PAE WHAKATUPURANGA: FUNCTIONAL FAMILY THERAPY CROSS GENERATIONS (PW: FFT-CG)

Formative Evaluation Report – Wave 2

Family Centre Social Policy Research Unit

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ORANGA TAMARIKI
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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 Formative Evaluation Report Wave 2.

Ko te hāngai pū o tēnei wāhanga o te kaupapa nei he āta titiro e pēhea ana ngā whakahaerenga o te kaupapa nei a Te Pae Whakatupuranga i waenganui i te Tangata Whenua o Aotearoa me ngā Uri Moutere o te Moana-nui-a-Kiwa kei Aotearoa e noho mai nei.

E mihi kau ake ana ki ngā whānau i whai wāhi mai i roto i te kaupapa nei, ā, ka mihi hoki ki te kaumātua, ngā tohunga tikanga ā moutere, tae atu ki ngā kaimahi katoa o Youth Horizons.

Hei whakamutu ake me mihi ka tika hoki ki Te Pūtahitanga Rangahau a Oranga Tamariki me te Rōpū Arataki i te kaupapa o Te Pae Whakatupuranga FFT-CG 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 for this Formative Evaluation Report Wave 2.

The focus of this wave is on how well Pae Whakatupuranga I FFT-CG is accommodating the cultural worldviews of Te Ao Māori and Pasefika Peoples.

We firstly acknowledge the families who generously shared their stories and experience of the programme. We acknowledge the Youth Horizons Kaumātua and cultural supervisor, the Pasefika cultural leaders, the therapists and managers at Youth Horizons.

We also wish to acknowledge the Oranga Tamariki Evidence Centre and the Pae Whakatupuranga FFT-CG Steering Group for their reviews of drafts of this formative evaluation report.

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

EXECUTIVE SUMMARY

Report context

Pae Whakatupuranga: 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 families/whānau/aiga. This happens through the facilitation of positive change in family systems. This programme is an adaptation of the original Functional Family Therapy (FFT) model, which is designed and owned by 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: the original FFT model; Whaitake Whakaoranga Whānau (WWW), whose purpose is to ensure that whānau experience therapy that is respectful of and consistent with Māori values, processes, and culture; and Uputāua Pan-Pacific Cultural Framework (Uputāua), a Pasefika framework that recognises many of the cultural and spiritual protocols that are central to Pacific communities, in a model designed to increase cultural understanding and skills for family therapists working with aiga.

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). Youth Horizons (YH), 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) is undertaking a multi-year evaluation of Pae Whakatupuranga I FFT-CG (July 2019 to June 2022). This 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 Wave 1 evaluation was largely a baseline report about the first six months of the programme's operation. It focused on the first evaluation objective and is an early part of the formative evaluation that is taking place from July 2019 to December 2020. (The formative evaluation will be followed by an impact evaluation.)

In this Wave 2 formative evaluation the primary question is *How well does Pae Whakatupuranga I FFT-CG fit in with the cultural worldviews of Te Ao Māori and Tafa o le Pasefika?* (See page 11 for the evaluation methodology and constraints.)

Results

Snapshot of progress as at 28 April 2020

42 families have started Pae Whakatupuranga I FFT-CG

- **30** are active
- **2** completed the programme
- **10** exited early

Te Ao Māori has been woven into Pae Whakatupuranga I FFT-CG **effectively**

Good start made on interweaving the cultural worldview of Pasifika peoples

Recruitment and progress of clients

Pae Whakatupuranga I FFT-CG was reaching and retaining fewer Māori and Pasefika clients at 28 April 2020 than anticipated

Progress has been slower than anticipated in implementing the programme. It was expected that 40 clients would enter the programme in the first six months of the pilot (to December 2019) and a further 40 to June 2020. On a pro rata basis, 70 families were expected to have entered the programme by end April 2020. As at 28 April 2020, a total of 42 clients had entered the programme; of these, two (one whānau Māori and one Pākehā) had completed the programme, 10 had dropped out, and 30 were active. Fifty-two families did not access the service after being referred.

Nineteen clients had been assigned to a therapist but not begun treatment at 28 April. One reason for this delay is the long engagement process needed to engage effectively with whānau and aiga. The COVID-19 pandemic is also likely impacting on progress for the most recent referrals.

Māori and Pasefika Peoples make up the two largest groups of clients referred to therapy, but they have proportionately higher rates of clients who never begin or do not complete treatment at 21 clients (49 percent) and 11 clients (50 percent), respectively, compared to Pākehā at 7 clients (30 percent).

Ensuring whānau/aiga/families are interested in taking up services is important: nine Māori, two Pasefika, and four Pākehā clients declined services, perhaps because of the whakamā/ma/shame that clients and their parents may feel about making their need for such services known to other family members or an aversion to seeking such treatment.

Accommodation by Pae Whakatupuranga I FFT-CG of the cultural worldviews of Te Ao Māori and Tafa o le Pasefika

The formal data collection systems do not capture information about how much the pilot has accommodated cultural worldviews, apart from providing a cultural satisfaction form at the end of the therapy.

Appendices 1 and 2 outline data and category mis-matches between the international CSS data collection and analysis categories and the Aotearoa/New Zealand-focused HCC data systems and categorisations. The databases need to be reconciled to suit the Aotearoa context to give us greater insight into the different trajectories of Māori, Pasefika, and Pākehā clients in terms of referring agencies and categories of ethnicity. Additions to current data collections, including greater use of the cultural satisfaction form, and formalised terminology in the case notes to capture cultural processes, would also assist us in understanding how well the model accommodates different worldviews in practice.

FFT-LLC international reporting requirements remain for the pilot. Issues identified in the Wave 1 Report, such as standardised expectations of time frames for the phases of treatment, remain at this time.

Pae Whakatupuranga I FFT-CG has accommodated the cultural worldview of Te Ao Māori as expressed through WWW effectively, although some aspects of implementation have impeded its effectiveness at this early stage

Therapists, supervisors, and advisors shared the belief that there was no fundamental conflict between the FFT and WWW approaches; in fact, WWW was designed to fit with FFT. YH's overall organisational commitment to kaupapa Māori approaches is seen as pivotal to this success.

WWW training appeared to work well for therapists, who appreciated having WWW trainers who were able to provide practical illustrations and examples of the application of the WWW concepts in the context of FFT therapeutic delivery and practice. Therapists said their cultural training had influenced their practice in several ways, including employing specific aspects of WWW both in their dealings with clients and as reflective practice for themselves. However, therapists and other YH staff commented strongly on the intense and exhausting nature of training simultaneously in the first two approaches, and latterly three, as Uputāua training began.

The consensus view of YH staff was that Māori cultural supervision was extremely valuable in providing the therapists with appropriate cultural guidance and opportunity for reflection. Therapists also appreciated the accessibility of the YH Kaumātua, who was able to locate their work with Māori clients within an Ao Māori context.

Therapists felt that more information about the clients, especially their cultural background, would assist therapists during the referral process to prepare for therapy engagement. Examples included specific ethnic and iwi affiliations. Managers cited the higher rates of housing insecurity and consequent changing living situations among Māori whānau, including moving among biological or kaupapa-based whānau, which meant that many do not meet the criterion for inclusion in the programme of the index client living with their family of origin, as an example of possible systemic bias that leads to exclusion from the programme.

Whānau engaged in therapy felt respected and listened to, and liked their therapist. Several noted the value of whānau activities initiated by therapists which, in contrast with 'talk therapies', were experienced as less intensely focused on individuals. Group activities worked well to strengthen whānau communication. Several Māori whānau felt that, although the therapist was respectful and

making every attempt to be culturally responsive, the fact that they were not ethnically matched impeded success.

The time frames in the original model have been relaxed for cultural considerations in New Zealand, especially for the time from assignation to a therapist to beginning therapy. It is unclear whether these extended timeframes will remain in the future.

The WWW model effectively provides encouragement and endorsement for therapists familiar with or steeped in Te Ao Māori to use their existing cultural knowledge and approaches. There is a need to reconsider the criteria for future therapist selection, to ensure successful candidates are firmly grounded in Māori or Pasefika cultural knowledge.

Pae Whakatupuranga I FFT-CG is in the early stages of accommodating the cultural worldview of Tafa o le Pasefika as expressed through Uputāua

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.

The experience of interweaving WWW and FFT provides a hopeful pathway towards an interweaving of Uputāua and demonstrates the need for sufficient time for the task so the careful work of integration is possible.

The process must also take account of the fact that worldviews may not be aligned – for example, mainstream worldviews of independent youth may not be consistent with Pan-Pacific views of collective aiga and collective responsibility for aiga wellbeing. It is important that the challenges of collectivist and individualist cultures are explored with the therapists.

Uputāua theory and practice were not as well established in Pae Whakatupuranga I FFT-CG as WWW at the time of the evaluation. Training in the approach began this year. However, a significant start has been made, and the Uputāua model provides a clear guide and pathway forward.

The therapists' training in Uputāua was only partially completed. All therapists expressed the view that they had not had enough time with the Uputāua approach and were not confident in applying it in practice, but most indicated that with time they would be competent.

Pasefika aiga did not receive enough information about the process before starting treatment and were unsure about the therapeutic approach in the beginning. Earlier explanation would have helped them understand what was happening as it evolved.

Pasefika aiga were mainly positive about their experience of therapy and felt they were safe, respected and had a voice in the therapeutic process. This was enhanced by the Pasefika therapist. Nevertheless, two of the three aiga expressed concerns about differences between therapists' views about young people and aiga relationships and roles within their cultures.

The Uputāua model grew out of a Samoan base, to embrace a Pan-Pasefika approach to values across Pasefika indigenous cultures. There remains a need to draw out the similarities between the cultures and their values, and name them in their languages, so that the broad range of Pacific communities can relate to and own the approach.

A long-term plan also needs to be developed with timelines for the training and supervision of therapists and other staff comparable with the WWW approach.

Uputāua has achieved a lot, considering its recent inclusion in the programme. For it to become fully embedded in Pae Whakatupuranga I FFT-CG, a similar focus and commitment of time and resources will be required. As with WWW, ongoing consultation with Elders and Pasefika clinicians and social scientists will help to strengthen the roll out.

Recommended next steps for improvements in Pae Whakatupuranga I FFT-CG's accommodation of the cultural worldviews of Te Ao Māori and Pasefika Peoples

The FCSPRU makes the following recommendations in the light of this formative evaluation:

1. *Cultural accommodation:*
    a. Recruit skilled therapists, recognised cultural family support people,[1] and other staff to mirror more closely the proportions of clients from the Māori and Pasefika communities, and include a criterion for selection that successful candidates who will work with whānau and aiga are firmly grounded in Māori or Pasefika cultural knowledge. This will encourage more rapid engagement and understanding, and reduce their burden of cultural learning.
    b. Seriously consider those with recognised cultural knowledge[2] and experience as whānau or aiga support people within their cultures, as being as important as those with mainstream therapeutic training.
    c. The current plan for the training and supervision of therapists and other staff in the Uputāua approach be extended into future years and develop a comparable commitment with the WWW approach.
    d. Establish a mechanism to review progress in building Pasefika cultural awareness and competency in therapeutic practices in Pae Whakatupuranga I FFT-CG and YH.
2. *Measuring progress:*
    a. Implement a process to reconcile HCC data from YH and collaborating agencies, with data on the FFT-LLC database, to provide greater insight into the different trajectories of Māori, Pasefika, Pākehā and other clients.
    b. Consider establishing specific terminology in the case notes to capture information about cultural processes for the HCC database.
    c. Consider completing the Cultural Satisfaction Report after the whānau/aiga/family has completed two sessions with their therapist, to provide a baseline for clients' cultural satisfaction assessment at the completion of therapy.
3. *Recruitment and progress of clients:*

[1] Such as those who are recognised in Māori and Pasefika communities as 'go to' people for assistance with family problems and difficulties.

[2] Ibid.

a. Continue to work on implementing the recommendations in the Wave 1 formative evaluation report, which aim to increase agencies' understanding of the reasons for families deciding not to take part in therapy after they have been allocated a therapist, and to improve the retention and updating of clients' contact information (recommendations 1 and 2 in the Wave 1 report).

b. Explore with referring agencies ways to normalise family therapy as a way to help their taiohi/tupulaga talavou/youth and their whānau/aiga/family.

4. *Referrals to YH:*

    a. Review the criteria for acceptance into the programme to identify and remove any systemic cultural biases, such as requirements for the index client to live with their family of origin.

    b. We suggest referring agencies provide more information about clients referred to YH, especially their cultural background such as specific ethnic and iwi affiliations and languages spoken, to assist therapists to prepare for therapeutic engagement.

5. *Early engagement with whānau/aiga/families:*

    a. Consider developing language-appropriate packs of information about the therapy, its purpose and processes, and likely outcomes, to be given to whānau/aiga/families prior to their first therapy appointment, to enable them to maximise the benefit of the therapy.

6. *Therapist training:*

    a. Ensure all therapists are fully trained in the near term in understanding the embodiment of Pasefika cultural ways and values in Uputāua and applying them confidently in their practice.

Methodology

This is a formative evaluation designed to assess early progress and identify lessons for future implementation, in relation to accommodating the cultural worldviews of Te Ao Māori and Tafa o le Pasefika in Pae Whakatupuranga I FFT-CG. We considered how well the FFT framework was aligned with WWW and Uputāua, and evaluated the processes of accommodating and interweaving in terms of: documentation, including manuals and data collection; referral; training; cultural supervision; and implementation.

At the time the evaluation was undertaken, YH therapists were familiar with and well trained in the Te Ao Māori model, WWW; however, they were in the early stages of their Uputāua training which only began this year (2020).

The evaluation employed a mixed-method evaluation strategy of both qualitative and quantitative analyses.

The qualitative analysis drew on interviews with seven whānau and aiga (including the young person, known as the 'index client') who have used Pae Whakatupuranga I FFT-CG. This is a third of the Māori and Pasefika families who were active cases worked with by YH therapists. YH also tried to recruit families who were referred but never began treatment. However, they were unsuccessful.

Two focus groups were also held with therapists training in and delivering the model, and individual interviews were undertaken with provider (YH) management, supervisors, advisors, the YH Kaumātua, and the developer of the Uputāua model.

The quantitative analysis investigated data about Pae Whakatupuranga I FFT-CG referrals, engagement and non-engagement, uptake, and completion and non-completion rates drawn from the standard FFT-LLC database (CSS) and the YH database (HCC) on 28 April 2020, the date agreed with the Oranga Tamariki Evidence Centre for administrative data collection.

Themes drawn from interviews were integrated with the story provided by the quantitative data to reach indicative findings. In essence, this report provides valuable insights into the experience of those accessing and delivering the programme at 28 April, and records the efforts being made by those delivering the programme to provide an intervention that honours the Māori and Pasefika cultures of the young people and their families who took part.

Constraints on this evaluation

The interviews were conducted from 28 April to 10 July 2020. This time period included the total COVID-19 lockdown. This lockdown meant some of the programme's training and therapy sessions had to be moved online, conducted by phone or delayed.

The lockdown also extended the timeframe for interviewing and exacerbated the difficulty YH and FCSPRU had locating and recruiting families for interview. Other reasons some families did not participate in the evaluation included: they did not respond to attempted contact by YH staff and the evaluators; their circumstances made interviewing impractical (for example, shifting to new accommodation); and they were reluctant to revisit a challenging time that they had put behind them.

OVERVIEW OF WAVE 2 EVALUATION

This Wave 2 formative evaluation addresses the question, *How well does Pae Whakatupuranga I FFT-CG accommodate the cultural worldviews of Te Ao Māori and Tafa o le Pasefika?*

Evaluating how Pae Whakatupuranga I FFT-CG accommodates cultural worldviews

In order to evaluate the effectiveness of Pae Whakatupuranga I FFT-CG in accommodating different cultural worldviews at this early stage of implementation, we analysed several aspects of the prevalence and depth of cultural interweaving:

What do the formal data collection systems tell us or not tell us about the experiences of whānau and aiga referred to Pae Whakatupuranga I FFT-CG? We looked at the nature of the data that was collected, analysed it, and identified areas for improvement. We also identified what the data told us about comparative rates of and reasons for referral, engagement, and non-engagement, drop-out, and completion of therapy for Māori, Pasefika, Pākehā and other clients.

The quantitative data was drawn from the CSS and HCC databases as at 28 April.

What progress has been made in weaving the three distinct approaches together? We considered how well the Māori, Pasefika, and original approaches were aligned and evaluated the processes of accommodating and interweaving the FFT framework with WWW and Uputāua in terms of: documentation, including manuals and data collection; referral; training; cultural supervision; and implementation.

What have been the whānau and aiga experiences of Pae Whakatupuranga I FFT-CG? This includes whānau and aiga assessments of various aspects of cultural accommodation and cultural comfort.

We have treated the results for Māori and Pasefika Peoples separately for these two latter questions (progress in weaving the approaches together and the experiences of whānau and aiga) in order to create an integrated picture of progress to date in accommodating Te Ao Māori and Tafa o le Pasefika.

The qualitative analysis draws on a limited number of interviews with youth, whānau, and aiga who have used Pae Whakatupuranga I FFT-CG services (seven in total), therapists training in and delivering the model, provider (YH) management, supervisors, advisors, the YH Kaumātua, and the developer of the Uputāua model (Table 1).

Table 1. Sample for Wave 2 formative evaluation qualitative analysis

	Type of interview	Number of interviews
Kaumātua	Individual	1
Pasefika Framework Developer	Individual	1
Management	Individual	3
Cultural supervisors	Individual	2
Therapists (5)	Focus Group	2
Whānau/aiga	Family	7
Total		16

Most staff were interviewed from 28 April to 8 May, inclusive, with the Pasefika cultural supervisor and the Uputāua framework creator interviewed in late May. Whānau and aiga were interviewed from 19 May to 10 July, inclusive. All whānau and aiga interviews were conducted by Zoom or phone, largely because of the COVID-19 restrictions.

Constraints on the evaluation

This report records the results of the Wave Two formative evaluation, which tracks early progress in implementing the pilot Pae Whakatupuranga I FFT-CG programme, specifically in relation to accommodating the cultural worldviews of Te Ao Māori and Tafa o le Pasefika.

The statistics recorded here were correct at 28 April 2020, the time agreed with the Oranga Tamariki Evidence Centre for administrative data collection. At that time, there were 30 active cases and two young people and their families had completed the therapeutic programme. Since that time, more cases have been completed. Four months later at 26 August 2020, there were 26 active cases and nine completed cases.

The formative evaluation records the views of those involved in the programme, who were interviewed from late April to early July 2020. This period included COVID-19 lockdowns at various levels, which disrupted some of the therapy training and therapeutic endeavours, and necessitated either a pause in the process or the use of digital technology to proceed with therapy.

While the training of therapists in the Te Ao Māori model WWW is well established, training in the Tafa o le Pasefika model Uputāua began this year. At the time of their interviews, therapists had undergone two training sessions in the Uputāua framework and two cultural supervision sessions and were thus at an early stage in their training. Since then a further training session and a supervision session has taken place.

This formative evaluation also records the views of four whānau and three aiga, a third of the active or completed Māori or Pasefika cases, the cultural groups selected for this wave of the evaluation. Of the 32 families who were involved in or had completed the programme at 28 April, 20 were Māori or Pasefika. The reasons more families did not participate in the evaluation are multiple: they include the impact of COVID-19 and the total lockdown experienced in New Zealand; families' non-response to attempted contact by the YH staff and then some of those who agreed proved to be uncontactable by the evaluators; families' circumstances, such as volatile housing, or having lost contact with their young person, which made interviewing impractical; and families' reluctance to revisit a challenging time that they had put behind them. YH also tried to recruit families who were referred but never began treatment, but these proved even harder to reach.

This is not an evaluation of the total programme. It is the second formative evaluation designed to assess early progress and lessons to be learned for future implementation and fine tuning, in relation to accommodating the cultural worldviews of Te Ao Māori and Tafa o le Pasefika. It will be followed by two impact evaluations. It does, however, provide valuable insights into the experience of those accessing and delivering the programme as it had been implemented at 28 April, and records the efforts being made by those delivering the programme to provide an intervention that honours the Māori and Pasefika cultures of the young people and their families who took part within the context noted here.

1. WHAT DOES THE DATA TELL US ABOUT MĀORI AND PASEFIKA PEOPLES IN PAE WHAKATUPURANGA I FFT-CG?

Summary

The formal data collection systems do not capture information about how much the pilot has accommodated cultural worldviews, apart from providing a cultural satisfaction form at the end of the process. Data from YH and collaborating agencies need to be integrated more fully with data stored on the FFT-LLC database (CSS) to suit the Aotearoa context, to give us insight into the different trajectories of Māori, Pasefika, and Pākehā clients. This would assist in understanding how well the implementation of the model accommodates those worldviews in practice.

Appendices 1 and 2 outline areas of data and category mis-match between the international CSS data collection and analysis categories and the Aotearoa/New Zealand-focused HCC data systems and categorisations. The question of ownership and copyright arrangements for the clinical manual, raised in the Wave 1 Pae Whakatupuranga I FFT-CG Formative Report, remains unresolved but in negotiation at the time of writing. FFT-LLC international reporting requirements remain standardised for the pilot model. Issues identified in the Wave 1 Report (e.g. ethnic categories; standardised expectations of time frames for various phases of treatment) remain at this time.

As at 28 April 2020, the pilot was taking longer than initially anticipated to build client case numbers. Although the programme's target was 70 cases started by April, only 42 had entered the programme by that date, 10 of whom had subsequently dropped out. There were only 30 active cases and two families had completed their treatment since the programme's inception in July 2019. Nineteen clients had been assigned to a therapist but not begun treatment at 28 April. One reason for this delay is the long engagement process needed to engage effectively with whānau and aiga. The COVID-19 pandemic is also likely impacting on progress for the most recent referrals.

Māori comprised the largest group of clients. However, almost half never began or did not complete their treatment. Many who did not begin did not meet the criterion of the index client living with their family of origin, or refused to participate. They had fewer sessions than Pākehā or Pasefika clients.

Pasefika comprised the next largest group and almost half never began or did not complete their treatment. They also frequently did not meet the criterion of the index client living with their family of origin, and were the least likely group to complete the first two phases of treatment.

Nine Māori, two Pasefika, and four Pākehā clients declined services, perhaps because of the whakamā/ma/shame that clients and their parents may feel about making their need for such services known to other family members or an aversion to seeking such treatment.

1.1 Formal data collection systems

Data are generated by two different systems:

- The FFT-CG (CSS) data generation process follows the FFT LLC international standard. The types of data required for entry into the CSS reflect the stages of treatments described in the FFT model. Specific dates correspond to specific activities initiated and completed by therapists and their clients. Ethnic categories correspond with US categorisations, rather than Aotearoa/New Zealand ethnic categories.
- The HCC database is maintained by the YH Trust and reflects the Aotearoa/New Zealand context, including ethnic categories. There are more records of referred cases in the HCC than in the CSS database. Cases that are not yet allocated are not entered into the CSS database. Referrals in the HCC database include both cases that are awaiting allocation and those that have been allocated to a therapist. However, the HCC treatment records have no data on treatment progress dates, unlike the CSS. Outcomes are recorded in both databases: the HCC set covers relatively few indicators compared with the CSS.

Appendices 1 and 2 provide a detailed analysis of the commonalities and differences between the two data systems, their implications, and areas where reconciliation may be beneficial.

The data generated by the FFT-CG process do not capture any information about how much the pilot has accommodated cultural worldviews. The recording of the cultural interweaving process is challenging for several reasons. Cultural training in the use of the WWW and Uputāua frameworks was conducted separately from training in the standard FFT process; therefore, there is no specific element in the CSS database to capture this process.

There is little in the way of direct input into the system on cultural comfort, awareness, or issues.

> *No, I think the answer is [there is] no formal way of assessing* [cultural processes] *…. if I were checking with them how are they using the language of the framework. …. when we enter the case notes into CSS there's a few boxes that are blank …. and we've decided to start recording our process around WWW and Uputāua in there so that we can …look at the case notes and see … elements of waewae pakura in the case note itself.* (Practice Lead)

There is no standardised way of recording cultural processes in case notes. Constructing a way of doing this so it avoids adding to therapists' paperwork and is appropriate for Te Ao Māori and Pasefika worldviews will be difficult to achieve, but is likely to prove useful for therapists and managers.

The Cultural Satisfaction Form may provide another measure. It is not part of either formal database, but is completed manually and extracted into Excel for storage. At present, it is completed by clients at the end of their therapeutic process and therefore reflects cumulative impact, rather than progress during treatment. The form could also be used after families have completed two sessions with their therapist to assess clients' early assessment of the cultural aspects of the therapeutic process.

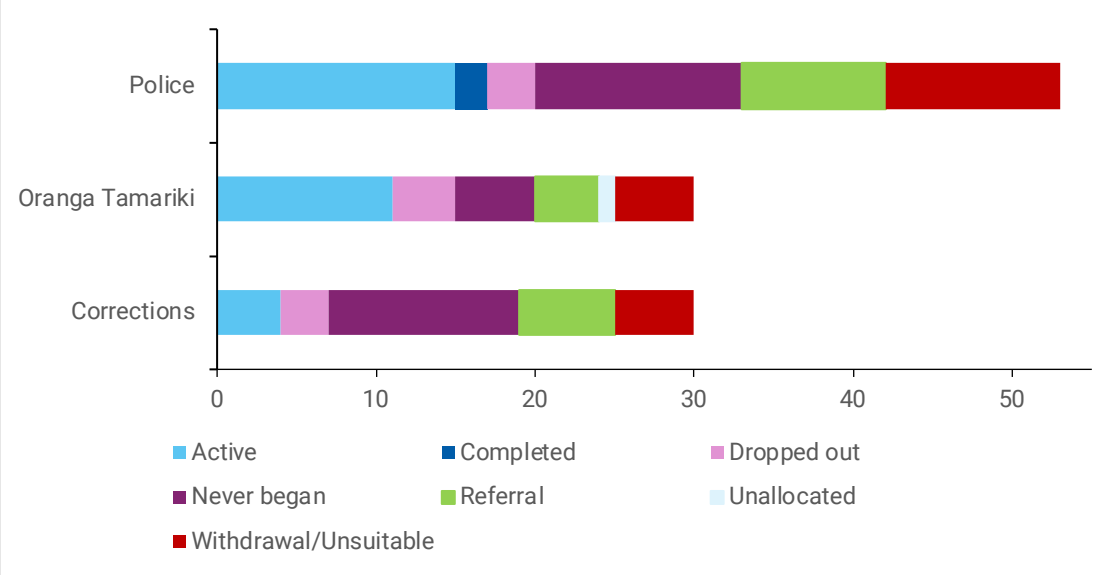
> *I can have a look at, you know, are they doing the cultural satisfaction surveys and what is it telling them. But I would only do that quarterly or every six months or whenever the evaluation team wants it. But we don't have kind of baseline information to complete it.* (Management 1)

1.2 Referral sources, treatment progress, and ethnicity

Figure 1 shows the total number of clients by source of referral and their progress towards or in the treatment process. The figure identifies the main sources of referral for all Pae Whakatupuranga I FFT-CG clients and their participation or non-participation in the service.

As at 28 April 2020, 113 clients had been referred to Pae Whakatupuranga I FFT-CG. The Police were the most common referrers, with 53 cases or 48 percent of total clients. Oranga Tamariki–Ministry for Children and Corrections both referred 30 people, approximately 26 percent of clients.

Figure 1. Referral sources and status of clients



The treatment progress of the clients is slow (Figure 2 below). Of all 113 referrals to YH by 28 April, 46 percent (52 clients) did not enter treatment. They either declined treatment or were withdrawn as not suitable (19 percent: 21 clients), had not yet been assigned to a therapist (1 client), or did not enter treatment after being assigned to a therapist (27 percent: 30 clients). The remaining 17 percent (19 clients) had not yet started treatment with their assigned therapist.

This means that at 28 April, a little more than a third (37 percent or 42 clients) of the 113 clients referred to YH had used or were using Pae Whakatupuranga I FFT-CG services. These comprised 10 (9 percent) who began but dropped out, 30 (27 percent) in progress, and two (2 percent) who had completed treatment.

Figure 2. Client progress at 28 April 2020

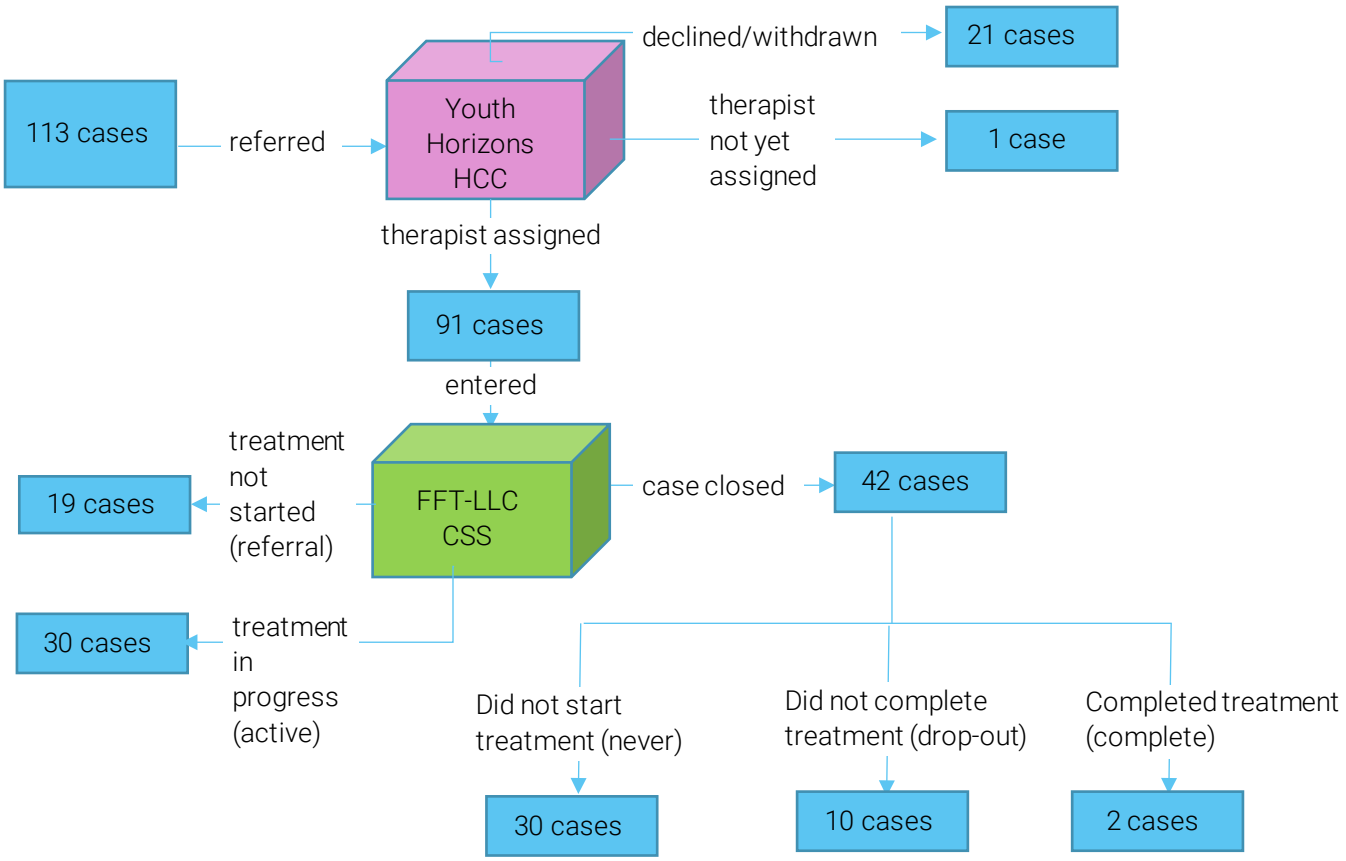


Figure 3 below displays the ethnic breakdown of cases by source of referrals. Māori clients are present in large numbers in all three sources of referral, (15 clients referred by Police, 13 by Oranga Tamariki and 15 by Corrections) whereas Pākehā clients are referred primarily from the Police (19 clients). Two Pākehā clients were referred by Oranga Tamariki. Pasefika are present in referrals from the three agencies, with more from Corrections (10 clients) and Oranga Tamariki (seven clients). Police referred five Pasefika clients. Police and Oranga Tamariki have Māori, Pasefika, and Pākehā referrals: Corrections have Māori and Pasefika referrals only.

Figure 3. Client base of three sources of referral in CSS

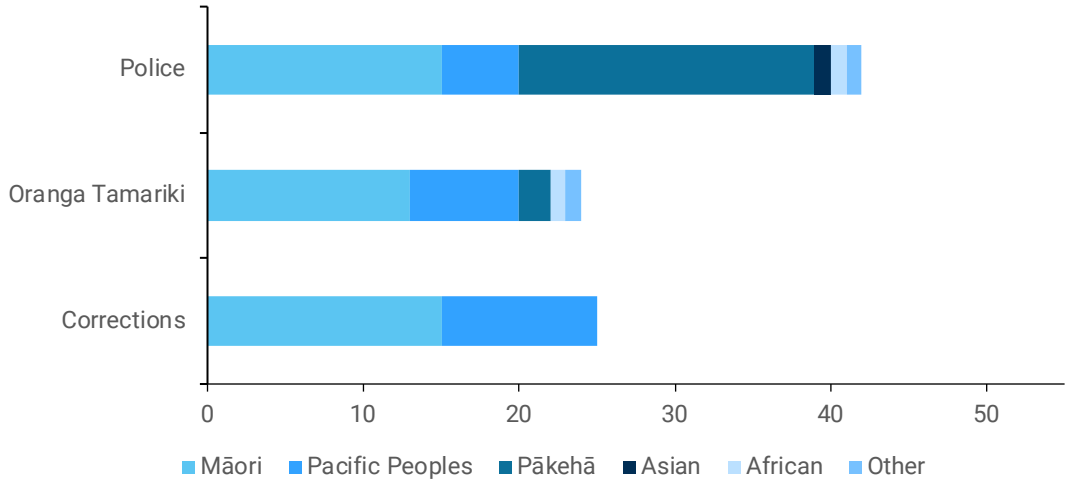


Figure 4 shows the current age range of Pae Whakatupuranga I FFT-CG clients, from 10 to 25 years old, with the majority aged 15 (24 clients) and 16 years old (21 clients).

Figure 4. Age distribution of index clients recorded in CSS

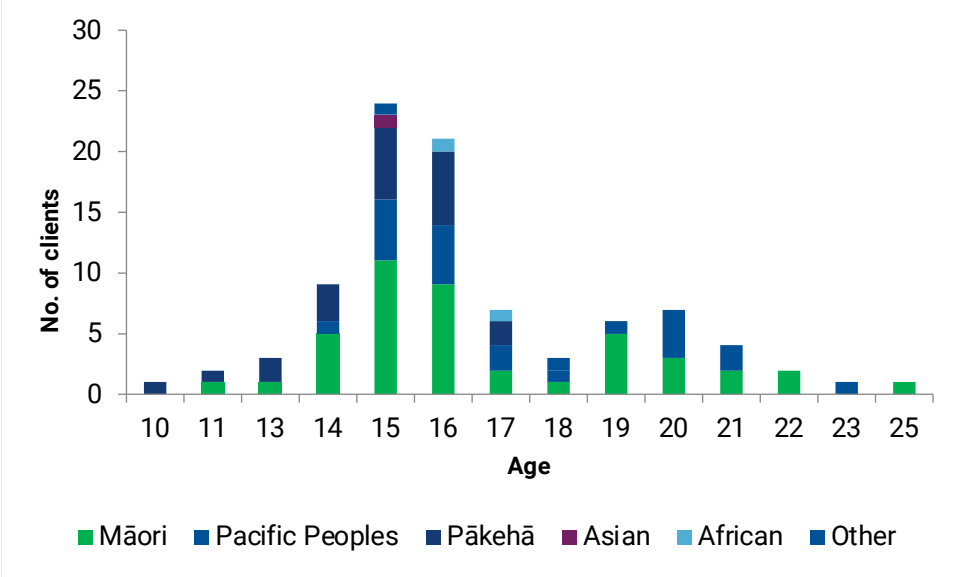
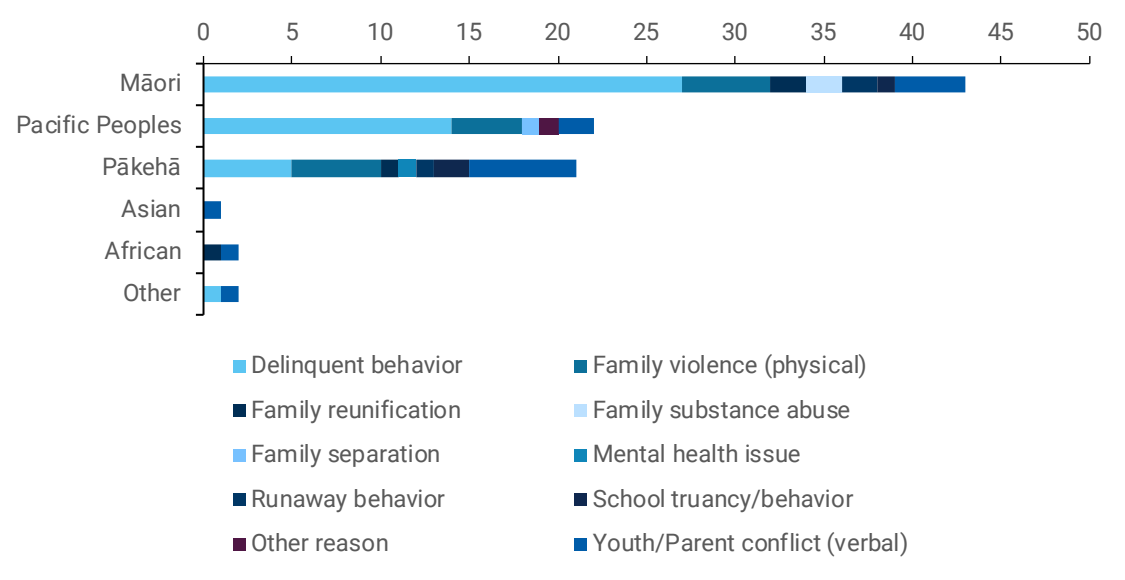


Figure 5 below shows the three most common reasons for referring clients to the service: delinquent behaviour (47 cases), youth and parent verbal conflict (15 cases) and physical violence in the family (14 cases). These problems are not equally prevalent in the three largest ethnic groups. Māori and Pasefika clients tend to be referred for delinquent behaviour (27 and 14 clients, respectively), but Pākehā clients tend to be associated primarily with family violence (five clients) and youth and parent verbal conflict (six clients).

Figure 5. Reasons for using services

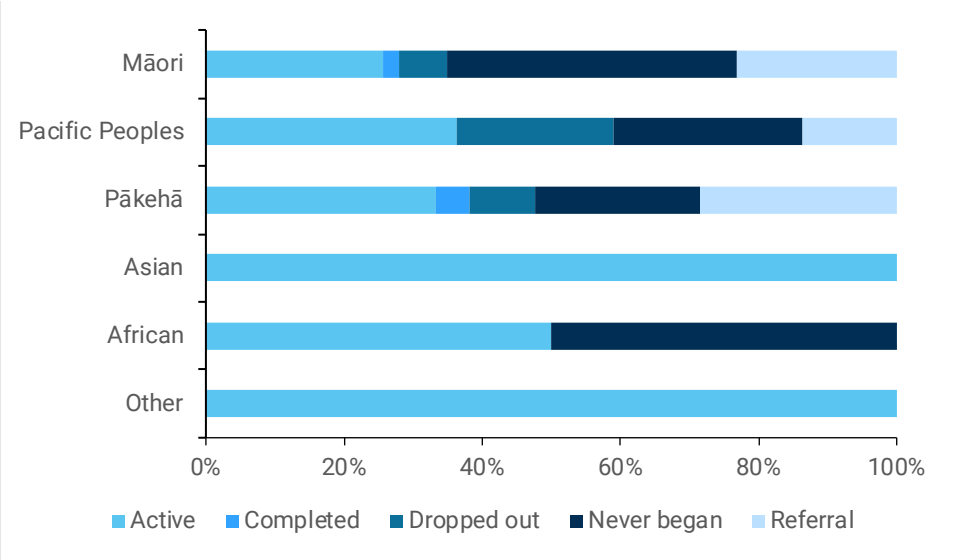


The challenges associated with engaging Māori and Pasefika clients are reflected in the data on the status of clients in each ethnic group (Table 2). Māori and Pasefika Peoples make up the two largest groups of clients referred to therapy, but they have proportionately higher rates of clients who never begin or do not complete treatment at 49 percent (21 clients) and 50 percent (11 clients), respectively. Pākehā clients have a lower rate of non-engagement, at 33 percent (seven clients). Figure 6 below illustrates these data on treatment status graphically.

Table 2. Ethnicity and treatment status of clients

	Referral	Active	Closed: completed	Closed: drop out	Closed: never began	Total (number)	Total (%)
Māori	10	11	1	3	18	43	47
Pasefika	3	8	0	5	6	22	24
Pākehā	6	7	1	2	5	21	23
African	0	1	0	0	1	2	2
Asian	0	1	0	0	0	1	1
Other	0	2	0	0	0	2	2
Total (number)	**19**	**30**	**2**	**10**	**30**	**91**	**100**
Total (%)	**21**	**33**	**2**	**11**	**33**	**100**	

Figure 6. Treatment progress by status of ethnic groups (percent)



1.3 Treatment uptake, withdrawal, and non-participation

Table 3 gives the reasons for the 51 referrals who were withdrawn or declined treatment before being assigned a therapist and those who never began treatment after being assigned a therapist. The two most common reasons are clients were not suitable for the service as some criteria were not met:18 cases and clients declined to participate in the service:15 cases. Examples of clients not meeting the criteria for service are discussed below the table.

Table 3: Reasons for cases that were withdrawn/unsuitable or never began treatment

	Withdrawn/unsuitable	Never began
Criteria not met	12*	6
Declined services	1	14
Never attended initial appointment		1
Not able to contact	1	6
Conflict with other treatment		2
Youth whereabouts unknown		1
Withdrawn by referrers	7	
Total	21	**30**

* This number includes **did not meet entry criteria** and were **referred to another service**.

Managers stated that it was very common for the index client not to be living with their parents/carers.[3] This highlights the fact that the living situations of potential index clients can change in the short time before and after a referral is made.

The service entry criteria contain items that may affect Māori and/or Pasefika. For example, the criterion of living with a parent or primary caregiver may make a young person ineligible to receive or to continue receiving the service if they move residence, even though they are moving within their extended whānau, aiga, or metaphorical whānau.[4] Higher rates of shared care among whānau and/or aiga and higher incidence of unstable or insecure accommodation may make it more likely that Māori and Pasefika youth will be identified as ineligible to receive the service.

Ensuring whānau/aiga/families are interested in taking up services is equally important, which is suggested by the nine Māori, two Pasefika, and four Pākehā clients that declined services. There is no information about the motivations that lead whānau/aiga/families to decline the service. However, this may be because of the whakamā/ma/shame that clients and their parents may feel about making their need for such services known to other family members, or an aversion to psychological therapies and seeking professional services amongst numbers of Māori and Pasefika people.[5] The data also show that four Māori, one African, and one Pasefika client could not be contacted, and the location of one Māori youth was not identified.

1.4 Progress through treatment

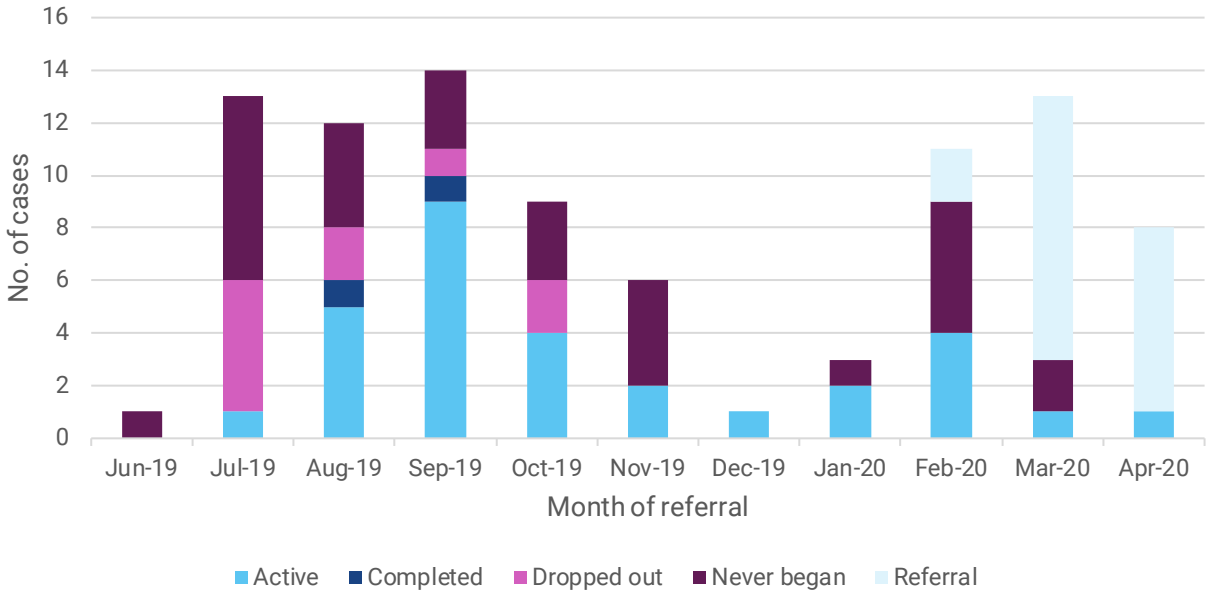
Case progression and ethnicity

The slower than expected progression of clients through Pae Whakatupuranga I FFT-CG cannot be attributed entirely to the COVID-19 lockdown. Figure 7 below displays the number of cases according to their status and the month of their referral being recorded in the CSS. Most of the never began cases were referred before the lockdown, especially in the first months of the pilot from July to November 2019. There are fewer such cases in subsequent months, except for February 2020, with five cases classified as never began. These latter cases are likely to have been impacted by the lockdown.

As can be seen, all 10 cases that did not complete their treatment (drop out) were referred to YH in the early months of the pilot, with five cases in July 2019, two cases in August 2019, one case in September 2019 and two cases in October 2019. The referrals that did not begin treatment occurred in the early months of the pilot to March 2020.

[3] Or is within 6 weeks of release from an institution to parental/caregiver care.
[4] Metge introduced the concept of 'metaphorical whānau' as applied particularly to Māori living in urban areas away from traditional papakainga. The term 'kaupapa based whānau' is also sometimes used. Metaphorical whānau for Māori and Pasefika Peoples in cities might include kohanga reo or kura whānau, sports or cultural groups, gang or church based metaphorical whānau. Metge, J. (2014). *New growth from old: The whanau in the modern world.* Victoria University Press.
[5] Lee, C. H., Duck, I. M., & Sibley, C. G. (2017). Ethnic inequality in diagnosis with depression and anxiety disorders. The New Zealand Medical Journal (online), 130 (1454), p 10.

Figure 7. Client status by recorded month of referral



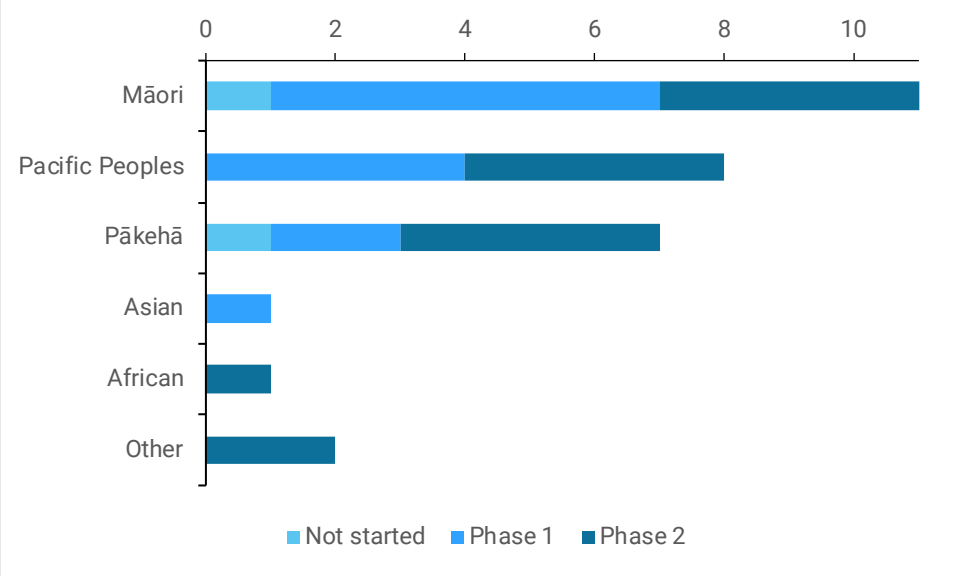
The two completed cases were referred in August and September 2019, making the time for a complete treatment quite substantial, at about seven to eight months. A large proportion of the referrals made in March and April 2020 had not started treatment at the time this data was collected (April 2020) and were still classified as referral. This coincides with the COVID-19 lockdown period, which is highly likely to have affected the ability of therapists to engage with clients referred to them.

There is a difference in the extent of engagement with therapy of those who agree to participate among ethnic groups, especially in the three main client groups. Table 4 shows that on average Māori and Pasefika clients had fewer sessions than others, especially when compared with Pākehā clients. Figure 8 shows that Māori clients have the greatest number (11) of active clients, but only four (36 percent) have reached Phase 2; one client has not had any sessions and six (55 percent) are still in Phase 1. Pasefika Peoples have a higher rate of clients reaching Phase 2, with four of eight in Stage 2. Pākehā have a slightly higher rate of clients reaching Phase 2, at four (57 percent).

Table 4. total and average sessions completed by active clients

	Total sessions	No. of clients	Average sessions per client
Māori	49	11	4.5
Pasefika Peoples	34	8	4.3
Pākehā	46	7	6.6
Asian	5	1	5.0
African	9	1	9.0
Other	20	2	10.0
Total	**163**	**30**	**5.4**

Figure 8. Progress of active clients by ethnic group



When we look at clients who started treatment but did not complete the two initial phases, the four cases that are treatment failures are one Māori and three Pasefika clients (Table 5). This further highlights the challenges of engaging with and maintaining the participation of Māori and Pasefika clients.

Table 5. Reasons for cases that started but did not complete by ethnicity

	Not treatment failure			Treatment failure	
Reasons for drop-out cases	Māori	Pasefika Peoples	Pākehā	Māori	Pasefika Peoples
Administrative discharge	1				
Moved prior to completing the programme	1	1	1		
Quit after at least one session				1	2
Runaway					1
Youth referred to other services		1	1		
Total	**2**	**2**	**2**	**1**	**3**

The data to date has highlighted the longer-than-expected treatment progress of clients, which is most pronounced among Māori and Pasefika Peoples, the two largest client groups. The main reason for this appears to be the engagement challenges, which vary according to the context of various whānau/aiga/families.

> *That .... process of engagement is super important. And it's a very delicate .... process. It's really case by case with families. We can have any family that can be sitting on our caseload for a month or two months sort of thing. Obviously, we don't want to have... so much time that's lapsed that we haven't had engagement with .... because we've got other families that*

> *we also need to be working with. …. So, if we know the family circumstances are such that …. they've demonstrated that they are motivated. And maybe there's some things that are happening in the background that we would perhaps …. allow more time for that. But then for other families, if it's really a clear indication that, you know, this is just something that's not actually workable at this time …. If we need to take more time and engagement, then we will. And there's nothing in the FFT model that says we can't.* (Therapist Group 1–Therapist 1)

> *Some of the literature I've read … they're saying they're expected to be a 12-week programme, two weeks for the engagement on average …. And yet there were … families that may have been experiencing more fighting at that time or things were more risky …. There would be an encouragement for us as therapists to try and get in more sessions at that time because there's more risk, so we need to be able to just try to work through that faster, I suppose, or reduce the risk faster. …. the way that we've been working with families, whether it's because when you're* [the] *therapist or not… you know, is really working with the rhythm of the families as well. So that's also what FFT allows for …. finding what the rhythm of the families are and working with that.* (Therapist Group 1–Therapist 2)

Interviews with managers also suggest that they underestimated the time and effort required for therapists to absorb the required knowledge and skills and to apply them confidently in practice.

> *I think we underestimate the actual amount of time and resource and energy that it would take …. to incorporate cultural models of practice. And I think possibly we under-predicted the amount of work that that actually requires. …. And yes, yet we don't know what the impact of that would be, how successful that the impact of what the benefit will be, but just intensive resource alone. …. I think that's the learning that we need to take some intention to try and weave models like this into someone's brains.* (Management 2)

2. PILOT IMPLEMENTATION OF PAE WHAKATUPURANGA I FFT-CG

Pae Whakatupuranga FFT-CG aims to provide a training and implementation package that accommodates cultural differences and maintains a phased therapeutic model. When fully developed, it is expected to comprise an interweaving of three separate approaches into one, Pae Whakatupuranga I FFT-CG. They are:

- FFT - a model developed in the USA and brought to Aotearoa approximately a decade ago.
- WWW - an Ao Māori framework designed to place Māori perspectives as central and interwoven with FFT therapeutic processes.
- Uputāua – a Pasefika cultural framework that originated from Samoan foundations and recognises the uniqueness of different Pasefika ethnic groups and draws on their shared strong heritage that often draws them together. Uputāua in Pae Whakatupuranga I FFT-CG is designed to increase cultural understanding and skills for therapists working with aiga.

Further explanation of these three approaches is included at Appendix 4.

Pae Whakatupuranga I FFT-CG is unique in that it represents a weaving together of WWW and FFT approaches, and the recent inclusion of the Uputāua model. The extent of accommodation of different cultural worldviews in the core elements of Pae Whakatupuranga I FFT-CG is examined across five aspects of the pilot programme: weaving FFT, WWW, and Uputāua together, including in manuals and data collection; referral processes; training of therapists; cultural supervision; and implementation.

This is followed by a summary of how taiohi/tupulaga talavou/youth and whānau/aiga/families experience the programme. It should be read with some caution, as the sample of taiohi/tupulaga talavou/youth and whānau/aiga/families who agreed to be interviewed for this evaluation was small – four whānau identifying primarily as Māori and three Pasefika aiga. Two of these Māori whānau identified Māori and Pasefika descent in the taiohi/youth of the whānau.

In addition, the sample accessed for interviewing were those who had completed at least a portion of the Pae Whakatupuranga I FFT-CG. This means the sample was biased towards those who chose to engage with the therapy, which could mean comparatively higher levels of motivation, comfort with the prospect of whānau/aiga/family therapy, and/or satisfaction with the therapeutic process.

Further, those whānau/aiga/families who did not engage with or did not complete therapy were not available to be included in the analysis, despite the efforts of the YH staff (see Constraints on the evaluation above).

Te Ao Māori is considered first, followed by Tafa o le Pasefika.

2.1 Te Ao Māori

Pae Whakatupuranga I FFT-CG to date has focused primarily on inter-weaving FFT principles and processes—a phased American-oriented approach—with the Te Ao Māori worldview expressed in WWW. In effect, it involves putting a Māori cultural lens on a Western process. This section examines how the process of interweaving strands of FFT and Te Ao Māori is proceeding to date.

In summary, the integration of the FFT and WWW models is proceeding well and YH's overall organisational commitment to kaupapa Māori approaches is pivotal to the success of the integration.

2.1.1 Weaving WWW and FFT together

Manuals

The three components of Pae Whakatupuranga I FFT-CG have their own standard manuals and training methods and materials. The Pae Whakatupuranga I FFT-CG Clinical Manual, which aims to combine these into one cohesive package, is not yet finalised. It consists of a largely standard FFT clinical manual (although designed for cross-generations, wider age groups than usual for FFT) in which elements of Te Ao Māori from WWW are woven throughout the text.

WWW within Pae Whakatupuranga I FFT-CG

The as-yet unpublished draft Pae Whakatupuranga I FFT-CG manual that includes material about WWW describes WWW and its purpose in the following terms:

> *Whaitake Whakaoranga Whānau is a process framed within Te Ao Māori principles which is compatible with FFT and aims to enhance FFT for whānau Māori. It offers a Māori-centred approach that helps therapists draw on their personal and cultural selves in a way that aligns with the FFT model. It portrays both the therapeutic process and therapeutic use of self, conceptualised through the philosophical underpinnings and rituals of Te Ao Māori. When the therapist is well versed with mātauranga Māori, reo Māori and tikanga practices alongside FFT and clinical competence, stronger outcomes for Māori are evident*[6].

WWW was developed to provide a framework for New Zealand therapists to deliver the FFT model effectively to Māori clients/whānau, utilising Māori concepts and processes.

> *And that's one of the things that we're hoping … we're able to… rearrange some of the American way of thinking and doing things and the jargon and putting it into a very Aotearoa way of doing things. Because it's the way that we know how. We're not American.* (Kaumātua)

The weaving together of WWW and FFT is a unique feature of Pae Whakatupuranga I FFT-CG. One of the primary authors and trainers in the WWW model described the intent of the model in the following terms:

> *Giving it [FFT] just, that extra tikanga and whakaaro Māori way of being gives …. FFT more mana…. And I always have the belief you know you have a Western model and a Māori model, and you put the two together, you have something that's more powerful than just the Western model or a Māori way of thinking. You have something absolutely powerful.* (Kaumātua)

[6] Robbins, Michael, S. et al. (2020) (Unpublished draft) Pae Whakatupuranga I Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc). Seattle, WA. p 8.

Therapists, supervisors, and advisors shared a belief that there was no fundamental conflict between the FFT and WWW models; in fact, WWW was were designed to fit the FFT approach.

> *I definitely see consistency between the two [FFT and WWW]. And if we think back to like who started to develop it like in terms of Māori …. [they] developed that to be able to understand FFT from a Māori perspective. And I think that's exactly what it's done.* (Therapist Group 2 – Therapist 1)

An important example of accommodation of Te Ao Māori within the FFT approach is that cultural supervision is explicitly included and prioritised in the draft manual.

The development of the draft Pae Whakatupuranga I FFT-CG manual was described by one participant as an attempt to incorporate or accommodate WWW within an FFT framework, without changing the fundamental tenets of FFT.

> *So, what we're trying to do is bring basically we're now calling it the Pae Whakatupuranga clinical manual and we're trying to integrate the Whaitake and Uputāua into it without changing the FFT stuff. So, we've basically slotted pieces in. And so, you'll see when you look at it, but we think it works quite well.* (Management 1)

Data collection

There is insufficient information in the formal data systems to track progress in accommodating Te Ao Maori worldview in the programme (see **What does the data tell us about Māori and Pasefika peoples in Pae Whakatupuranga I FFT-CG?** above).

2.1.2 Referrals

Criteria for referral and engagement

As previously noted, some of the referral criteria may contain systematic biases which may contribute to the higher rates of **did not begin** and **did not complete** cases recorded for Māori whānau. The key inclusion criterion that the young person lives with their parents or carers, and higher rates for whānau and aiga of changing living situations might mean that Māori and Pasefika youth are more likely to be identified as ineligible to receive, or to continue receiving, the service.

Additional information on ethnic and cultural background in referrals

Interviews with management and therapists indicated that more information about the clients obtained during the referral process, especially their cultural background, would assist therapists to prepare for therapy engagement. Examples of this type of information include specific ethnic and iwi affiliations and languages spoken.

Therapists and management understood that the cultural awareness of the people with whom whānau (and aiga) first encounter in the referral process is important. This first referral contact creates an impression that is highly likely to influence the potential participant's subsequent choice of whether to participate in or to decline the service.

> *And that's so critical for when you come to the pre engagement. When you're at pre engagement. To know to hit the right note to make sure you've got that you're contacting the right people, you've got the right people in the room.* (Management 1)

This issue is discussed further in 2.1.5 below, in the paragraphs about changes in therapists' practice.

2.1.3 Training

Therapists were undergoing training in three distinct areas: FFT-CG, WWW, and Uputāua.

WWW was developed by FFT-trained Māori therapists and the Kaumātua, all of whom possess deep Māori cultural knowledge, to fit with an FFT therapeutic approach. It is generally seen as a good 'fit' with FFT therapy philosophically and in practice. Therapists appreciated the value of having WWW trainers who were able to provide practical illustrations and examples of the application of the WWW concepts within the context of FFT therapeutic delivery/practice.

WWW emphasises flexibility in relation to whānau rangatiratanga and the tikanga around fitting in with the protocols and practices of the home people (the whānau). Following the lead of the whānau is a principle in WWW that aligns well with the FFT principles of **matching** and **meeting the whānau where they are at**.

> *The WWW does have like the spiral[7] going in and out…It's not 'a family starts here and follows this and then follows that out'. …you might jump around a bit and that's okay… mixing and matching depending on what the family needs or depending on what you need to match to that family.* (Therapist Group 2–Therapist 2)

In relation to the training experience, all commentators were positive about the value of having an FFT-trained cultural supervisor guiding therapists through the journey of knowing and applying Māori worldviews and processes and interweaving these through the FFT model in a marae-based setting. Therapists found the WWW training valuable, well-aligned to the FFT therapeutic model, and rewarding.

> *From what I have seen and heard, they are doing really, really well, they're enjoying the mahi that they're doing. They find it challenging, but a good challenge. You know, and learning so much along the way in ways of being* (Kaumātua)

> *Not only the language piece of it. It was also giving us a chance to …. see things from a different route as well. …. there's a continuum …. there's, it's not like one size fits all. …. it gives us this room to see new ways and opportunities of culture.* (Group 2–Therapist 3)

However, therapists and other YH staff commented on the very intense and exhausting nature of training simultaneously in three models, as Uputāua training began. At the time of writing, WWW and FFT training had been ongoing since the pilot's inception, with most therapists and some other YH staff attending six full training sessions. Each training component was estimated to last for 12 months.

Our analysis of the information to hand leads to the following observation about therapist selection and training in the future:

- Therapists come with a range of backgrounds; however, most are new to FFT, WWW, and Uputāua. Western social service and therapeutic knowledge and experience are generally greater among therapists than Māori or Pasefika cultural knowledge.
- The draft Pae Whakatupuranga I FFT-CG Manual states, *When the therapist is well versed with mātauranga Māori, reo Māori and tikanga practices alongside FFT and clinical competence, stronger outcomes for Māori are evident.* If the therapist selection process

[7] This spiral is called Takarangi.

valued or prioritised Māori cultural knowledge and experience and/or familiarity with FFT therapeutic approaches, the heavy training demands on therapists may be less onerous.

The WWW model effectively provides encouragement and endorsement for therapists familiar with or steeped in Māori cultures to use their existing cultural knowledge and approaches. This is a smoother path to the integration of cultural world views within the Pae Whakatupuranga FFT-CG model, than learning and applying several new models simultaneously.

Reviewing the selection criteria for therapists, as suggested above, would undoubtedly reduce the pressure experienced by current therapists. Nonetheless, all therapists will be required to immerse themselves in and deeply understand one, and possibly two, cultural worldviews that are different from their own. Te Ao Māori and Tafa o le Pasefika must both be understood by the therapist workforce if they are to provide a secure environment for therapy. There may be a need to review the timing and sequencing of the training to ensure all three perspectives are understood and able to be put into practice.

> *…. all this learning together and feeling the pressure of timeframes …. can get really overwhelming sometimes and and in an ideal world, …. we would have a longer amount of time …. to be able to learn. Actually, all three [are] different. …. not together at one time. So, I think in the last six weeks or so …. when we've been still learning elements of the functional family therapy and still learning, obviously the WWW and then still learning [that] and now learning the Pasefika framework. That's a lot for us.* (Therapist Group 1–Therapist 2)

2.1.4 Cultural supervision

An important example of accommodation of Te Ao Māori within the FFT approach is that cultural supervision is explicitly included and prioritised in the manual. WWW requires cultural supervision as an ongoing component of training and practice. The Draft Pae Whakatupuranga: Functional Family Therapy: Cross Generations Clinical Manual states that:

> *WWW is animated through the processes of cultural supervision and reflection…. In the context of Pae Whakatupuranga, cultural supervision refers to the oversight and support provided by a knowledgeable guide with clinical and cultural expertise. The cultural supervisor uses Whaitake Whakaoranga Whānau to support therapists from non-Māori and Māori backgrounds to develop cultural confidence in working with Māori clients and families. S/he facilitates individuals' reflective practice and group learning to enable therapists to grow their level of cultural confidence…specifically to …. make the transition from a theoretical understanding to applied practice and lived experience.*
>
> *Deliberate structured reflection helps therapists embody and embed this learning. This approach …. enables therapists to build a flexible and responsive approach to working with whānau.*[8]

This is a clear accommodation of Māori worldviews within the FFT model.

[8] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc). Seattle, WA., p 21-22.

Cultural supervision in practice

Therapists receive regular fortnightly cultural supervision. The Māori cultural supervisor is trained in both FFT and WWW models.

The consensus view of YH staff (including therapists, management, clinical/cultural supervisors and Kaumātua) was that Māori cultural supervision was extremely valuable. Access to guidance about the application of FFT within a Māori cultural framework was available through regular cultural supervision from a Maori cultural knowledge holder who is also an experienced FFT supervisor/practice leader. In the context of Pae Whakatupuranga I FFT-CG the cultural supervisor provides advice, direction, and clarification, and in-depth training that seeks specifically to weave WWW into FFT-CG practice and address therapists' practices and queries.

> *I'm sure she would have shared this with you, but she has a fortnightly programme that has prompts and what they're going to be talking and they talk through each of the kupu on the Takarangi and then the therapist completes a reflective journal. …. it's really important for you to know about the cultural supervision aspect because I think that's a very strong part of the model*. (Management 1)

Guidance from the YH Kaumātua is also available to therapists on an as-needed basis.

Therapists and management found frequent cultural supervision was needed to help the therapists achieve the shifts in their worldview by unpacking layers of concept and meaning and practicing new approaches.

> *The more you talk about it, the deeper your understanding becomes also the awareness that there's also so much to continuously learn.* (Therapist Group 2–Therapist 3)

> *It's like a resource that you can use with all whānau. It's not just something that you forget about, it's something that becomes intrinsic in your practice.* (Therapist Group 2–Therapist 1)

The approximately one-hour cultural supervision session every fortnight has become a special time where therapists can share their struggles and find support and motivation in their therapy journey.

> *.. the space where we could talk about issues or complications or struggles we were having without it being in relation to the model so you created a space within our team where we were able to express those things in a really safe way.* (Therapist Group 2–Therapist 2)

At the time of writing, cultural supervision was provided via Zoom meetings because of the COVID-19 lockdown. While not ideal, therapists and the cultural supervisor did not see this as negating the value and centrality of Māori cultural supervision within the FFT framework.

2.1.5 Implementation of Pae Whakatupuranga I FFT-CG in therapeutic practice

The implementation of Pae Whakatupuranga I FFT-CG is occurring simultaneously with training in FFT-CG, WWW, and Uputāua. This section considers the implementation of Pae Whakatupuranga I FFT-CG in the context of Te Ao Māori, from the perspectives of therapists and YH staff, including management, cultural supervisors, and the Kaumātua.

Organisational culture – YH

Organisational culture is an important factor for cultural accommodation in implementation. YH has a visible organisational commitment to Te Tiriti o Waitangi and to Māori principles and values. Staff, including therapists, supervisors, and management, expressed the view that the overall organisational commitment to kaupapa Māori approaches, was pivotal to the organisation's ability

to meaningfully include and centralise WWW training and implementation through the Pae Whakatupuranga I FFT-CG approach.

Therapists said that they have received significant support from YH during the training process. Because Māori and cultural approaches have been prioritised and are visible throughout the organisation, trainee therapists feel that they have been well supported to learn, discuss, and engage with new learning about kaupapa Māori. Several informants expressed the view that another organisation that lacked a central and visible commitment to kaupapa Māori may well struggle to meaningfully adopt and implement Pae Whakatupuranga I FFT-CG.

> *I think you need to have that environment that's going to be open to it to in order for it to work. So yeah, YH definitely good on that one. …. you could tell that there was a priority around Te Ao Māori and understanding how we would work with Māori families…. If this had been rolled out in a different organisation, I think you'd get a very, very different approach.* (Therapist Group 2–Therapist 2)

The support comes in many forms, including cultural supervision and the availability of the Kaumātua.

> *But we have a good system where we …. do tell people, you know, even if it's the personal stuff, of course, please go see the Kaumātua like …. have kōrero or just let some of that go and get some aroha from him.* (Cultural Supervisor)

Flexibility of the FFT model

Staff interviewed for this evaluation considered that the nature of the FFT model was such that an expectation of cultural accommodation was almost inherent in the model. FFT principles highlight the need to accommodate cultural processes and enable this process by the openness or flexibility of the model.

> *The concepts involved in FFT and the phases of the programme are about engaging with people, understanding dynamics between people, and then trying to identify strategies that might help people change those dynamics and sustain that change as principles. … so pivotal things around the relationship between people fit into that framework of understanding and engaging with people in a way that's meaningful for them, as that is the basis of therapeutic engagement. So …it would be hard to see how it [culturally specific approaches, including WWW] wouldn't fit. So, it naturally aligns to me. …. The point of FFT is that you fit to the family … So, kind of any framework that's got relevance to the culture you work with, if it's based on relationships between people, how people relate to each other, then it's going to fit naturally.* (Management 2)

> *So, it [FFT-CG] is, you know, still a model, and I like that I can be me, be Māori you know you can be you. And that's what I like about this model, it's not so rigid.* (Management 1)

FFT-LLC, the owners of the FFT models, relaxed some of the more prescriptive elements of their models for the Pae Whakatupuranga I FFT-CG pilot. For example, the timeframes for moving through phases, particularly the engagement, trust, and motivation phases, have been relaxed. Therefore (even without the COVID-19 crisis) the expectation of FFT therapy completion within 12 sessions has not been adhered to for this pilot. Additional time and attention have been recognised as needed in the timeframes around the processes of engagement, whakawhānaungatanga, and whakatau.

FFT-LLC has exhibited flexibility around accommodating processes such as whakatau, whakawhānaungatanga, rangatiratanga and relating to Māori culture at one level. The common

elements of distrust of authorities, distrust of some 'helping' agencies, and distrust of mental health and therapeutic services often inherent in indigenous people who are positioned within colonising systems are likewise accommodated in the Pae Whakatupuranga I FFT-CG pilot programme.

> *You know when you go in, you're actually going to leave a mark on these people, you're going to leave an impression of who you are with these people and it's from that contact whether they'll say yes come back again or they're going to ignore you. And they'll just be another piece another family that will fall off the radar because you didn't make that impression in the first place …. that's what I see WWW doing is putting the positive way to a Māori wairua, whakaaro and spin on FFT which works well for our people anyway in that very Pākehā way of doing things that works well anyway.* (Kaumātua)

It is however unclear whether the flexibility afforded during the pilot of the Pae Whakatupuranga I FFT-CG model will be extended over time. FFT-LLC collects data internationally with requirements for those providing FFT therapies to submit detailed information, including timeframes for therapeutic processes. Other adaptations of the FFT model have included extended timeframes to accommodate the characteristics of their client base, and this may be an adaptation that is necessary to ensure the success of Pae Whakatupuranga I FFT-CG. However, it may be that much of the delays are due to this pilot is being delivered by a sample of relatively inexperienced therapists learning a brand-new model, and as they become more proficient in implementing the model with fidelity, it is likely there will be a reduction in the overall length of service.

Changes in therapists' practice

Therapists who had undergone WWW training said that their cultural learning through WWW had influenced their practice in several ways:

Therapists' attitudes to and perspectives of whānau: As Pae Whakatupuranga I FFT-CG principles began to provide frameworks for practice, therapists spoke of using concepts from FFT and WWW to conceptualise and guide their practice. The notion of a **mana enhancing** approach and **meeting the family where they are at**, drawn from WWW and FFT respectively, provide examples of how these concepts and frameworks influenced therapists' views of and approaches to whānau.

> *The mana enhancing approach…is so critical … so to basically bring optimism and hope and to reduce the feeling of judgment that these families feel. And I think there's a really good match with Functional Family Therapy. And I think that's why it works so well. Because you're working with the family where it is, and improve the functioning where they are, not to something else, not to someone else's view of what a good family looks like.* (Management 1)

Therapists employed specific aspects of WWW in their practice with whānau: The Takarangi, a central tenet within the WWW training, was mentioned frequently by therapists as assisting them to work out where they and whānau were positioned in their engagement and therapeutic processes. The first three elements of the Takarangi identified in the draft Pae Whakatupuranga I FFT-CG manual, are whakatau, whakawhānaungatanga, and whakakaha.

> *So, we sort of found that we were already using, especially the first three elements* [in the WWW model]. …. *We were already using those elements because they just fit so incredibly well with the first phase of FFT. And just working with Māori whānau in the first instance. That's just such an important thing. And as part of the process of getting to know one another, whether it's them getting to know us or us getting to know them.* (Therapist Group 1–Therapist 2)

Therapists employed aspects of WWW as reflective and process tools for themselves: As therapists developed deeper understandings of processes, such as whakatau, they sometimes incorporated these into their own processes. For example, when whakatau was viewed as a process that went beyond rituals of encounter or engagement, therapists understood the significance of having a settled mind and spirit themselves, and practised this prior to meeting with whānau.

> *I think that for everyone, it's different …. it might be listening to music or, you know, like going and parking around the corner before I see a family and just settling myself. …. The times where I've been rushing and just run into a family and haven't been able … to do that, it's never gone as well as when you do get to that.* (Therapist Group 2–Therapist 2)

Cultural backgrounds influence not only the therapist's cultural training process, but also the immediate impression whānau will have of them: this is an inherent challenge of the Pae Whakatupuranga FFT-CG model in accommodating three worldviews. For example, on the one hand, whānau have different expectations of incoming guests who have different cultural backgrounds.

> *There are some families who when hosting …. don't want you to feel…I don't know. Sometimes when we work with them …. they won't put their needs out there because they're so used to working and having to mould themselves into the dominant way of doing things, which is not their culture, that they don't expect or anticipate or they're not going to impose upon you.* (Management 2)

On the other hand, therapists who have different cultural backgrounds will have to think differently when working with a family from a different cultural background: they will have to put themselves into a different state of thinking in order to align their worldviews with whānau/aiga. This requires concentration and commitment from the therapist.

It was also pointed out by some therapists that whānau/aiga may have limited or lesser expectations of a culturally different therapist than one from their own culture. Faced with a Pākehā/European therapist, whānau/aiga may expect and accommodate a comparative lack of cultural knowledge or understanding. In contrast, the expectation and/or the experience of cultural understanding may be higher with a therapist of similar ethnic and cultural background.

However, therapists, the Practice Lead, and the Kaumātua all said that therapists can work successfully with whānau/aiga/families provided they are genuine and humble, seeking families' support and letting families guide them in their therapy journey.

> *Somebody who is non-judgmental somebody who absolutely respects who they are. Somebody who understands that they have a whakapapa. You only need to walk into a house and people pick up your wairua. And they go 'ah no – you're all shit' …. So, you know…having to be genuine and having those tikanga you know. The true deeper sense of aroha, manaakitanga, wairuatanga, whānaungatanga, and then absolutely having a deep understanding on who they are.*(Kaumātua)

> *But I think that above all the messaging has been you check with the family. They are the experts ….you're guided by them*. (Management 2)

> *…. come with humility and humbleness, and heart. So it's I'm not coming into your whānau as an authority. I'm coming in to get to know you. And if you come and with the humility and humbleness, and the fact that it is honouring that you have allowed me into your space, into your home, and to you, …. you always start on the right foot, as far as I'm concerned.* (Therapist Group 2–Therapist 2)

2.1.6 Voices of taiohi/youth and whānau

This section considers how taiohi/youth and whānau Māori/Māori families experience Pae Whakatupuranga I FFT-CG. As noted above, these are the responses from four Māori whānau and should be read with some caution.

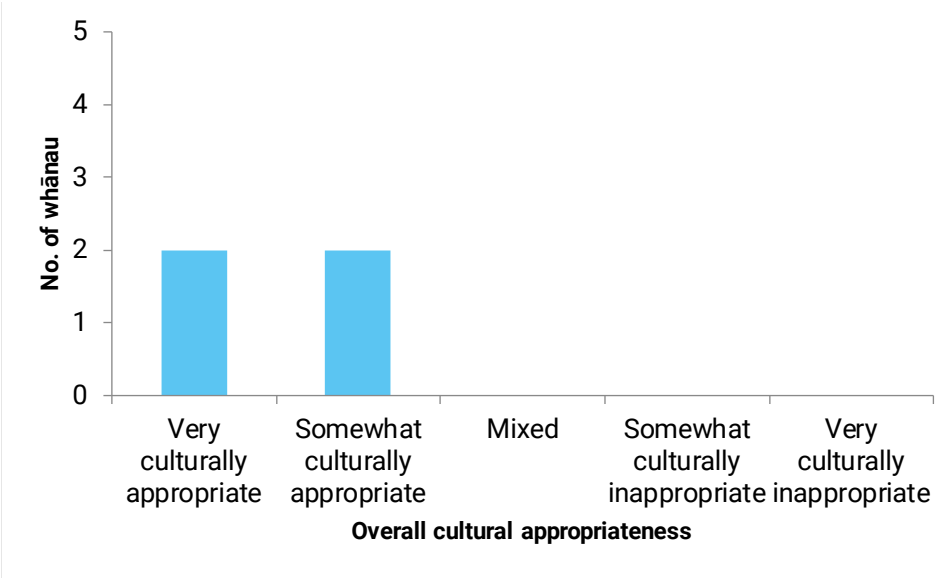
Implementation of Pae Whakatupuranga I FFT-CG with whānau

Youth and whānau participating in this evaluation completed a series of Likert Scales assessing various aspects of their experience of the therapy.

Whānau who actively engaged in Pae Whakatupuranga I FFT-CG therapy uniformly indicated that they felt "very safe and respected" throughout the therapy. Most (three out of four) also indicated that they were fully informed about the therapy and understood the therapeutic process; one whānau felt neither informed nor uninformed. Three of the four whānau interviewed also considered that all their views were considered and respected throughout therapy, with one whānau indicating a "mixed" experience. Three of four whānau indicated that they had participated fully in the process. One whānau said that they participated "a bit".

The overall assessment of cultural appropriateness by whānau ranges from "very" to "somewhat" appropriate (Figure 9). None of the whānau assessed the programme as culturally inappropriate.

Figure 9. Overall cultural appropriateness



There are several factors contributing to this overall rating. While three of the whānau felt fully informed about the therapy process, one whānau was not totally satisfied with a number of aspects. This whānau had mixed feelings about receiving support in terms of awhi, tautoko, and manaakitanga and did not feel informed enough to understand what was happening during the process.

> *She taught us a little bit but not, not a lot about it. Yeah.* [during the referral process] …. *she* [the therapist] *just gave me her card.* (Whānau 1)

However, three whānau, including the whānau who did not feel fully supported or informed, indicated that they participated fully in the process.

Further, three of the four whānau felt they had had a full voice in the therapeutic process—all their views were considered and respected.

In terms of feeling enabled to find resolution to problems, barriers, and misunderstandings during therapy, two whānau indicated that the therapy helped "a lot", and two felt that therapy had helped "a bit". The three whānau who responded to the question about affirmation of cultural perspectives indicated that they felt their cultural perspectives were understood and affirmed "a bit".

When whānau were asked how supported they felt in accessing wider whānau involvement as a result of or through the therapy, two whānau said that the therapist or therapy "did not assist at all", a reflection of the fact that wider whānau were not available in these cases. One whānau said the therapy/therapist assisted "a lot", and one said that the therapy has assisted "a bit" in accessing wider whānau.

In summary, aside from the whānau who had mixed feelings about receiving support in terms of awhi, tautoko, and manaakitanga, the Likert Scale responses did not include any responses that might indicate a feeling of lack of support, non-participation, or inappropriateness in relation to the therapeutic processes. In addition, all clients said that they had not felt pressured or coerced by any outside party to engage in the therapy.

Therapists used culturally cognisant methods

Whānau described examples of therapists using culturally cognisant methods in their interactions with them, likely displaying fundamental learnings from WWW, particularly in the engagement phase. Whānau Māori described therapists practising elements of whakatau and whakawhānaungatanga in their interactions with them:

> *She was speaking about …. all her background on where she came from…. I think that was really good, that she shared all of that …. She like she asked us where we were from and just my kids because they're half Niuean …as well… and we explained that and she got all of it. Yeah, yeah. She just she tried to do things.* (Whānau 1)

> *…. that's how we met – a karakia and then we went through our whakapapa, the three of us.* (Whānau 4)

Clinical delivery and whānau kawa

Essentially the implementation of the cultural frameworks results in whānau maintaining rangatiratanga in setting the *kawa* of engagement and delivery of therapy. WWW encourages therapists to be aware and respectful of whānau preferences culturally, spiritually, and physically and to weave cultural concepts into clinical delivery in the Pae Whakatupuranga FFT-CG phases. That this was being practised by therapists is evidenced in methods of engagement such as the place/location of sessions, whānau preferences for protocols such as karakia (or not) and whakatau practices, the whānau hierarchy.

> *When I told her…. I was a Christian she was, she was, very respectful.* (Whānau 2)

> *It was just at the beginning because he* [son] *preferred not to have a karakia …. he preferred like 'oh I'm here I just want to get into it'.*

> *Everything that concerned* [son] …. [the therapist] *based it around what he had.…* [the therapist] *came in the mornings coz he had* [a course] *in the afternoon. …. We felt better if we met at home. Oranga Tamariki opened up a room but we felt it would be better for comfort for* [son] *to meet at home and it was.* (Whānau 3)

Recognition of Te Ao Māori concepts and worldviews

The WWW training incorporates a holistic Te Ao Māori view, and including sharing of whakapapa, whakatau, and whakawhāngatanga may allow therapists to relate and engage better with whānau during therapy. An attitude described by some whānau as respectful and non-judgemental on the part of therapists towards their whānau made them feel more receptive to participate in therapy.

> *That is the one reason why I was open and honest with [the therapist], for her openness and honesty towards me and my son….*
>
> *It opened up something new, something we were trying to work through, with no obstacles or anything like that, it was straight to where we are at the time with him.* (Whānau 4)

Matching of therapists with whānau

All whānau indicated that they "liked" their therapist. Whānau sometimes indicated that they knew that their therapist was trying hard, and they did not want to say anything that might be perceived as negative about them. However, some whānau members saw the cultural and life experience differences between them and their young people, and the therapist, as a barrier to understanding, and doubted that therapists could understand or relate to the complexity of issues that youth and whānau faced.

> [The therapist] *didn't 'get' him…I think it meant that you know we just couldn't work with her properly …. like she'd come over and do a session …. but she didn't realise that there were all these other you know….* (Whānau 1)
>
> *Wish* [we] *had someone of similar background* – [they] *would understand better. Like a therapist from our background sort of thing. Yeah …. like* [they have] *been through it.* (Whānau 1)

Although ethnicity matching is not a current priority, in some circumstances this could be beneficial to the therapy. As the cultural advisor noted, there are facets of culture that may not be readily learned or understood by others and they are within a person "it's in here" (Kaumātua, tapping chest and stomach area). Several Māori whānau felt that, although the therapist was extremely culturally respectful and was making every attempt to be culturally responsive, the fact that they were not ethnically matched impeded success.

> *She was always very respectful. But, you know, at the same time …. she's not Māori, which, you know, is a … given ….* [you] *can see that that difference …. working with Māori to Māori can have.* (Whānau 3)
>
> *If we had a—I mean I'm not saying that she wasn't good but—a Māori feel?* (Whānau 1)
>
> *I think he would, he would have been more opened up* [to someone with the same background] *Yeah, because that's what he was hiding, uh, he was not always telling her why he was angry or how he felt. He just felt like sometimes that she didn't get it.* (Whānau 1)
>
> *I think it meant that…. we just couldn't work with her properly because she …. didn't realise that you know, like she'd come over and do a session with* [the young person's name], *but she didn't realise that there were all these other* [things happening] *you know like his friends were coming in and out of the house and he couldn't concentrate. …. She tried her hardest …. to finish it but she didn't notice* [the young person's name] *mind wasn't always there…. It was like she wanted to do a lot more with us, but because it was like walking on eggshells when she came over to our house* (Whānau 1)

Language can be a barrier for clients if the therapist does not speak their first language, particularly for some of the Pasefika aiga. If therapists are competent in speaking the client's preferred language it can assist in therapy with Māori whānau and Pasefika aiga in terms of relatability, building trust, and engagement:

> *"Actually [the therapist] speaks the reo… she was just trying to coz it's [son] that speaks the reo – I don't…he was listening, he was listening.* (Whānau 4)

Whānau activities

Several whānau noted the value that they found in whānau activities or exercises initiated by therapists. In contrast with 'talk therapies', with the therapist at the centre, and particularly 'one-on-one' counselling or therapy sessions with the young person, whānau activities were experienced as less intensely focused on individuals.

> *I found it, that it was working because we're all sitting around on you know like we're sitting around on the floor. We were doing like little post it notes. You know like write what was what was happening on that day or what went wrong on that weekend. Yeah, and we all did it together. So, I found it was really good to hear my kids' comments…. I thought it was really working with all my other kids. It was just nice to have them all there to participate in it.* (Whānau 1)

> *I know he* [the young person] *didn't like the one on one with her. He liked it as a family, all the time that we did things.* (Whānau 1)

> *They had a lot of games together and spent time together …. and she* [therapist] *took the time to look up what ADHD was …and to see how she could interact with her.* (Whānau 2)

2.2 Tafa o le Pasefika

Ole Uputāua ma lana mau i Tu ma Aga faa le Atu Vasa ma lona lalagaina i le Pae Whakatupuranga Functional Family Therapy Cross Generations

E faatulou atu ile Paia ma le Mamalu o le Tagata o le lau ele'ele.

O outou Sa ma Faiga o le a nuunuu atu i le upega lauga

E faatulou atu foi i taitai o le galuega i le Pae Whakatupuranga Functional Family Therapy Cross Generations.

Ae faapea Taiulu o le Atu Vasa ma lau Susuga Dr Byron Seiuli, o e na fita I tuga i le tapenaga o le Uputāua Pan Pacific Cultural framework ma lona aoaoina.

Ae faatalofa atu foi I le Mamalu o le au faigaluega.

We acknowledge the First Peoples of the Land.

We acknowledge with gratitude the leadership of the Maori Elders who provided space for the Uputāua Pan-Pacific Cultural Framework.

We acknowledge the Leaders of Pae Whakatupuranga who provided support for the inclusion of the Uputāua Pan-Pacific Cultural Framework into Pae Whakatupuranga Functional Family Therapy Cross Generations.

We acknowledge the Pacific Leaders and Dr Byron Seiuli and the support of the Pacific cultural supervisor, Synthia Dash.

We acknowledge the therapists and their supervisors who work daily with whanau and aiga to co-create positive change in their lives.

We acknowledge whānau and aiga whose daily struggles both illuminate and energise us to always improve our work.

In this Pasefika section we begin by acknowledging all those who have been involved in the inclusion of the Uputāua Pan-Pacific Cultural Framework into Pae Whakatupuranga I FFT-CG. This inclusion is contextualised by the whakapapa of WWW and the development of Pae Whakatupuranga I FFT-CG, as set out in the draft Pae Whakatupuranga I FFT-CG clinical manual (Seiuli 2020 p 160–163).

2.2.1 Including Uputāua in Pae Whakatupuranga I FFT-CG

The concept of Uputāua derives from two words: upu (word) and taua (significant, important, or precious). Thus, Uputāua means the words or sayings that are significant, important, and precious.

Uputāua originated from Samoan foundations and *recognises the uniqueness of Pacific identity that encompasses different languages, traditions and ways-of-being for each Pacific ethnic group. Significantly, Pacific people [also] share a strong heritage that often draws them together.*[9]

The Uputāua Pan-Pacific cultural framework is premised on shared conceptual elements across Pasefika indigenous cultures, including the key Pasefika concept of aiga, kaiga, magafaoa (family). Two further key concepts in Uputāua that are identifiable in Pacific cultures are relational boundaries and spirituality. The Uputāua "approach denotes the notion of advancement towards a proposed space" within which "parties respectfully negotiate." [9]

With this intention, Uputāua refers to a therapeutic approach from a Pan-Pacific or Pasefika perspective. This approach centralises the importance of spirituality, intergenerational relationships and the boundaries, roles, and responsibilities for the wellbeing of the collective.

WWW and Pae Whakatupuranga I FFT-CG provide a hopeful pathway towards an integration of world views. They also point to appropriate timing so that the careful work of integration is made possible.

This process is subject to the fact that these worldviews may not be aligned; for example, mainstream world views of youth perceives that they can be independent at age 18 where they are expected to be self-determining in life choices. This may not be consistent with Pan-Pacific views of collective aiga and collective responsibility for Aiga wellbeing.

There are commonalities across Pasefika cultures; however, there are uniquenesses also. This was acknowledged by both the Uputāua framework developer and the cultural supervisor. The challenge is to identify the similarities across Pacific cultures and develop therapeutic knowledge of and skills in the unique elements of Pacific cultures that are pertinent to aiga and youth development.

… there's a platform to utilise ethnic Pacific models and approaches that can still work with those groups. So what I'm saying is this approach is …an offering. This model is a start and those other groups can take this and throw it out and keep what they want and then build on that. And I'm fine. And for me the start of the folauga [journey] is the important point, and then others can help them and continue the journey. (Pacific framework developer)

O le Talaaga (the history) o le Uputāua Pan-Pacific cultural framework and Pae Whakatupuranga I FFT-CG

FFT was launched in New Zealand in 2009, the same year as Te Rautaki Maori o Kia Puawai, YH's Māori Strategy. The initial framework for WWW was created in 2010.

A consistent commitment has been made since that time to support WWW's development and interweaving into FFT-CG as a critical element of Pae Whakatupuranga I FFT-CG. This has included consultation with the Waikato-Tainui College of Research and Development in July 2019 on the original approach and

[9] Seiuli, B. M. S. (2013). Uputāua approach: researching Samoan communities. In N. Seve-Williams, M. Taumoepeau, & E. Saafi (Eds.), *Pacific Edge: Transforming knowledge into innovative practice*. Research papers from the fourth Health Research Council of New Zealand Pacific Health Research Fono (p. 16, p 71–86). Health Research Council New Zealand. Accessed at: https://researchcommons.waikato.ac.nz/handle/10289/9971

measures, and again in May 2020 on the documentation of WWW in the draft clinical manual. The FFT-CG model was launched in July 2019 and became Pae Whakatupuranga I FFT-CG in September of the same year.

The development of WWW and its weaving into Pae Whakatupuranga I FFT-CG included multiple noho Marae training sessions and took time and careful consideration. This provides a positive road map for the integration of indigenous culturally based approaches to therapeutic models such as FFT-CG. This gradual development has ensured that the breadth of knowledge contributed from the indigenous culture of Aotearoa has been woven with care into Pae Whakatupuranga I FFT-CG. Elders, leaders, and workers have nurtured WWW into its present form in Pae Whakatupuranga I FFT-CG.

The relatively recent inclusion of the Uputāua Pan-Pacific approach within Pae Whakatupuranga I FFT-CG, since July 2019, reflects a desire by the YH Kaumātua and leadership to include a Pan-Pacific therapeutic approach for work with Pasefika aiga and young people. Its ongoing development and alignment within Pae Whakatupuranga | FFT-CG is still unfolding.

The first significant steps in the inclusion of Uputāua with Pae Whakatupuranga I FFT-CG were taken in mid-2019 when Dr Byron Seiuli met with the WWW development team to ensure that the two frameworks were aligned and complementary. Uputāua has been included in the Pae Whakatupuranga I FFT-CG therapists' training and cultural supervision, and in the clinical manual in the past 14 months.

Inclusion of Uputāua in the Pae Whakatupuranga I FFT-CG clinical manual

Pae Whakatupuranga I FFT-CG includes the Uputāua Pan-Pacific Cultural Framework approach in its clinical training manual.

The gradual and well-thought-out development of WWW is a positive signpost for Uputāua and the inclusion of Uputāua in the clinical manual in Wahanga (sections) 3-9 is welcomed. The support by the Kaumātua for the inclusion of Uputāua was noted with appreciation by both the framework developer and the cultural supervisor.

2.2.2 Referral

Interviews with the three Pacific aiga highlighted their appreciation of their therapist's genuineness in approaching their aiga. This was achieved through a journey where both aiga and their therapist gradually got to know and trust each other.

> *She* [the therapist] *opened herself and then we opened ourselves. So, it's like opening ourselves to each other. And she explained what she does, and why she is there and it's like we work together* (Aiga J)

The therapist was then able to bring the family members together to communicate with each other by gradually unpacking problems so that they moved from a difficult beginning to a stage where they can relate to each other.

> *She'd come in every week and talked with us how we could communicate better. We were getting along very well. (Aiga K)*

One aiga felt less sure about the therapeutic approach in the beginning and, although they appreciated it in practice, they would have appreciated it and benefited from more information early on so they could better understand what was happening as it evolved.

> *I'm just looking maybe at the beginning I just needed a little bit … of information about what's involved … instead of me wondering and before the person comes to your door. Or even just a phone call before the person comes in to meet the family and the young person…* (Aiga J)

The second aiga was directed as part of a community-based sentence to take part in the Pae Whakatupuranga I FFT-CG programme. It is important that the referring agencies are well informed about Pae Whakatupuranga I FFT-CG so they can support the aiga that they refer with clear information and the aiga know what they can expect.

> *His* [the young person's name] *probation officer called to let us know about the programme. that's what he* [the Probation Officer] *told us to do at the time that they gave us* [the sentence] *…. we have to do it. It's part of a sentence.* (Aiga L)

Aiga would benefit from more information about the steps involved in the process and the explanation for such steps, so that they can be more prepared and ready for the treatment.

2.2.3 Training

Uputāua training was at an early stage at the time of the interviews for this evaluation. The timing of the interviews with the Uputāua developer, Pacific cultural supervisor, and therapists coincided with the timeframe for some of the preliminary training and supervision. The first Uputāua cultural framework training session (4.5 hours) for therapists occurred in early March 2020. The first Pacific cultural supervision session (1.5 hours) occurred on 20 March, immediately prior to the Covid-19 lockdown. The second Uputāua Pan-Pacific cultural framework training session (three hours) occurred on 7 April 2020 during lockdown. It was conducted online. The second Uputāua cultural supervision session with the therapists on 5 May (1.5 hours) was also conducted online.

The limitations of online training are well-known – it is difficult to pick up non-verbal cues and the restriction of having only one speaker at a time impedes the free flow of information and discussion. This will no doubt have contributed to the therapists' sense of intensive training requirements. Nevertheless, all the therapists who were interviewed were consistent in their keen support for the Uputāua training to continue.

All therapists said that they had not had enough time with the Uputāua model, and were not confident in speaking about the model or in applying the model in their practice. However, most indicated that with time they will get to the right point.

> *I don't think we've had enough learning …about it to be implemented into my practice. … we don't delve in as much as we have with WWW, I don't think we're giving it enough justice.* (Therapist Group 2–Therapist 1)

Both the Pacific framework developer and the cultural supervisor expressed the view that more work is needed as this is just a start of a journey of building cultural awareness and competency in therapeutic practices in Pae Whakatupuranga I FFT-CG

and YH. More work is needed in completing the first phase of the Uputāua training, as well as extending training opportunities and cultural supervision.

Uputāua Pan-Pacific Cultural Framework training and cultural supervision has continued beyond the period covered in this evaluation. Assessment of subsequent training, supervision, and therapeutic work will be included in the next stage of the evaluation.

2.2.4 Implementation of Pae Whakatupuranga I FFT-CG in Pasefika therapeutic practice

The first step of inclusion of the Uputāua approach in the clinical manual has been reached. Careful integration into each of the phases will take time, patience, and openness to Elder voices who bring wisdom to these discussions and dilemmas that occur when two cultures meet.

The inclusion of Uputāua within the Pae Whakatupuranga I FFT-CG approach is in progress; therefore, Uputāua theory and practice are not as established in Pae Whakatupuranga I FFT-CG as WWW. With appropriate time frames, support, and reviews, full integration is possible. Following the road map created by the development of WWW, and weaving it together with Pae Whakatupuranga I FFT-CG, will enable Uputāua to be successfully included within the Pae Whakatupuranga I FFT-CG approach.

> *And we've actually been through the process now to the point where we … agree on the recommendation put forward with adopting Uputāua* [as] *our Pasefika cultural framework rather than developing one from scratch.* (Pacific Cultural Supervisor)

The Uputāua Pan-Pacific Cultural Framework is a distinct approach in itself, as is FFT-CG. While developed separately, the Uputāua Pan-Pacific cultural framework was perceived to be fundamentally compatible with Pae Whakatupuranga I FFT-CG because they agree on the relational principle of engagement.

The developer of Uputāua describes the cultural competency of Uputāua Pan-Pacific framework as *'the foundation of who we are.'* As Uputāua was created within the Samoan space, the design is intended to be a guide for Pasefika youth and their families rather than an interpretation of any other therapeutic model.

In Pae Whakatupuranga I FFT-CG and Uputāua, there is an insistence on respectful approaches and principles to guide therapeutic responses to Pasefika aiga. However, there are complexities that need to be addressed; for example, if the relational connection with aiga is not created well, the therapeutic work and engagement are much less likely to succeed or be of value to the recipient aiga.

> *.. .they may take a while, they won't work with you if they don't get you or if they don't trust you.* (Pacific framework developer)

The most distinctive issue that has emerged from discussions with the Pacific framework developer, the cultural supervisor, and the therapists, has been the concept of family and cultural structures. 'Pacific cultural structures' refers to the roles within

society and family. In the Pacific cultural structure, the young are part of the collective with clear parental roles assigned in the family. In the Pae Whakatupuranga I FFT-CG approach, the *"interventions are to be matched to certain qualities including family structure."*[10]

The following quote exemplifies the conceptual problem that exists between some therapists' understanding of the general FFT approach, and Pasefika concepts of aiga, the role of parents or matua, and the role of young people, particularly as they are translated into practice.

> *How do we match because we don't want to be culturally disrespectful and not matched to the cultural hierarchy.* (Practice Lead)

This practical therapeutic dilemma can be expressed as "How do we acknowledge the roles of parents as providers and guardians, while at the same time open space for the voice of a young person? How do we maintain the intergenerational responsibilities and roles of aiga, kaiga, and magafaoa to work collectively towards their wellbeing?" These questions, and the complexities from which they arise, can be resolved by further training, cultural supervision, and discussion.

The same tension between collective wellbeing and individual self-determination appears in the following quote from one of the therapists, talking about the dilemmas she sees her clients grappling with:

> *"There is tension… but does it have to ruin my relationship with my kid ? .. .I like that it brings it back to the collective because …do you want to risk … your values and your cultural beliefs or do you want to lose your kid" is the main thing that I got out of all these families that I'm working with* (Therapist Group 2–Therapist 3).

At this early stage in the implementation of training and supervision in the Uputāua Pan-Pacific approach, therapists interviewed were in consensus that more work was needed on the weaving together of Pae Whakatupuranga I FFT-CG and the Uputāua approach. Therapists felt in general that they needed *"more time in order to unpack the Pacific cultural framework"* in order to *"do it justice"* because *"I want to make this work"*. This is unsurprising, as they were relatively newly recruited and very new to the Uputāua framework.

2.2.5 Voices of Aiga, Tupulaga talavou (young people) and therapists

This section considers how Aiga, Tupulaga talavou (young people) and the therapists have experienced the Uputāua Pan-Pacific Cultural Framework and Pae Whakatupuranga I FFT-CG. Three of the seven Aiga/families who were interviewed identified as Pasefika. Aiga participating in this evaluation also completed a series of Likert Scales assessing various aspects of their experience of the therapy.

[10] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc. Seattle, WA., p 10.

Voices of Aiga

Uputāua is both a Samoan and a Pan-Pacific cultural framework. It has brought Pan-Pacific spirituality and the importance of intergenerational aiga relationships into the practice of Pae Whakatupuranga I FFT-CG.

For example, it is important to establish positive relationships with both generations, in therapeutic work with Pasefika young people and their families and parents. Matua, or parents, will always remember how they have been responded to by therapists and other referral agencies when they have been seeking help for their families.

The therapist

Most aiga liked the warmth and empathy of the therapist, and appreciated what their therapist was trying to achieve with them through a journey where both aiga and their therapist gradually got to know and trust each other. The Pacific Island therapist approached the family in a way that was culturally appropriate and was perceived as a connection enhancer.

> *At the beginning when she came in… we needed time to get to know the person. As we go along, we bring up [a] topic… and then the therapist tries to find a way to work on it.* (Aiga J)

When the worker's relationships with the aiga connect well, the progress and benefits for the young person, and therefore their aiga, is unlimited.

> *She'd come in every week and talk with us how we could communicate better. We were getting along very well.* (Aiga K)

Another aiga expressed their gratefulness to the therapist for helping their young person open up and interact during treatment.

> *He [the young person] enjoyed and he shared it. He opened up … it's the relationship with the therapist as a person. So, it's not like he's holding himself back and …he can ask something.* (Aiga J)

> *He learned some stuff during the programme. He enjoys asking questions, saying something or being involved in whatever the topic or activity we do. We are all involved. So, he's ok, he enjoyed it.* (Aiga J)

Cultural appropriateness

When interviewed about cultural appropriateness, aiga who had been assigned the Pacific Island therapist immediately remarked on how she had helped them feel more connected. They did not have to explain themselves and connection occurred more easily. Two aiga considered the service as being very culturally appropriate and one was unsure.

Comments from aiga who appreciated the work that was carried out with them show the benefits that accrue when the therapist is appropriate and sensitive to the intergenerational aiga members.

> *She* [the therapist] *is a Pacific islander herself. She's helping …to put us back into our cultural way of doing things and to speak up… we are Pacific Island. …She's*

> *great in doing that …. to see our Island people coming on board and involved our family as well …. for us to feel affirmed as Pacific people* (Aiga J)

> *So wonderful* [therapist name]. *Yeah. …. I think she is like …Tongan as well, because I think they understand more, Pacific Islands [people] as well*. (Aiga L)

One aiga talked of their experience with another service they had been involved with:

> *A therapist or psychiatrist came around to talk to [the young person's name] for some reason [the young person's name] didn't wanna talk to him. It just depends on his mood…he wasn't in that sort of mood that day, I don't know what was bothering him…so it stopped there for the psychiatrist.* (Aiga K)

The aiga contrasted this with the therapist from Pae Whakatupuranga I FFT-CG, who had been able to connect well with their young person.

Careful and gradual questions that confirm parental roles, while simultaneously creating an appropriate space for the voice of the young person, will assist therapists as they work through these complexities.

The therapeutic process

Pasefika families appreciated the process in practice, despite feeling unsure about the therapeutic approach at the beginning. The Uputāua Pan-Pacific Cultural framework approach in the clinical manual notes:

> *The Pasefika family must feel a strong sense of ownership in their pathway of change for it be lasting. They must feel respected and be treated with dignity …A therapist who can provide this for the Pasefika family will find willing and active participants in the process of therapeutic change.* (Seiuli 2020 p 151)

One aiga was neutral or only slightly positive about almost all aspects of the process, except for cultural identity, which was rated as "did not help or affirm [my cultural identity] at all".

However, all aiga felt that access to the service via the therapists was easy. Two aiga gave the highest rating to having a voice during the process, feeling safe and respected, actively participating in the treatment, and affirming their cultural identity. This pattern shows that while there is room for improvement, the Pasefika therapist was considered positively by the aiga.

Some issues were raised about the efficacy of the process. Aiga had different opinions about the level of support received from the therapists, and all thought that they had only "a bit" of help in overcoming barriers and/or solving problems. Only one aiga thought they fully understood the therapy process; the other two felt that they had 'some information' and understood 'some things'. These views, and the perceived lack of information provided to aiga, especially at the start of their treatment journey, highlight the need for more early support to help aiga be prepared for the treatment process.

The path forward

Complexities remain on the path to weaving the Uputāua Pan-Pacific Framework into Pae Whakatupuranga I FFT-CG. Some examples are given below.

One aiga interviewed pointed to their frustration that as parents they did not feel that their views were taken sufficiently seriously by a drug and alcohol counsellor. The addictions service was working alongside this Pacific family at the same time as the aiga were being served by the Pae Whakatupuranga I FFT-CG therapist. This raises the question of Pae Whakatupuranga I FFT-CG's responsibility when an associated service works in ways that contradict the programme's fundamental concept of respecting family structures.[11]

Another family raised the need for increased sensitivity to relational boundaries. They preferred that their situation not be shared with other extended family members and that their preference be respected. Sometimes Pasefika aiga will prefer not to take the focus out of the nuclear family. These sensitivities are likely to vary due to different experiences and feelings in differing aiga, and therapists need to be alert to the preferences of their clients.

> *She's helping us with just our family* (Aiga J)

Finally, one aiga felt the voices of individual young people had been made preeminent over the aiga parental voice, despite the emphasis in the clinical manual on matching the client's family structures. This suggests that therapists need to take particular care to understand the varying cultural conceptions of family structures across their client groups, and their implications for their therapeutic practice.

> *listening more to what we want as parents…for once please listen to us because we live with our children… and we know what's going on. And we want the safety of our children too.* (Aiga K)

Despite these challenges, aiga found the treatment worthwhile.

> *The reason why we stayed in the programme, it's because, he's getting a little help from the programme as well. I think it was a great experience.* (Aiga L)

[11] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc.) Seattle, WA., p 153.

CONCLUSIONS AND RECOMMENDATIONS

The WWW approach is well embedded in the Pae Whakatupuranga I FFT-CG pilot programme. The training in and supervision of the approach has been ably led by the Kaumātua and cultural supervisor. It was incorporated at the beginning of the programme. It has been well planned, consistent, and thorough. WWW is accessible to the therapists and the overall YH team who appreciate its value. The knowledge gained and reflective processes have influenced the therapists as they have endeavoured to embrace the model in their practice.

The four Māori whānau who were interviewed were actively engaging in the therapy and found the therapists to be well-meaning, respectful, culturally aware, and sincere. Overall, they have enjoyed the discussions and group activities and found them beneficial. However, this needs to be balanced with the data for all Māori who have been referred to the programme that show Māori have disproportionately higher rates of never beginning or not completing treatment, and make slower progress through the treatment phases.

Whānau also expressed a desire for therapists to have a more similar life experience and culture to themselves, to ease understanding and avoid a lot of explanation. Many of these families have survived tough life experiences and lived in a Māori world. Future recruitment of therapists could seriously consider recognising cultural knowledge and experience as whānau support people within Māori communities, as being as important as mainstream therapeutic training when working with Māori whānau.

The Uputāua approach is much more recent and training only began in March 2020. It is yet to be fully embedded in the Pae Whakatupuranga I FFT-CG programme. However, a significant start has begun, and the Uputāua model provides a clear guide and pathway forward. That, plus the training and supervision that is accompanying it, is enabling the inclusion of a Pasefika indigenous world view in the further development of Pae Whakatupuranga I FFT-CG in Aotearoa.

The leadership and generosity of WWW in paving the way for indigenous knowledge and training is particularly acknowledged, as well as those who have led the development of the programme to date. These have created the space for Uputāua to further enrich the model.

Pasefika aiga were mainly positive about their experience of therapy. They felt they were safe, respected. and had a voice in the therapeutic process. This was enhanced by the Pasefika therapist. Nevertheless, they considered they did not receive enough information about the therapy, and two of the three aiga expressed concerns about differences between the therapists' views about young people and aiga relationships and roles within their cultures.

As with Māori whānau, they had proportionately fewer sessions. They also had the highest treatment failure with two aiga who quit after at least one session and another aiga with a young person that ran away. However, to their credit, they had proportionately the most participants reaching Phase 2 of the treatment programme.

The Uputāua model grew out of a Samoan base, to embrace a Pan-Pasefika approach to values across Pasefika indigenous cultures. There remains a need to draw out the similarities between the cultures and their values, and name them in their languages, so that the broad range of Pacific communities can relate to and own the approach.

A long-term plan needs to be developed with timelines for the training and supervision of therapists and other staff comparable with the WWW approach. Uputāua has achieved a lot considering its recent inclusion in the programme. For it to become fully embedded in Pae Whakatupuranga I FFT-CG, a similar focus and commitment of time and resources will be required. As with WWW, ongoing consultation with Elders and Pasefika clinicians and social scientists will help to strengthen the roll out.

Improving cultural data and measurement. There is a clear lack of cultural measurement data. There is value in developing the HCC database to create specific cultural measures that capture processes and outcomes. The Cultural Satisfaction Report, which is filled out at the end of the therapeutic engagement, could also be used early in the treatment, after two therapy sessions, to provide feedback and to function as a baseline measure. In time, such measures could be commended to FFT-LLC as an innovation to the CSS database.

Appendices 1 and 2 outline areas of data and category mis-match between the international CSS data collection and analysis categories, and the Aotearoa/New Zealand-focused HCC data systems and categorisations. Data from YH and collaborating agencies need to be reconciled with data stored on the FFT-LLC database (CSS), to suit the Aotearoa context and to give us insight into the different trajectories of Māori, Pasefika, Pākehā and other clients. This would provide greater accuracy and assist us in understanding how well the model accommodates those worldviews in practice.

Recommended next steps for improvements in Pae Whakatupuranga I FFT-CG's accommodation of the cultural worldviews of Te Ao Māori and Pasefika Peoples

The FCSPRU makes the following recommendations in the light of this formative evaluation:

1. *Cultural accommodation:*
    a. Recruit skilled therapists, recognised cultural family support people,[12] and other staff to mirror more closely the proportions of clients from the Māori and Pasefika communities, and include a criterion for selection that successful candidates who will work with whānau and aiga are firmly grounded in Māori or Pasefika cultural knowledge. This will

[12] Such as those who are recognised in Māori and Pasefika communities as 'go to' people for assistance with family problems and difficulties.

encourage more rapid engagement and understanding and reduce their burden of cultural learning.

b. Seriously consider those with recognised cultural knowledge[13] and experience as whānau or aiga support people within their cultures, as being as important as those with mainstream therapeutic training.

c. The current plan for the training and supervision of therapists and other staff in the Uputāua approach be extended into future years and develop a comparable commitment with the WWW approach.

d. Establish a mechanism to review progress in building Pasefika cultural awareness and competency in therapeutic practices in Pae Whakatupuranga I FFT-CG and YH.

2. *Measuring progress:*

a. Implement a process to reconcile HCC data from YH and collaborating agencies, with data on the FFT-LLC database, to provide greater insight into the different trajectories of Māori, Pasefika, Pākehā and other clients.

b. Consider establishing specific terminology in the case notes to capture information about cultural processes for the HCC database.

c. Consider completing the Cultural Satisfaction Report after the whānau/aiga/family has completed two sessions with their therapist, to provide a baseline for clients' cultural satisfaction assessment at the completion of therapy.

3. *Recruitment and progress of clients:*

a. Continue to work on implementing the recommendations in the Wave 1 formative evaluation report, which aim to increase agencies' understanding of the reasons for families deciding not to take part in therapy after they have been allocated a therapist, and to improve the retention and updating of clients' contact information (recommendations 1 and 2 in the Wave 1 report).

b. Explore with referring agencies ways to normalise family therapy as a way to help their taiohi/tupulaga talavou/youth and their whānau/aiga/family.

4. *Referrals to YH:*

a. Review the criteria for acceptance into the programme to identify and remove any systemic cultural biases, such as requirements for the index client to live with their family of origin.

[13] Ibid.

   b. We suggest referring agencies provide more information about clients referred to YH, especially their cultural background such as specific ethnic and iwi affiliations and languages spoken, to assist therapists to prepare for therapeutic engagement.

5. *Early engagement with whānau/aiga/families:*

   a. Consider developing language-appropriate packs of information about the therapy, its purpose and processes, and likely outcomes, to be given to whānau/aiga/families prior to their first therapy appointment, to enable them to maximise the benefit of the therapy.

6. *Therapist training:*

   a. Ensure all therapists are fully trained in the near term in understanding the embodiment of Pasefika cultural ways and values in Uputāua and applying them confidently in their practice.

APPENDIX 1. DATA GENERATION PROCESSES

The CSS data generation process follows the FFT-LLC international standard

CSS access levels ensure information confidentiality without modification

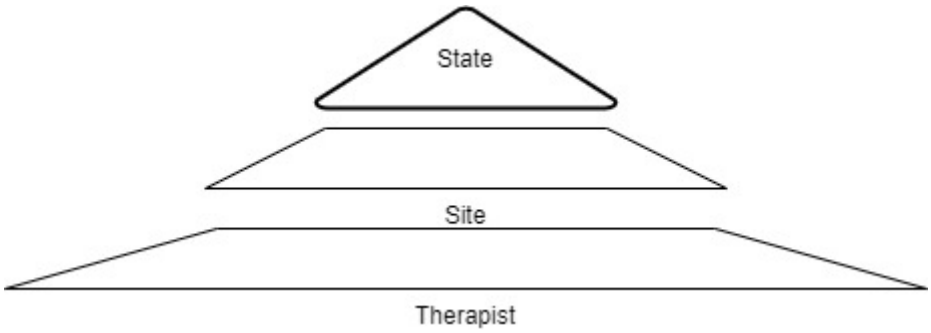
There are three access levels in the CSS recording system (Figure 13). The highest level is the state level, accessible to those with state roles (state coordinator, QA/QI Managers) or who have been granted permission by FFT. At this level, users can access all three levels of aggregate data.

The site level covers workgroup and therapist data, accessible to administrators, supervisors, and evaluators.

The therapist level restricts access to data input during the FFT process, and ensures that therapists can access data about their own clients only. They have no access to any other level of aggregate data, unless they are also administrators or evaluators.

This ensures that the therapists cannot view any confidential information that they have not entered themselves, and site managers manage the data for their region only.

Figure 13. Three access levels in the CSS system



While therapists can edit information such as case notes and client characteristics, they must follow the FFT-LLC international design which includes predetermined choices to ensure comparability across countries. Neither therapists nor site managers can modify these choices. A problem arises when these choices, for example, the names of reference agencies and ethnicities of clients, are not suitable for the Aotearoa/New Zealand context.

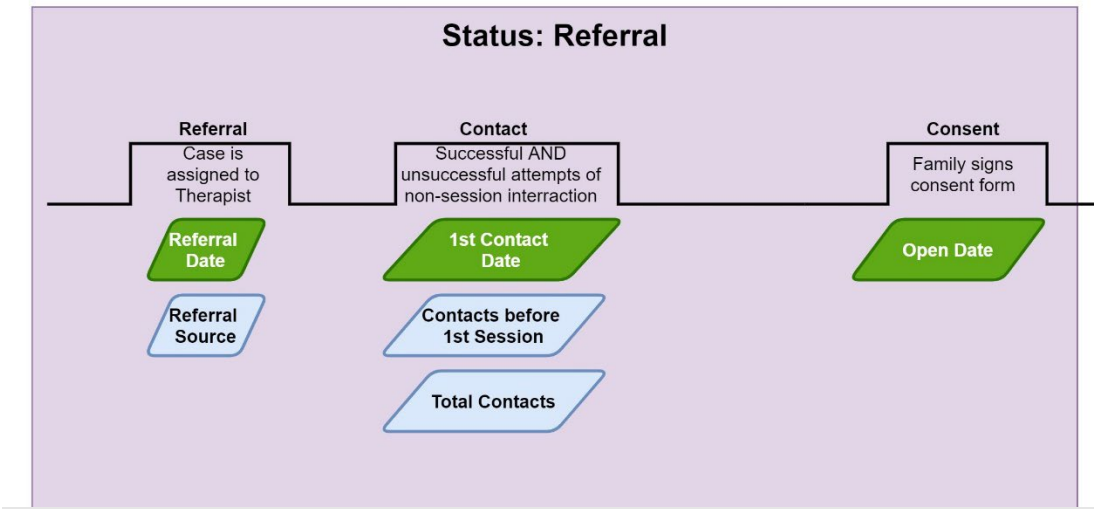
The CSS design reflects the FFT model and is geared towards time measurement

The types of data that are required for entry by CSS design reflect the stages of treatment described in the FFT model, with specific dates corresponding to specific activities initiated and completed by therapists and their clients. In general, three stages corresponding to three types of case statuses are recorded.

In the first stage, ***referral*** (Figure 14), the process is concerned primarily with the therapist getting to know the family. When a case is assigned to an FFT therapist, the status of the case is *referral*, and a data entry of ***referral date*** is recorded. After being assigned, the therapist will attempt to get into contact with the family, which consists of outreach, referral sources, and other systems involved with the case. These contact attempts are not session activities. Sessions are face-to-face family meetings that result in movement towards phase goals. Both successful and unsuccessful attempts are recorded. There is no distinction made in terms of types of contact made with families or referral sources. The three data entry inputs are the **first contact date**, the number of contacts made before the first session (**contacts before first session),** and the total number of contacts made (**total contacts**).

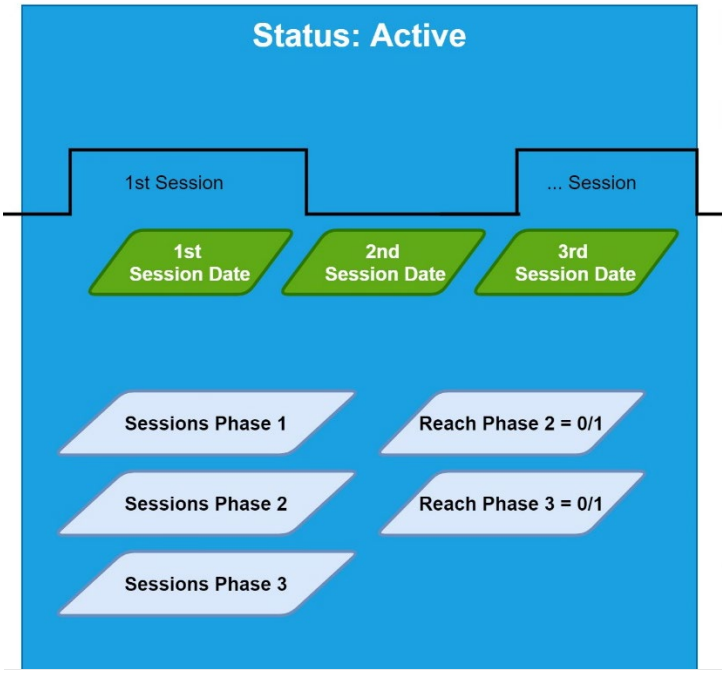
When the family signs the consent form, a data entry of **Open Date** is entered.

Figure 14. Referral stage



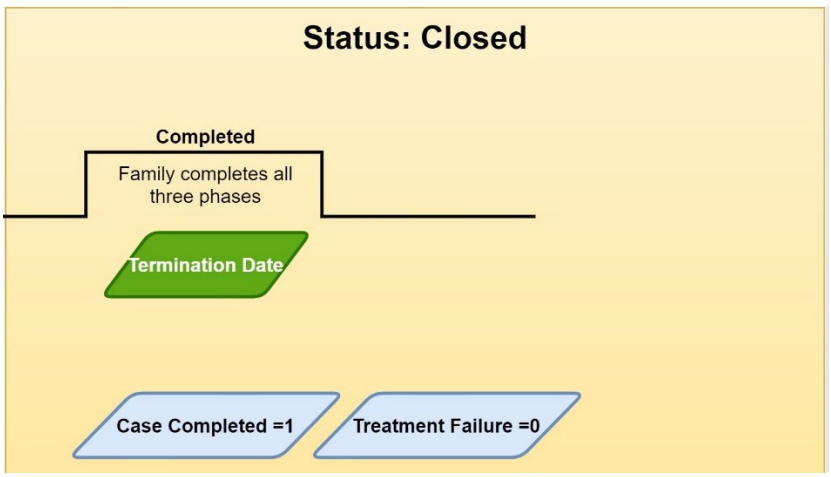
The second stage is the treatment process (Figure 14a). In this stage, the therapist and the family engage in the three phases of treatment. Once a session is entered the case moves to **active status**. Data on the date when treatment sessions occur and whether the family progresses to the next session are entered. The data include the **first session date,** the **second session date,** and the **third session date;** whether they reach phase 1, 2, or 3; and the total number of sessions in each phase.

Figure 14a. Treatment stage



If the family completes all three phases, the case is considered a **completed case** (Figure 15). Data on this category of case is entered as **case completed=1** and if it is a treatment success, **treatment failure=0**. In this final stage, a **termination date** is entered.

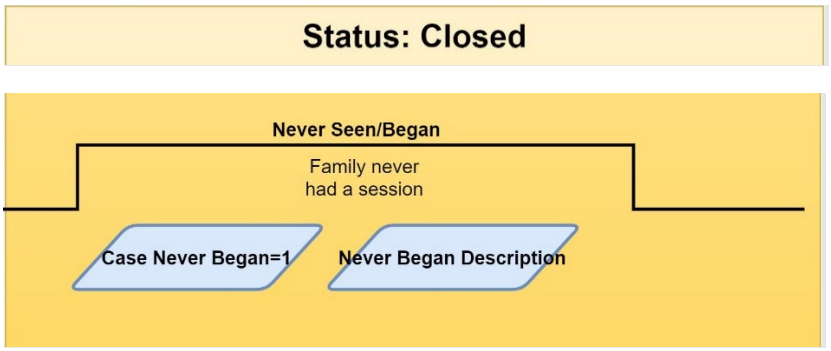
Figure 15. Termination stage



The three stages described above refer to successful treatment. Other scenarios are captured in the **case never began** and **drop out** situations. The two situations are captured differently in the final stage.

If all contacts, whether successful or not, result in the family not taking part in any session, even if they have signed the consent form, a data entry of **case never began** will be recorded, along with the reasons under the heading **Never began description** (Figure 16).

Figure 16. Termination stage for 'never began' cases



The reasons for 'never began' are:

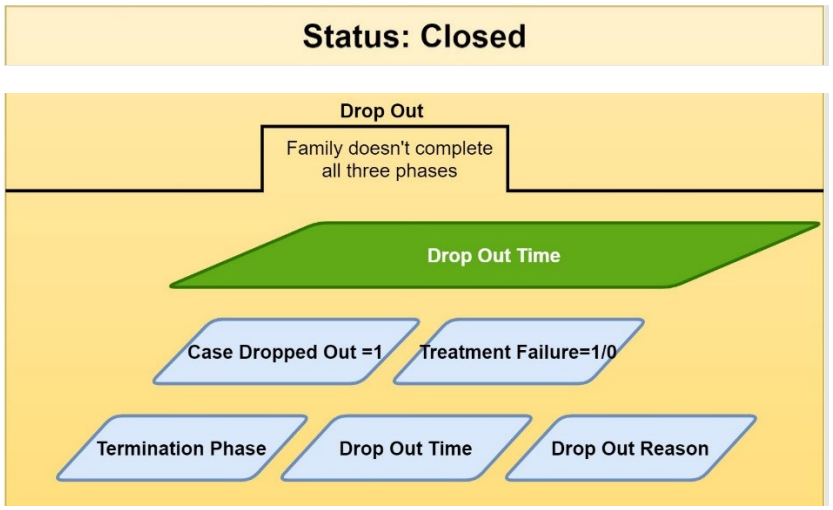
- *Criteria not met for FFT*: This 'never seen' category is for families who do not meet the inclusion criteria for FFT. This option includes situations where the family condition has changed after referral and the therapist assigned, which make the case unsuitable.
- *Other treatment conflict*: This 'never seen' category is for families who did not start FFT treatment as they were already enrolled in different treatment services.
- *Not able to contact:* This 'never seen' category is for families who were not able to be contacted by the therapist. The therapist attempted all possible ways of contacting the family, and no contact was successful.
- *Declined services:* This 'never seen' category is for families who refused to authorise FFT services.

The following are the options for those who signed the consent form.

- *Never attended initial appointment:* This 'never seen' category is for families who authorised and agreed to receive FFT services but never attended any scheduled FFT sessions.
- *Youth whereabouts unknown*: This 'never seen' category is for families who authorised and agreed to FFT services but the youth could not be located.
- *Referral criteria not met for programme/agency*: This 'never seen' category is for families who do not meet the inclusion criteria for a programme or agency.

When a case is interrupted and the family does not complete all three phases of treatment, a **non-completed case** or **drop out** case is recorded. Data on **drop out time**, the corresponding treatment phase **termination phase** and the **drop out reason** are entered (Figure 17).

Figure 17. Termination stage for 'drop out' cases



Not all drop out cases are recorded as treatment failure and included in the formula for calculating success. The following are the reasons for drop out that are not associated with treatment failure and not included in the calculation.

- *Administrative discharge*: This non-completion category is for families that were discharged by the FFT agency because they (a) did not meet the criteria for FFT, (b) were incarcerated for pre-referral reasons only, or (c) funding for treatment was terminated.
- *Moved*: This non-completion category is for families that were terminated because the youth was moved outside the service delivery area during FFT treatment.
- *Referred to other services:* This non-completion category is for families that were terminated because (a) the referral source ended treatment due to overlapping services or (b) the family was initially referred to FFT and other services and decided to go to the other services.

The following are the options for recording treatment failure

- *Incarcerated*: This non-completion category is for families that were terminated because the youth was placed in a "justice commitment facility" (a youth justice facility in Aotearoa/ New Zealand) during treatment and/or was scheduled to go to a commitment facility at the end of treatment for activities/violations that occurred once treatment started. If clinical contact occurs during the detention or incarcerated period the case may remain open.
- *Placed out of home:* This non-completion category is for families that were terminated because the youth was placed in foster care or long-term psychiatric placement (or to a similar treatment setting) before the completion of services.
- *Quit after first session*: This non-completion category is for families that were terminated because the family quit after receiving at least one FFT face-to-face session. This category captures all cases that drop out of FFT prior to the planned discharge.

- *Runaway:* This non-completion category is for families that were terminated because the youth ran away from home for an extended period, preventing services from being completed.
- *Youth deceased:* This non-completion category is for families that were terminated because the youth died during treatment.

In all situations, a **termination date (date closed)** will be entered that corresponds either to the date of the last clinical contact with the family or the date of last attempt at clinical contact with the family.

The CSS database provides FFT outcomes and time efficiency measurement

The case data table (Figure 34) gives all data entered except session notes and the outcome measures for Therapist Outcome Measure (TOM), Youth Outcomes Questionnaire (YOQ), Client Outcome Measure for Adult (COM-A) and Client Outcome Measure for Parent (COM-P).

Figure 18. Data interface for site access level

Only the latest status is recorded in the case data table. Previous changes are captured through the entries of **first session date** (status changes from 'referral' to 'active'), **date closed** (status changes from 'active' to 'closed'), **drop out time** (status changes from 'active' to 'closed').

The raw data in the **case data table** is then used to generate two reports:

- Case Tracking Report;
- Case Demographics.

The **Case Tracking Report** gives analytical information on the status of treatment organised by state, site, and therapists. There are five parts in this report.

In the first, information is provided on the total number of cases referred within a time frame and the total number of cases still in 'referral' or 'active' status for each therapist. Measurements of time efficiency are given by the average number of days from the date of referral to first contact and the average number of days from the date of referral to the case being opened.

The second part gives the number of closed cases by each therapist. This includes (i) completed cases, (ii) drop out or non-completed cases, and (iii) never began cases.

The third part analyses the quantity and quality of completed cases for each therapist.

- The **quality indicators** are (i) outcome (positive or not significant) and (ii) youth status at termination (remain at home with family or not, enrolled in educational/vocational program or not, and don't engage in violence or not).
- The **time efficiency** indicators are (i) average number of days from date of referral to first contact date for completed cases, (ii) average number of contacts between date of referral and first session date for completed cases, (iii) average number of days from referral date to open date for completed cases, (iv) average number of days from referral date to first session date for completed cases, (v) average number of days from first session date to second session date for completed cases, (vi) average number of days from second session date to third session date for completed cases, (vii) average number of days in programme for completed cases, (viii) average number of total sessions and (ix) average number of sessions for each of the three phases (engagement and motivation, behaviour change, and generalisation).

The fourth part gives information on the number of 'drop out' cases and their situation for each therapist: reasons for dropping out and whether they are considered treatment failures are given. Information on the progress of treatment is given in terms of the phase and the number of sessions completed.

The **time efficiency** indicators for non-completed cases are (i) average number of contacts between date of referral and first session date, (ii) average number of days from referral date to open date, (iii) average number of days from referral date to first session date, (iv) average number of days from first session date to second session date, (v) average number of days from second session date to third session date, and (vi) average number of days in programme.

The final part of the report analyses the reasons for 'never began' cases for each therapist.

The Case Demographics Report provides the number of cases by gender, age, ethnicity, family status, educational status, referral type, referral source, primary and secondary referral reasons for overall total referrals, and completed and non-completed cases.

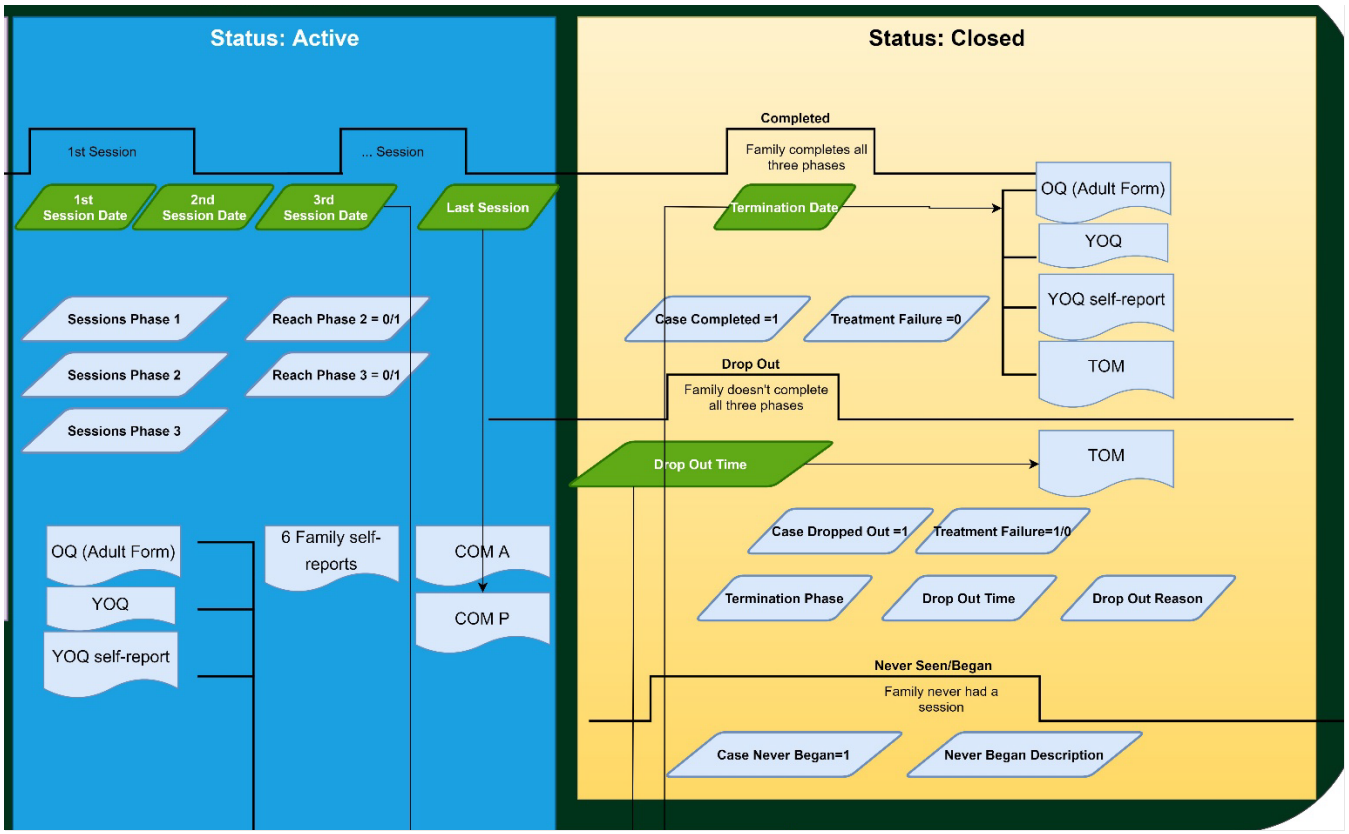
The CSS database maintains different outcome measures during the treatment process. These are qualtric[14] forms used before and after treatment to evaluate treatment effect (Figure 19)[15]. The Outcome Questionnaires (OQ) are for parents and youth over 18 years old to self-report. The Youth Outcomes Questionnaire (YOQ) is for parents to assess youth 10 to 17 years old. The YOQ - SR is for youth aged 10 to 17 years old to self-report. These OQ and YOQ forms are completed by the third session as a pre-treatment measurement, and again at discharge as a post-treatment measurement.

At discharge, youth 10 to 17 years old further complete the COM - A form for adolescents and their parents complete the COM - P form to assess the adolescents.

Those who completed or dropped out during the treatment also receive the TOM prepared by their therapists. No TOM is completed for 'never began' cases.

[14] This means the responses are converted into numeric values to enable evaluation, especially before and after treatment.
[15] This is based on FFT-CG documentation requirements as at 2 August 2019.

Figure 19. Outcome measures generated by CSS



The Cultural Satisfaction Form is entered separately on a Google form and extracted into Excel for storage. It is not entered in the CSS. The HCC data maintained by YH reflects the Aotearoa/New Zealand context

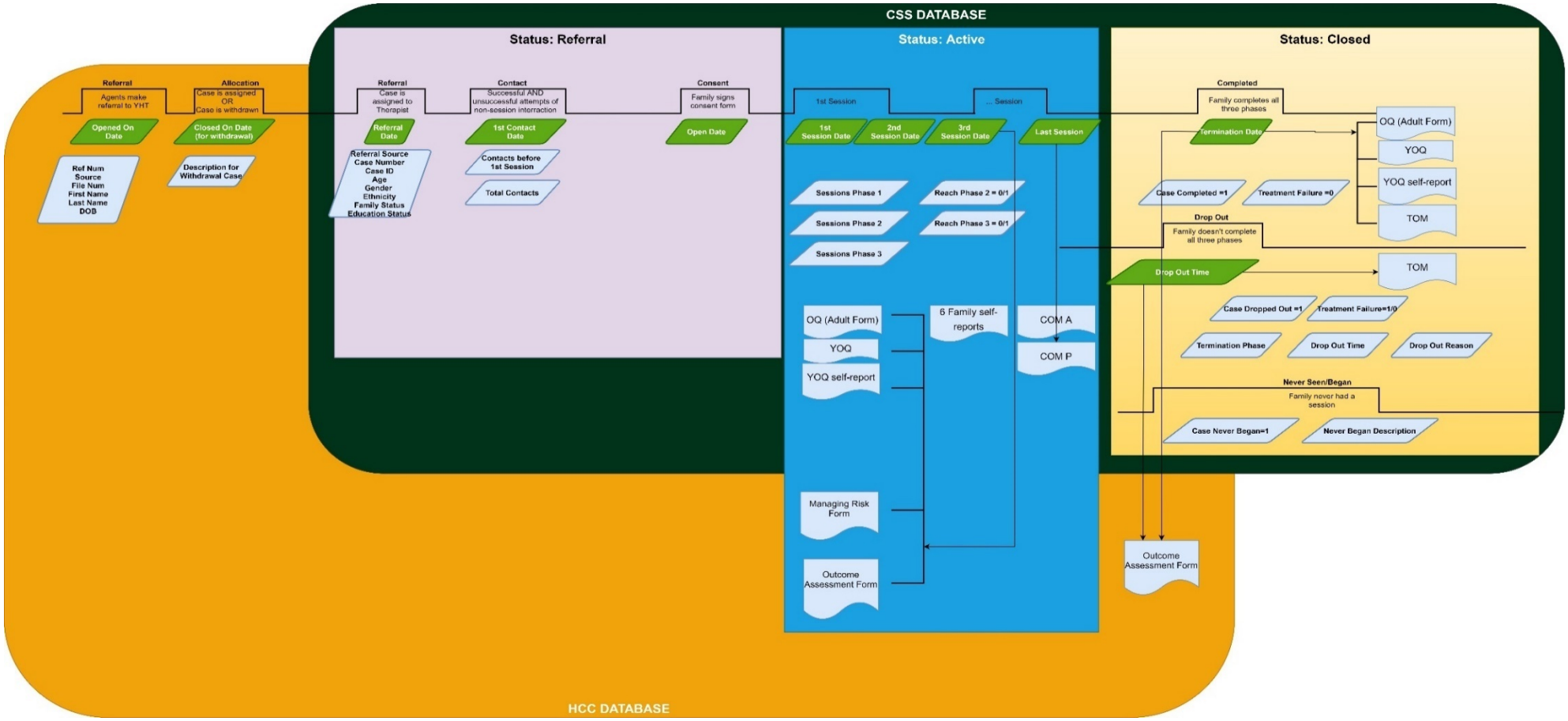
The HCC database is maintained by the YH Trust to record their therapeutic services, one of which is FFT-CG. In comparison with the CSS database, HCC has an additional record of the referrals that are not allocated to therapists because of withdrawal or lack of suitability (Figure 20). Therefore, there are more records of referred cases in the HCC referral process. 'Referral' in the HCC database includes those that are subsequently allocated to the therapists (*Referral* in the CSS database) and those that are not allocated and therefore not entered in the CSS database. However, the HCC records of treatment have no data on treatment progress dates. The outcome indicators are recorded in the Outcome Assessment form, completed pre-treatment at the third session and at again post-treatment at discharge. A Managing Risk form is completed by the third session and updated at 90 days and at discharge.

The choices in the HCC for referring agencies and ethnicities are preferable as they reflect the Aotearoa/New Zealand context. The CSS and HCC have overlapping entries of data such as family status, reasons for cases that never began, etc.

A lagging problem occurs in the data flow from HCC to CSS. A case can already be assigned a therapist in HCC before the client account is opened in CSS. As a result, CSS does not recognise the client, making this client's status 'unallocated', which does not record the actual situation.

Further, because of the time problem in the data flow from HCC to CSS, overlapping data entries may contain different data. We performed a review of design between HCC and CSS for other overlapping entries of data (see Appendix 2) for data generated between June 2019 and April 2020. Although there are few observations of disagreement in data entry for ethnicity, living, or educational situation before and after treatment, or in the reasons for 'never began' and 'drop out' cases, these disagreements present data cleaning problems that may become more complicated once the programme is rolled out on a larger scale.

Figure 20. HCC and CSS data generation processes



Reconciliation of HCC and CSS databases requires a unique identifier

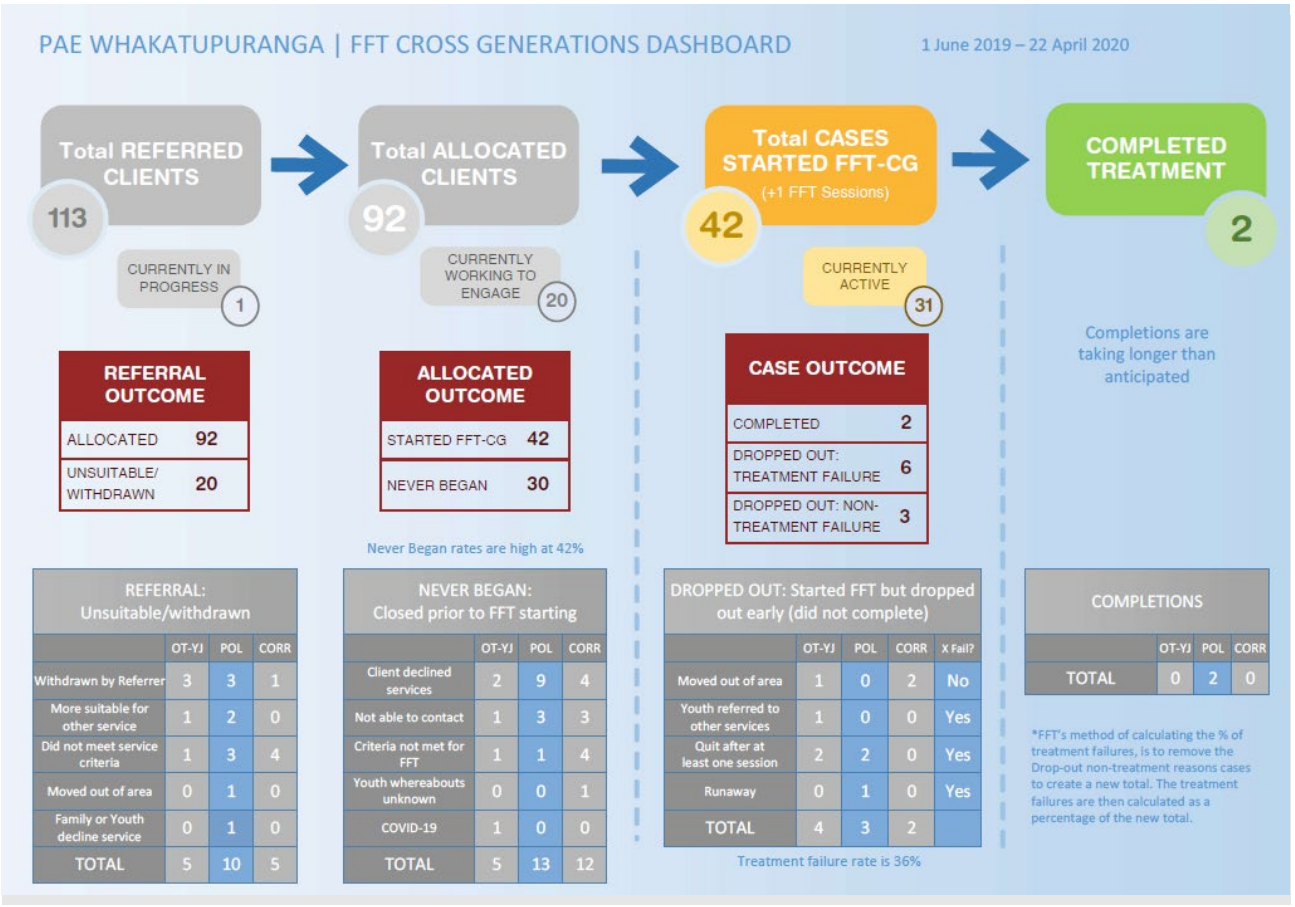
A reconciliation between HCC and CSS is performed every four to six weeks in preparation for the Steering Group meeting. The reconciliation is based on an identifier ('Case Number' in CSS and 'File Number' in HCC) to match the data records in HCC to CSS. The main information to match is *referral source,* which is correctly entered in HCC for three referring agents: Corrections, the Police, and Oranga Tamariki. This information is not compatible with CSS. At present, the FFT-CG Data Administrator must reconcile the two databases (CSS and HCC) in a separate Excel sheet for tracking and evaluation.

The reconciliation is used by YH in New Zealand to prepare the **Pae Whakatupuranga FFT-CG pilot monitoring dashboard.** This tool is designed to monitor the progress of the pilot through focusing on progress through the stages of the treatment process. Data from the **case data table** and data on the number of referrals received and their suitability are included and analysed in the first part of the Dashboard report. Subsequent parts analyse the progress across time for allocated cases ('referral' status in CSS system); active cases, drop-outs, (early exit), and 'never began' cases. The Dashboard consolidates these analyses to create projections and plans for the subsequent roll-out.

The identifier needs to be unique in each database in order to perform the reconciliation between HCC and CSS. However, on occasions the identifier has two to three rows of data reflecting different periods of treatment. Each unique identifier should have only one row of data that reflects the most up-to-date information. The lack of this is problematic for reconciliation because it can result in the data from HCC being matched to an earlier record in CSS or vice versa. This would not reflect the most up-to-date situation of the client and may result in incomplete data entry. This problem also leads to a different number of cases in the two systems, with consequent errors in the data summary, the extent of which depends on the number of double or triple entries for the identifier.

Figure 21 gives the content of the dashboard prepared for the period 1 June 2019 to 22 April 2020. It is noted that CSS and HCC data on 22 April 2020 and on 28 April 2020 are the same; no new information was added during this period. The mismatch between HCC and CSS due to the identifying problem described above led to the incorrect numbers shown in Figure 22.

Figure 21. Monitoring dashboard from 1 June 2019 to 22 April 2020



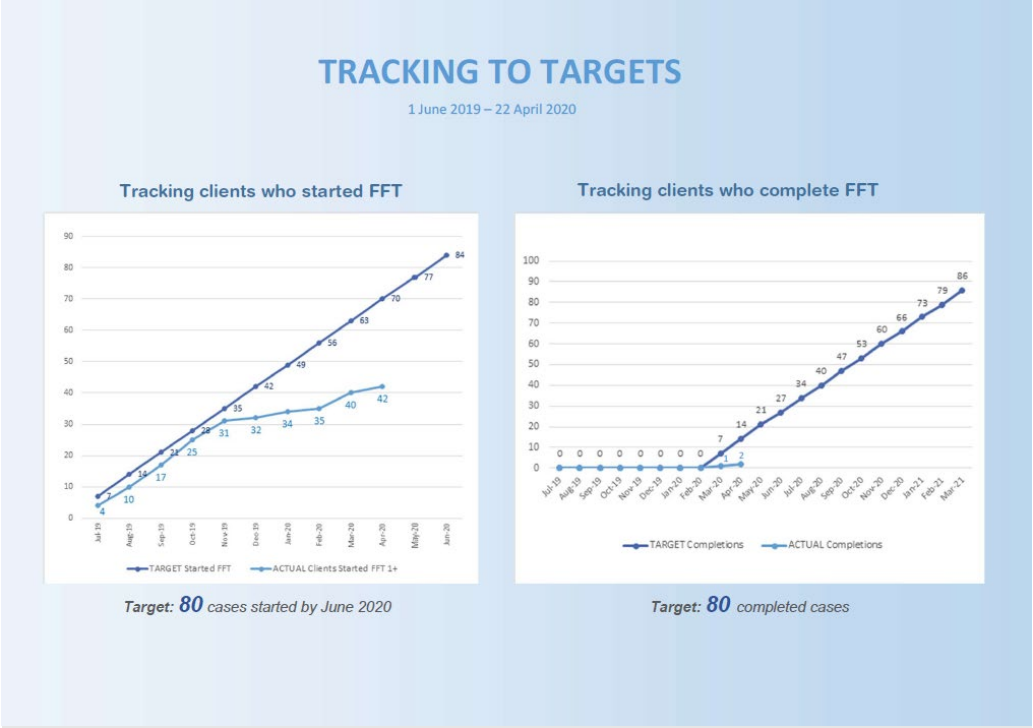
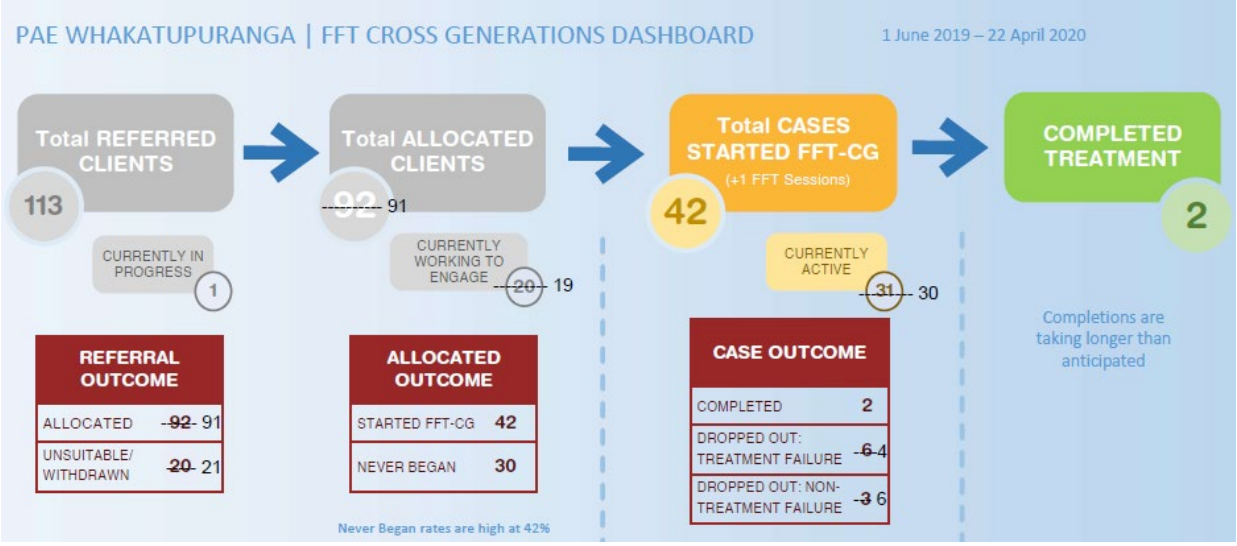


Figure 22. Corrected dashboard as at 28 April 2020



Measuring the cultural interweaving process is challenging and largely not visible

Recording the cultural interweaving process is challenging

Cultural training in the use of the WWW and Uputāua frameworks was conducted separately from training in the standard FFT process. Therefore, there is no specific design in the CSS database to capture this process. Currently, cultural training results are captured in the case notes prepared by therapists for their own reflection and for preparation for client meetings.

> *No, I think the answer is* [there is] *no formal way of assessing* [cultural training] …. *if I were checking with them how are they using the language of the framework. …. when we enter the case notes into CSS there's a few boxes that are blank …. and we've decided to start recording our process around WWW and Uputāua in there so that we can go in and like look at the case notes and see … elements of waewae pakura in the case note itself ….* [it's] *just one place to capture it.* (Practice Lead)

> *So, we just thought in that way that it helps them talk about it and think about it…There's a box that you can enter. And when you're about to do your session note and we agreed to kind of write a piece in there about what you want as a goal for the whānau. …. what's your goal from a Māori perspective, what kind of strategies are you going to do, think about, or what sort of support?* (Cultural Supervisor)

There is no requirement to use specific terminologies in the case note, which makes it possible to record cultural processes.

> [There are] *no barriers from …. us using the WWW as our terminology. So, we've had freedom, I suppose, to be able to figure out where we want to put everything.*

> *And I know for some Māori practitioners that are already doing FFT and I've seen some of the case notes the way that they integrate the technology and Te Ao Māori I suppose.* (Therapist Group 1–Therapist 1)

However, the development of a design for formal recording of cultural interweaving practices is challenging for several reasons. First, as described above, the CSS design is fixed and not modifiable to allow international comparisons of the FFT model in practice. Second, it is challenging to conceptualise the design.

> *But then we have to think about how can we actually fit this into report writing or case notes, how can we actually fit* this [in] *with the work that we're doing on a small standard basis sort of thing. So that's the stage that we're at at the moment. And that brings with it a set of challenges.* (Therapist Group 1 – Therapist 2)

Finally, there is the challenge of balancing the recording process and paperwork. Therapists already have been subject to a heavy training load and many forms and data entry requirements. Any additional formal assessment must be useful and suitable for Te Ao Māori and Pasefika worldviews.

> *This very consistency and I think I don't know, one of the things is just* [the] *paperwork. …. It's just not our people. You know …. all the forms they have Yeah, I think it takes a bit of skill. It took me a while to get …. the flow of it.* (Cultural Supervisor)

The Cultural Satisfaction Form could be employed at more stages

The two cultural satisfaction forms completed by two clients in two completed cases give a very high evaluation of the service in terms of cultural accommodation. Responses were given to the following dimensions of satisfaction:

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

Except for items 7 and 10 which had one 'mostly' and one 'very much' response, all other items receive two 'very much' responses. The comments are also very favourable.

> *Since my son has started he's come out of his shell and isn't so standoffish, or mistrusting. Thank you so much* (Whānau 1)

Although the number is small, it shows that the effort in accommodating cultural worldviews is appreciated and suggests that the service is moving in the right direction.

> *We tend to take a little bit of a long time and in FFT steps to get whānau going, that we have a good completion rate once we do get going*. (Cultural Supervisor)

The cultural satisfaction form completed by clients is one way of evaluating the success of interweaving cultural processes into the FFT process. However, it is not clear when would be the optimum time to complete it. There may be some benefit in moving this type of assessment to a point earlier in the process rather than the end so the therapists could have information early on to work on improvements.

> *I can have a look at, you know, are they doing the cultural satisfaction surveys and what is it telling them. But I would only do that quarterly or every six months or whenever the evaluation team wants it. But we don't have kind of baseline information to complete it.* (Management 1)

APPENDIX 2: OVERLAPPING CSS AND HCC DATA

The following types of data entry were identified as overlapping in the CSS and HCC: ethnicity, living situation of the young person before and after treatment, educational situation of the young person before and after treatment, and reasons for 'never began' and 'drop out' cases (Tables 6 to 12 inclusive).

The blue boxes indicate information agreement between the two databases. There are several data entries outside the blue boxes, indicating disagreements that need checking.

Table 6. Comparison of ethnicity data entry between HCC and CSS

	CSS categories of ethnicity – entry 'Ethnicity'								
HCC categories of ethnicity – entry 'Ethnicity 1'	Asian	Biracial /Mixed	Black	Māori	Other	Pacific Islander	Samoan	White	Total
Chinese	1								1
Indian					1				1
Asian (not further defined)								1	1
African			1						1
Cook Island Māori				4		6			10
NZ Māori			1	38		1			40
Niuean						1			1
Samoan						2	5		7
Tongan						5			5
Other Pacific		1							1
Pacific Island (not further defined)						1			1

NZ European/ Pākehā				1				14	15
European (not further defined)						1		6	7
Total	**1**	**1**	**2**	**43**	**1**	**17**	**5**	**21**	**91**

Table 7. Comparison of data entry for living situation prior to treatment between HCC and CSS

	HCC categories of living situation – entry 'Living situation Pre'							
CSS categories of living situation – entry 'Family Status'	*No entry*	Living with biological parent/s	Living with flat-mates	Living with parent/s	Living with partner/ spouse	Living with whānau	*No info because not active**	Total
Extended family caregivers	1					3	5	9
One parent figure - biological	2	3	1	8		1	22	37
One parent figure – non-biological							1	1
Other					1		3	4
Two parent figures-1 biological/1 non-biological	1	2		2			4	9
Two parent figures - biological	3	1	1	9			13	27
Two parent figures - non-biological	2			1			1	4
Total	**9**	**6**	**2**	**20**	**1**	**4**	**49**	**91**

* Inactive and therefore not recorded in the CSS system

Table 8. Comparison of data entry for education prior to treatment between CSS and HCC

	CSS categories of education – 'Educational status'					
HCC categories of education – entry 'Education Pre'	Other	Youth is enrolled in a non-traditional educational setting - trade or technical school	Youth is enrolled in a traditional educational setting (public or private)	Youth is home schooled	Youth is not enrolled in any educational programme and has not received diploma or GED	Total
No entry	2	2	4	1		9
Alternative education	1	3				4
Charter school (secondary)			1			1
In full-time paid employment (Over 30 hours per week)	1					1
In part time paid employment (Under 30 hours per week and not studying)					1	1
Mainstream high school			2			2
Mainstream private school (includes private/religious school)			2			2
Mainstream school (includes private/religious school)			1			1
Mainstream/private high school			4			4
Not in education, training, or employment	5		1		8	14
Not in school (only for children aged six or older)	1				1	2

On another course					1	1
*No info because not active**	9	8	13		19	49
Total	**19**	**13**	**28**	**1**	**30**	**91**

* Inactive and therefore not recorded in the CSS system

Table 9. Comparison of entry for post-treatment living situation between HCC and CSS

	CSS categories of living situation after treatment – entry 'Youth Status Home' meaning 'Remaining at home with family'				
HCC categories of living situation after treatment – entry 'Living situation post'	Unknown *	No	Yes	*No entry**	Grand Total
No entry			1	27	28
Living with biological parent/s		1			1
Living with flatmates		1			1
Living with parent/s			4	3	7
Living with partner/spouse		1			1
Living with whānau		1	1		2
Living with whānau carer/s			1		1
Secure CYF or YJ residence		1			1
No info because not active*	29		1	19	49
Total	**29**	**5**	**8**	**49**	**91**

* Inactive and therefore not recorded in the CSS system

Table 10. Comparison of data entry for post-treatment education status between HCC and CSS

	CSS categories of education after treatment – entry 'Youth status enrolled' meaning 'enrolled in educational/vocational programme'					
HCC categories of education after treatment – entry 'Education post'	Unknown	Don't know	No	Yes	(blank)*	Total
No entry		1			27	28
Alternative education					1	1
Charter school (secondary)				1		1
In full-time paid employment (Over 30 hours per week)				2	1	3
In part time paid employment (Under 30 hours per week and not studying)					1	1
In training programme (employment related, 30hours + per week)				1		1
Mainstream private school (includes private/religious school)				2		2
Not in education, training, or employment			4			4
Unknown		1				1
No info because not active	30				19	49
Grand total	30	2	4	6	49	91

* Inactive and therefore not recorded in the CSS system

Table 11. Comparison of reasons for 'never began' cases between HCC and CSS

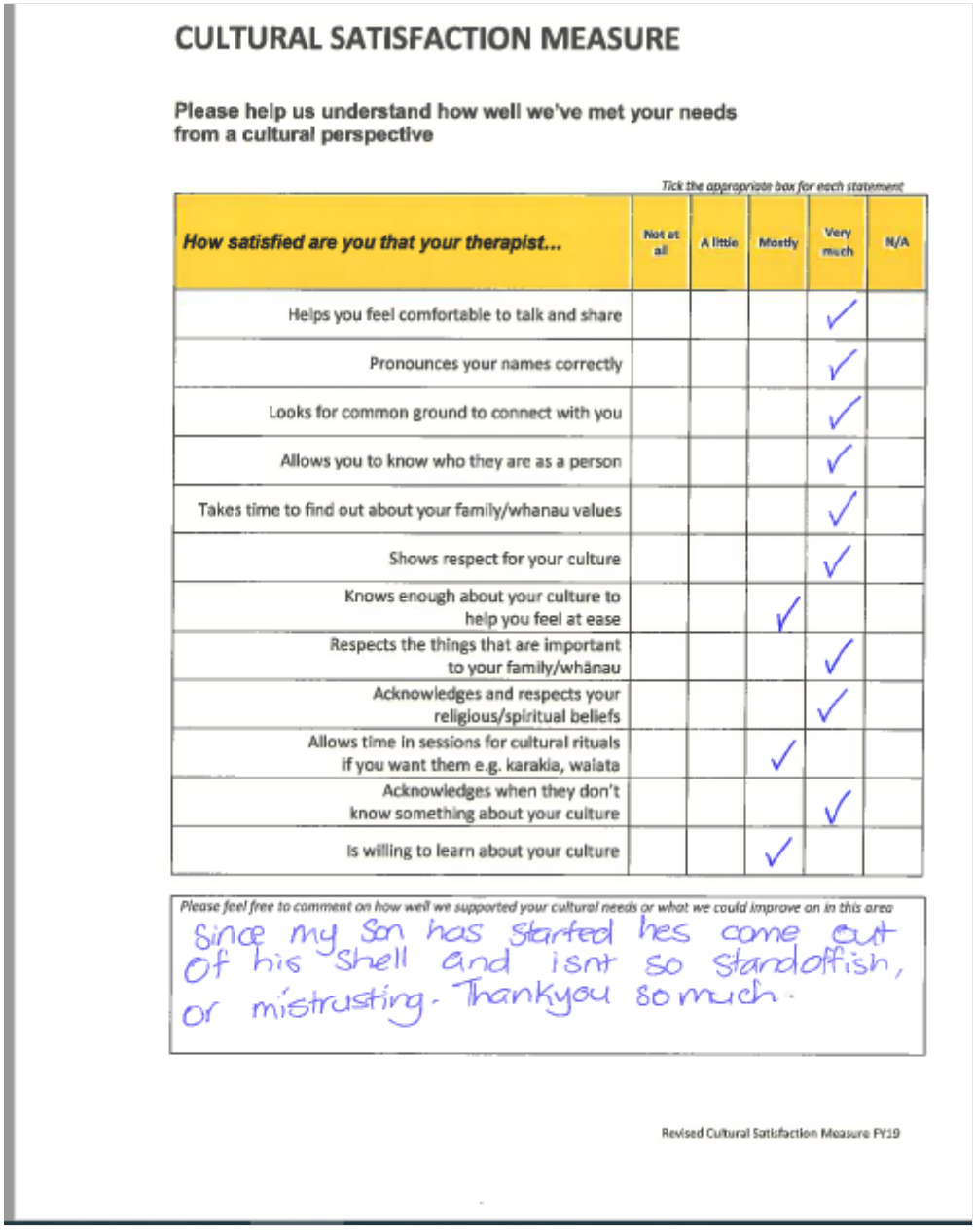
	HCC categories of reasons for 'never began' cases – entry 'Outcome'						
CSS categories of reasons for 'never began' cases – entry 'Never began description'	No entry	COVID-19 related	Did not meet service entry criteria	Family or youth decline service	Family/ Youth could not be contacted	Withdrawn by referrer	Total
Criteria not met for FFT	1		2		2	1	6
Declined services				13		1	14
Never attended initial appointment			1				1
Not able to contact					6		6
Other treatment conflict		1		1			2
Youth whereabouts unknown			1		0		1
Total	**1**	**1**	**4**	**14**	**8**	**2**	**30**

Table 12. Comparison of reasons for 'Drop Out' cases between HCC and CSS

	HCC categories of reasons for 'Drop out' cases – entry 'Reason for early discharge'						
CSS categories of reasons for 'drop out' cases – entry 'Drop out reason'	No entry	Client/ family withdrew	Early closure due to significant improvement in behaviour	Family could not be contacted	Moved out of area	Placement break-down	Total
Administrative discharge				1			1
Moved prior to completing the programme			1		1	1	3
Quit after at least one session		2				1	3
Runaway				1			1
Youth referred to other services	1	1					2
Total	**1**	**3**	**1**	**2**	**1**	**2**	**10**

APPENDIX 3: CULTURAL SATISFACTION FEEDBACK

Māori whānau feedback form: cultural satisfaction



CULTURAL SATISFACTION MEASURE

Please help us understand how well we've met your needs from a cultural perspective

Tick the appropriate box for each statement

How satisfied are you that your therapist...	Not at all	A little	Mostly	Very much	N/A
Helps you feel comfortable to talk and share				✓	
Pronounces your names correctly				✓	
Looks for common ground to connect with you				✓	
Allows you to know who they are as a person				✓	
Takes time to find out about your family/whanau values				✓	
Shows respect for your culture				✓	
Knows enough about your culture to help you feel at ease			✓		
Respects the things that are important to your family/whānau				✓	
Acknowledges and respects your religious/spiritual beliefs				✓	
Allows time in sessions for cultural rituals if you want them e.g. karakia, waiata			✓		
Acknowledges when they don't know something about your culture				✓	
Is willing to learn about your culture			✓		

Please feel free to comment on how well we supported your cultural needs or what we could improve on in this area

Since my son has started hes come out of his shell and isnt so standoffish, or mistrusting. Thankyou so much.

Revised Cultural Satisfaction Measure FY19

APPENDIX 4: EXPLANATION OF THE THREE MODELS INTERWOVEN IN FFT-CG

The three distinct models included in Pae Whakatupuranga I FFT-CG are outlined in this Appendix.

Functional Family Therapy (FFT)

The nature of FFT approaches with youth and families was discussed in Wave 1 of this formative evaluation. Wave 1 of the formative evaluation examined the conceptual basis on which a therapeutic model originating from a Western world view and context (FFT), was integrated with WWW – a model based firmly in a Māori worldview. The consensus view of therapists, supervisors, and management, as expressed to us in Wave 1 of the formative evaluation, was that the FFT model could comfortably accommodate Māori worldviews and therapeutic approaches and vice versa. In large part this was because the FFT model, featuring a phase-based framework, was flexible in how therapists conceptualised youth and families and how they approached or implemented the various phases of engagement, motivation, relational assessment, behaviour change and generalisation.

The FFT-LLC Clinical and Research Director noted that, across all models and particularly Pae Whakatupuranga I FFT-CG, which is in development and piloting:

> *The emphasis is on a 'phase-based' progression of index clients and families/whānau/aiga through a therapeutic behaviour change process – as opposed to a prescribed therapeutic delivery template.*
>
> *FFT therapists are not trained to follow a specific behavioural template. This position provides the 'space' for therapists to approach therapy from a range of culturally constituted world-views, and to utilise culturally specific concepts and motivators according to what is most consistent with client cultural contexts.*[16]

Similarly, it was posited that Māori values, principles, and worldviews can be maintained and remain central using an FFT approach. We were advised that therapists could operate from their own cultural base as Māori and deliver Pae Whakatupuranga I FFT-CG effectively.

[16] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc. Seattle, WA., p 3.

Te Ao Māori: Whaitake Whakaoranga Whānau (WWW)

WWW[17] is a framework for understanding and employing Māori worldviews in therapeutic contexts. The framework was developed for the Waikato FFT team in YH by Kaumātua Pita Te Ngaru and FFT therapist Mariana Hiriaki over a decade ago with the principles of FFT in mind. It is arguably able also to stand alone as a kaupapa Māori training tool. The model, framed in Te Ao Māori principles and developed by FFT-trained therapists, is compatible with FFT and serves as a 'negotiated space' to explore culturally based approaches to FFT.

'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.

> …. *instilled into me…. this thing does not belong in a physical sense to me or anything at all. It belongs to them. So, it's about upholding their mana.*
>
> *The old people handed me the taonga to look after, and to teach, to carry on. I only look after them. I don't own them.*
>
> *I just protect them and really protect them to make sure that they still have that integrity and mana and wairua.* (Kaumātua)

The background to the creation of the WWW framework was described as occurring when Māori first trained in FFT methods, then delivered the therapy to whānau Māori and concluded that it 'didn't work'. Discussing the apparent failure of the model with whānau Māori, it was decided that a Māori therapist, delivering FFT to Māori clients, could and should deliver the model using their own cultural knowledge and processes. The direction given was:

> *If you're Māori, do it and do it in the way that you would do it. Don't do it in an American way because you're not American.* (Kaumātua)

Following this advice, it was found through experience that FFT could be delivered effectively to whānau Māori by a Māori therapist using their own Māori worldview and Māori processes.

Therefore, the purpose of WWW is to ensure that whānau experience therapy is respectful of and consistent with Māori values, processes, and culture. This is a critical point of engagement to ensure a connection between whānau and the therapist. If the

[17] This is based on the Whaitake Whakaoranga Whānau – FT-CG Cultural Framework background document. Youth Horizons Kia Puawai (unpublished).

connection is not established properly, therapy is unlikely to be completed or to be successful.

The creators of WWW emphasise that the framework is firmly located in and accountable to Te Ao Māori values, principles, and ways of being. It simultaneously affirms Māori culture-centred practice and provides a framework for teaching non-Māori therapists aspects of Māori cultural ways of thinking and understanding, being, connecting, and behaving.

> *It's not about adapting. That's definitely the wrong word, to adapt ….* [it's] *an indigenous way of thinking and an indigenous way of being.*
>
> *It just means having to really delve more into it and to really expand on it a lot more for them* [tauiwi] *to deeply understand what it is. Just to get a glimpse of what it is that I'm trying to talk about and I'm only talking about a glimpse, not the real hōhonu depth stuff that you and or I or our people can … actually understand because It sits in here* (taps chest-stomach area). *As you know, it fits in here for people, or for Māori, and* (for Pākehā) *it's just up in here* (taps head) *and they're trying to work it out. It doesn't fit because it clashes with their own stuff, whereas for Māori - it sits right here (*taps chest-stomach area). (Kaumātua)

An example of difference between Western and Māori worldviews is described below.

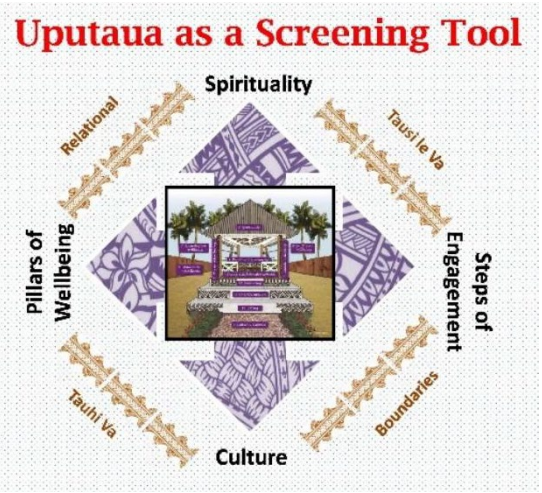
> *Māori do not have time…because there is no 'time' on the marae.* [It's] *daytime, night time, kai time, sleep time. That is the only time we have. Between all of that is mahi and respecting one another and all of our tikanga and kawa that we have that go into that. And Māori need time and a space to think. And so, going into a Pākehā world, they want you to think there and then. And they want the answer now. Whereas you coming to a Māori world it's like, well, …. there's a lot more that I actually need to consider. I need to consider the impact of what these things are on me, my whānau, my hapu, my marae, my iwi, the rohe that we're in. What is the impact of all of the stuff that's going to happen, on that? But I need to think Māori first and think, what are the impacts on all of those different levels. I can't just say give you an answer of 'Yes!' Now! Straight away! I need to sit and think about the impact … Pākehā can't understand it.* (Māori Kaumātua)

The documentation of WWW contains an elucidation of the key aspects of Te Ao Māori – Māori principles, practices, and frameworks – to educate therapists about this cultural way of seeing, thinking, and being. The WWW manual is a clearly crafted and presented document. It is the result of putting a Māori cultural lens on a Western process, where Kaumātua guide therapists through the journey of experiencing Māori spaces and methods, building understanding, and applying Māori worldviews and processes to themselves and in therapeutic contexts.

WWW begins by providing a framework for understanding through key concepts and principles before moving on to protocols and procedures. The outcome of the journey is a 'negotiated space' where aims are achieved using Western and Māori worldviews.

Pasefika worldview: Uputāua

Uputāua and its key components[18]



The components of the Uputāua Therapeutic Approach provide 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 – pre-engagement, engagement/treatment, and post treatment.

Spirituality acts as the covering that endorses safety and protection when engaging Pasifika clients. Spirituality supports both religious practices and the maintenance of divine connections that were observed prior to Christianity. This component of the Uputāua model advocates that one must provide space to explore the role of both traditional and religious spirituality in a family's life.

Culture and customs, as represented by the land, stand for the practice and maintenance of Pasifika ways and its values. This will be different from one Pacific group to the next. This component serves as the "place of belonging" (similar to turangawaewae in Māoridom), where the family is reminded of their ancestral connections, customs, and rituals within their adopted homeland. This cultural space enables families to access both traditional and contemporary knowledge to support them in their development and on their healing journeys. Because culture plays a vital role in the lives of Pasifika people, therapeutic treatment needs to be informed about any specific protocols that may assist Pacific clients during the various phases of their therapeutic journey. In this regard, having a "cultural advisory" person or group is key to working sensitively with Pacific people.

The family and relational network must cater for the complexities of cultural variants that may exist within each and every Pasifika family group. The structure of many Pacific families may contain traces of the traditional culture as well as a diversity of other ethnic mixes. Significantly, belonging to a family structure that is strong, nurturing or communal may not be the reality for all Pacific people. But generally the family and

[18] Taken directly from Seiuli, B. (unpublished draft 2020). *Uputaua and its key components*. In: Whaitake Whakaoranga Whānau Functional Family Therapy Cross-Generational Clinical Training Manual, pp 43–46.

relational network, together with the church, are places where Pasifika identity is nurtured. Here roles and responsibilities are observed and serve their purpose.

Relational boundaries are the internal boundaries that exist within family groups. These boundaries serve to maintain internal and external safety limits for family members. In Pacific families every member is responsible for safeguarding and honouring family relationships. Furthermore, family and community relationships are the essence of Pacific social etiquette, hence the constant need to guard that etiquette. Failure to maintain such boundaries has in some instances led to trampling on the mana (sacredness) of people. When this has happened, they have refused to engage until the space was healed. If the therapeutic space is deemed unsafe, the prospect of achieving beneficial outcomes can be severely hampered.

Pillars of Wellbeing

Physical wellbeing, the first pillar, recognises and values the importance of all areas of physical wellness for Pacific people. Physical wellbeing is often the starting point for exploring Pacific people's holistic health. Other areas that connect to physical health can include people's living status, employment, church connections, and so on. Examining these areas using the Uputāua framework allows for a greater understanding of the nature and extent of Pacific people's wellbeing.

Social wellbeing, represented by the second pillar, includes Pacific people's friendly, obliging, warm, and cheerful personas. Collective and shared responsibilities require members to follow family loyalty in their acts of service, not independently, but as a close unit that supports individuals whenever and wherever the need exists. For many, their extended social structure, with its adhering patterns of support, provides a stabilising force when their life is impacted by a crisis or other challenges. Examining the various roles that social connection has in the lives of Pacific families can generate greater understanding of the influence that their wider network and communities plays in their lives.

Psychological wellbeing is the third pillar. This area relates to the decision making and thinking processes. Psychological wellness is a crucial component in the process of adapting and coping with life situations with which one is confronted from time to time. Clinical observation reveals that this area is often neglected but is crucial to good therapeutic outcomes. An increased focus on mental health and wellness makes this a vital area for attention. Psychological wellbeing enables Pacific people to cope with life stresses and to achieve optimum health.

Emotional wellbeing as represented by the fourth pillar is central to Pasifika personhood, but it is one that is rarely acknowledged or given much attention. It is well documented that a significant stress for Pacific people is caused by their continued struggle for economic survival while balancing cultural responsibilities and family obligations. As a result:

- Many face an enormous mental health and financial burden to make ends meet.

- When communication within a family unit is hampered, healthy emotional development and security may be disrupted or weakened.

The result of unchecked emotional turmoil, particularly among younger Samoans, can be devastating. The Uputāua framework provides space to explore this pillar of wellbeing with Pacific clients, especially given the weighty responsibilities many of them and their families may face at times.

External boundary is an extension of the internal boundaries. It needs ongoing care, similar to that being observed within relational connections. Taking care of the relationship between external agencies (such as referrer, other interested parties, therapists, etc.) ensures that harmony is achieved between professionals, the wider community and the Pacific family. It needs to be supportive and transparent. This component serves as the forum in which negotiating desired outcomes, specific timeframes, accountabilities and responsibilities for treatment takes place. The ability of professionals to take care of this boundary helps to avoid previous mistakes that led to the unintentional trampling on Pacific people's dignity and that of their community.

Steps of Engagement

The gifting process is the first of the three steps of engagement. This step is a reminder that the gift of healing lies within the relational bonds that are formed between Pacific families and the therapist in the journey of therapeutic engagement. In this space of engagement, the process of gifting manifests itself in acts of generosity with knowledge, time, resources, and reciprocal support. For Pasifika people, respect and compassion remains the cornerstone of Pacific identity. Generosity is a hallmark of Pacific people's reciprocal culture. In many relational contexts not only is gifting an imperative practice but it is generally expected, so it pays well for you to be prepared in advance.

A collaborative approach represents the second step. It pays attention to the therapeutic process of co-collaboration (see White & Epston, 1990) between therapists and Pasifika families in the therapeutic process. Intentional collaboration is a "we" approach, one that is relational and community-based, not isolated or individuated. Co-collaboration acknowledges Pacific people's expertise and wisdom in their lives and healing journeys. It allows the voice of Pacific families a place of pre-eminence in the therapeutic engagement that privileges their indigenous cultural knowledge alongside western approaches such as FFT.

Maintaining honour and dignity is the final step of engagement, reminding therapists of the role that honour and dignity plays in Pacific people's lives. The therapist must remember to enter the sanctity of the family in a spirit of humility. Here it is advisable for therapists to learn how to defer honour and respect that acknowledges Pacific families as expert navigators of their life journeys. Maintaining honour and dignity is an intentional and purposeful therapeutic value that supports the expressed life narratives of individuals, families and their wider community of support. This reciprocal process allows therapists and Pacific families to honour each other throughout all the processes involved in therapeutic treatment.