behind cultural confidence or competency. We don't want staff going out and not have any cultural thinking involved in that process. It strengthens our ability to think through and gives us more to go in with.* (IEW2 Management 2)

Similarly, therapists described experiences with aiga where cultural training and supervision helped them successfully navigate their intervention during therapeutic sessions. An example was given when a therapist brought in a Pasefika minister (matua) into a meeting with her client's aiga to enhance their mana. This was guided by a cultural understanding of meeting the aiga's needs.

The therapist brought what the aiga needed but was worried that she did not follow FFT methodology.

> *The whole session was done in the language that I didn't understand and I questioned myself if that was really an FFT session. It was very cultural and it was really helpful for this Pasefika family, the feedback that came was 'this is the stuff that we were needing. This is the light that we were wanting this is our light at the end of our tunnel that we're at' and that feedback came from dad who wasn't engaged at all before. So I chose to let go of FFT in that moment to allow for that to happen, but got the clash that oh, my gosh I'm not honouring FFT space.* (IEW2 Therapist 2)

Practice Lead and Cultural Supervisor subsequently explained to her that she was actually applying the matching principle in FFT, but within a cultural context. In this case they were able to match the aiga hierarchy with the presence of a pastor who was able to connect to the father who had not engaged in the therapeutic sessions.

> *We need to be able to bring these cultural leaders who have mana and who have trust because dad was so vulnerable. He was so vulnerable, and he was hurting. But he needed a safe space to be able to communicate that. And we have to recognise that there are times when we cannot be everything that a family needs. My therapist was a female and dad is a male, and so there was a disconnect there. She is not of the same culture. So, the presence of the pastor made all the difference. We can't be him but we can be guided by him and supported by him.* (IEW2 Management 2)

The presence of cultural support did not interfere with the therapeutic sessions, instead it has enhanced the effectiveness of the treatment.

> *Before Mum and kid was still meeting, but we wanted changes that were above superficial, real changes for the family, and we had a sense that Dad was crucial for this. Matua agreed to meet with us and consult with us. And then he agreed to come out and meet the family, and the family agreed to meet him. And then he attended several sessions with us and the dad became engaged. And then he stepped back and therapy continued with all those family members present practising the skills and engaged at this level that they weren't before.* (IEW2 Management 2)

The interweaving of Māori and Pasefika cultures into FFT-CG methodology has made the Pae Whakatupuranga | FFT-CG team aware of the importance of having solid cultural preparation and training in order to carry out culturally appropriate sessions with whānau/aiga/families. This has enabled the therapists to approach their clients and deliver the therapy in a culturally respectful way, as Table 7 shows.

The Kia Puāwai management gave an example of a recently joined Pākehā therapist who successfully delivered Pae Whakatupuranga | FFT-CG in a culturally appropriate way to a Māori whānau. The therapist approached the whānau with a humble self, checking if he was appropriate and asking for permission to apply his cultural understandings. This approach changed the Māori whānau in a positive way as all members started engaging through the cultural activities.

> *[Therapist] asked 'Would you like me to open with a karakia' and then got feedback like, 'You're really good with us. You're doing the karakia really well'. And then eventually that same family asked 'We want to find out new kind of karakia' as he has the karakia booklet. And he gave them the booklet to let them open session with karakia. Now the two youngest kids, who haven't been involved that much, are regularly opening with karakia – the ones he printed out for them.* (IEW2 Management 2)

The whānau in this example gave more details on how respectful the therapist was of their culture.

> *As soon as [therapist] came in, he took his shoes off. And he asked to do a karakia for the meeting. And he would ask if it was appropriate to start the karakia in Māori or it was okay for him to try and speak different Māori words and stuff like that. A very respectful guy.* (IEW2 Mā #1)

This approach also worked well for whānau who were not as aware of their own culture. They still recognised the respectfulness of the therapists and appreciated how the therapists opened themselves to them.

> *[Therapist] was just a good fit as my daughter would not work with someone who might not have cultural knowledge as she is half Māori half Samoan. I don't feel like she targeted one particular culture. But with her body language and with the way she spoke, I felt like she was knowledgeable, like she knew our culture and all that kind of stuff. If there was some sort of lingo that [young person] brought up she didn't understand she would ask about it. And I think she adapted well.* (IEW2 Mā #3)

All interviewed Pasefika aiga felt fully respected and understood by the therapists. However, the feedback was general without any specific details about how therapists had approached them in a Pasefika way or how it fitted with their Pasefika worldview.

> *The way she dressed…The way she wore her hair…When she spoke, it was down to earth. She did not make us feel that she was an officer. She was just really laid back and down to earth and just shared experiences that we could relate to, which made us feel comfortable. We were able to relax and open up more. She just felt like a family member.* (IEW2 Pas #3)

> *Therapist was really good at staying in touch, and we had a good relationship and connected to her regularly. When she came and brought some food it was like a family to us.* (IEW2 Pas #2)

Other Pasefika aiga did not feel a cultural approach was relevant.

> *We're quite quiet. We keep to ourselves quite a lot. We don't do Pacific languages or go to church – we are just us. But [therapist] is very good we felt respected 100%.* (IEW2 Pas #1)

The Kia Puāwai managers were very proud of how cultural protocols have been internalised as a normal practice at Kia Puāwai so that new therapists could come on board and quickly pick that up.

> *That's where, as an organisation, Kia Puāwai wants to move. It's not enough just to talk about having these beautiful values and, you know, pay lip service to it. It's like, how are we being thoughtful and how are we really trying to honour the dignity and the beauty of the cultures of Māori, Pasefika and any culture that's in front of us.* (IEW2 Management 2)

Cultural satisfaction surveys

The cultural satisfaction surveys completed by young people and their parent(s)/carer(s) provide further support for this outcome. Two versions were administered. The early version had eight questions; the later version had 12 questions. All questions asked respondents to identify the number that expressed their level of satisfaction with a number of statements: 4 referred to 'very much', 3 to 'mostly', 2 to 'a little' and 1 to 'not at all'.

Table 7 shows that the average ratings are all higher than 3 for each aspect of cultural appropriateness. Some aspects had an average of 4, meaning all respondents were very much satisfied with how the therapists had approached them. Where there is dual identity, both ethnicities are recorded.

Table 7. Average scores of responses to the cultural satisfaction form (including both young person and parent(s)/carer(s))

Part 1: 12-question survey

		Māori (N=25)	Pasefika (N=9)	Pākehā (N=30)	Other (N=7)	Overall (N=67)
How satisfied are you that the therapist:	Helps you feel comfortable to talk and share	3.40	4.00	3.50	3.71	3.52
	Pronounces your names correctly	3.88	3.89	3.97	4.00	3.93
	Looks for common ground to connect with you	3.56	4.00	3.57	3.86	3.63
	Allows you to know who they are as a person	3.64	3.89	3.60	3.71	3.64
	Takes time to find out about your family/ whānau values	3.64	4.00	3.84	3.57	3.74
	Shows respect for your culture	3.88	4.00	3.79	3.86	3.85
	Knows enough about your culture to help you feel at ease	3.50	3.61	3.59	3.67	3.56
	Respects the things that are important to your family/ whānau	3.80	4.00	3.84	3.86	3.83
	Acknowledges and respects your religious/ spiritual beliefs	3.64	4.00	3.86	3.57	3.75
	Allows time in sessions for cultural rituals if you want them	3.61	3.89	3.83	3.50	3.71
	Acknowledges when they don't know something about your culture	3.68	3.89	3.77	3.57	3.72
	Is willing to learn about your culture	3.64	3.89	3.68	3.71	3.69

Part 2: 8-question survey

		Māori (N=6)	Pasefika (N=2)	Pākehā (N=3)	Other (N=4)	Overall (N=12)
How satisfied are you that the therapist:	Respects your culture	4.00	4.00	4.00	3.5	3.83
	Knows enough about your culture to help you feel comfortable	4.00	4.00	4.00	3.75	3.92
	Gives information in ways that aid your understanding	3.67	4.00	3.33	3.75	3.75
	Pronounces your names correctly	4.00	4.00	4.00	3.75	3.92
	Looks for common ground to connect with you	4.00	4.00	4.00	3.75	3.92
	Works in partnership with you to achieve change	4.00	4.00	4.00	4	4.00
	Takes time to find out about the family's beliefs and values	4.00	4.00	4.00	4	4.00
	Respects things that are important to the whānau	4.00	4.00	4.00	3.75	3.92

Source: Microsoft Power App form data extracted by Kia Puāwai. Accessed 04 Aug 2022.

Māori and Pasefika cultural training and supervision

The therapists have found the Māori cultural supervision to be very helpful in implementing the programme in general, but particularly with Māori clients. Pita Te Ngaru is the kaumātua for the Kia Puāwai organisations throughout the country. He leads noho marae for staff and other training events. Liesl Niania-Sharples is the Māori Cultural Supervisor who provides regular (usually fortnightly) two hour training sessions and monthly supervision for the therapists.

Unfortunately, cultural trainings the therapists previously carried out, such as noho marae, became impracticable because of the impact of the COVID-19 pandemic. Instead, they learned 'around the table' using the manual[16] developed for Pae Whakatupuranga | FFT-CG. Cultural supervision has also become a key component in helping new therapists learn the Kia Puāwai cultural approach to FFT.

The interviews recorded very positive feedback on the frequency of cultural supervision, and how it had helped therapists understand cultural protocols, building their cultural competence, and navigating therapeutic sessions with clients. The Māori cultural supervisor was viewed by some as providing a helpline for therapists by having open discussions with them as a team to sort out problems and enhance their understanding of the cultural framework in FFT context.

> *During cultural supervision, we talk about the model and how to use the framework to plan for the different cases. That's given us all so much more confidence going in and working with Māori whānau.*
>
> *Having that ability to reach out to our cultural supervisor to discuss what's the best way to match to this whānau really helped alongside the clinical standard of FFT.* (IEW2 Therapist 1)
>
> *[Cultural supervision] is definitely very helpful. We don't know everything, and we do encounter challenges from time to time and that's allowing whānau to be different, to be unique. We're not dealing with them like as a blanket, we're dealing with them as individuals and challenges that come up from time to time you definitely need to bring it back to cultural supervision.* (IEW2 Therapist 2)
>
> *It is amazing that our staff and our therapists are still having weekly or fortnightly cultural supervision. I'm really blown away by this. They are absolutely fluent in Pae Whakatupuranga. They live in and breathe it in and talk in it. That's the magic of having the cultural supervision all the time. It's part and parcel of their everyday life, not just at work, but even at home. I'm absolutely blown away by it. I think it's very amazing to be able to do that.* (IEW2 Kaumātua)

Cultural supervision has helped therapists with pronunciation, with knowledge about kupu, what good cultural therapy entails and how to apply it in day-to-day situations. New therapists are encouraged to check anything with the cultural supervisor they are not sure about. For example, would it or would it not be appropriate to practice an exercise, or to check on a strong role played by a whānau member, or to ask a cultural supervisor to help them understand the role of teenagers on marae.

For the Māori cultural supervision, the general feedback was about the effectiveness of frequent reflection and practice during supervision. This has helped therapists build up their own lenses of culture through which they can better understand what is going on. They can then plan how to match that to whānau at their own pace.

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[16] Ibid.

> *It is certainly a challenge to learn a model alongside with gaining cultural awareness and consciousness. I have to admit initially I thought this is too much to be doing all at once, but then through cultural supervision, by sitting in it and relaxing in it, my level of confidence is rapidly increasing and I got to a personal space of comfort that allowed me to actually absorb more.* (IEW2 Therapist 2)

The Pasefika cultural training and supervision is appreciated by the therapists also. The Uputāua framework was developed by Dr Byron Seiuli who is a clinical psychologist. Like the Kia Puāwai kaumātua, he works across a number of the programmes Kia Puāwai delivers. He introduced the Uputāua framework to the service and has led various training days. Synthia Dash provides most of the ongoing Pasefika cultural support and capacity building with therapists. She also works across a number of other programmes in the greater Kia Puāwai organisation.

During the last year of the pilot programme, after a period of consultation with Pasefika community leaders, a Pasifika Matua Council made up of Matua from the nine main Pacific Island groups was established. The Council provides ongoing expert pan-Pacific and ethnic-Pacific cultural advice, guidance, support, and leadership, to the organisation. This includes providing cultural support for therapists.

This initiative is appreciated by therapists who have noticed the respect aiga members, including younger people, show in the presence of the Council members. The Pasefika Council can also provide cultural support for aiga to help therapists engage on a deeper level.

> *We've now got a Pasefika Council which are leaders from churches and other organisations across the Pacific Nations, and I think it's been incredible to be able to draw on all that knowledge. I noticed the respect that comes from younger ones and I found that amazing, Kia Puāwai have given us access to a powerful resource.* (IEW2 Therapist 2)

The Uputāua framework was introduced to the service in 2019 when the Whaitake Whakaoranga Whānau was well established in the organisation. The training began with a lot of momentum but it became more difficult when it was forced to go online because of the COVID pandemic. The Pasefika training and supervision is not as structured and frequent as the Māori cultural supervision.

Therapists were keen to embrace the Pasefika world they were being introduced to but described it as an 'ongoing' process where their understanding is still being developed. Their experience of Uputāua was described a little differently from Whaitake Whakaoranga Whānau with Uputāua as being more practically based and Whaitake Whakaoranga Whānau more conceptually based.

> *The Uputāua framework isn't to be used in the same way with Whaitake Whakaoranga Whānau. For example, I can say I need a bit of whakapono or I need the faith or a bit of strength in Whaitake Whakaoranga Whānau whereas in Uputāua it would say I need to focus on my emotional wellbeing – this doesn't resonate as well.*

> *There's just a difference I am trying to get my head around and would like to grapple with it more but not sure how to do that.* (IWE2 Therapist 2)

A therapist spoke of ways she was endeavouring to apply the Uputāua framework to therapeutic practice with aiga.

> *With Pasefika families it's really hard to tap into their spirituality because of the stigma that comes with it. Also, you can't quantify faith. So if they believe in God for healing…we don't come in and say go to the doctor or say their faith is wrong.* (IWE2 Therapist 2)

They clearly appreciated the ways the Pasefika training and supervision process had helped develop their understanding and practice with aiga. They have used the training they have received to be as understanding and responsive as possible with Pasefika aiga, as the cultural satisfaction scores showed.

> *[Pasefika Cultural Supervisor] taught us we can never be culturally competent when we walk into a Samoan family – so being Samoan doesn't mean we are all the same in the way we enact the culture.* (IEW2 Therapist 2)

However, they said they had only attended one recent workshop on Pasefika culture and they were aware they weren't receiving the ongoing two weekly supervision in Pasefika cultural practice that they were in things Māori.

> *Unfortunately, it's like Pasefika culture being the 'poor cousin' of Māori culture – we get weekly cultural supervision for Te Ao Māori, we get noho … but with Uputāua the Pasefika framework we haven't had as much, we don't get regular Uputāua supervision, we did immersion day but nowhere near as consistent as Māori.*
>
> *FFT definitely allows for Uputāua and Uputāua definitely allows for FFT so there's a good marriage there but, in the knowledge of how that's gonna play out I'm still learning and I'm still a baby so I am exercising a lot of cultural humility here.* (IEW2 Therapist 2)

One of the managers offered an important reflection on the complexities involved given the range of cultures in Island nations of the people seeking help.

> *I think the journey [of interweaving Uputāua into FFT-CG] is slightly newer. They've spent a lot of time engaging with different Pasefika groups to get better understanding of all the differences because it's a lot different if you're Fijian than if you are Samoan. They've spent a lot of time kind of stepping into those different worlds to learn and to understand more. But there's just a lot more to understand if that's not where you're from or who you are.* (IEW2 Management 1)

1.5 Young people's living situation and their education or employment

Living situation

With the pilot programme reaching its final stage, therapists have become clearer about what they want to achieve for their clients in relation to whānau communication about young people staying at, or leaving, home. The improved communication within whānau/aiga/family members has facilitated conversations initiated by young people about becoming independent, instead of them simply leaving their whānau/aiga/family in conflictual ways. This has definitely helped them to hear each other and for young people to work through the issues with their parent(s)/carer(s).

> *There'll be times when young people are wanting to move out independently and maybe this is an issue of conflict but the skills from the programme and the consistent contact has helped them to be able to hear each other and experience each other differently. To understand other people's perspectives and where the person might be coming from may not necessarily help us actually coming to a conclusion that everyone's happy with because sometimes it's just not achievable. But being able to talk about it, without escalation and to feel like you're being understood and heard and validated in those moments is what we're wanting to achieve. (IEW2 Therapist 1)*

Table 8 gives information about the living situation of the 97 index clients before and after participating in the programme, excluding those who are still participating in the programme (active cases). The data are for all clients who have used the service (42 completed and 55 dropped out). The pink cells refer to no change.

At the end of the programme 80 young people stayed with their whānau/aiga/family (Table 8 part 1). The majority (76 of this group) who were living at home before treatment continued to do so; they include 39 completed cases and 37 dropped-out cases (Table 8 parts 2 and 3). The other four were living outside their home before moving back to stay with their whānau/aiga/family. They include one completed case and three dropped-out cases.

Nine cases were living independently after participating in the programme. Of those cases, six had been living independently before treatment. Two who did not complete treatment were staying with their whānau/aiga (one Māori and one Pasefika) and one dropped-out case of other ethnicity was in foster care (Table 8 part 3).

Seven young people who did not complete their treatment, either had unknown situations (two Māori, one Māori/Pasefika, one other ethnicity), or ended in prison (one Pasefika), or in a secure residence (one Māori, one Māori/Pasefika). These seven young people were however living with their whānau/aiga before treatment (Table 8 part 3).

Table 8. Improving clients' living situation

		Living situation after treatment (part 1 – all participants excluding active cases)					
		Living with parent(s) or whānau	Living independently	Prison	Secure OT/CYF/YJ residence	Unknown	**Total before treatment**
Living situation before treatment	Living with parent(s) or whānau	76*	2	1	2	4	**85**
	Living independently**	4	6				**10**
	Foster care		1				**1**
	Secure OT/CYF/YJ residence				1		**1**
	Total after treatment	**80**	**9**	**1**	**3**	**4**	**97**

		Living situation after treatment (part 2 – completed cases)		
		Living with parent(s) or whānau	Living independently	**Total before treatment**
Living situation before treatment	Living with parent(s) or whānau	39		**39**
	Living independently	1	2	**3**
	Total after treatment	**40**	**2**	**42**

		Living situation after treatment (part 3 – dropped out cases)					
		Living with parent(s) or whānau	Living independently	Prison	Secure OT/CYF/YJ residence	Unknown	**Total before treatment**
Living situation before treatment	Living with parent(s) or whānau	37	2	1	2	4	**46**
	Living independently	3	4				**7**
	Foster care		1				**1**
	Secure OT/CYF/YJ residence				1		**1**
	Total after treatment	**40**	**7**	**1**	**3**	**4**	**55**

*Each of these cells shows the number of clients who changed from the situation in the row to the situation in the column.
**Living independently: Living with flatmates, or Living with partner/spouse, or Living in a hostel.

Source: HCC data reconciled with CSS (01 Jun 2019 – 31 July 2022). Accessed 04 Aug 2022.

Overall, the programme has largely achieved its goal of helping young people to stay at home or move successfully to independent living. This outcome was achieved for all completed cases. However, for dropped-out cases, exceptions to this general trend were noted for Māori and Pasefika clients.

Education, employment and training (EET)

Therapists set realistic targets for enabling their clients to either stay or get into education, training or employment. They were aware of the various factors young people needed to consider. They placed importance on them understanding their own needs and being able to speak without fear with their whānau/aiga/family about them. They also encouraged them to communicate effectively with social workers and other public agencies. Mainstream schooling was not always the appropriate option for the programme's clients.

> *It's helped them to feel confident enough to advocate for themselves, being able to talk to their probation officer or OT about what they want, you know, the fact that they don't want to be in a mainstream school they want an apprenticeship, they want other things … without being spoon fed from someone else; the same confidence they have in discussing those things with their own family. The goal is for them to be able to go on the path that they actually will feel the best.* (IEW2 Therapist 1)

Some of the interviewed whānau/family described improvements in their children's situations. Parents of a Pākehā family described how the young person had started applying for several jobs while doing trainings. The mother of another expressed her relief that her son has moved from being withdrawn from school into developing an interest in a particular field of education and would like to pursue official training in that area.

> *Son: I mean, mostly just like drama stuff because I like doing that*
>
> *Mother: We've talked through ideas about what [young person] could do. He couldn't get back into the mainstream schooling, because of missing out on so much but when COVID-19 calms down, we can look at applying for some courses and do a foundation in creative fields.* (IEW2 Pāk #4)

Although most interviewed whānau/aiga/family did not provide any feedback on the impact of siblings of index clients, one whānau mother mentioned that the young person did not return to school, but all the other young people returned to school after they participated in the programme.

> *My kids (younger brothers) are back in school now. They weren't going to school prior to the therapy sessions. They were working. I would only get told at the end of the term. They hadn't been going to school for two months in a row. And since the family therapy sessions, they've never missed a day of school.* (IEW2 Mā #1)

In this case it was the restored family dynamics that have benefitted other members of the whānau in achieving EET outcome.

Table 9 gives information about changes in the education and employment activities of clients. The programme has substantially achieved its goal of ensuring young people stay in school, return to education, or further their employment opportunities.

At the start of the programme 58 were in education, employment or training (EET). After participating in the programme, 63 were in education, employment or training, 23 were not in EET. After-treatment information was not available for 11.

Of the 63 participants who achieved the EET outcome, 39 maintained the same EET status (highlighted purple cells in Table 9 part 1). Of the remaining 24 (highlighted in green cells in Table 9 part 1):

- Two changed between mainstream and alternative education
- Two moved from alternative education to be in university
- Two moved from education to finding employment
- One stopped their employment to join mainstream education
- 15 moved from not in EET into alternative education (eight), full- or part-time employment (five) and training or work-based programme (two)
- Two without pre-treatment information joined EET after treatment (one in mainstream education and one in full or part-time employment).

The 23 participants who did not achieve the EET outcome included 19 participants who were in the same situation before and after treatment, and four participants who quit their education after participating in the programme. These four participants did not complete their treatment (dropped-out cases) and include two Māori (one referred for mental health issue and one referred for delinquent behaviour), one Pasefika (referred for delinquent behaviour) and one Pākehā (referred for physical family violence).

The 11 participants whose EET outcomes were unknown include one Māori client who was in alternative education before completing his treatment (Table 9 part 2), and ten clients who did not complete their treatment (Table 9 part 3). Seven of these ten were in EET before stopping their treatment (three Pasefika, one Māori/Pasefika, one Māori and two other ethnicities) and three had unknown EET status before and after treatment (two Māori and one Pasefika).

Table 9. Improving education and employment

Before therapy	After therapy (all participants excluding 22 active cases) – part 1							
	Alternative education	Mainstream education	Full- or part-time paid employment	Training or work-based programme	Not in education, training, or employment	University	Unknown	Total before treatment
Alternative education	7	1	1	-	3	2	4	18
Mainstream education	1	23	1	-	1	-	2	28
Full- or part-time paid employment	-	1	9	-	-	-	1	11
Training or work-based programme	-	-	-	-	-	-	1	1
Not in education, training, or employment	8	-	5	2	19*	-	3	37
Unknown	-	1	1	-	-	-	-	2
Total after treatment	16	26	17	2	23	2	11	97

Before therapy	After therapy (Completed cases) – part 2							
	Alternative education	Mainstream education	Full or part-time paid employment	Training or work-based programme	Not in education, training, or employment	University	Unknown	Total before treatment
Alternative education	3	1	-	-	-	1	1	6
Mainstream education	1	14	1	-	-	-	-	16
Full or part-time paid employment	-	-	3	-	-	-	-	3
Not in education, training, or employment	5	-	2	1	9	-	-	17
Total after treatment	9	15	6	1	9	1	1	42

Before therapy	After therapy (Dropped-out cases) – part 3							
	Alternative education	Main-stream education	Full or part-time paid employment	Training or work-based programme	Not in education, training, or employment	University	Unknown	Total before treatment
Alternative education	4	-	1	-	3	1	3	12
Mainstream education	-	9	-	-	1	-	2	12

Full or part-time employment	-	1	6	-	-	-	1	8
Training or work-based programme	-	-	-	-	-	-	1	1
Not in education, training, or employment	3	-	3	1	10	-	3	20
Unknown	-	1	1	-	-	-	-	2
Total after treatment	7	11	11	1	14	1	10	55

Source: HCC data reconciled with CSS (01 Jun 2019 – 31 July 2022). Accessed 04 Aug 2022.

1.6 What helped or hindered the programme from achieving its outcome?

The culturally interwoven approach is helpful for families of different ethnicities

As the findings reported in earlier sections have shown, the cultural interweaving approach has substantially improved the quality of therapy with Māori and Pasefika families. Interestingly, this approach has also made Pae Whakatupuranga | FFT-CG a programme that suits a wider client base beyond Māori whānau or Pasefika aiga as well.

> *We actually use the framework with a Pākehā family as well, so we constantly look at how we can apply the model, constantly use it and reflect on it and use it with different whānau.* (IEW2 Therapist 1)

This approach is characterised by the following important features:

Whānau/aiga/families are offered hope and encouraged to be their own agent of change

FFT outlines the principles of minimising blame and changing to a positive focus during the motivation stage. Pae Whakatupuranga further encourages these principles by uplifting the mana of whānau/aiga/families, providing the therapists with the means and knowledge to be able to achieve this with clients.

> *Whānau experienced a different way of engagement. We were actually caring about their overall wellbeing and acknowledging that they've got amazing abilities. We really focus on how awesome they are despite the reasons that they were referred. It's not about the kid or the kid's problems or the offence the kid has done. We get them to be able to stand on their own two feet without services involved.* (IEW1 Therapist 1)

> *It allows you to tap into whānau knowledge. Instead of us working* **on** *whānau we're actually working together* **with** *whānau to reach a certain thing. The model helps me with a new way of looking, being able to see the noble intentions, the strength within*

> *the difficulty and channel that strength towards their benefits. We let them exercise their control and freedom and autonomy in a manner that enhances their own wellbeing. There's some sense of hope there's some sense of vision.* (IEW2 Therapist 2)

> *It is guided by families. Asking for guidance, asking for boundaries around what would or wouldn't be appropriate, giving them complete self-determination (rangatiratanga) so they are able to determine how they practise and how they want to engage with us, how they want these sessions to go. And when they feel empowered to be able to make those even the smallest of decisions, they buy into the programme.* (IEW2 Management 2)

We had positive feedback from families who are not Māori and Pasefika regarding this approach.

> *She didn't really say too much about what was coming up, but there were exercises about identifying our family values and talking about what our family meant. It's not the kind of thing that you normally do, so it was actually quite nice.* (IEW2 Pāk #3)

> *I suppose I was quite guarded and set in my answers with regards to what was going on. But [therapist] respected me in that she said she heard me and she said 'how about we try thinking about this way or could you try looking at it from this point of view' and I felt that I could trust her.* (IEW2 Pāk #2)

Therapists are humble and place themselves alongside whānau/aiga/family without judging

The therapists seek to match themselves with whānau/aiga/family so that client and their parent(s)/carer(s) do not feel that they are being assessed or spoken down to. They consciously endeavour to reduce the feelings of judgement that families often experience in social programmes after the difficulties and traumas they have experienced. The therapists spoke of the privilege of being able to engage with people in difficult circumstances and the need to seek guidance and approval from them as much as the family seeks the same. One manager further explained why this is an important feature of the model.

> *One key part of the model is around taking the context that whānau and rangatahi share with you and giving a positive aspect. Because often people hear what was wrong or what they need to fix what was broken. This model doesn't focus on that. It focuses very squarely on why people might be choosing to do those things even if they're not helpful, and the positive story that sets around those choices. Then it helps whānau to see those things and helps them to believe in themselves.* (IEW2 Management 1)

This approach was also was succesfully adopted for families of ethnicities other than Māori/Pasefika.

> *Some of the stuff we started doing at first, different scenarios, different exercises, I kinda knew wouldn't actually work. But the discussion with [young person] and that sort of thing I think was the biggest, probably one that actually helped. [Therapist] got a*

way of bringing things out of people that we they don't feel like they're being judged or anything so they can actually talk about stuff in a different way, and the other person like [young person] or [Mum] don't get upset about it. She was good, she didn't point the finger at [young person], she just said things in general. [Therapist] never came and said that we're here because [young person] was naughty. (IEW2 Pāk #1)

The therapists are committed and persistent with families

The positive aspirations of the therapists make them strongly committed to the cause of helping their clients. They are, in most cases, persistent in connecting with families during their difficult times, whether they are due to trauma, financial hardship, or the COVID-19 pandemic.

> *What made it successful for whānau is probably the persistence of the therapists, the strength and resilience to keep working and fighting with the whānau even when they're hard to connect with themselves. I think that is probably the biggest success factor, especially when we look at COVID-19. The therapists were able to figure out how to deliver a treatment that is only meant to happen face-to-face. They've been able to do it not face-to-face through COVID-19 pandemic and keep delivering the completion rates. That's amazing.* (IEW2 Programme Manager)

> *We've had some really good feedback from families in terms of the level of support and the tenacity with which we've shown our commitment to them.* (IEW2 Management 2)

This approach works for all whānau/aiga/family regardless of their ethnicities. The willingness of the therapist to show empathy and persistently seek solutions to the problems client families have has proved to be useful.

> *[Therapist] never gave up. Exercises that didn't work at the time [with young person] were brought up every now and then and it started getting [young person] thinking about it a lot more than in the past. My daughter had been through lots of different people and got different helps. and she couldn't connect with them. She really connected with [therapist] and I think that made the difference.* (IEW2 Pāk #1)

> *[Therapist] had to be incredibly patient. Not everybody was on board. [Therapist] was really good. She had a few techniques and was like super patient.* (IEW2 Pāk #3)

> *When I was having my challenges with [young person], when we were in lockdown, she was always on the other end of the phone if I needed to talk to her and gave me some guidance.* (IEW2 Mā #3)

In one example the mother was impressed by the way the therapist was willing to engage with her withdrawn son through social activities. Both the young person and his mother were touched by the unexpected activities and the sincerity of the therapist.

> *[Young person] was struggling with his confidence and trust and with attending school. [Therapist] has gone over and above, she offered to take [young person] to school. She even went out to McDonalds to chat with him. I know other people would*

do that for the service but [therapist] really would have done anything for [young person]. (IEW2 Pāk 4)

The holistic dynamics of whānau/aiga/family is considered, not just the index client

The FFT model is not about individual therapy. It involves all family members. This principle aligns well with Māori and Pasefika world views which are more collective than individualistic. The therapists, who were trained in both the FFT model and these cultural worldviews, have successfully applied a more relational collective approach for all whānau/aiga/family. This was recognised by the stakeholder as well as the participating family.

> *Their approach doesn't just single out the individual, which is what we do so often. For example, we go to the one with the addiction. We'll give them all the language all the thinking, all the frameworks but we don't bring the whole social grouping or family unit along with them. I think that's a real success that [the programme] is working with the whole family.* (IEW2 Stakeholder 2)

> *It was more like an overall family therapy, not just a therapy for [young person]. In the past we had psychologists and therapists but they were all about her, it was not about the whole family. This was the first time.* (IEW2 Pāk 1)

Outcomes for Pākehā families

Pākehā families have achieved significant outcomes during the pilot process. All interviewed Pākehā families confirmed the improvements they experienced in family dynamics and communication.

> *We're definitely well back on track and communicating well. We've got a teenager back that is prepared to communicate.* (IEW2 Pak #1)

> *We actually came together for a full hour at least once a week and we never do that. It was good to get the families together, it was good to talk about things. I think the program is invaluable. For me during such a difficult time I thought it was a bit like a beacon of hope.* (IEW2 Pak #3)

> *it was really good for me to be able to put processes in place to make their home a safe place, a place where they could feel safe and communicate how they're feeling and be okay, with it, not feel judged or anyone angry.* (IEW2 Pak #2)

Other expectations were also met through the programme. For example, one Pākehā family wanted the young person to overcome his negative feelings at school.

> *I just wanted him to come out of this feeling a little bit more confident and more positive and more hopeful and have a little bit more trust in people because he'd been let down by quite a few people and that's what caused him to not attend school. [Therapist] was absolutely fantastic and she definitely was somebody that [young person] can trust and it showed [him] that this world could be trusted. She definitely brought that part of it and gave him some ideas and strategies to cope with things and be positive with the future.* (IEW2 Pak #4)

Pākehā parents learned more skills. Some described role-playing and small tasks given by therapists during sessions to bring family members closer to each other.

> *We played strategy games, not just talking sessions. It was interactive which was really good for giving us strategies to cope with things. No matter what the problem was there will always be coping strategies that you can use from the programme to apply to whatever the issue is.* (IEW2 Pāk 4 Mother)

> *Are you angry, do you feel lonely are you tired if you are feeling out of sorts, what can you do in that moment to sort of calm down, give yourself time to breathe before you speak about it, and that's just worked wonders for my family. All the tools that we have been using productively I'm putting forward for the family, you know, just keep using stuff that worked for our family, we still use today, it's just become a daily paddle of what we do and our routine. (IEW2 Pāk 2 Mother)*

As an example, the father of one family shared how he found himself changed after participating in the programme.

> *We learned a bit about ourselves as well...It made me realise I can't hold together everything. That is just not gonna work so you start looking at what is more important and things you can actually do to help them.* (IEW2 Pāk 1 Father)

Even when Pākehā families were not as aware of their own culture as other ethnicities, they still recognised the respectfulness of the therapists and appreciated how they opened themselves to them.

> *When she first came in, she asked us if we have any religious point of views or if we wanted to do a prayer first. And we stated that wasn't us. From then before she asked us a few questions she would start with telling us a little bit about something in her family or her life to make us feel comfortable about talking about the things that were going on in our lives. She was definitely very sensitive and we totally felt respected and comfortable.* (IEW2 Pāk #1)

Teamwork and support from management have been key to meeting new challenges

The teamwork among therapists, their cultural supervisors and the practice lead was often referred to in interviews, alongside the support they received from their managers and the programme's steering group.

The therapists, especially those who were new, felt free to voice their difficulties among their team and seek support.

> *Being able to say out loud that I'm struggling with this I'm struggling with that and, from my end not being judged and being completely accepted for… it's fine we're all experiencing… our team environment has made it so incredibly accepting.*
>
> *That we would all rally around that person to try and help them.* (IEW2 Therapist 1)
>
> *It didn't really make sense to me, but then the more I practiced it, the more it became more natural. I'm feeling a lot more confident and it is because I am not embarrassed by the team, not being judged by my really bad pronunciation of the words and me*

> *asking can you say that again. It is about being upheld by the team, having them hold me in this space and then helping me to be able to hold the families in that same space as well.* (IEW2 Therapist 2)

The feeling of being well supported by their team is widely shared by the therapists. This helped them feel more confident in practicing FFT-CG and especially the culturally interwoven Pae Whakatupuranga framework. It also encouraged them to overcome the heavy training loads and the challenges of engaging with clients participating in the programme.

> *I'm confident in who I am and my own culture and the team that I belong to. I'm confident in their support.* (IEW2 Therapist 2)

> *I am in awe of how the therapists and this team have maintained their ability to hold emotional space for these families when they themselves have been journeying through some really difficult times with the pandemic, with losses and their own family health scares. My team has remained being open for each other, being vulnerable with each other, being supportive. With that level of commitment, it's just a shout out to this team of people who have hung in there with such tenacity. They know that we're supposed to be finishing with more families at higher caseloads. It bums them out. They don't want it to be this way, and so they've had to live with that. But through it all just the level of commitment has been phenomenal.* (IEW2 Management 2)

The teamwork was further supported by strong leadership and management. The therapists said they had an 'amazing' Practice Lead that 'always tried as best as she can to ensure that therapists stay in the right track'. (IEW2 Management 2). They also referred to the Māori Cultural Supervisor who provided the much-needed support in exploring, understanding, and applying cultural practices whenever they needed it.

> *We've got the Practice Lead that was able to get the uniqueness of every team member, to get the best of all of us. It has been the magic that has happened within the team environment.* (IEW2 Therapist 1)

> *The beautiful thing was the level of support that we have in explaining and managing tensions between accountability and fidelity to the FFT model and Pae Whakatupuranga. When we're dealing with culture we can't go wild and do everything under the heading of culture. [Practice Lead] has been beautiful in managing those spaces for myself and the team in areas where I struggle to match the two.* (IEW2 Therapist 2)

> *I'm working with an amazing team and being supported so consistently. There's always that communication within a team no matter what time of the day it is.* (IEW2 Management 3)

> *These are really well-trained, well-supported practitioners or therapists – that is what it feels like to me.* (IEW2 Stakeholder 2)

Many positive comments were made about the governance of the programme, especially during the COVID-19 pandemic. The organisation was seen to have responded flexibly and provided help for therapists when engaging with clients.

> *Being able to be really flexible and meet whānau where they're at. We've been really able to support them through a really challenging time. They had all of these external challenges from COVID and all of the pressures that have come with that. The programme has allowed us to support families through not just challenges with family dynamics, but also a number of other challenges during COVID. We've been able to be really flexible, we've been able to meet them on Zoom. We've been able to have phone calls.* (IEW2 Therapist 1)

> *I think the rest of our approach in terms of buy-in from executives has been really strong, which is probably why we've been able to run this kind of a pilot for this long through COVID.* (IEW2 Programme Manager)

Challenges in referrals and caseloads have slowed down the programme

The reduction in referrals has hindered the progress of Pae Whakatupuranga | FFT-CG. In the first six months of the pilot, the monthly numbers of referrals were generally over ten. These numbers were under ten during the 2020-2021 period and were smaller in the beginning of 2022 (Figure 12). Strangely, fewer referrals have been forthcoming as the programme has become more established with clear procedures, good therapeutic training, cultural trainings and supervision, and as the therapists have become more experienced. Therapists and managers described how this lower referral trend has hindered them from making progress towards larger client numbers and led to an unintended increase in treatment time.

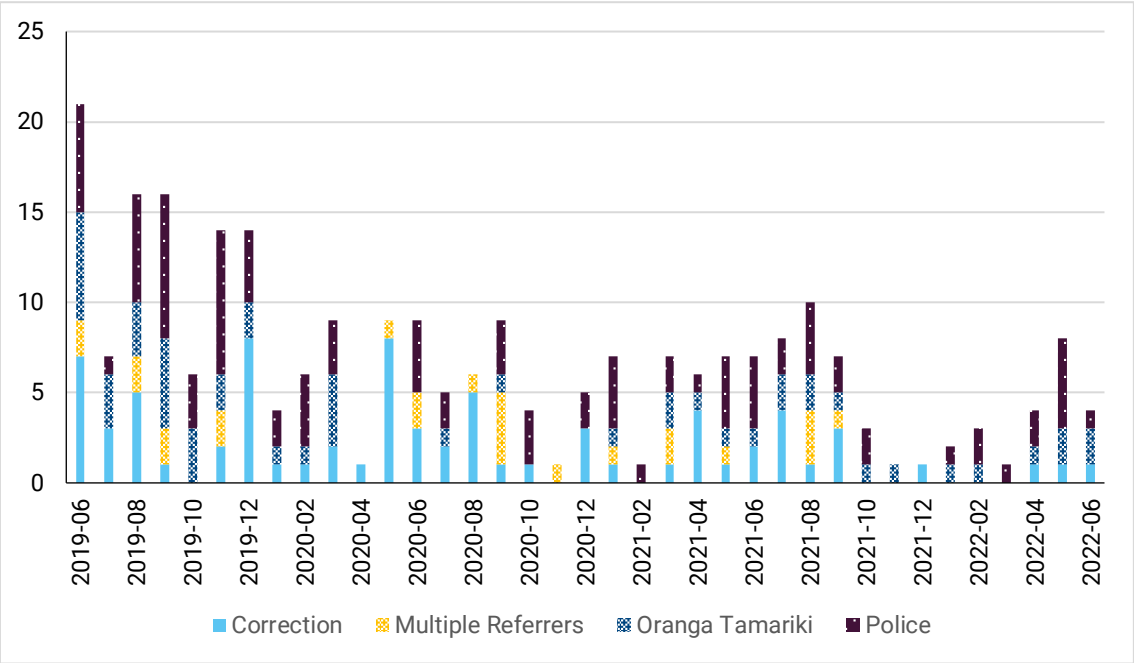
> *My therapists have had a lower than desired caseload. We're on like six or seven at the moment. If we had more waitlisted, we would have made decisions in the way that we executed the programme differently. For example, last night I just completed a family after more than a year. That may not have happened if we had a waitlist, we would have pushed them through quicker. For therapists, it's an unusual kind of conundrum. If you have only two or three sitting on a caseload, what you end up doing is stressing and worrying about those three families. A lot of the therapists haven't had full caseloads for a long time.* (IEW2 Management 2)

> *We literally don't have a waitlist. I go round sites trying to drum up referrals. There is no waitlist.* (IEW2 Management 3)

The COVID-19 outbreak has been the major cause of referral reductions and this impact is described in more detail later. However, the reduction was not the same for all referral sources. The Police have been more consistent than other sources in making referrals to the programme.

> *It has been Covid-related. Our referral sources are experiencing fatigue. They weren't going out seeing their clients face-to-face. So, in the same way, they were having the same kind of struggles that we were having.* (IEW2 Therapist 1)

Figure 12. Number of referrals by month and agencies



Source: HCC referral data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

Unlike other referral sources, the Police saw families at home more frequently because of 'call-outs' for them and they often involved therapists in this process. In this way Police were more set up for working in partnership with the programme.

> *Police did a much better job at that. They immediately would say 'Hey, therapist, come and meet this whānau with me. We want to refer them.' I think that's why Police have been so successful in their referrals, whereas Corrections and Oranga Tamariki worked under the pump in sending referrals. Sometimes they were acceptable ones, sometimes not.* (IEW2 Programme Manager)

In addition, Police seemed to have a clearer pathway than other agencies. One Pākehā family gave an example of seeing the therapist as a part of the Action Plan for the young person developed by Police. Unlike other agencies the Police never shut down or worked from home, even during the COVID-19 outbreak.

> *Police never shut down. They never worked in bubbles. They just carried on. referring right away.* (IEW2 Management 2)

For Corrections the process was different, and the cohort were generally older and more difficult to engage. Pae Whakatupuranga | FFT-CG is about the whole whānau/aiga/family, but Youth Justice in Corrections often focuses on just the young person. Probation officers from Corrections did not always go to clients' houses for a visit.

> *The team were new to working in the Corrections space and it's taken a while to get those relationships going and working well. The steering group's helped a lot but it's difficult working across multiple government services. The other thing is historically and culturally, I don't think we've worked with whānau who are quite as service-*

fatigued and mana-stripped as perhaps those from Corrections. (IEW2 Management 1)

The clients [young people] reported to probation officers. Sometimes probation officers will know the family. Sometimes not. We [Pae Whakatupuranga | FFT-CG] found it much more effective to go out first to the whole whānau, so that the whole family could have a voice around what happens for their family. But it is not necessarily part of the probation office's wheelhouse to go out to see families. That's not necessarily part of their day-to-day role. (IEW2 Management 2)

Interviews with stakeholders from Corrections mirrored this problem. Both interviewees mentioned the need to establish a 'liaison role' to facilitate better understanding and cooperation in the referral process. This role could fill in the gaps that were driving down their referral numbers.

There have been peaks and troughs in terms of referrals from Corrections. Every organisation has its own way of doing things and processes are hardly ever integrated. This is not our core business, but it is a big part of the business. Corrections is probably one of the most difficult partners to work with. So I think there needs to be a liaison role that get between all the organisations, a special person to want to really drive the uptake or to promote the programme in those kind of environments, someone who's got that passion and ability. (IEW2 Stakeholder 2)

Speaking from Corrections, I know that at the very beginning we were getting haphazard referrals. Kia Puāwai then started sending out the liaison person to engage with our staff, socialising the importance of the right referrals, the eligibility criteria, which improved the effectiveness, ethic, efficiency of the programme ability. (IEW2 Stakeholder 3)

Referrals from Oranga Tamariki have been fewest when compared with the Police and Corrections. Oranga Tamariki was more heavily affected by the COVID-19 outbreak because the staff worked in bubbles which impacted on the referral process. In addition, Oranga Tamariki has probably been more cautious in finding suitable referrals for Pae Whakatupuranga | FFT-CG.

Having worked at Oranga Tamariki, I could tell you that 90% of the kids on their caseload could come to us. Whether they're a good fit or not, that's a completely different story. But we're not talking about trying to figure out which kids would be best suited to us. There was excitement, everyone believes in the programme, believes that we're doing well but then doubts started to create, why aren't people faring? (IEW2 Management 3)

OT social workers in certain areas for example are very protective of Pasefika young people and are not necessarily going to refer to us unless they know we have the 'goods'. (IEW2 Therapist 1)

There were discussions about improving the referral process so stakeholders from referring agencies could be more involved in the programme. This will require some changes in these agencies' processes and probably a lot of goodwill from the staff.

There's been a number of whānau that have come through that haven't been right for the programme. A couple of weeks ago I suggested that we get those referral people, like Police, Oranga Tamariki and Corrections to come through and we have a noho about how the programme really happens. Then they should be able to really understand the type of whānau and young people that they're referring. (IEW2 Kaumātua)

Corrections are aware of [the low referral numbers]. There is a growing desire to move into that space where probation officers are more engaged with the whole family group. I felt like because it is our wheelhouse, we were able to do this and now Corrections can join with us on this and see. (IEW2 Management 2)

MINISTRY UPDATE: The number of referrals has recently increased. Kia Puāwai will continue to monitor the 'never began' referrals and provide feedback to their referrers. Some referrals may become inappropriate because the family's situation changes (e.g., the young person absconds). Such changes cannot be anticipated by partner organisations.

1.7 The COVID-19 pandemic and its impact on delivery and uptake

After six months into its early life, the pilot Pae Whakatupuranga | FFT-CG faced an unexpected challenge – the COVID-19 outbreak. The pandemic has affected the programme severely in many aspects. Though it is hard to quantify the impact in numbers, the following qualitative analysis shows how COVID-19 has negatively undermined the delivery, uptake and consequently intended outcomes of Pae Whakatupuranga | FFT-CG.

COVID-19 reduced referrals and subsequently the number of caseloads

All stakeholders spoke of the adverse impact COVID-19 had on referrals to the programme. The pandemic affected the way they worked by limiting interaction and their workforce's health and wellbeing.

I think referrals dried up. Agencies like ours were struggling with the pandemic, let alone referring people. There was probably less attention to caseloads sooner than needed. And we only really focused on the high risk rather than on, you know, treatment and better outcomes. (IEW2 Stakeholder 2)

As with the referring stakeholders, Pae Whakatupuranga | FFT-CG staff and members of whānau/aiga/family have been sick or have been unable to keep in touch because of COVID-19 isolation requirements. This has hindered the promotion of the programme and subsequent work with families.

Staff being sick, being away from work for long periods of time due to illness, slowed everything down. Without my intake specialist being able to go out to sites and having those face-to-face conversations that's really inhibited the number of referrals that we've received. We're not moving as many families through the model as we would like, which impacted the outcomes in terms of what we were contracted to see a certain number of families. (IEW2 Management 2)

It's so hard to even get the families to meet up with you for the first time because it's just sickness all over the place. First the daughter had COVID, then mum had COVID then the daughter had the flu, then I came down with COVID. It's been weeks of us not being able to even meet, because we were all sick.

For big families, where there were 7, 8, 9, 10 people in the home, and they just came down one after another, it took forever.

Two years ago if we had a cold we would still go to work, and now we don't do that. The families delay contact and we do too especially if they have younger children. (IEW2 Therapist 1)

Even when referrals were made, quite a number of whānau/aiga/family were not keen on treatment that used tele-health methods.

A lot of the families that we work with are not wanting to meet on Zoom. They're wanting to delay and say 'look, can we please meet in person that feels a lot different'. (IEW2 Therapist 1)

The small number of caseloads also made it difficult for effective evaluation as it did not allow for statistical significance with such a small sample. This was a further drawback for the pilot programme.

I don't think we have enough numbers to prove. We need 100 or 200 completions, but we've never achieved that. COVID really messed up everything. We just couldn't get those numbers. (IEW2 Programme Manager)

COVID-19 reduced training opportunities for therapists

Another challenge brought about by the COVID-19 pandemic was the reduced modes of trainings for therapists. Because of isolation requirements, new therapists did not have as many interactive cultural trainings as the earlier group. This has hindered their ability to acquire the needed cultural understanding and competence because they were not submerged in the learning opportunities with noho marae to more fully appreciate the benefits of the cultural frameworks.

It's been really disappointing that our new therapists have not been able to do noho [marae stay] to learn the framework rather than through weekly supervision. That incorporates the framework so much better than learning around the table…they haven't been able to experience that. (IEW2 Therapist 1)

COVID-19 reduced effectiveness in session delivery

The biggest impact of the COVID-19 pandemic was on the effectiveness of treatment delivery. Meeting online through Zoom or talking by phone has, in most cases, not been a good match for whānau/aiga/family. The cultural engagement process is not as compatible with an environment that is not face-to-face.

Therapists expressed difficulty engaging with young people and their whānau/aiga/family. In connecting with Māori whānau, they cannot practice giving kai or do manaakitanga properly.

In delivering sessions, they cannot apply the FFT engagement tools or engage whānau/aiga/family effectively in activities.

> *It was really awkward to meet online, I asked them to move it face to face: "I'll bring some kai around we'll just have a chat to get to know you better then we can move forward and see if this is a programme that you want to do, no pressure". When we actually got to meet face-to-face they said, "Oh, this is this is way different this is much more relaxed." Based on my experience meeting online hasn't been a good match for Māori. To do manaakitanga you need to feel the energy and everyone can pick up on each other's while we're actually in the room.* (IEW2 Therapist 1)

> *How do you keep the interest, how to not sound monotonous coming online? It feels very impersonal. We have to become very creative with engagement tools. Compared to being in the same room, not knowing whether they're doing what you're asking them to do is very difficult.* (IEW2 Therapist 2)

Families provided similar feedback for online/phone sessions.

> *We had sessions on the phone. It took a long time with COVID-19. When we started our sessions, he was not interested it took eight weeks to start him off.* (IEW2 Ma #2)

> *I preferred face to face I didn't like Zoom meetings. I found them absolutely hopeless. I would start losing concentration, because [therapist] wasn't there, [young person] would wander off.* (IEW2 Pāk #1)

> *Unfortunately, we had the last few sessions over Zoom and or phone and [young person] did not really like the sessions and I could imagine lots of other families would find it hard to actually be in front of a screen. I think we'll relate more to somebody in person especially when we're doing things like role plays and stuff like that. I just don't feel like kids would feel connected to somebody just over a screen*. (IEW2 Pāk #4)

> *It was really cool when we met face-to-face, it was more cohesive. Zoom meetings were not consistent enough for them to fully engage in it*. (IEW2 Pāk #2)

In addition to the engagement difficulties, the break between sessions due to COVID-19 isolation caused disruption to the dynamics between therapists and whānau/aiga/family. Sometimes this disruption was helpful so that young people and their parent(s)/carer(s) had time to reflect on what they learned during sessions. Most of the time, however, the disruption hindered the progress to better whānau/aiga/family dynamics. It also prolonged the length of treatment unhelpfully.

> *[the break from time to time] gave us time to work on things, for [young person] to reflect on things. The interruption was well timed a bit because [young person] was trying to get over it so that gave her that little bit of a break and then by the time we were back into it again because [therapist] was so engaging it actually brought us back.* (IEW2 Pāk 1)

> *I'm not a fan of doing things over the phone, I'd much prefer face-to-face. We did attempt to do an online session, but it just didn't work. So we had to wait until we could get back into the face-to-face session. If we were able to do the regular weekly*

> *sessions as we had planned we probably would have been affected a bit more because she would do really well and then something might happen and she would go off the rails and do something. And then it took like ten steps back. COVID-19 really interfered with it. I definitely think we would have done better if we were able to do our sessions without the disruption of COVID-19. Due to COVID-19 what should have been like a straightforward 12 or so weeks was actually spread over more than six months.* (IEW2 Mā #3)

In response to this challenge, the therapists were very persistent and creative in applying their skills to a new context of engagement and interaction, but it had consequences on the length of treatment.

> *COVID-19 's been tricky for whānau, for therapists, for engagement because we've had such long periods of lockdown. We talked about this kind of treatment pacing, which is how long you move through an intervention and the implications of not being able to meet face-to-face. It slowed it down quite significantly and that's been a bit of a hindrance to outcomes. If I was trying to hover around a little cell phone and include everyone, I don't think it can be helpful. It is really limiting.* (IEW2 Management 1)

> *It's taking much longer to move through the model with families that are consistently cancelling, rescheduling and then staff who are getting sick. And then, the motivation built was just lost when they had a lockdown. It's not necessarily only families who don't have great access to Internet, to Wi-Fi, to devices, but some families were so chaotic that really going out and stalking them is the only way you get them on board. And you can't you just cannot do that online. Having said that, a therapist recently was trying to re-engage a family and sent them a message saying, 'I'm going to be on Zoom. Here's the link at this time. I hope to see you there'. That didn't work. But, she kept trying. And it's uncomfortable. And no one loves that. No one likes calling families. But actually it's not personal. And we don't take people not responding to us personally. It took her nine weeks to get in front of the family. And when they could finally do face-to-face, he was crying. He was just overcome with emotion because she hadn't given up on him.* (IEW2 Management 2)

COVID-19 further impacted the expected outcome of the pilot programme by limiting options for young people who wanted to go back to education, employment or training. One Pākehā family described how COVID-19 has hindered her son's progress to participate in training after being in the programme.

> *Just really bad timing with COVID-19 it basically halts any progress. [Young person] has not attended school pretty much since he was 14. Now he is positive about trying to do some further training, but with COVID-19 at the moment, unfortunately, we can't. We haven't been able to apply strategies that we were taught to actually get [young person] back to school because of COVID-19.* (IEW2 Pāk 4)

COVID-19 undermined the flow of information to stakeholders

The provision of feedback to referrers on the progress of their clients was undermined by the COVID-19 outbreak. Kia Puāwai had worked hard in response to the requests from referrers to report back on how each young person/rangatahi progressed through the

programme. This was communicated back to referrers either through meetings organised by the steering group, or by therapists sending reports.

> *That was part of the programme. Everyone was reported back about what was happening. You had a good breakdown of the goals and what stage they were at achieving those goals.* (IEW2 Stakeholder 1)

> *The reporting has been conducted for us in a bi-monthly way. The reporting would indicate if those measures (goals of the programme) have been achieved. And the therapists reported on engagement at a high level or lacking engagement.* (IEW2 Stakeholder 2)

However, this feedback process and the flow of information was disrupted by the COVID-19 outbreak.

> *So, we usually get someone coming through the office to describe in detail about the programme and how it all began. But we lost touch with it over COVID-19, with everyone being scared to move into other people's offices, but hopefully that can pick up again.* (IEW2 Stakeholder 1)

1.8 Unintended consequences of the current programme implementation

Caseloads are taking longer than FFT-CG international standard

The US FFT model is driven strongly by time length data, with detailed data entries on specific dates (Referral Date, Open Date, First Contact Date, First Session Date, Date Closed) to count how many days clients have spent in each stage of the programme (Days from Referral Date to Open Date, Days from Referral to First Session, Days from Open Date to First Session, Days in Program). When this model was adapted to become the Pae Whakatupuranga | FFT-CG programme, the time length element became less important, especially in the pilot stage, and flexibility has become a key to successful delivery. Therapists and managers explained why expectations of how long a case should be are unrealistic, as the Pae Whakatupuranga | FFT-CG programme has now been wrapped in a culturally appropriate approach that emphasises proper engagement with young people and their whānau/aiga/family. That matching process requires tenacity and flexibility from therapists.

> *There can be expectations from professionals that we should have something done by a certain point. It could be challenging to explain that, as the journey is a bit of a roller coaster and it takes patience.*

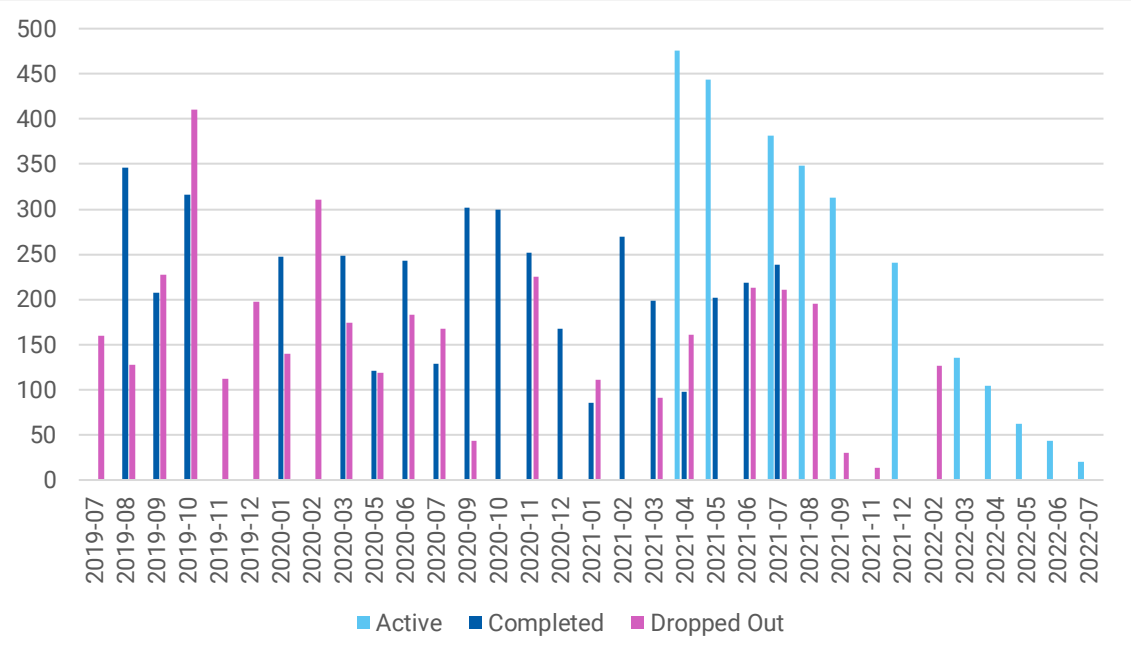
> *There might be some organisations or practitioners who have some kind of expectation about young people moving through our programme at a certain pace. It's disappointing when they don't have the same experiences as we have, they couldn't understand where we were coming from, the perspective of what we do how we do it, why we do it and therefore don't understand the time that it might take to do Pae Whakatupuranga.* (IEW2 Therapist 1)

I know everyone has struggled with building rapport with the family. And it took a minimum of six months for one social worker to get in touch and try and work with the family, to become more closely knit with them. (IEW2 Stakeholder 1)

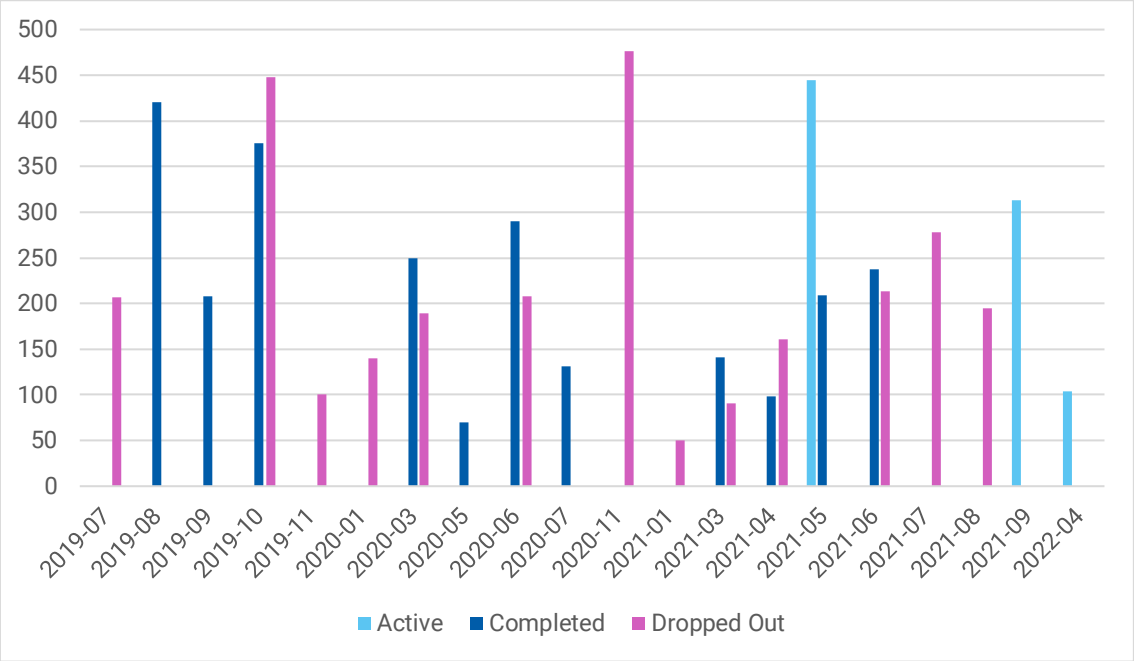
To be honest, it's [time length] unusual but I know this is really important. Without a few more sessions, that could have been a non-completion if we hadn't been tenacious. Their life was chaotic, being able to be flexible is important. (IEW2 Management 2)

Data on the number of days in the programme for completed, dropped-out and active clients show no clear difference between those statuses. There was a gradual decrease in the treatment time length of participants after six months of the pilot, however this trend is not totally consistent, with peaks and troughs and a reverse increasing trend in recent months (see Figure 13). In fact, those who recently joined the programme and are currently active seem to have longer treatment times than those who joined before and completed or dropped out. This is reflective of the feedback from therapists and managers at Kia Puāwai about the lower-than-expected caseload, which in turn tends to lead therapists to hold on to their cases longer (see section 1.6). When ethnicities are considered, again there are no clear differences between those who had at least one Māori identity, Pasefika identity and Pākehā identity (Figure 13).

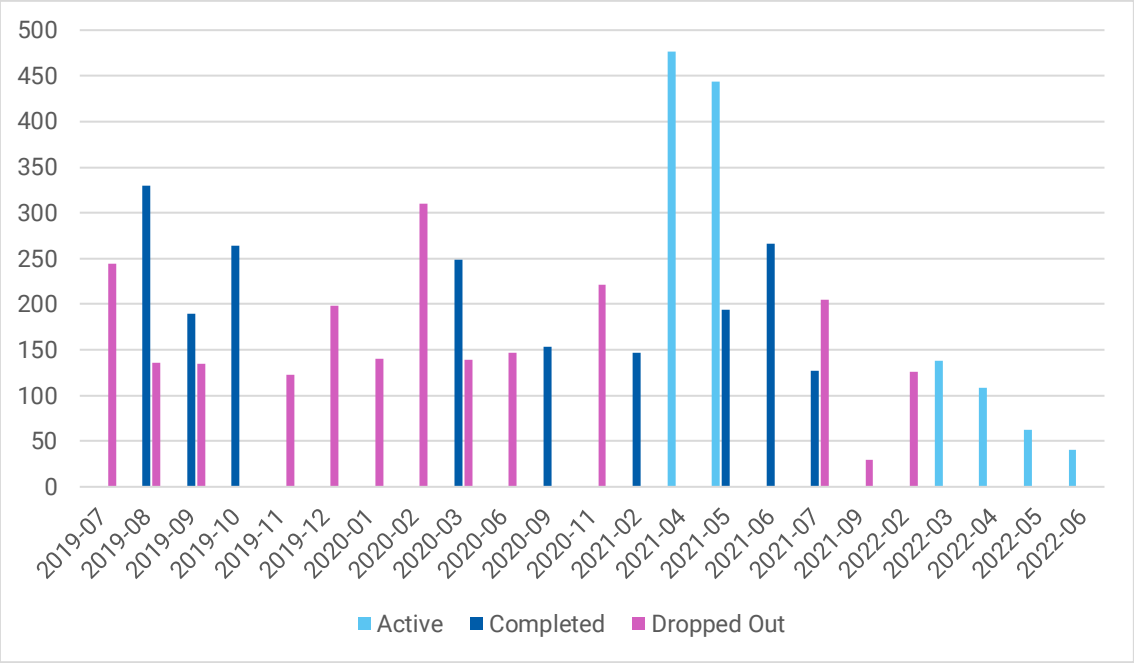
Figure 13. Average number of days in programme for all participants by start month



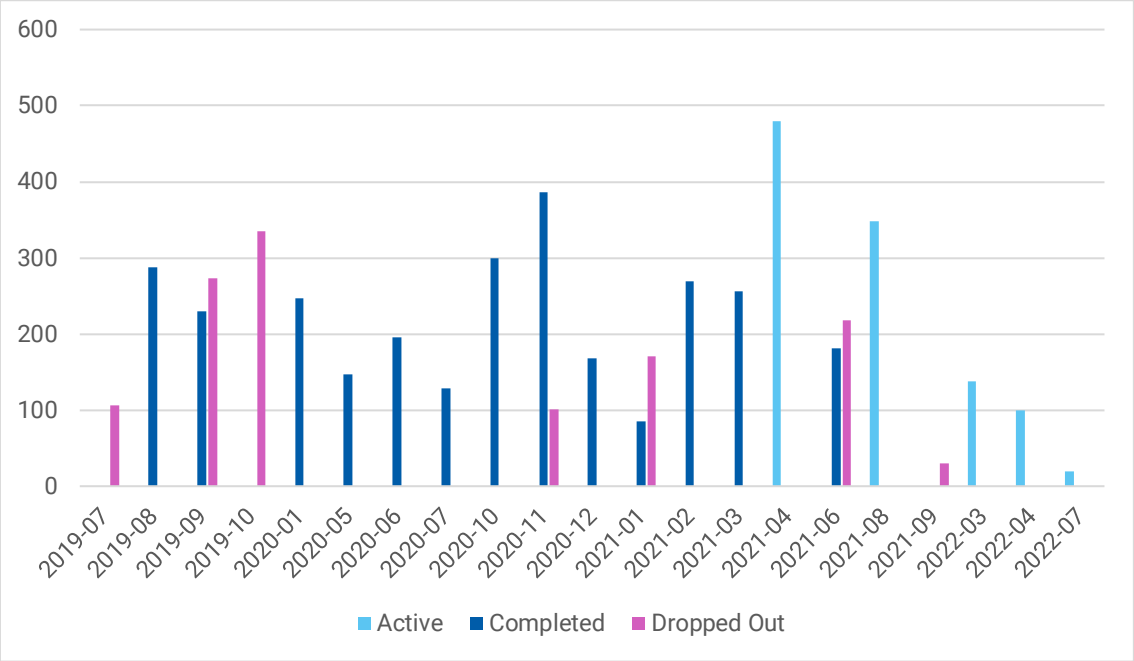
Average number of days in programme for participants identified as Māori (including dual identity) by start month



Average number of days in programme for participants identified as Pasefika (including dual identity) by start month



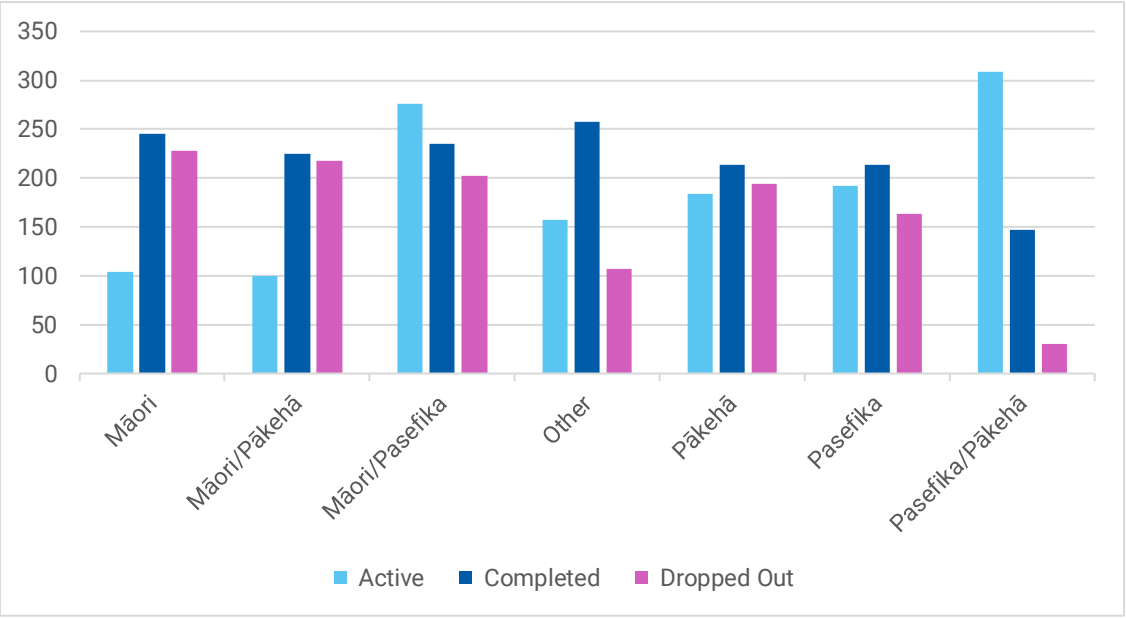
Average number of days in programme for participants identified as Pākehā (including dual identity) by start month



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

As of 31 July 2022, young people and their whānau/aiga/family spent on average 195 days participating in the programme. Those who completed their treatment took 227 days on average. Those who did not complete their treatment (dropped out) took 176 days on average and those who are still participating in the programme have spent 179 days on average. There is no clear time differences between the three major ethnic groups as Figure 14 shows.

Figure 14. Average number of days in programme for all participants by ethnicity and participation progress



Source: CSS data (01 Jun 2019 – 31 Jul 2022). Accessed 04 Aug 2022.

1.9 Improving programme effectiveness

Supporting and strengthening Pasefika cultural training and supervision

The Pae Whakatupuranga cultural focus on weaving knowledge is at the heart of this programme. The weaving together of cultural knowledge through the Whaitake Whakaoranga Whānau and Uputāua frameworks with the FFT clinical knowledge comprise the unique value of the service. In section 1.4 'Māori and Pasefika cultural training and supervision', we noted that the Māori cultural training and supervision has a longer history in the programme and takes place more frequently. We also noted that the therapists consider they are at an earlier point in the learning cycle with Pasefika cultural practice in their work.

The service could be improved further with a more planned approach to the interweaving of the Uputāua framework into the service in a manner similar to that achieved in the interweaving of the Whaitake Whakaoranga Whānau framework into practice and supervision. Therapists could enhance both their skills and confidence when working with Pasefika aiga with a more planned regular cultural supervision and training programme. This would need to be developed carefully so as not overload the training programme, but be sufficient for therapists to grow their cultural capacity and have a regular time, at least each month, to be trained and discuss relevant cultural matters with their Pasefika supervisor.

Some therapists are concerned that they do not receive sufficient Pasefika referrals to be able to practice Uputāua.

> *We haven't had the referrals to be able to practice UT. The service and programme and concepts are very effective, but we cannot prove that because we have not had the numbers of anyone going through that.* (IEW2 Therapist 1)

However, analysis of the uptake and participation data in section 1.1 'Overview of referred and participating clients' shows that Pasefika people are the second largest group referred, followed closely by the Pākehā group. Despite this, the Pasefika group had the highest dropout rate and the lowest completion rate. This presents a challenge to the service. It illustrates the size of the task the programme has commendably set itself with the Pae Whakatupuranga cultural goals.

The higher dropout and lower completion rates for Pasefika aiga are worthy of attention at the end of this pilot programme. An increased investment in time and resources into further Pasefika cultural training and supervision will help upskill therapists' understanding of Pasefika cultural processes and enhance the Pae Whakatupuranga goals of the service. It will further weave the Uputāua framework holistically into the programme.

> *Yeah, we haven't had as much training [in Uputāua]. I personally feel like talking about conceptual things, like particular components of the overarching goals. Like gifting is something that you do. Like spirituality is something that you consider. It doesn't feel like you can weave it in to FFT as easily. Because that's like a step-by-step type of things. You must consider hierarchy, you must consider those types of processes.* (IEW2 Management 3)

Only because it seems like the emphasis is Māori and that's how that works. I think we could have been stronger at all kinds of different cultures. But I think our biggest focus first is Māori and then everything else so [Uputāua] is coming along. They're still doing it. They're still interweaving it through their supervisions and training, it's still progressing, just not as strong as the multi approach. (IEW2 Programme Manager)

Supporting and strengthening Pasefika cultural training and supervision can be expected to improve both the participation and outcomes for Pasefika aiga.

MINISTRY UPDATE: Monthly Pasefika cultural sessions are now occurring which is enabling therapists to work more confidently with Pasefika aiga. Access to cultural leadership has grown with the inception of the Matua Council which has provided significant support to the team.

Improving understanding of intake and referral issues

Data reported on earlier in the text showed two problems that have arisen with referrals. Quite a number of them seem to be inappropriate, given that over 50 percent are coded 'never began' which means they didn't make it to a first interview. The other problem is that referrals slowed down substantially during the last year of the pilot to June 2022. During the first six months July to December 2019, the monthly referrals were generally over ten. During much of the COVID pandemic period, they were generally between five and ten. However, in the final year of the pilot to June 2022, they had generally reduced to under five.

There are a number of mitigating explanations suggested by management which will certainly explain some of the reasons, but the drop in referrals is large and it would be worthwhile developing a more evidential process for understanding the problems. Sixty percent of those who were referred to the service but 'never began' either didn't meet the criteria, or were withdrawn or referred to different services. The main mitigating factor suggested is that when a referral is made it is probably suitable for the programme, however prior to allocation to a therapist the family's situation may change. For example, a young person may have absconded, a more serious crime might have been committed, the family might have been forced into emergency housing and couldn't be contacted, etc. These situations could usefully have resulted in new codings, such as 'Withdrawn referrals/Referred to different services'.

No doubt this explanation may well explain a good number of the 'never began' category, but does it explain most of them? We simply don't know and it would be worthwhile developing an evidential database that could explain what is happening here. It could suggest, for example, that referring agencies may need different ways of being informed about the programme and the whole process of referrals could be increased and become more efficient.

With regard to the slowing down of referrals, again very plausible explanations have been suggested. A primary one is that following the period of COVID isolation, referring organisations experienced a number of problems that affected referrals. These included staff sickness, low staff numbers because of their difficulties with recruitment, the gradual transition from working from home back to offices, teams being split and working different

days, etc. As with the problems of inappropriate referrals, most of these factors were outside the scope of Kia Puāwai ability to influence. It would be helpful though, to develop an evidential base to better understand all the factors that may be impacting on the referral process.

Since the pilot finished, and thus beyond the scope of this report, it has been drawn to our attention that referrals have begun to improve again which is heartening. There was even a small waiting list of clients early 2023, but newly-employed staff were expected to reduce that quickly. The improvement is welcome, but it doesn't invalidate the recommendation to gather the data for greater understanding and future reference.

We are informed that the intake worker position is now a full-time role. At the time of interviewing in 2022, the position was filled by a therapist working part-time. We interviewed some of her families and she was considered very competent in both roles. However, her return as a full-time intake worker is important, given the question we are raising over some of the referral issues. The intake worker has a really important role in bridging the gap between referring agencies and Kia Puāwai. The intake specialist needs a wide brief to work with referring agencies in creative ways to better inform the organisations and excite them about the rehabilitative qualities of the Pae Whakatupuranga | FFT-CG programme.

For the Police, this gap is not as wide as the other two agencies – Corrections and Oranga Tamariki – due to procedures specific to each agency. Even when the procedures are compatible though (for example the 'call-out' situation at Police that enables them to engage Kia Puāwai staff as soon as possible) it is important to have a role that constantly promotes the programme and makes sure that referrers understand the programme well enough to make the right referrals.

> *I highly recommend having an intake specialist like a relationship manager with your stakeholders. It is so effective and it allows the Practice Leader to focus on the clinical development of staff.* (IEW2 Management 2)

Another benefit of having intake specialist(s) is that as a member of the Kia Puāwai team the person in this role will be well-trained in the Pae Whakatupuranga cultural approach, unlike referrers who are not always aware of it. Currently, referrers often rely on information provided in non-personal ways, but a specialist intake worker can take the time to more fully inform referrers of the nature and benefits of the programme, as the following quote from a referrer shows:

> *Q: Have you had an opportunity to read that [the manual on Pae Whakatupuranga | FFT-CG]?*
>
> *A: No.*
>
> *Q: It's based on a Māori approach to things. Do you think that approach has been effectively interwoven into the FFT?*
>
> *A: I'm not too sure. I only got updates when we had to have another FGC because one of the boys re-offended. I'm not sure how effective the philosophy was closer to the actual programme because like I said before, it's pretty hard to catch up with and*

there's not much around the design of the programme or philosophy. I don't really get the philosophy of the FFT programme. We mostly talked about programmes at FGC but I can understand the minimum. (IEW2 Stakeholder 1)

An intake specialist could consider bringing a therapist with them when appropriate, to start engaging with whānau/aiga/family early on.

> *Having that connection before they begin service could have been a learning for us and we could have done that better. Sometimes you get a social worker or somebody who is going to refer to Kia Puāwai and they just do out a sheet and flick it off to without saying like 'Hey, family, here's what this is about. Here's how it will work with you. Let me bring a therapist to talk to you', because the therapists actually know how to speak to the families to explain the therapy better than any of the social workers or referrers.* (IEW2 Programme Manager)

The Kia Puāwai intake workers are and have been flexible when helping agencies and clients to overcome the bureaucratic processes of referrals to enable appropriate people to join the programme, as the following example illustrates:

> *[An example family] were self-referral, like no one has reached out to us and said, 'Hey, could you take a referral for this family?' I told them 'Leave it with me. I'm going to get my intake specialists to contact Police who have been out to the house a number of times. We will write the referral, Police will sign it off and we will see you soon'. And they were like 'What do I do? Do we need to call the Police?' I'm like, 'You don't need to do anything. We're going to do it'.*
>
> *Police hadn't seen [this family] or a call out for six months. But that didn't stop them. We said 'We've got a family who would like some support. Would you back a referral?' 'Absolutely'.*
>
> *So, flexibility is really, really good. (IEW2 Management 2)*

It all helps.

Having a post-completion procedure that helps with whānau/aiga/family after participation

A recurring theme from previous evaluations was the need for activities after clients completed treatment. One Pākehā family suggested a 'checking-in' process to see how the family was progressing after treatment, or forming a network for participants to share experiences.

> *What I would suggest perhaps some checking afterwards to see how people are. A little bit more structured – sort of three months in six months in a year's time something like this (IEW2 Pāk 4)*
>
> *It almost would be good to have more continuation in some form, rather than just having to just move on and not have anything. Maybe it could progress from a one-on-one meeting with one person to some sort of group thing the kids can attend, children*

> *that are in the same sort of situation, a bit of community help, having other children that you can reach out to and be friends.* (IEW2 Pāk 4)

These ideas are coming from client families and could be useful in terms of achieving long term outcomes. If they are considered, the specific activities would need to be discussed and designed carefully. The clients of Pae Whakatupuranga | FFT-CG tend to go through a lot of systems and need holistic social and economic interventions, not simply therapeutic intervention. A subsequent support procedure or network could be implemented that socially connects the whānau/aiga/family who have completed the treatment but do not have the opportunities or capacity to pursue training or to apply for employment. Connecting whānau/aiga/family with others may not only be useful for addressing behavioural issues but would also provide support for those who are struggling with their own livelihood and issues of housing and low incomes.

> *When we talk about reducing re-offending for our rangatahi, it's currently inter-generational as we know. We shouldn't be waiting for our people to get into prisons before they start learning their identity. Reducing reoffending is not just for one, two, three, four agencies. It's for society.* (IEW2 Stakeholder 3)

Improving referral process to match the programme with client need

Quantitative analysis of outcome scores in YOQ, YOQ-SR and OQ highlights the relatively better performance of those under 18 years old (YOQ, YOQ-SR results before and after treatment) versus those 18 years old and older (OQ results before and after treatment). This result was supported by qualitative analysis, which highlights the need to intervene earlier, before a young person reaches the pivotal time of becoming an adult and before whānau/aiga/family are already worn out by unsuccessful interventions by different systems.

> *I would prefer to get families before they had fallen off the cliff. It's getting to the ones before they get in the system. That is important. Parents know that when you are not getting the correct answer you can't work your relationship with your kids. When it's not going well, they just don't know what to do about it. But they didn't know which services can help.* (IEW2 Management 3)

> *Everyone that I talked to has had problems with kids just as they start coming into puberty. If we had this intervention when she was, say, 11 years old, things would have been different for me because I could have changed my parenting ways as well, because it's a whole family thing.* (IEW2 Pāk #1)

As the programme has reached its final pilot stage, it could be considered time to review and refine the referral process so that a good match can be made between the methodologies provided by the therapeutic services and the needs of referred clients. This should not be seen as a 'cherry-picking' process but rather a therapeutic needs-matching process to ensure that different problems are dealt by appropriate approaches. Some problems could be prevented from getting worse by early interventions as described by the manager and the Pākehā family above. Other problems which have become more complicated will require a more comprehensive approach where different aspects are considered to ensure the effectiveness of the programme.

> *…. Understanding what the referral is, what type of whānau or what type of young people, what is the referral possibly going to look like. Really understanding that so that they know where they're going to go with the therapy.* (IEW2 Kaumātua)

This would also have the added benefit of being able to more realistically discuss with referring agencies, firstly the type of problems that are successfully resolved in the programme, and secondly reduce the 48% of referrals that never begin therapy.

2. LESSONS FOR FUTURE EXPANSION AND SUSTAINABILITY

2.1 Cultural integrity and subsequent training is key to programme expansion

2.1.1 Cultural trainings and FFT-CG trainings should be done at the same time

The pilot Pae Whakatupuranga | FFT-CG has shown how the cultural interweaving process has successfully improved the effectiveness of FFT-CG, not only for Māori and Pasefika clients but also for clients of other ethnicities, especially Pākehā clients. The rationale of these cultural worldviews resonates well with living situations of whānau/aiga/families who seek help from the Pae Whakatupuranga | FFT-CG programme. It does so, because this approach is about enhancing identity, bringing hope and confidence, and offering empathy at a personal and family level, rather than a conventional therapeutic intervention where whānau/aiga/family tends to be reminded about pathologies in their lives and what has been going wrong. For whānau/aiga/family that have been through many traumatic experiences, this approach is what they find different. It focuses on a deep level of engagement, where therapists are able to build a trusting relationship with young people and members of their whānau/aiga/family, and cultural understanding is key to this process.

The interviews in this evaluation have shown, that having cultural frameworks that can be consistently interwoven into all aspects of delivery makes the most difference for this programme.

> *Learning FFT, learning Uputāua, learning Whaitake Whakaoranga Whānau, that's a lot when you first start, but that really deepens your ability to practice well. (*IEW2 Therapist 1)

> *What is very unique is Kia Puāwai came with a cultural framework Whaitake Whakaoranga Whānau and we coupled it up with the Pacific framework and then they overlaid or underplayed the clinical approach. They then pulled that into a manual and that's an actual practice manual for clinicians. They embedded that as part of their training for all therapists and now that cultural approach is embedded in the practice with whānau. That practice framework is quite unique across New Zealand. That's probably one of the biggest things that I'm most pleased with. That was [the kaumātua] and [Pasefika framework creator] who pulled that together and made it a real tangible thing that was used and demonstrated through interventions. You can see the actual output, how therapists relate to and connect with whānau.* (IEW2 Programme Manager)

> *I've always said if you get a FFT and you get a Māori and you put the two together, you have something that is more powerful than FFT by itself. And that is what the staff are doing, the conversation they are having.*

One of the biggest things for me is making sure that, if we've got new therapists coming in, that they trained in all of them [FFT, Māori cultural training and Pasefika cultural training] all at the same time, not three separate trainings. (IEW2 Kaumātua)

The management, stakeholders and the kaumātua all expressed satisfaction with how therapists have achieved cultural competency in their practice, which is the result of successful cultural interweaving process with FFT and subsequent trainings and supports on a regular basis.

In the first year it was tricky because they learnt each piece individually and then tried to weave it. But now it's very much a part of the team. When they have their team meetings, they will talk about Pae Whakatupuranga and use that to describe their feelings. They have woven into their practice with whānau, and the way they engage with whānau, the way they reflect on practice, they've done a really good job of that. (IWE2 Management 1)

To see the passion that kaumātua had to share and it's received and reciprocated by the practitioners. They are really engaged. They can see the absolute positive from mahi and the narrative… That's another successful part of the programme. (IEW2 Stakeholder 3)

What I got the other day from our hui, the newest member hasn't even done any of the trainings but because of how the rest of the staff talk and do things and he's been in the cultural supervision, he is making headways. FFT and Pae Whakatupuranga, he's just picked that right up and he's running with it. I'm really happy with that. So we need to make sure staff are fluent in FFT, Pae Whakatupuranga and Uputāua. (IEW2 Kaumātua)

2.1.2 Close consultation with cultural framework creators, cultural supervisors and the whole cultural team should be maintained

Given the importance of cultural interweaving in the practice of FFT-CG, expansion of the programme needs to maintain a strong consistency of the interweaving and training process.

The consistency of training is really important. My worry is if you went and you gave this to Oranga Tamariki, it would just be called a passion and it just wouldn't be done in a way it should be. The priority has to be the consistency of how you practice, making sure that you've got support from the team and the team is set up with people that aren't judging. (IEW2 Management)

To maintain this consistency, interviewed stakeholders and staff all highlighted the need to discuss any future developments with the kaumātua and the support team.

Have that very first kōrero with matua [kaumātua] to see how he thinks it can roll out would be the best. (IEW2 Stakeholder 3)

I think if it's going to be rolled out elsewhere, making sure that there are huge discussions with the Pae Whakatupuranga team, myself and the cultural supervisor. Because, for me I'm absolutely over the moon we've got Pae Whakatupuranga book, a

training manual, videos they can look at during training. Over the course of the pilot, we've been able to create some amazing resources. If it is going to kick off, make sure that there will be lots of conversations with us because we've got heaps that we're able to share to make sure that it is a success. (IEW2 Kaumātua)

I would need to have cultural supervision and I would need oversight from kaumātua. I mean you have to get licenced to provide FFT itself through the governing body. I think the assessment of the services regarding cultural responsiveness would be a necessity around deciding where to place that expansion.

As an example, we have a role that's a kind of cultural advisor or rather a coordinator. The role is to go out and meet with whānau about therapists and the model, and also coordinate services. That role was really great and I think it is important to respond to the context you're delivering it and what sort of support role might be suited. (IEW2 Management 1)

2.2 Choice of expanding referral sources is to be considered against the model's integrity and funding resources

There were several lines of discussion about expanding referral sources when the programme is to be rolled out. For example, school referrals have recently been noticed as a source that is quite compatible with the programme. Two Pākehā families had difficulty with their children struggling at schools. The father expressed the wish to join the programme earlier as young people would then receive intervention earlier, rather than going through unsuitable programmes beforehand. It would have been much better and probably easier for the family.

Four or five years, I had been trying to get help and get thrown from one thing to another, things that weren't working. Being able to know that this sort of service is available sooner wouldn't have ended us up down the track of troubles. She [young person] started developing more problems and she was just becoming more and more into herself, self-harm and running away.

I think of schools and when they've got kids that start to be a major problem in school. [Young person] got expelled from three schools before. If they had the ability to join, if there are people that we can be put in touch with it might have helped prevent some of the things that we ended up going through later. (IEW2 Pāk #1)

The other Pākehā family suggested widening channels of referral. After participating in the programme, she recommended it to other people who were not aware of it. She suggested making this widely known as a Family Therapy programme.

When the Police referred to Kia Puāwai, I had no idea what it was about, that they actually even existed, that we could get some family therapy. I now speak quite highly of it to people, 'Can you try contacting Kia Puāwai because I had such a good experience'. I don't know if a lot of people know about it or people realise that they can have access to a service like this. I believe that once everybody knows that it's there, more will get to the programme. (IEW2 Pāk 2)

The managers supported this idea, giving an example of how families have reached out to Kia Puāwai directly to access the programme. Widening channels of referral will enable the programme to reach clients in need at an earlier stage, before they get to more difficult stages, for example, through the Justice system.

> *I was receiving referrals through the Kia Puāwai inbox. This family sounds like a good FFT family. I might be slightly biased, but that's how we came across them previously and I'm sure that there are many more like that who just haven't had interactions yet with Youth Justice. Across our current stakeholders, the most likely partner that we have that may have heard of these families is Police. Across that continuum, Police are probably hearing about families before Youth Justice or Corrections. Also, we were able to take referrals from schools. I don't know how but it was a psychiatrist, a GP and a nurse that gave them the pamphlet. (IEW2 Management 2)*

One stakeholder suggested using Family Group Conference (FGC) as a channel of referral for this programme because of a good match between the cultural approach of Pae Whakatupuranga | FFT-CG and the issues whānau coming to FGC often have.

> *I don't know why I haven't pitched to FGC because we just keep going with the same programmes. They have to meet certain criteria or they won't be accepted as high risk. We are left with a pool of whānau out there that pretty much can't go anywhere because they don't fit with these other programmes.* (IEW2 Stakeholder 1)

However, discussions about widening sources of referral need to consider the impact on the programme model. The Programme Manager explained the challenges when expanding referral sources. The first challenge would be how the programme could incorporate a self-referral stream. It may have to be run under the management of the Ministry of Health as a health programme. That could impact on how the model would be designed and implemented so as to meet the general requirements of the Ministry of Health. Secondly, widening sources of referral could change the funding model, which might require a different design and implementation.

> *I would love to be able to see self-referrals because there are reasons why whānau do that. And honestly, when they reach out that first time, if you don't fix it or if you don't help and support them in that first instance, they'll have to go through the motions until they get to a place where they're involved with Justice or Oranga Tamariki from a care perspective before they can get the help that they've been asking for the whole time.*
>
> *But then it becomes the Ministry of Health issue with the help with mental health and no longer Oranga Tamariki issue, which will bring complications as I would not want to change any of the framework. I do not want to stop doing this part of therapy, as I believe they are the right steps.*
>
> *While we have an across agency approach, it's not funded across its agencies. Oranga Tamariki has funded the whole thing and Police and Corrections have benefitted from it. We are happy about that as we want to be and have good partners in the community.*

But if all three had been funding, it would have been stronger and easier to be able to roll out. But I'm not sure as it may involve different procedures, and everybody is struggling and fighting for funding and it really complicates things. (IWE2 Programme Manager)

2.3 Data recording and tracking process

Originally designed by FFT international to capture the performance of the model, data recording, monitoring and analysis is an important process of Pae Whakatupuranga | FFT-CG. The data is used by FFT international to evaluate and compare the performance across different organisations in different countries. For managers and stakeholders, this data process gives them insights into how well the programme has progressed, and how well it has achieved the intended outcomes. Using the information generated by this process, Kia Puāwai has developed a dashboard to provide a monitoring tool for management and stakeholders to keep track of the programme (Appendix 2).

The data recording for Pae Whakatupuranga | FFT-CG is quite rigorous, and it will be important for any new development to continue that commitment. The database is transparent and reports key aspects of progress and outcomes effectively, as the data in this report demonstrates. Community organisations in New Zealand are often much less rigorous in their data collection and it will be important that any future expansion maintains the current transparent standards of recording. It is a strength and an essential aspect of the programme.

That said, as we have identified in the previous evaluation waves, the current process of data recording could be improved. Although it provides transparent and important information on the programme, it could be improved and become less onerous.

It is fragmented and requires many reconciliation efforts. Two systems are currently used to record the progress data of Pae Whakatupuranga | FFT-CG. CSS is used by FFT international, and even though it was upgraded into a new platform in 2020 that has allowed for more flexible entries to suit the New Zealand context, it is not adequate to capture the ethnicities and sources of referral for participants in the programme accurately. HCC is used by Kia Puāwai (the implementation agency) and has been the primary source of accurate data on ethnicity and the referring agencies within the New Zealand context.

There are overlapping entries in demographic characteristics of the participants, for example the primary ethnicity, the living situation, and the education status, that do not always agree[17]. There are additional entries in HCC to capture extra progress information that are not captured by CSS. Also, outcome data is currently stored in different platforms (see Appendix 1 for the sources of data used for evaluation) which complicates data retrieval.

Expansion of the programme and the sustainability of the programme needs to consider all of the above factors in data recording and the tracking process. A clear procedure to

[17] In this report we use HCC for data on ethnicities, living situation before and after treatment, education before and after treatment. We use CSS for case progress status and reasons for referral.

establish the required data input needs to be set up that allows the subsequent development of a dashboard that it is able to link up all relevant data. In doing that, it is important to ensure matching data between FFT-CG international (CSS) and the implementation agency (HCC in this case).

> *MINISTRY RESPONSE: We do not think that the inability to link the CCS system used by FFT to the HCC system used by Kia Puāwai makes the programme less sustainable. Nor do we believe that it impacts our ability to report back on outcomes or other data. This is an issue experienced by many other agencies delivering FFT globally*.

2.4 Staff safety and stability and organisation flexibility must be considered for sustainable expansion

The outbreak of COVID-19 has highlighted the importance of being flexible, especially from a management perspective. It has also shown the importance of having committed staff with the tenacity to work well through difficult times. The programme requires a stability of service through unexpected events like a pandemic, and through staff changes and turnover.

> *So, it was [staff name 1] and then it was [staff name 2] and then it was [staff name 3] and then it was [staff name 4] and now it's me. [Staff name 4] had a baby and has gone and [staff name 5] had a baby and has also gone.* (IEW2 Management 3)

> *It would be helpful to look at recruiting in a way that maintains the likelihood of staff retention. It's been difficult to put up with the number of staff changes. Also there's been staff changes of our stakeholders and there's been lockdowns which have really restricted the ability to go out and even have that face-to-face connected relationship.* (IEW2 Management 2)

To achieve this, it is important to recruit the right staff and retain them with safe and stable working conditions.

> *We've actually had quite a number of staff leaving, not just us but in other organisations. And I'm not sure what that's about, it could be money or growth opportunities, or not enough trainings due to the last two and a half year of COVID-19. People are wanting job stability.* (IEW2 Kaumātua)

> *I was very surprised that in her first visit [therapist] turned up on her own. It would be good to ensure their safety going into somebody's home, just knowing that they have a lifeline or something that they could do to get out of a situation quickly.* (IWE2 Pāk #1)

Analysis of the helping factors in the programme has shown that successfully interweaving the cultural frameworks and the subsequent training and regular cultural supervision process is key to service delivery. It not only provides understanding and skills, it also develops teamwork, shared values and respect among staff members. Staff can come from different backgrounds, as long as they have the needed skills and qualities, and an open mind for learning together and working respectfully and cooperatively.

You know, being a Māori doesn't mean you will get the absolute trust and confidence of our people. It takes some time to get the trust and confidence of anybody. We've already got the model, that's the successful key component. We've also got the operational arm that keeps us all tied in together. (IEW2 Stakeholder 3)

3. CONCLUSIONS

What do the findings tell us about responses to the evaluation questions?

The findings of this evaluation have been set out systematically to respond to and answer, to the extent possible, the primary evaluation question which is categorised into the six sub-questions. The primary question for this impact evaluation is: *To what extent has the programme achieved its wellbeing and pilot infrastructure outcomes, by mid-2022?*

The six key evaluation questions address specific dimensions of progress towards the wellbeing and infrastructure outcomes goals. The responses are outlined in order under each question.

Some repetition is unavoidable because some evaluation questions draw on findings that are just as relevant to other questions. For example, in response to KEQ 1 about outcomes for Māori and Pasefika people, the findings referred to may also be relevant to KEQ 4 about what has been learned that can improve the effectiveness of the programme and KEQ 6 about making the programme more sustainable. Likewise, some findings that are pertinent to KEQ 2 about what helped or hindered the programme to achieve its outcomes are also likely to be relevant to KEQ 3 about unintended consequences of the programme and KEQ 6 about lessons learned that will make the programme sustainable. Although it is inevitable that certain findings will be referred to under more than one KEQ, the context will be different.

KEQ 1: How well did the programme achieve outcomes for Māori and Pacific Peoples, including the outcomes they wanted to achieve for their whānau/family through FFT-CG?

119 clients and their whānau/aiga/families participated in the pilot over the three-year period. While 22 are still active, 42 completed the therapeutic course and 55 dropped out. Of the 97 whose cases are closed (i.e., not including the currently active cases), Māori and Pasefika had lower completion rates than Pākehā, at 42% and 31% respectively, while by comparison 64% of Pākehā completed[18].

The therapeutic course has five primary stages of treatment: Engagement; Motivation; Relational assessment; Behaviour change; and Generalisation. If we add those who reached the final generalisation stages of the course to those who fully completed, then the Māori rate increases to 50%, the Pasefika to 38%, and Pākehā to 71%.

The programme manages to take Pākehā clients through the full course to completion more successfully than it does for Māori and Pasefika clients. It should be borne in mind though, that the client base is drawing upon households experiencing serious social, legal and economic difficulties for whom the programme was designed. Furthermore, the Māori and

[18] These counts used dual cultural identity, i.e., if a client has both Māori and Pasefika cultural heritage they figure in both the Māori and Pasefika counts.

Pasefika referrals are more than two and a half times more likely to be referred for delinquent behaviour than the Pākehā referrals (see Figure 3).

However, the interviews with Māori whānau and Pasefika aiga have consistently stated, throughout each wave of the evaluation process, that the therapy has enabled a distinct improvement in communication and family dynamics for them. They refer to finding new ways to talk with each other about their feelings and resolve conflicts. Whānau and aiga members spoke of how they had learned to discuss hard issues in a safe way so that matters do not escalate.

A comparison of the levels of distress experienced by younger Māori and Pasefika clients (11 to 17 years) before and after treatment showed serious levels of distress pre-treatment and substantial reductions in distress after treatment. These changes were less pronounced for the older clients (18 to 24 years). They also assessed their own improved family dynamics as being 'a lot better' which was a higher score than the Pākehā assessment, and parents referred to learning new parenting skills.

The distinctive cultural achievement of the entire programme is demonstrated in the cultural approach to therapy. The Pae Whakatupuranga interweaving of the Māori and Pasefika cultural frameworks with FFT enables the therapists to fully engage in the cultural world views, while also drawing on the developed wisdom and experience of the international FFT organisation.

The Pae Whakatupuranga process is continuous with ongoing cultural supervision and training which enables the therapists to mature in their cultural sensibility within the therapeutic process. A manual has been devised that sets out the interweaving principles and practice of the Whaitake Whakaoranga Whānau Māori framework, the Uputāua Pasefika framework, and FFT. It is a substantial achievement. The consistently high scores on the cultural satisfaction forms filled in by clients clearly demonstrated their appreciation of the rich cultural approach the service provides.

Overall, the programme has achieved substantial outcomes for Māori and Pacific Peoples. The cultural approach to therapy is greatly appreciated by clients and the ongoing cultural training and supervision has developed confidence and skills among the therapists. Both the interviews and the data from the various assessment forms for clients and their families attest to the positive changes in family dynamics and communication.

The challenges are to develop successful ways to improve the therapeutic completion numbers and restore Pasefika cultural training and supervision to the level it was prior to key staff moving on.

KEQ 2: What helped or hindered the programme from achieving its outcomes?

Things that have helped the achievement of good outcomes are:

1. Improved family communication has enabled better conversations between young people and their whānau/aiga/families around key independence issues of leaving home and participation in education, employment, and training (EET).
2. The culturally interwoven approach has improved therapy for Pākehā and other ethnicities as well as for Māori and Pasefika clients.
3. Teamwork and support from managers have been key to meeting new challenges.

Things that have hindered the achievement of good outcomes are:

1. The referral process and resulting lower caseload, part of which is outside Kia Puāwai control, have under-supplied client families who could have benefitted from the demonstrated success of the programme.
2. Although very good cultural support is available, the less frequent and regular Pasefika cultural training and supervision has somewhat reduced the early momentum of Pasefika cultural learning and engagement with the therapists and Pasefika clients.

The improved quality and safety of conversations between young people and their whānau/aiga/families has enabled them to work through their issues of independence, particularly where they live, without simply leaving in conflictual ways. At the end of the programme, 80 young people out of 97 who had finished treatment, chose to continue living with their families. All of those who completed therapy either stayed at home or moved successfully into independent living.

At the start of the programme, 58 of the 97 participating clients were in some form of EET. The outcomes for 11 clients is unknown, but after treatment, 63 of the remaining 86 clients were participating in EET. Fifteen had moved from not being in EET to becoming active in EET. Three of the 58 in EET at the start of the programme no longer participated. In the interviews, families considered the improvement in EET participation was a result of better communication within their families that had been aided by the therapy they had received.

As has been noted, the cultural interweaving approach of Pae Whakatupuranga has substantially improved the quality of therapy for Māori and Pasefika clients. It was noted by therapists, managers, and Pākehā clients that it had also enriched the experience and outcomes of therapy for the full range of clients of all ethnicities. The attributes of the approach that families identified helped them were:

i. The focus on the holistic dynamics of whānau/aiga/families rather than just the index client

ii. The emphasis on minimising blame and using a positive focus that enhances the mana of all people

iii. The humble approach of the therapists who place themselves alongside whānau/aiga/families without judging

iv. The commitment and persistence of the therapists to achieve good outcomes for the clients.

The successful outcomes for Pākehā families, when the therapeutic process is interwoven with the Māori and Pasefika cultural frames, confirm the positive experience all the Pākehā client families reported during the interviews.

The teamwork among the therapists, their cultural supervisors, the Practice Lead, and other managers was frequently identified as a source of support and sustainability. This was sorely tested during the COVID-19 pandemic which they managed well and in a sustainable way.

There are also processes that have hindered the achievements of the programme. Chief among them is the referral process which has been problematic throughout the pilot programme. As noted in the overview of findings section, it is our view that reporting referrals that 'never began' misrepresents the effectiveness of the programme. Most of the categories used in the US CSS monitoring system for 'never began' were questionable. There are a number of mitigating explanations because of events that can occur between referral and treatment, but it is quite possible a number of these are simply inappropriate referrals

The categories may have a different application in the US. Figure 1 in this evaluation, using the CSS monitoring system, shows 249 referrals with less than half going on to become participating clients. Gaining good evidence about the 'never began' referrals will help the service understand more precisely what is happening and could enable the development of a more targeted and efficient referral base.

The other problem in the referral process is the reduction in the number of properly referred client families. Over the final year of the pilot, they dropped below five, apart from one exceptional month. As noted earlier, we have been informed that the referral numbers have begun to pick up since the pilot was completed but it remains important to monitor the referral processes.

KEQ 3: What are the unintended consequences of the programme?

The main unintended consequence affecting the programme was the COVID pandemic. Impacts are further set out in KEQ 5 below.

KEQ 4: What has been learned that can improve the effectiveness of the programme in the future?

KEQ 2 addressed the matters that helped or hindered the programme from achieving its outcomes. Consolidating the three actions that helped the programme the most is an important learning. They were: 1) improved family communication; 2) continuing the Pae Whakatupuranga interweaving; and 3) the teamwork and support from managers.

There are two other improvements that may increase the programme's effectiveness that are worthy of consideration:

1. Developing a post-treatment procedure for young people and whānau/aiga/families who would appreciate it.
2. Matching referrals more with what Kia Puāwai does best. The quantitative data indicates more success with clients under 18 years old. Schools could be looked to as a referral source where young people are either offending or at risk of offending. This is an addition, not a suggestion of neglecting those 18 years and over.

A recurring theme from the previous evaluations is the need for some form of post-treatment activities for those who consider they could benefit from them. It was probably too early to consider this possibility when the programme was being developed, but now that it has an early form of maturity and there are increasing numbers of ex-clients, it is worth considering people's requests for it. This could take the form of a checking-in process, developing a network of parents or young people, or creating useful activities like those used by FFT therapists that families enjoy.

These activities could provide support for those who have slipped back. They may also offer young people who have been through the whole process and are willing to help others, go through it. A buddy system, for example, could be developed. These suggestions need to be considered in light of the value they offer, and resources required to make them happen sustainably.

A further effectiveness measure that has emerged from the findings is that the quantitative analysis from the various CSS questionnaires shows the service is more successful, and therefore better matched with those under 18, than the older age group. This is not a recommendation to abandon those 18 years and over who need a service like this. It is rather an invitation to reflect on where the current successes are more prevalent, and at a time when referrals need to be built up, consider where the service can successfully increase its contribution.

Staff and families have referred to getting the programme to people while they are younger and preventing the tougher problems that emerge with age. It could be worth considering referrals being extended to the education system where counsellors, social workers and psychologists often engage with families who have much the same difficulties as clients currently participating in the programme.

KEQ 5: How have COVID-19 alert levels affected the delivery and uptake of the programme, and the programme intended outcomes?

The COVID-19 pandemic affected the delivery and uptake of the programme in the following ways as it:

1. reduced referrals and subsequently caseloads
2. reduced training opportunities for therapists
3. reduced effectiveness in session delivery
4. undermined the flow of information to stakeholders.

The pandemic reduced the flow of referrals. Stakeholder agencies spoke of coping with their immediate problems with staff loss and client unavailability due to illness and sick leave, and focusing less on other matters like referring out to agencies like Kia Puāwai. When referrals did arrive, Kia Puāwai then had their own problems with members of their staff on sick leave and the delays sometimes negatively impacted on engagement. Furthermore, some members of whānau/aiga/families who had become sick or had been unable to keep in touch because of the COVID-19 isolation requirements, either never got started or did not later return. These problems created an extra hurdle to early and ongoing engagement.

The cultural training at the heart of the Pae Whakatupuranga interweaving approach had developed a good rhythm with in-person training, noho marae experiences and close interpersonal teambuilding. The isolation requirements of the COVID-19 pandemic reduced the modes of training opportunities for therapists. This impacted negatively, particularly on new therapists, who did not have as many interactive cultural trainings as the earlier group.

The biggest impact of the COVID-19 pandemic however, was on the effectiveness of treatment delivery. Whānau/aiga/families often found it difficult to talk about deep personal matters online through Zoom or by phone. The therapists were not able to practice all of the aspects of the manaakitanga they were taught, like personal embrace, e.g. hongi, kihikihi, giving kai and the extra opportunities to connect warmly possible when they are in the room with the clients. Families also noted that the breaks between sessions, caused by the isolation requirements, often disrupted the dynamics they experienced with the therapists.

The flow of information to stakeholders was also disrupted. The personal connections that are important for further referrals, moved online, and due to sick leave were less regular. Stakeholders reported the lack of contact with Kia Puāwai staff coming through their offices over the COVID-19 period led them to lose touch in some cases.

KEQ 6: What lessons have been learned about making the programme sustainable?

Three key lessons have been learned about making the programme sustainable. These are:

1. Cultural integrity and subsequent training and supervision is key to programme expansion.
2. Improving the referral process.
3. Data recording and tracking process.

In KEQ 1 and 2 responses above, the significance of the Pae Whakatupuranga interweaving of the Whaitake Whakaoranga Whānau Māori framework and the Uputāua Pasefika framework with FFT has been clearly outlined. It is the innovative heart of the programme that has been designed to address the problem of New Zealand's consistent failure to provide culturally appropriate effective services for Māori and Pasefika young people who are at risk of offending. The inequities that follow from the failure to address this problem

throughout the Police, Corrections, Oranga Tamariki and Justice systems in Aotearoa have been well documented[19].

The collaboration with the successful US-based FFT LLC that incorporates the two cultural threads is innovative and proving to have some measurable degree of success as the evaluation of this three-year pilot programme shows. A critical part of that success has been the close involvement of whānau/aiga/families and their deep cultural ways of seeing the world and doing things. At the heart of this has been the rigorous approach to cultural integrity, training and supervision.

KEQ 2 above noted the need to study the referral process of the 'never began' category and monitor the current increase in referrals since the pilot was completed. It is the view of the evaluators that there is no lack of young people within the referring organisations who could benefit from the programme. A greater understanding of the obstacles within referring agencies will help streamline the referral process. Continuing to develop strategic approaches to the referring agencies, such as targeting supervisors, presenting very good communication materials, etc. all help.

Recommendations to extend the referral base into the education system were also made by interviewees. This would play to the programme's strengths with young people and enhance the preventive aspect of the work. School counsellors, social workers and psychologists often engage with families who have much the same difficulties as clients currently participating in the programme and they could be helped, preventing problems before they reach the more law enforcing services of the state.

We have pointed out in earlier evaluations of the programme that while the current data recording is transparent and useful, it is unnecessarily complicated because the CSS system used by FFT international is not linked to the HCC system used locally by Kia Puāwai. The CSS system does not record New Zealand ethnicities accurately, nor the sources of referral for participants. There are overlapping entries, e.g., the primary ethnicity, living situation, and education status of participants, that do not always align.

The system currently requires reconciliation efforts because the data in the two systems is not matched. Important outcome data is stored on both platforms which unnecessarily complicates the retrieval of key information. It is important that matching data is used on both systems that allows speedy and up-to-date retrieval, and a current dashboard that is congruent with both systems.

[19] Oranga Tamariki Evidence Centre (2022) *Disparity and Disproportionality in the Care and Protection System to June 2021* www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Report-on-disparities-and-disproportionality-experienced-by-tamariki-Maori/Report-on-disparities-and-disproportionality-experienced-by-tamariki-Maori.pdf

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4. RECOMMENDATIONS

The pilot of Pae Whakatupuranga | FFT-CG from 2019 to 2022 has developed and refined different stages of the pilot programme. After two formative evaluations and one impact evaluation prior to this fourth evaluation, the programme now has established procedures for referrals, uptake, service delivery and case closed outcome evaluations. The programme has been designed to work in the difficult area of reducing youth offending and enhancing client family wellbeing in culturally appropriate ways, so success needs to be understood in terms of the widespread ethnic biases and struggles many services designed to turn around youth offending have had in New Zealand.

The two impact evaluations, especially this one, have identified successes in delivering effective family therapy services to Māori and Pasefika clients, as well as clients of other ethnicities, mostly Pākehā families. The pilot also met with the substantial challenge of the COVID-19 pandemic, which further highlights its success in continuing to respond well to client whānau/aiga/families during a very difficult time for it and other agencies.

Our previous evaluations have made numbers of recommendations, many of which have been taken up by the programme. Given the emerging early maturity of the service and its comparative success, we put forward the following four recommendations.

Prioritising Pasefika cultural training and supervision

The Pasefika cultural leaders have, and continue to contribute a lot to the overall programme. There is a current need to increase the momentum of Pasefika cultural training and supervision for therapists to enhance their cultural capacity and build confidence. An investment of resources and time that prioritises frequent and regular training and supervision at least once a month would enable therapists to work more confidently and effectively in the early interviews in particular. The data shows a higher drop out and lower completion rates for Pasefika aiga. Therapists have appreciated the Pasefika training and supervision and would be responsive to further support.

Study the referral process and diversify strategies with referrers

More than half the referrals are categorised ‘never began’ because they don’t reach the point of a first interview with the service. There are mitigating reasons for at least some of them because their status may change between the referral and contact with Kia Puāwai. However, the number is large and may relate to uninformed or unsupported referrals. There is a need to gain information on the referral pathways to provide solid evidence on what is happening and how the situation can be improved.

There was also a substantial reduction in referrals during the last year of the pilot, even though they were higher during the main period of the COVID lockdown requirements. We are informed they have increased again since the pilot and this research was completed. There is a need to acquire solid evidence about what is working and what doesn’t work in the referral space, so that the process can be more streamlined.

Various innovative strategies have been tried to streamline the referrals and the service will benefit from further work in this area. It could include: liaising with referrers to find suitable programmes and processes within each referring agency to promote the programme and skills of Pae Whakatupuranga | FFT-CG; pointing out to referrers the high level of 'never began' categories and highlighting appropriate referrals; continuing to engage appropriately with referred whānau/aiga/families before starting treatment; ensuring therapists liaise appropriately with referrers about the progress or otherwise of the referred clients; and developing face-to-face and social media communication processes that will enthuse referrers and target appropriate referrals to the programme.

Consideration could also be given to widening the referral network to include schools and the possibility of self-referrals by whānau/aiga/families where young people have offended or are at risk of offending.

Develop matching data processes between the CSS and HCC systems and comprehensive data entry training for therapists

The current data systems are unnecessarily complicated and not matched which makes the retrieval of monitoring data difficult.

It is recommended that:

a. Outcome data measured by FFT procedures are matched with the correct progress stages (before/after treatment, at completion of treatment), and with the correct client groups (age group), ethnicities, living situations and education as used in New Zealand with consistent entry categories.

b. Matching data is used on both systems to allow speedy and up-to-date retrieval, enabling a current dashboard that is congruent with both systems.

c. Continue to develop comprehensive data entry training providing an understanding of both systems for therapists. This would help ensure that data entry is neither fragmented nor incomplete {with missing values} so that the systems are comprehensive and information is transparent.

Consider developing a post-treatment procedure for young people and whānau/aiga/families who would like it

As numbers of client whānau/aiga/families have suggested, a post-treatment, or various post-treatment, arrangements could be developed. They could take the form of a checking-in process, developing a network of parents or young people, or creating useful activities like those used by FFT therapists that families enjoy. They could provide support for those who have slipped back, and may also support young people who would be willing to help others to develop a buddy system.

APPENDIX 1.

Analysis and outcome questionnaires

The quantitative analysis interrogated both administrative and qualtric[20] data stored in different databases. The following describes the quantitative data and the analyses used in measuring progresses of the project's intended outcomes.

Improving the way family members interact and communicate and family wellbeing: We used Qualtric scores from the Youth Outcomes Questionnaire (YOQ), Youth Outcomes Questionnaire self-reported (YOQ-SR), Client Outcome Measure for Adolescent (COM-A), Client Outcome Measure for Parent (COM-P), Outcome Questionnaire (OQ) and Cultural Satisfaction Form. The YOQ, YOQ-SR, COM-A, COM-P questionnaires are designed to measure perception of behaviours, and are to be completed either by parents in evaluating their 10–17-year-old children (YOQ, COM-P) or by 10–17-year-old children themselves (YOQ-SR, COM-A) or by parents and adolescents over 18 years old on themselves (OQ). The Cultural Satisfaction Form was first designed to have eight questions (short form) but then was revised to have twelve questions (long form). YOQ, YOQ-SR, COM-A and COM-P data were retrieved from CSS; OQ data was retrieved from the provider's website and the Cultural Satisfaction Form was provided by Kia Puāwai. Details of the questions asked for these measurements are provided later in this Appendix. In relation to Family Harm, we used data provided by Police about reported Family Harm incidents before, during and after treatment.

Helping young people to stay at home or transition successfully to independent living: We used data stored on HCC about the living situations of the index clients before and after participation in the programme.

Helping young people either stay in school or return to school, training or employment (Education, Employment and Training – EET): We used data stored on HCC about the EET status of the index clients before and after participation in the programme.

We analysed data collected on clients who used the services and have closed their cases, either via completion (completed) or by dropping out of the service (dropped out). Data on other situations are either not collected (e.g., outcome data on clients who never began the service) or are not suitable (e.g., outcome data on clients who are still using the service – active cases). Each observation for each outcome measurement corresponds to one completed questionnaire. Table 10 describes the collection method and frequency of data sources.

[20] This means the responses are converted into numeric values to enable evaluation, especially before and after treatment.

Table 10. Sample for Wave 4 impact evaluation quantitative analysis

Outcome data	Completed by	Frequency	Database
Youth Outcomes Questionnaire (YOQ)	Parents to assess youth 10 to 17 years old	Twice: pre-treatment (completed by third session) and post-treatment (completed at discharge)	OQ Analyst Website[21]
Youth Outcomes Questionnaire self-reported (YOQ-SR)	Youth aged 10 to 17 years old to self-report		
Client Outcome Measure for Adolescent (COM-A in old CSS and COM-Y in new CSS)	Youth 10 to 17 years old	Once: At discharge	CSS[22]
Client Outcome Measure for Parent (COM-P in old CSS and COM-C in new CSS)	Parents to assess youth 10 to 17 years old	Once: At discharge	
Outcome Questionnaire (OQ)	Parents and youth over 18 years old to self-report	Twice: pre-treatment (completed by third session) and post-treatment (completed at discharge)	OQ Analyst Website[23]
Cultural Satisfaction Form	Parents and young people	At discharge	Excel sheet extracted from Microsoft Power Apps
Living Situation	Therapists	Twice: pre-treatment and after treatment	HCC
Education, Employment and Training (EET)	Therapists	Twice: pre-treatment and after treatment	HCC

[21] www.oqanalyst.com/11027/Logon.aspx?ReturnUrl=%2f11027

[22] Old platform: www.fftcss.com/CSSEval/EvalHome.asp New platform: https://apps.fftcss.com/account/login

[23] www.oqanalyst.com/11027/Logon.aspx?ReturnUrl=%2f11027

Cultural Satisfaction form

Short form

How satisfied are you that:

1. the therapist: respects your culture
2. knows enough about your culture to help you feel comfortable
3. gives information in ways that aid your understanding
4. pronounces your names correctly
5. looks for common ground to connect with you
6. works in partnership with you to achieve change
7. takes time to find out about the family's beliefs and values
8. respects things that are important to the whānau

Rating guide

Very much = 4
Mostly = 3
A little = 2
Not at all = 1

Long form

How satisfied are you that:

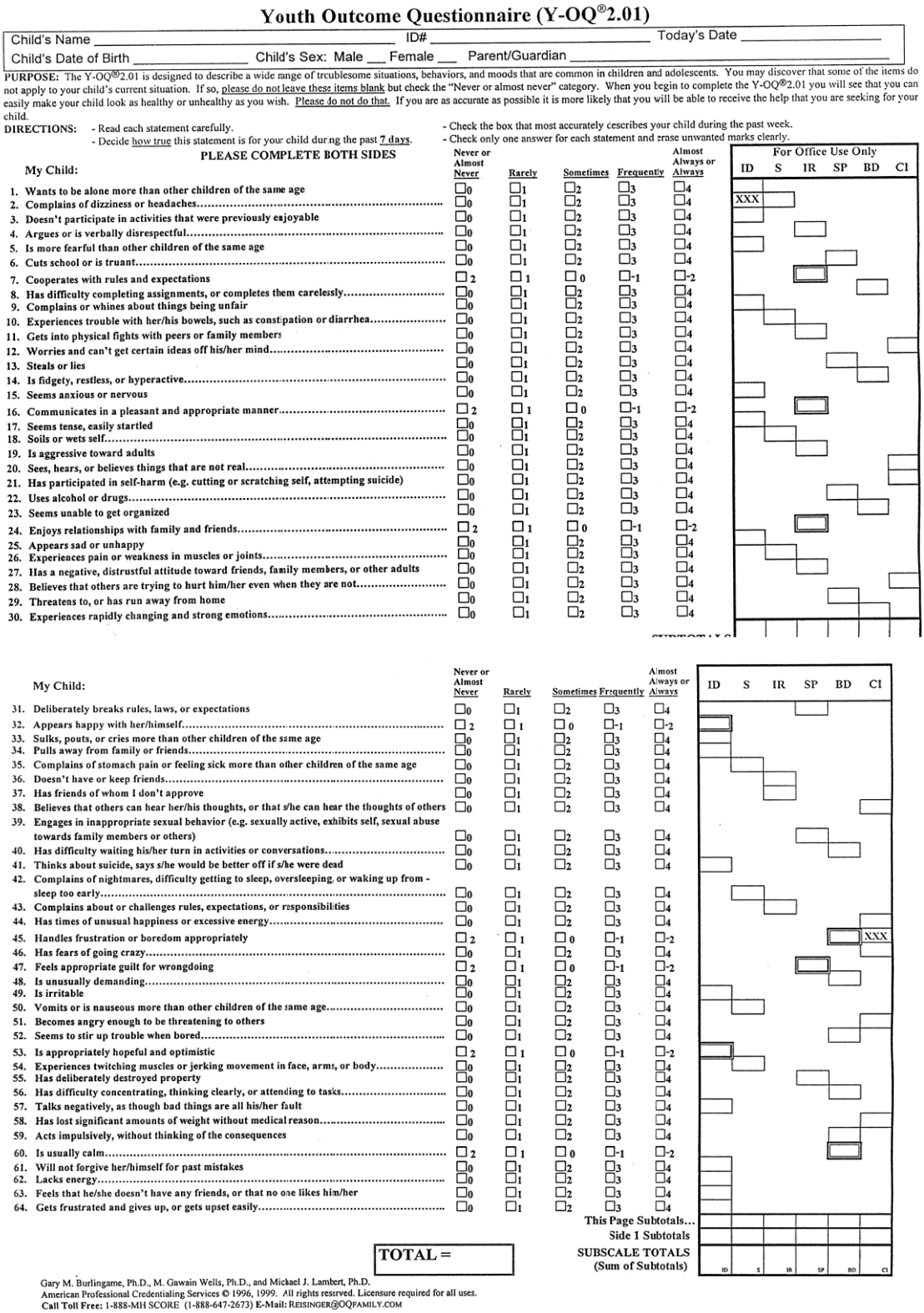
1. the therapist: helps you feel comfortable to talk and share
2. pronounces your names correctly
3. looks for common ground to connect with you
4. allows you to know who they are as a person
5. takes time to find out about your family/ whānau values
6. shows respect for your culture
7. knows enough about your culture to help you feel at ease
8. respects the things that are important to your family/ whānau
9. acknowledges and respects your religious/ spiritual beliefs
10. allows time in sessions for cultural rituals if you want them
11. acknowledges when they don't know something about your culture
12. is willing to learn about your culture

Rating guide

Very much = 4
Mostly = 3
A little = 2
Not at all = 1

Source: Kia Puāwai

Youth Outcome Questionnaire (YOQ)



Youth Outcome Questionnaire (Y-OQ®2.01)

Child's Name _____ ID# _____ Today's Date _____

Child's Date of Birth _____ Child's Sex: Male ___ Female ___ Parent/Guardian _____

PURPOSE: The Y-OQ®2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

DIRECTIONS: - Read each statement carefully. - Decide how true this statement is for your child during the past 7 days. - Check the box that most accurately describes your child during the past week. - Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. Wants to be alone more than other children of the same age	☐0	☐1	☐2	☐3	☐4
2. Complains of dizziness or headaches	☐0	☐1	☐2	☐3	☐4
3. Doesn't participate in activities that were previously enjoyable	☐0	☐1	☐2	☐3	☐4
4. Argues or is verbally disrespectful	☐0	☐1	☐2	☐3	☐4
5. Is more fearful than other children of the same age	☐0	☐1	☐2	☐3	☐4
6. Cuts school or is truant	☐0	☐1	☐2	☐3	☐4
7. Cooperates with rules and expectations	☐2	☐1	☐0	☐-1	☐-2
8. Has difficulty completing assignments, or completes them carelessly	☐0	☐1	☐2	☐3	☐4
9. Complains or whines about things being unfair	☐0	☐1	☐2	☐3	☐4
10. Experiences trouble with her/his bowels, such as constipation or diarrhea	☐0	☐1	☐2	☐3	☐4
11. Gets into physical fights with peers or family members	☐0	☐1	☐2	☐3	☐4
12. Worries and can't get certain ideas off his/her mind	☐0	☐1	☐2	☐3	☐4
13. Steals or lies	☐0	☐1	☐2	☐3	☐4
14. Is fidgety, restless, or hyperactive	☐0	☐1	☐2	☐3	☐4
15. Seems anxious or nervous	☐0	☐1	☐2	☐3	☐4
16. Communicates in a pleasant and appropriate manner	☐2	☐1	☐0	☐-1	☐-2
17. Seems tense, easily startled	☐0	☐1	☐2	☐3	☐4
18. Soils or wets self	☐0	☐1	☐2	☐3	☐4
19. Is aggressive toward adults	☐0	☐1	☐2	☐3	☐4
20. Sees, hears, or believes things that are not real	☐0	☐1	☐2	☐3	☐4
21. Has participated in self-harm (e.g. cutting or scratching self, attempting suicide)	☐0	☐1	☐2	☐3	☐4
22. Uses alcohol or drugs	☐0	☐1	☐2	☐3	☐4
23. Seems unable to get organized	☐0	☐1	☐2	☐3	☐4
24. Enjoys relationships with family and friends	☐2	☐1	☐0	☐-1	☐-2
25. Appears sad or unhappy	☐0	☐1	☐2	☐3	☐4
26. Experiences pain or weakness in muscles or joints	☐0	☐1	☐2	☐3	☐4
27. Has a negative, distrustful attitude toward friends, family members, or other adults	☐0	☐1	☐2	☐3	☐4
28. Believes that others are trying to hurt him/her even when they are not	☐0	☐1	☐2	☐3	☐4
29. Threatens to, or has run away from home	☐0	☐1	☐2	☐3	☐4
30. Experiences rapidly changing and strong emotions	☐0	☐1	☐2	☐3	☐4

For Office Use Only

ID	S	IR	SP	BD	CI
XXX					

My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. Deliberately breaks rules, laws, or expectations	☐0	☐1	☐2	☐3	☐4
32. Appears happy with her/himself	☐2	☐1	☐0	☐-1	☐-2
33. Sulks, pouts, or cries more than other children of the same age	☐0	☐1	☐2	☐3	☐4
34. Pulls away from family or friends	☐0	☐1	☐2	☐3	☐4
35. Complains of stomach pain or feeling sick more than other children of the same age	☐0	☐1	☐2	☐3	☐4
36. Doesn't have or keep friends	☐0	☐1	☐2	☐3	☐4
37. Has friends of whom I don't approve	☐0	☐1	☐2	☐3	☐4
38. Believes that others can hear her/his thoughts, or that s/he can hear the thoughts of others	☐0	☐1	☐2	☐3	☐4
39. Engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse towards family members or others)	☐0	☐1	☐2	☐3	☐4
40. Has difficulty waiting his/her turn in activities or conversations	☐0	☐1	☐2	☐3	☐4
41. Thinks about suicide, says s/he would be better off if s/he were dead	☐0	☐1	☐2	☐3	☐4
42. Complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from - sleep too early	☐0	☐1	☐2	☐3	☐4
43. Complains about or challenges rules, expectations, or responsibilities	☐0	☐1	☐2	☐3	☐4
44. Has times of unusual happiness or excessive energy	☐0	☐1	☐2	☐3	☐4
45. Handles frustration or boredom appropriately	☐2	☐1	☐0	☐-1	☐-2
46. Has fears of going crazy	☐0	☐1	☐2	☐3	☐4
47. Feels appropriate guilt for wrongdoing	☐2	☐1	☐0	☐-1	☐-2
48. Is unusually demanding	☐0	☐1	☐2	☐3	☐4
49. Is irritable	☐0	☐1	☐2	☐3	☐4
50. Vomits or is nauseous more than other children of the same age	☐0	☐1	☐2	☐3	☐4
51. Becomes angry enough to be threatening to others	☐0	☐1	☐2	☐3	☐4
52. Seems to stir up trouble when bored	☐0	☐1	☐2	☐3	☐4
53. Is appropriately hopeful and optimistic	☐2	☐1	☐0	☐-1	☐-2
54. Experiences twitching muscles or jerking movement in face, arms, or body	☐0	☐1	☐2	☐3	☐4
55. Has deliberately destroyed property	☐0	☐1	☐2	☐3	☐4
56. Has difficulty concentrating, thinking clearly, or attending to tasks	☐0	☐1	☐2	☐3	☐4
57. Talks negatively, as though bad things are all his/her fault	☐0	☐1	☐2	☐3	☐4
58. Has lost significant amounts of weight without medical reason	☐0	☐1	☐2	☐3	☐4
59. Acts impulsively, without thinking of the consequences	☐0	☐1	☐2	☐3	☐4
60. Is usually calm	☐2	☐1	☐0	☐-1	☐-2
61. Will not forgive her/himself for past mistakes	☐0	☐1	☐2	☐3	☐4
62. Lacks energy	☐0	☐1	☐2	☐3	☐4
63. Feels that he/she doesn't have any friends, or that no one likes him/her	☐0	☐1	☐2	☐3	☐4
64. Gets frustrated and gives up, or gets upset easily	☐0	☐1	☐2	☐3	☐4

ID	S	IR	SP	BD	CI
				XXX	

This Page Subtotals...

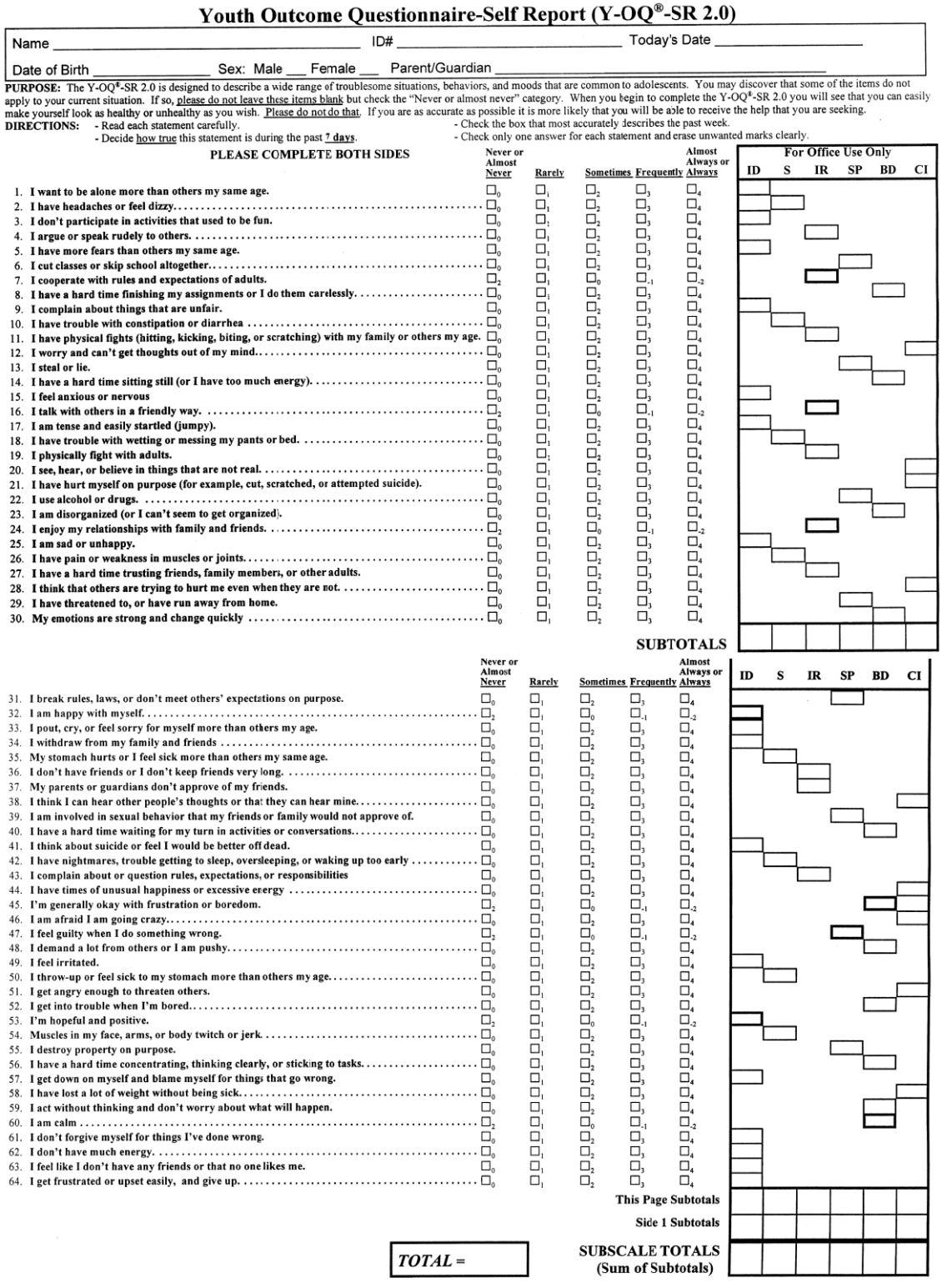
Side 1 Subtotals

SUBSCALE TOTALS (Sum of Subtotals)

TOTAL =

Source: Project documents

Youth Outcome Questionnaire – Self Report (YOQ–SR)



Youth Outcome Questionnaire-Self Report (Y-OQ®-SR 2.0)

Name _____ ID# _____ Today's Date _____

Date of Birth _____ Sex: Male ___ Female ___ Parent/Guardian _____

PURPOSE: The Y-OQ®-SR 2.0 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®-SR 2.0 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS: - Read each statement carefully. - Check the box that most accurately describes the past week.
- Decide how true this statement is during the past 7 days. - Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I want to be alone more than others my same age.	☐0	☐1	☐2	☐3	☐4
2. I have headaches or feel dizzy.	☐0	☐1	☐2	☐3	☐4
3. I don't participate in activities that used to be fun.	☐0	☐1	☐2	☐3	☐4
4. I argue or speak rudely to others.	☐0	☐1	☐2	☐3	☐4
5. I have more fears than others my same age.	☐0	☐1	☐2	☐3	☐4
6. I cut classes or skip school altogether.	☐0	☐1	☐2	☐3	☐4
7. I cooperate with rules and expectations of adults.	☐2	☐1	☐0	☐-1	☐-2
8. I have a hard time finishing my assignments or I do them carelessly.	☐0	☐1	☐2	☐3	☐4
9. I complain about things that are unfair.	☐0	☐1	☐2	☐3	☐4
10. I have trouble with constipation or diarrhea	☐0	☐1	☐2	☐3	☐4
11. I have physical fights (hitting, kicking, biting, or scratching) with my family or others my age.	☐0	☐1	☐2	☐3	☐4
12. I worry and can't get thoughts out of my mind.	☐0	☐1	☐2	☐3	☐4
13. I steal or lie.	☐0	☐1	☐2	☐3	☐4
14. I have a hard time sitting still (or I have too much energy).	☐0	☐1	☐2	☐3	☐4
15. I feel anxious or nervous	☐0	☐1	☐2	☐3	☐4
16. I talk with others in a friendly way.	☐2	☐1	☐0	☐-1	☐-2
17. I am tense and easily startled (jumpy).	☐0	☐1	☐2	☐3	☐4
18. I have trouble with wetting or messing my pants or bed.	☐0	☐1	☐2	☐3	☐4
19. I physically fight with adults.	☐0	☐1	☐2	☐3	☐4
20. I see, hear, or believe in things that are not real.	☐0	☐1	☐2	☐3	☐4
21. I have hurt myself on purpose (for example, cut, scratched, or attempted suicide).	☐0	☐1	☐2	☐3	☐4
22. I use alcohol or drugs.	☐0	☐1	☐2	☐3	☐4
23. I am disorganized (or I can't seem to get organized).	☐0	☐1	☐2	☐3	☐4
24. I enjoy my relationships with family and friends.	☐2	☐1	☐0	☐-1	☐-2
25. I am sad or unhappy.	☐0	☐1	☐2	☐3	☐4
26. I have pain or weakness in muscles or joints.	☐0	☐1	☐2	☐3	☐4
27. I have a hard time trusting friends, family members, or other adults.	☐0	☐1	☐2	☐3	☐4
28. I think that others are trying to hurt me even when they are not.	☐0	☐1	☐2	☐3	☐4
29. I have threatened to, or have run away from home.	☐0	☐1	☐2	☐3	☐4
30. My emotions are strong and change quickly	☐0	☐1	☐2	☐3	☐4

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ID	S	IR	SP	BD	CI

SUBTOTALS

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. I break rules, laws, or don't meet others' expectations on purpose.	☐0	☐1	☐2	☐3	☐4
32. I am happy with myself.	☐2	☐1	☐0	☐-1	☐-2
33. I pout, cry, or feel sorry for myself more than others my age.	☐0	☐1	☐2	☐3	☐4
34. I withdraw from my family and friends	☐0	☐1	☐2	☐3	☐4
35. My stomach hurts or I feel sick more than others my same age.	☐0	☐1	☐2	☐3	☐4
36. I don't have friends or I don't keep friends very long.	☐0	☐1	☐2	☐3	☐4
37. My parents or guardians don't approve of my friends.	☐0	☐1	☐2	☐3	☐4
38. I think I can hear other people's thoughts or that they can hear mine.	☐0	☐1	☐2	☐3	☐4
39. I am involved in sexual behavior that my friends or family would not approve of.	☐0	☐1	☐2	☐3	☐4
40. I have a hard time waiting for my turn in activities or conversations.	☐0	☐1	☐2	☐3	☐4
41. I think about suicide or feel I would be better off dead.	☐0	☐1	☐2	☐3	☐4
42. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early	☐0	☐1	☐2	☐3	☐4
43. I complain about or question rules, expectations, or responsibilities	☐0	☐1	☐2	☐3	☐4
44. I have times of unusual happiness or excessive energy	☐0	☐1	☐2	☐3	☐4
45. I'm generally okay with frustration or boredom.	☐2	☐1	☐0	☐-1	☐-2
46. I am afraid I am going crazy.	☐0	☐1	☐2	☐3	☐4
47. I feel guilty when I do something wrong.	☐2	☐1	☐0	☐-1	☐-2
48. I demand a lot from others or I am pushy.	☐0	☐1	☐2	☐3	☐4
49. I feel irritated.	☐0	☐1	☐2	☐3	☐4
50. I throw-up or feel sick to my stomach more than others my age.	☐0	☐1	☐2	☐3	☐4
51. I get angry enough to threaten others.	☐0	☐1	☐2	☐3	☐4
52. I get into trouble when I'm bored.	☐0	☐1	☐2	☐3	☐4
53. I'm hopeful and positive.	☐2	☐1	☐0	☐-1	☐-2
54. Muscles in my face, arms, or body twitch or jerk.	☐0	☐1	☐2	☐3	☐4
55. I destroy property on purpose.	☐0	☐1	☐2	☐3	☐4
56. I have a hard time concentrating, thinking clearly, or sticking to tasks.	☐0	☐1	☐2	☐3	☐4
57. I get down on myself and blame myself for things that go wrong.	☐0	☐1	☐2	☐3	☐4
58. I have lost a lot of weight without being sick.	☐0	☐1	☐2	☐3	☐4
59. I act without thinking and don't worry about what will happen.	☐0	☐1	☐2	☐3	☐4
60. I am calm	☐2	☐1	☐0	☐-1	☐-2
61. I don't forgive myself for things I've done wrong.	☐0	☐1	☐2	☐3	☐4
62. I don't have much energy.	☐0	☐1	☐2	☐3	☐4
63. I feel like I don't have any friends or that no one likes me.	☐0	☐1	☐2	☐3	☐4
64. I get frustrated or upset easily, and give up.	☐0	☐1	☐2	☐3	☐4

	ID	S	IR	SP	BD	CI
This Page Subtotals						
Side 1 Subtotals						
SUBSCALE TOTALS (Sum of Subtotals)						

TOTAL =

Source: Project documents

Client Outcome Measure – Adolescence (COM–A)

Instructions:

Please help us understand what has changed since you and your family **began** counseling. Please use this scale to answer the questions below

5 Very much better
- Most all of the things you tried to change in counseling were successful, your family gets along very much better

4 A lot better
- Many but not all of the things you tried to change in counseling were successful, your family gets along a lot better

3 Some better
- Some of the things you tried to change in counseling were successful, your family gets along some better

2 Only a little better
- Few of the things you tried to change in counseling were successful, your family gets along only a little better

1 Things are no different
- The things you tried to change in counseling are no different, your family does not get along any better

0 Things are worse
- The things you tried to change in counseling are worse, your family gets along worse than before counseling

Please put the number from the scale above on the line next to the following questions to indicate your answer. Remember - answer according to how much has changed since you began counseling.

_____ 1. In general, how much has the family changed since you began counseling?

_____ 2. How much has the family changed its communication skills?

_____ 3. How much has your behavior changed?

_____ 4. How much have your parents improved their parenting skills?

_____ 5. How much have your parents changed their ability to supervise you?

_____ 6. How much change has occurred in the family conflict level?

Please stop here. THANK YOU for your help

Source: Project documents

Client Outcome Measure – Youth (COM–Y)

Please help us understand what has changed or not since counseling began. Some of the questions are about you and some are about your family. Please use this scale to answer the questions below.

- 5 Very much better - Most all of the things you or your family tried to change were successful. Things are very much better.
- 4 A lot better - Many but not all of the things you or your family tried to change were successful. Things are a lot better.
- 3 Some better - Some of the things you or your family tried to change were successful. Things are somewhat better.
- 2 Little better - Few of the things you or your family tried to change were successful. Things are a little better.
- 1 No Change - The things you or your family tried to change are no different.
- 0 Things are worse - The things you or your family tried to change are worse.
- N/A Not Applicable* - This was not an issue when counseling began and is not an issue now.

In general, how much has the family changed since you began counseling? **(N/A cannot be used here)**	How much has the family changed its communication skills?
How much has your behavior changed? **(N/A cannot be used here)**	How much have your caregiver(s) changed their parenting skills?
How much have your caregiver(s) changed their ability to supervise you?	How much change has occurred in the family conflict level?

Please answer the following questions about change in your behavior SINCE counseling began. **If the behavior was not a reason why you were referred to counseling, it is ok to use non-applicable.** Use the same scale as above.

How much did your illegal behavior change?	How much did your runaway behavior change?
How much did your school attendance change?	How much did your school performance (e.g. grades, behavior) change?
How much did your alcohol use change?	How much did your drug use change?

Source: Project documents

Client Outcome Measure – Parent (COM–P)

Instructions:

Please help us understand what has changed since you and your family **began** counseling. Please use this scale to answer the questions below

5 Very much better
- Most all of the things you tried to change in counseling were successful, your family gets along very much better, your adolescent's behavior is very much better

4 A lot better
- Many but not all of the things you tried to change in counseling were successful, your family gets along a lot better, your adolescent's behavior is a lot better

3 Some better
- Some of the things you tried to change in counseling were successful, your family gets along some better, your adolescent's behavior is some better

2 Only a little better
- Few of the things you tried to change in counseling were successful, your family gets along only a little better, your adolescent's behavior is only a little better

1 Things are no different
- The things you tried to change in counseling are no different, your family does not get along any better, your adolescent's behavior is no better

0 Things are worse
- The things you tried to change in counseling are worse, your family gets along worse than before counseling, your adolescent's behavior is worse than before counseling

Please put the number from the scale above on the line next to the following questions to indicate your answer. Remember - answer according to how much has changed since you began counseling.

_____ 1. In general, how much has the family changed since you began counseling?

_____ 2. How much has the family changed its communication skills?

_____ 3. How much has your adolescent's behavior changed?

_____ 4. How much have you improved your parenting skills?

_____ 5. How much have you changed your ability to supervise your adolescent?

_____ 6. How much change has occurred in the family conflict level?

Source: Project documents

Client Outcome Measure – Caregiver (COM–C)

Please help us understand what has changed or not since counseling began. Some of the questions are about you, some are about your child, and some are about your family. Please use this scale to answer the questions below.

- 5 Very much better - Most all of the things you, your child, or your family tried to change were successful. Things are very much better.
- 4 A lot better - Many but not all of the things you, your child, or your family tried to change were successful. Things are a lot better.
- 3 Some better - Some of the things you, your child, or your family tried to change were successful. Things are somewhat better.
- 2 Little better - Few of the things you, your child, or your family tried to change were successful. Things are a little better.
- 1 No Change - The things you, your child, or your family tried to change are no different.
- 0 Things are worse - The things you, your child, or your family tried to change are worse.
- N/A Not Applicable* - This was not an issue when counseling began and is not an issue now.

In general, how much has the family changed since beginning counseling? **(N/A cannot be used here)**

How much has the family changed its communication skills?

How much has your child's behavior changed? **(N/A cannot be used here)**

How much have you changed your parenting skills?

How much have you changed your ability to supervise your child?

How much change has occurred in the family conflict level?

"Please answer the following questions about change in your child's behavior SINCE counseling began. **If the behavior was not a reason why you were referred to counseling, it is ok to use non-applicable.** Use the same scale as above."

How much did your child's illegal behavior improve?

How much did your child's runaway behavior improve?

How much did your child's school attendance improve?

How much did your child's school performance (e.g. grades, behavior) improve?

How much did your child's alcohol use improve?

How much did your child's drug use improve?

Source: Project documents

Outcome Questionnaire (OQ)

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over th. .t week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name:_____ Age:____yrs.

Sex

ID#_____ M☐ F☐

Session #_____ Date____/____/____

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others.	☐4	☐3	☐2	☐1	☐0
2. I tire quickly.	☐0	☐1	☐2	☐3	☐4
3. I feel no interest in things.	☐0	☐1	☐2	☐3	☐4
4. I feel stressed at work/school.	☐0	☐1	☐2	☐3	☐4
5. I blame myself for things.	☐0	☐1	☐2	☐3	☐4
6. I feel irritated.	☐0	☐1	☐2	☐3	☐4
7. I feel unhappy in my marriage/significant relationship.	☐0	☐1	☐2	☐3	☐4
8. I have thoughts of ending my life.	☐0	☐1	☐2	☐3	☐4
9. I feel weak.	☐0	☐1	☐2	☐3	☐4
10. I feel fearful.	☐0	☐1	☐2	☐3	☐4
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐0	☐1	☐2	☐3	☐4
12. I find my work/school satisfying.	☐4	☐3	☐2	☐1	☐0
13. I am a happy person.	☐4	☐3	☐2	☐1	☐0
14. I work/study too much.	☐0	☐1	☐2	☐3	☐4
15. I feel worthless.	☐0	☐1	☐2	☐3	☐4
16. I am concerned about family troubles.	☐0	☐1	☐2	☐3	☐4
17. I have an unfulfilling sex life.	☐0	☐1	☐2	☐3	☐4
18. I feel lonely.	☐0	☐1	☐2	☐3	☐4
19. I have frequent arguments.	☐0	☐1	☐2	☐3	☐4
20. I feel loved and wanted.	☐4	☐3	☐2	☐1	☐0
21. I enjoy my spare time.	☐4	☐3	☐2	☐1	☐0
22. I have difficulty concentrating.	☐0	☐1	☐2	☐3	☐4
23. I feel hopeless about the future.	☐0	☐1	☐2	☐3	☐4
24. I like myself.	☐4	☐3	☐2	☐1	☐0
25. Disturbing thoughts come into my mind that I cannot get rid of.	☐0	☐1	☐2	☐3	☐4
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4
27. I have an upset stomach.	☐0	☐1	☐2	☐3	☐4
28. I am not working/studying as well as I used to.	☐0	☐1	☐2	☐3	☐4
29. My heart pounds too much.	☐0	☐1	☐2	☐3	☐4
30. I have trouble getting along with friends and close acquaintances.	☐0	☐1	☐2	☐3	☐4
31. I am satisfied with my life.	☐4	☐3	☐2	☐1	☐0
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4
33. I feel that something bad is going to happen.	☐0	☐1	☐2	☐3	☐4
34. I have sore muscles.	☐0	☐1	☐2	☐3	☐4
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐0	☐1	☐2	☐3	☐4
36. I feel nervous.	☐0	☐1	☐2	☐3	☐4
37. I feel my love relationships are full and complete.	☐4	☐3	☐2	☐1	☐0
38. I feel that I am not doing well at work/school.	☐0	☐1	☐2	☐3	☐4
39. I have too many disagreements at work/school.	☐0	☐1	☐2	☐3	☐4
40. I feel something is wrong with my mind.	☐0	☐1	☐2	☐3	☐4
41. I have trouble falling asleep or staying asleep.	☐0	☐1	☐2	☐3	☐4
42. I feel blue.	☐0	☐1	☐2	☐3	☐4
43. I am satisfied with my relationships with others.	☐4	☐3	☐2	☐1	☐0
44. I feel angry enough at work/school to do something I might regret.	☐0	☐1	☐2	☐3	☐4
45. I have headaches.	☐0	☐1	☐2	☐3	☐4

SD	IR	SR
DO NOT MARK BELOW		

+	+
Total=	

For More Information Contact:

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Source: Project documents

APPENDIX 2.

Pae Whakatupuranga dashboard