PAE WHAKATUPURANGA I FFT-CG WAVE 3 IMPACT EVALUATION REPORT

Family Centre Social Policy Research Unit

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

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Foreword

E mihi maioha ana mātou o Family Centre ki ngā tangata huhua, nā koutou i tuku mai i te hohonutanga me te whānuitanga a ōu koutou mātauranga e pā ana ki te kaupapa e kiia nei Te Pae Whakatupuranga, arā, Functional Family Therapy Cross Generations Impact Evaluation Report Wave 3.

Ko te hāngai pū o tēnei wāhanga o te kaupapa nei he āta kimi māramatanga e pā ana ki te whakaratonga mahi a Te Pae Whakatupuranga me ōna pānga ki te hunga rangatahi me o rātou whānau i roto i te tau tuatahi e whakahaerehia ake ana te kaupapa 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, te Rōpū Tohutohu me ngā kaimahi katoa o Youth Horizons.

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

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

The Family Centre Social Policy Research Unit wishes to thank all those who generously shared their knowledge and experience for the development of Pae Whakatupuranga: Functional Family Therapy Cross Generations (FFT-CG) Impact Evaluation Report Wave 3.

The primary focus of this wave is on understanding the effect the Pae Whakatupuranga I FFT-CG service is having on the wellbeing of young people and their whānau after a year of operation.

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, members of the Steering Committee and the therapists and managers at Youth Horizons.

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

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

Contents

Executive summary

Report context

Pae Whakatupuranga I Functional Family Therapy - Cross Generations (FFT-CG) is a pilot programme aimed at breaking the intergenerational cycle of justice involvement for rangatahi/young people and improving wellbeing for them and their 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 (referred to as FFT Standard), 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 in a model designed to increase cultural understanding and skills for family therapists working with aiga. The three approaches are:

- the original FFT model
- Whaitake Whakaoranga Whānau[1], whose purpose is to ensure that whānau experience therapy that is respectful of and consistent with Māori values, processes, and culture
- Uputāua Pan-Pacific Cultural Framework (Uputāua)[2], a Pasefika[3] framework that recognises many of the cultural and spiritual protocols that are central to Pacific communities.

The data for this evaluation was collected until 23 November 2020. Since the data was collected, there have been two key changes to the programme:

- the Referral Coordinator is now an Intake Therapist, who is a senior level therapist who will establish initial relationships with whānau/aiga/families and help the referrers work with them.

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

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

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

- the programme no longer operates under two cultural frameworks, but has a practice manual (Te Huarahi o Te Rangatahi, launched 26 November 2020) that draws together the therapeutic process and both cultural frameworks.

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 2023). The evaluation has three overall high-level objectives:

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

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

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

The desired pilot infrastructure outcomes[4] are:

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

[4] The term 'pilot infrastructure outcomes' refers to the new partnering model and practice manual that underpin the operation of the pilot.

This evaluation focuses on how well the programme is progressing towards achieving its wellbeing and pilot infrastructure outcomes. The Oranga Tamariki Evidence Centre is going to complete a separate assessment of the extent to which the programme is achieving its intended outcome of reducing young people's risk of re-offending.

Results

Snapshot of progress as at 23 November 2020

	66 families have started Pae Whakatupuranga I FFT-CG • 20 are active • 17 completed the programme • 29 exited early
	Good start made on: • increasing family cohesiveness: • helping young people stay at home or move to independent living • helping young people stay at or return to school, training, or employment
	Culturally appropriate practice manual in place
	Partner agencies working together effectively • Streamlining of referral process under way with recent appointment of Intake Therapist

Recruitment and progress of clients

As at 23 November 2020, a total of 120 clients had been referred to the programme. Seventeen had completed the programme (seven whānau Māori, two aiga Pasefika, six Pākehā families, one Asian family, and one 'other' family). Twenty-nine clients had begun the programme but not completed it (mainly because they dropped out after at least one session, or moved prior to completion), and 20 were active.

Six clients were referred but had not yet become active and 48 did not begin their treatment after being referred (30 Māori whānau, 11 Pasefika aiga, and seven Pākehā families). Reasons for not beginning treatment included the client not meeting the criteria for entry, declining services, and not attending the initial appointment.

Progress towards achieving wellbeing outcomes

The young person who has been referred to the service (the 'index client') completes a self-report just before discharge, after completing the treatment. It measures their perceptions of change across six dimensions: family status; family communication skills; youth behaviour; caregiver or parenting skills; caregiver ability to supervise; and family conflict level.

Overall, clients believe they've made very good progress across the six dimensions, with average responses ranging from 3 (somewhat better) for Pākehā clients to about 4 (a lot better) for Pasefika and Māori clients. Parents' perceptions of improvements in their children's behaviour are very high, around 4 (a lot better) for Māori, Pasefika, and Pākehā parents.

Increasing family cohesiveness: The data show that almost all clients have achieved the outcomes of increasing family cohesiveness through improved family communication and improving young people's perceptions of their parents and siblings. This lays the foundation for whānau, aiga, and families to resolve conflict.

The programme has helped parents to improve their communication skills by solving their own problems, as working through their problems with the therapist enabled parents to be more open with their children. Therapists also helped the young people speak their minds and participate in the conversation. As a result, the behaviour of the young people improved remarkably after participating in the programme: they opened up to their whānau/aiga/families and were motivated to participate in productive activities, such as returning to school and actively seeking employment.

Helping young people stay at home or move to independent living: this includes data about the living situation of 45 index clients before and after participating in the programme (17 completed and 28 dropped out). Data for all except one are available.

A majority (34: 80 percent) of the 42 young people who were living at home before treatment continued to do so. Of the remainder, one client moved from living at home to independent living with a partner and one to living with a flatmate. Three who were at home moved to judicial residential settings—one to prison (a Pasefika client who dropped out after less than six sessions) and two to residential care (Māori clients who dropped out after two or more sessions). The living situation of the remaining three clients is unknown.

Three clients changed from independent living with partners or flatmates before treatment to living at home after treatment.

Overall, the programme has largely achieved its goal of helping young people to stay at home or move successfully to independent living.

Helping young people stay at or return to school, training, or employment: The data on the same 45 young people show that the programme has made a good start on achieving this goal. At the start of the programme 25 were in education, training, or employment and 16 maintained this status after completion. Of the remaining nine, one found employment, one moved to further study, three were no longer in education, training, or employment, and no information was available for the four remaining clients.

Of the 18 clients who were not in employment, education, or training before treatment, nine began education, training, or employment, seven remained without education, training, or employment, and no information was available for the two remaining clients.

There is no information on two clients before treatment, but after treatment they were in education, employment, or training.

Progress towards achieving pilot infrastructure outcomes

The key findings are:

- Collaboration across partner agencies has been a feature of the programme's development to date. However, there is still a need to streamline and enhance the referral process to improve whānau/aiga/family take up[5].
- The programme is now supported by a culturally appropriate FFT-CG practice manual that weaves together Te Ao Māori, Tafa o le Pasefika, and Western approaches. Greater numbers of Māori and Pasefika therapists will assist the cultural integrity of the service.
- All therapists and the majority of referrers consider the programme has had a positive impact on the lives of participants. The number of participants who do not complete the programme remains a challenge.

Factors that help progress

At the start of the pilot, the Pae Whakatupuranga I FFT-CG therapists had to learn many things, including understanding the clinical and cultural elements of the therapy and the characteristics of the clients referred to the programme. Management strongly believe that the second year of operation will witness significant improvements in caseloads, as therapists are now more comfortable with the cultural dimensions of their work and experienced in service delivery.

[5] As noted above, an Intake Therapist has been appointed to enhance the referral process.

Māori whānau and Pasefika aiga have appreciated the efforts made to make the service culturally appropriate

YH has recognised the importance of cultural appropriateness through the introduction of matching the functional dynamics of Māori whānau and Pasefika aiga in delivering the service[6]. Their efforts have borne fruit: Māori whānau appreciated the therapists' cultural knowledge and respect. Whānau who completed the therapy were generally positive about their experience and particularly positive about the respectful and genuine nature of the therapists. No aiga were available for interview for this evaluation; however, earlier evaluation reports have documented aiga's affection for and appreciation of their therapist.

YH's strong history of embedding a knowledge of Te Ao Māori throughout the organisation is now being complemented by efforts to achieve similar results for Pasefika cultures. Special sessions have been delivered to enhance awareness of Pasefika cultures within YH, the Uputāua framework has been completed, and further Pasefika cultural training (including cultural experiences and interactions with aiga) and supervision sessions have occurred. Therapists are increasingly comfortable in their understanding of a Pasefika worldview.

Therapists' approach to their clients has greatly helped progress. It has already been an important factor in the success detailed above through therapists' 'strength-based' approach and genuine belief in families' capability. Solutions and strategies must be led by whānau/aiga/families.

Several skills were particularly useful in approaching and working with whānau/aiga/family and the young person. First, therapists understood and respected family dynamics. This was achieved in the great majority of cases. In contrast, a lack of attention to family dynamics on a few occasions (for example, some families felt more attention could have been paid to different family members and their views), led to a therapist having difficulty in connecting with the parents and in the family achieving cohesiveness.

Therapists exhibited flexibility and patience to stay on the journey with their clients. Meeting clients at their home, at times that suited them, was greatly appreciated.

Therapists were also successful in relating to young people by meeting them on their own ground. Largely, they had a good sense of the client's autonomy, understood what they wanted, and respected their decisions.

However, cross-generational disagreement in families about the therapeutic approach and whether the treatment had been successful has occurred a number of times with, for example, one occasion when a parent disagreed with her child about whether

[6] "FFT is a relational approach that matches interventions to the relational configurations of families. With delinquent or substance-abusing adolescents, this often involves accommodating families in which youth have considerable power to engage and motivate family members into the treatment process. However, with younger children in FFT-CW®, it is necessary to implement more "parent-driven" intervention strategies to build skills and create a family context in which youth can flourish." (FFT CHILD WELFARE (FFT-CW®), *Clinical Model*. https://www.fftllc.com/fft-child-welfare/clinical-model.html).

participation in the treatment was voluntary, and another occasion where a young person disagreed with his parent about the type of improvements the family had sought from the therapy.

Cultural training and supervision have been very effective and helped progress. Cultural training and supervision are one of the distinct features of Pae Whakatupuranga I FFT-CG.

The cultural training provided by Whaitake Whakaoranga Whānau and Uputāua goes beyond teaching the therapists practices such as wearing lavalava or removing shoes. The intensive training enables therapists to understand the principles and values of Māori whānau and Pasefika aiga, so they can understand and respond appropriately to the needs of their clients.

Ongoing cultural supervision provides a place for therapists to exchange their experiences, seek support, and share stories in understanding and applying cultural practices.

Effective collaboration across all stakeholders has helped progress. Pae Whakatupuranga I FFT-CG has a complex organisational structure whose Steering Group involves three major agencies (Oranga Tamariki, Corrections, and Police) and one prominent service provider (YH). It is closely monitored and supported by FFT-LLC in the United States, which is also a member of the Steering Group.

Each government department has their own priorities, interests, and pressures and operates a range of programmes and activities in their specialisation. The Steering Group has been a key part of maintaining coordination and programme impetus. Its members are at senior levels in their organisations and can drive the strategy forward in their own organisations. All are committed to ensuring that the project will succeed.

Factors that hinder progress

The challenges of socio-economic disadvantage and previous discrimination are likely to have hindered progress. Whānau/aiga/families are referred to Pae Whakatupuranga I FFT-CG by organisations whose clientele often experience highly disadvantaged social and economic circumstances, although Pākehā families tend to be less affected than whānau and aiga. This can make it difficult for clients and families to engage readily or progress through the treatment when they're worried about having food on the table, having somewhere stable to live, or securing employment, for example. Māori and Pasefika clients and families are also likely to have experienced structural racism in their interactions with authorities.

Further, the index clients tend to be older than the young people in the FFT programme YH currently provides, which caters largely for those with care and protection issues. They are also likely to have had more contact with the justice system, which increases the likelihood that they have had unsatisfactory experiences with officialdom previously.

This difficulty in engaging well was stressed by all the interviewed managers, therapists, the framework creator, and the Cultural Advisor. Consequently, progress in terms of completed cases and achieved outcomes has been slow.

The selection criterion for housing is limiting access to the programme. Unstable and/or expensive housing is a systemic issue that affects the majority of low-income families in Aotearoa/New Zealand. The client's housing situation is often the most pressing issue affecting their ability to enter the programme, as the selection criteria include a requirement that the index client lives with the most significant person/s in their lives, which is usually their whānau/aiga/family. Lack of stable accommodation can mean that this criterion is not met. Even if the family is accepted for treatment, stress from housing problems has prevented client engagement in many cases.

Imperfect coordination with other social services is hindering progress. The involvement of other social services may be a necessary condition for a family's success and the challenge of coordination across services is familiar to everyone who works in social service delivery. Comments from interviews make it clear that therapists need to be connected to a system of social, economic, and health support services in order to enable families to achieve good social and economic outcomes. This is a real challenge, both at the personal level of the therapist and at the organisational level of YH. The way forward is an issue for the next phase of the programme.

Client motivation or the requirement to participate can hinder progress. Many clients will have experienced similar services before entering Pae Whakatupuranga I FFT-CG and will be sceptical about success.

The reluctance of index clients and their whānau/aiga/families to participate in the programme was mostly associated with referrals from Corrections (58 percent of Corrections referrals did not begin the programme) and secondarily from Police (37 percent of Police referrals did not begin).

Regarding referrals from Oranga Tamariki Youth Justice (YJ), the largest proportion of these referrals dropped out of the programme (48 percent of YJ referrals).

Staff suggested that clients who had Court orders that require them to attend family therapy expiring after a short period, or FCG plans that expired in three months, were highly challenging to engage and retain in the programme.

Older clients tended to drop out more frequently when the required period of participation expired. Eight clients over 18 years old entered the programme, but only two have completed therapy, a much lower proportion at 25 percent, than for participants overall, who had a completion rate of 38 percent (17 of 45 entrants have completed the programme). This may be the consequence of older clients having experienced more years of difficult family relationships.

Case loading is taking longer than expected. Cases have tended to take a year or more to complete. Most of the completed cases were referred in August and September 2019 (10 out of 17 cases). Only one case was completed within six months.

Three issues have contributed to the delay in achieving the programme's intended caseload: designing and implementing a culturally sensitive approach with newly appointed therapists; managing the complex organisational design; and the characteristics of the clients and families referred to the programme.

The Covid-19 lockdowns have exacerbated the delays.

This may change in the future: newer therapists will experience properly sequenced training now that both Whaitake Whakaoranga Whānau and Uputāua are fully developed, and YH is building institutional knowledge about effective ways to engage and work with this cohort.

Unintended consequence of the programme

Implementing the programme has added to YH's knowledge and skills across several dimensions: Firstly, YH has expanded their cultural knowledge. They have also greatly increased their understanding of the operations of three major government agencies in the areas where their work touches YH. Finally, they have a much deeper insight into the subtleties and complexities of engagement with a cohort of whānau/aiga/families, whose multiple disadvantages and challenges require nuanced attentiveness and developed self-reflection on the part of the therapists who work with them.

Suggestions for improving programme effectiveness

1 Refine therapist selection. The intensive training and special requirements of weaving Māori and Pasefika cultural frameworks together with FFT Standard has resulted in heavy pressure on therapists newly recruited to the programme.

Future recruitment for programmes such as Pae Whakatupuranga I FFT-CG needs to continue to find people with persistence, cultural knowledge, and commitment. Suitable therapists should be familiar with the cultural worldviews of Māori and Pasefika. An increase in the number of frontline Māori and Pasefika workers would strengthen the therapist team's overall cultural competence.

Retaining therapists is also a challenge, but a shift to marketing the role's unique opportunities may assist, and the recent appointment of an advisor to strengthen YH's recruitment strategy is a promising step.

2 Continue to recruit cultural supervisors with both clinical experience and cultural competence. Therapists and the Cultural Advisor agreed that the cultural supervisor who provides ongoing support for the therapists should have both clinical experience and cultural competence in order to tailor their advice to the service the therapists are delivering.

3 Review treatment length and consider formalising post-treatment contact. At this stage of the pilot programme insufficient data have been generated to establish a general trend for time to complete treatment. This will become clearer during 2021, as the current therapists continue to gain experience and new recruits join a well-established programme with sequenced training, experienced supervisors, and more experienced referral agencies. At that point it will be possible to assess how much the current extended length is due to these factors, and how much is contributed by the needs of rangatahi and whānau.

Several clients expressed their gratitude for therapists keeping in contact after treatment ended, although this is not a formal part of the service. There may be value in the referrer offering post-treatment contact for six months with interested clients.

4 Expand access to support services. Several clients and therapists have seen first-hand the difficulties index clients and families faced in accessing local services that could help them overcome factors that were blocking their progress through treatment. As the programme matures, sites may be able to develop databases of available local support services they have found useful for their clients, so they can be shared among their therapists. We suggest that improving clients' and families' access to critical support, especially housing, should be explored by partner agencies.

5. Streamline and enhance the referral process. Clients, referrers and therapists would all benefit from greater flows of relevant information, from referral to treatment and beyond.

Referrers are the first point of contact with clients and the first opportunity to collect information about them. The more knowledgeable referrers are about the programme, the more motivated they will be to make referrals and the better they will be at providing useful information to clients and therapists. Problems with information flow are not the same across all agencies. Police officers are more likely to have contact with the whole whānau/aiga/family, whereas Probation officers' and YJ social workers' contact is more limited to the young person.

The suggestion was made that tino rangatiratanga (coming together with whānau pre-referral and empowering them to think if this is something that they want to do as a family) should be encouraged before making referrals, so that whānau/aiga/families feel in charge of changing their own lives. One family suggested the inclusion of schools as another source of referral, so young people who would benefit from the programme were identified earlier.

Several suggestions were made for increasing referrers' confidence in the programme, thus increasing referrals; these suggestions are detailed in the recommendations below.

6. Expand information flows from referrers to therapists. Therapists would benefit from knowing more about the client's family dynamics and cultural affiliations when they receive a referral, so they are well-prepared to work productively with their client.

Therapists suggested establishing a role of 'intake worker' who can provide the initial interaction with whānau/aiga/families to understand the family dynamics and motivate their engagement. This is a positive suggestion, but it would add an extra step in the referral-engagement process, which may increase the chance of disengagement. If this role were accepted by Oranga Tamariki, it may require three such workers to engage with the different ethnicities among clients.[7]

[7] As noted above, in March 2021 Oranga Tamariki changed the Referral Coordinator role to an Intake Therapist role.

Lessons for future expansion

FCSPRU has learnt three major lessons (in addition to the suggestions above) for any future implementation and development of Pae Whakatupuranga | FFT-CG from this evaluation:

(i) set realistic expectations about expected outcomes and the time needed to achieve them

(ii) have the project and implementation design and documentation ready, especially in terms of cultural frameworks, with skilled therapists appointed and trained, referral agencies well informed about the programme and its benefits, and supportive management processes

(iii) prepare for risks, such as the COVID-19 pandemic, that may disrupt engagement efforts, such as developing and trialling with therapists the equipment and protocols for remote or online therapeutic sessions.

Given the challenges canvassed above in implementing the model, it is important to have **realistic expectations** about the timeline and outcomes of the project. The goals of treatment completion and achieving the programme's outcomes for a full complement of clients within the time period that is the norm for FFT programmes, which is three to five months[8], may be better delayed until the end of the pilot.

The pilot Pae Whakatupuranga I FFT-CG programme has identified and resolved many issues in **project design and implementation**. Many processes have been built from scratch, such as cultural training and supervision, referral, and the operation of the Steering Group, and project documents have been developed. All remain as working processes and documents that continue to be refined and updated. Having **a clear plan for the set-up and implementation of the programme in new locations** will enable the scalability of Pae Whakatupuranga I FFT-CG. The more detailed the documentation, the easier it will be to scale up the programme, or to set it up and implement it in another location.

It is likely the current management structure will undergo **further development and refinement** as the programme expands in client numbers and across locations. For example, it may be appropriate to appoint cultural supervisors for different sites in Auckland as the volume of work increases. There may also be a need to set up smaller local implementation teams tailored to the scale and location of sites as the number of sites increases.

Recruitment of the right therapists and on-going support for them plays a critical part in preparing for implementation. Current therapists have successfully built their clinical and cultural competence in approaching whānau/aiga/family. However, it has taken a lot of time and resources to reach this point. Ideally, if the pilot is rolled out to new locations, then cultural training and supervision will be available for therapists from the start.

[8] 'FFT is a short-term, high quality intervention program with an average of 12 to 14 sessions over three to five months.' https://www.fftllc.com/about-fft-training/clinical-model.html

The timing of disruptive events such as COVID-19 may be unanticipated, but their occurrence should not be unexpected. Work remains to be done on assessing the risks and actioning risk mitigation strategies to minimise the disruption caused by such events.

Finally, several interviewees provided advice should the programme be delivered by a different service provider. In their view, the service provider needs:

- organisational features compatible with the model, such as experience working with young people, commitment to improving the wellbeing of whānau/aiga/family, and familiarity with government departments
- in-house expertise in cultural knowledge that can support the therapists in challenging situations.

Recommendations

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

1. Streamlining and enhancing the referral process

- Create greater flows of relevant information from referral to treatment and beyond.
- Consider encouraging pre-referral discussions so whānau/aiga/families feel in charge of changing their own lives.
- Increase referrers' confidence in the programme, thus increasing referrals, through:
    - nurturing close relationships between the programme and referral organisations to deepen each agency's knowledge of the work of the other agencies
    - providing referrers with brochures for parents and caregivers, in addition to the present brochure which is aimed at the young person, and providing brochures in culturally appropriate languages
    - clarifying the referral form so referrers know what information is useful to the programme; therapists would benefit from knowing more about family dynamics and cultural affiliations when they receive a referral, so they are well-prepared to work productively with their client
    - feeding summary information about the treatment progress of their clients back to referrers so they are aware of the programme's benefits.
    - Inviting Steering Group members from Police, Oranga Tamariki, and Corrections to consider cultural training for their referrers, to enhance their capacity for working with whānau and aiga.
- Explore options to increase referrals from Corrections, including the feasibility of putting the programme forward in the Youth Court so it could be considered as

an alternative to giving a sentence and putting the programme to the FGC where this is not already happening.

2. Improving programme effectiveness

- Refine the therapist selection criteria. Future recruitment needs to continue to find people with persistence, knowledge, and commitment. Suitable therapists should be well-grounded in the cultural worldviews of Māori and Pasefika.
- Continue to recruit cultural supervisors with both clinical experience and cultural competence.
- Increase the number of frontline Māori and Pasefika workers to strengthen the therapist team's overall cultural competence, sufficient to meet the cultural proportion of client whānau and aiga.
- Review treatment length in 2022, when the general trend for time to complete treatment will be clearer as current therapists gain experience and new recruits join a well-established programme.
- Consider encouraging referrers to offer post-treatment contact with interested clients for a six-month period.

3. Outreach for socio-economic support

- We suggest partner agencies work with others to improve clients' and families' access to critical support, especially housing.
- Expand access to local support services through establishing databases of services for clients.

4. Lessons for any future expansion

- Set realistic expectations about expected outcomes and the time needed to achieve them.
- Have the project and implementation design and documentation ready, especially in terms of cultural frameworks, with skilled therapists appointed and trained, referral agencies well informed about the programme and its benefits.
- Prepare for risks, such as the COVID-19 pandemic, that may disrupt engagement efforts.
- Regularly review the need for further development and refinement of management structures and in-house support as the programme expands in client numbers and, potentially, across locations.

Methodology

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

The qualitative analysis draws on 25 interviews in total, ten of which were with youth, whānau and families who have used Pae Whakatupuranga I FFT-CG services. The remaining interviews consisted of: referrers; therapists training in and delivering the

model; the Pasefika Cultural Advisor; the Pasefika framework developer; YH management (including the Referral Coordinator); and the Programme Manager.

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

The sample of clients for whom quantitative data are available is small. This is largely a consequence of the difficulties experienced in engaging and retaining clients and the impact of COVID-19 on clients' ability and willingness to engage in online or phone therapy sessions. The small sample size limits the generalisability of the results.

1. WELLBEING AND PILOT INFRASTRUCTURE OUTCOMES

Context

Functional Family Therapy (FFT) is a family-based treatment designed to address young people's behavioural problems and the family context within which they occur. Pae Whakatupuranga | Functional Family Therapy–Cross Generations (Pae Whakatupuranga | FFT-CG) is an adaptation of the original FFT model (referred to as Standard FFT), which is designed and owned by FFT LLC. The Pae Whakatupuranga | FFT-CG therapeutic approach has been co-designed by FFT LLC and Youth Horizons | Kia Puāwai (YH).

The programme includes cultural responsiveness to Māori and Pasefika peoples in recognition of the ethnic composition of the target group and in order to promote the relevance of Pae Whakatupuranga | FFT-CG in an Aotearoa context. Pae Whakatupuranga I FFT-CG aims to weave together three distinct approaches: the original FFT model; Whaitake Whakaoranga Whānau and Uputāua Pan-Pacific Cultural Framework (Uputāua).

YH is piloting Pae Whakatupuranga | FFT-CG in the Greater Auckland region for two years, from 1 July 2019 to 30 June 2021. It is governed by a Steering Group from all the partner agencies: Oranga Tamariki, Department of Corrections (Corrections) and the New Zealand Police (Police). The Steering Group also has representatives from YH and FFT LLC on it.

The desired wellbeing outcomes of the Pae Whakatupuranga | FFT-CG therapeutic intervention include:

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

The desired infrastructure outcomes include:

- collaboration across partner agencies
- the establishment of a culturally appropriate FFT-CG therapeutic manual and process, resulting in an adaptive service that weaves together Te Ao Māori, Tafa o le Pasefika, and Western approaches

- therapists and referrers perceive FFT-CG as having a positive effect on the lives of clients, referred people and their whānau, so continue to practice FFT-CG.

The Oranga Tamariki Evidence Centre is going to complete a separate assessment of the extent to which the programme is achieving its intended outcome of reducing young people's risk of re-offending.

This evaluation

The primary question for this impact evaluation is *How well is the programme progressing towards achieving its wellbeing and pilot infrastructure outcomes, by the end of 2020?*

Four sub-questions consider specific dimensions of progress towards outcomes:

1. How well is the programme achieving outcomes for Māori and Pasefika, including the outcomes they want to achieve for their whānau/family through Pae Whakatupuranga | FFT-CG?
2. What is helping or hindering progress towards achieving the outcomes?
3. What are the unintended consequences of the programme?
4. How could the programme improve its effectiveness, if required?

The secondary question is *What lessons can we learn for implementing the programme in other locations and its on-going development?*

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

This qualitative analysis draws on 25 interviews as shown in Table 1 below.

Table 1. Sample for Wave 3 impact evaluation qualitative analysis

	Type of interview	Number of interviews
Pasefika framework creator	Individual	1
YH Management	Individual	5
Programme Manager (Oranga Tamariki)	Individual	1
Pasefika Cultural Advisor	Individual	1
Therapists	Focus group	1
Young people/whānau/family	Family	10
Referrers	Individual	6
Total		25

The interviews were conducted from 8 October to 7 November 2020 and employed various modes, including face-to-face, phone, and Zoom.

Eleven interviews were planned by YH for six Māori whānau, three Pākehā families, one Pasefika aiga, and one family of 'other' ethnicity. However, due to unforeseen circumstances related to the serious health status of a member of the Pasefika aiga, interviewers did not have the opportunity to conduct that planned interview. This means no interviews with aiga were undertaken. Outcomes for Pasefika are reflected in the quantitative analysis and in the views of other stakeholders in the programme, including the Pasefika framework developer and the Pasefika Cultural Advisor.

Interviewers were matched culturally for the interviews with whānau and families; six were conducted face-to-face and the remaining four by Zoom or phone. Interviews with management, therapists, the Pasefika Cultural Advisor, the Pasefika framework developer, and referrers, were mostly conducted by Zoom or phone.

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

The outcome data are measured by responses to the OQ (Outcomes Questionnaire), the YOQ (Youth Outcomes questionnaire), and the YOQ-SR (Youth Self Report) before and after treatment, and responses to the COM-A (Client Outcome Measure (Adolescent)), the COM-P (Client Outcome Measure (Parent)), and the Cultural Satisfaction form at discharge. The OQ, YOQ, YOQ-SR, COM-A, and COM-P questionnaires measure the perceived behavioural performance or issues of the young person and their distress levels. Each completed questionnaire gives a score and is used as a data point.

Given the small amount of available data on the outcomes measured by the questionnaires and the Cultural Satisfaction form, we used tables and graphs instead of *t*-tests to identify any significant differences in measured outcomes before and after treatment.

Appendix 1 provides greater detail about our data sources, analytic methods, and examples of the questionnaires and forms listed above.

Our conclusions about the programme's impact in each of the areas for investigation set out above (outcomes for Māori and Pasefika, what is helping or hindering progress, an unintended consequence of the programme, and improving programme effectiveness) are described below.

1.1 Progress towards achieving outcomes

1.1.1 Recruitment of clients and progress through the programme

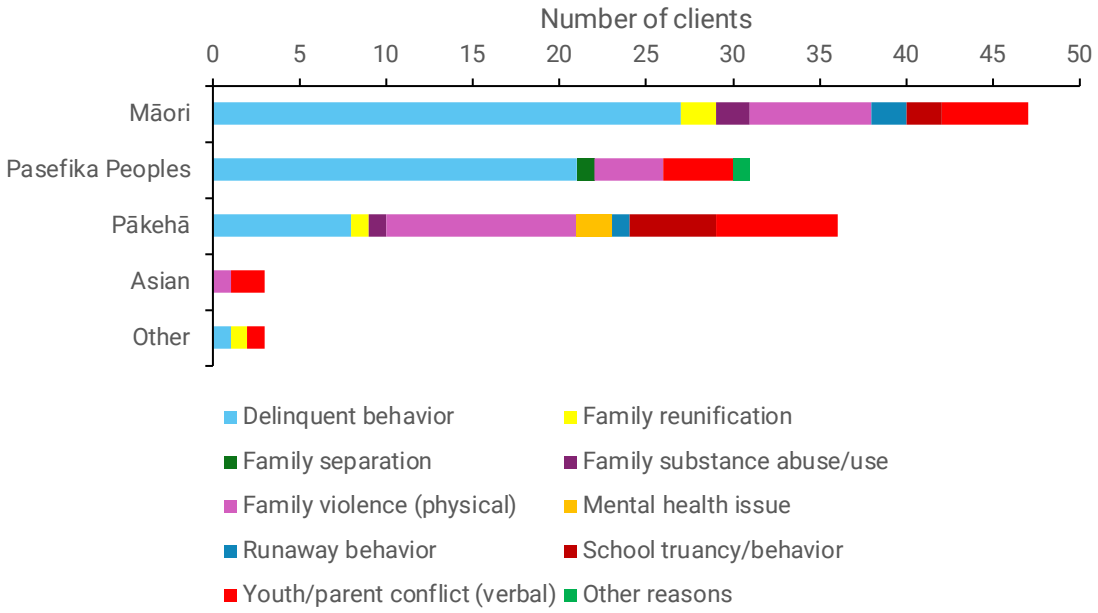
As at 23 November 2020, 120 cases had been referred to the programme. Figure 1 gives information on the ethnicity of the clients referred to Pae Whakatupuranga I FFT-CG and their reasons for using the service.

Māori and Pasefika peoples make up two thirds of the programme's client base, with Māori accounting for 47 (39 percent) and Pasefika 31 (26 percent) of families. Pākehā comprised the second largest group, with 36 families (30 percent). There were three Asian families and three families of other ethnicities.

The delinquent behaviour of the index client is the most frequent reason for referral for both Māori and Pasefika groups, accounting for more than half the referred cases. Physical family violence and verbal conflict between the young person and their parents are the two next most frequent reasons.

In contrast with Māori and Pasefika clients, the most frequent reasons for Pākehā referrals are physical family violence followed by delinquent behaviour by the young person.

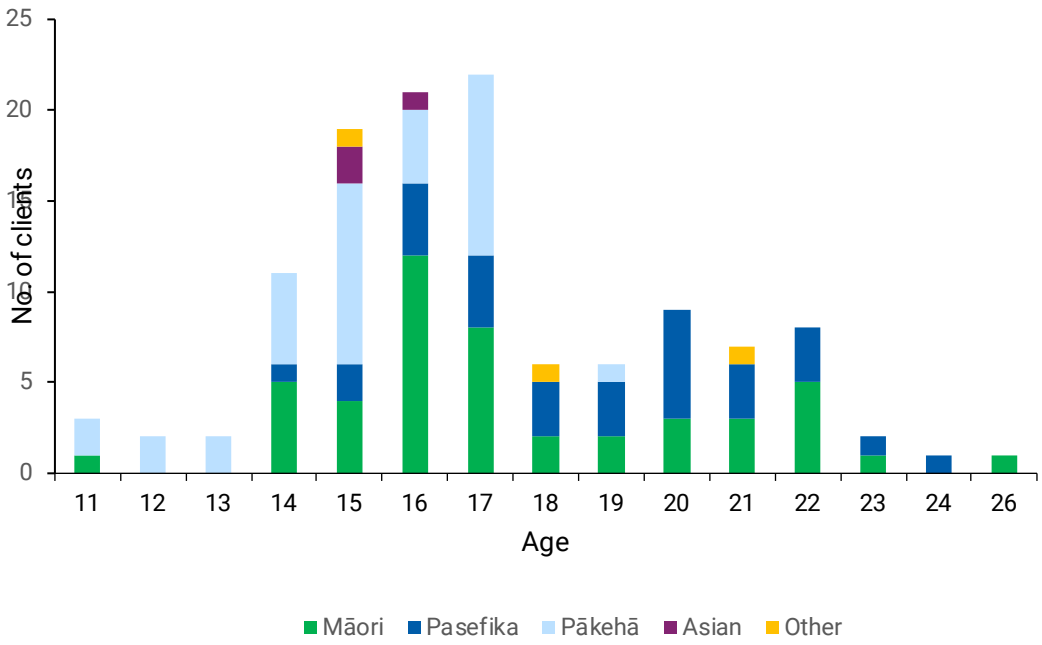
Figure 1. Reasons for being referred to the service by ethnicity



Source: CSS data (1 Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

Overall, the majority (80 of 120) of clients referred to the programme were under 18 years old. Figure 2 shows that Māori and Pasefika clients are between 11 and 26 years old. In contrast, Pākehā are mostly under 18 years old. Overall, the majority (80 of 120) of clients referred to the programme were under 18 years old.

Figure 2: Age and ethnicity of clients referred to the programme



Source: CSS data (1Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

Table 2 shows clients' progress through Pae Whakatupuranga I FFT-CG. Engagement remains a challenge for the programme, with 48 (40 percent) of clients never beginning their treatment. This proportion is highest for Māori whānau, at 64 percent (30 of 47), and lower for Pasefika aiga, at 35 percent (11 of 31). Reasons for not beginning treatment are discussed later in this report and include the client not meeting the criteria for entry, declining services, and not attending the initial appointment. Other reasons include therapists being unable to contact the client, or not knowing their whereabouts. Referrers may also on occasions do not have sufficient knowledge of the programme to be able to socialise it effectively with prospective clients. On occasions there is a conflict with other treatment the client is receiving.

Of the 46 clients who used the service and whose cases have been closed (closed completed + closed dropped out), only 17 clients (37 percent) completed treatment and 29 (63 percent) stopped before completion.

The completion rate is higher for Māori whānau, at 54 percent (seven of the 13 cases that used the service), and much lower for Pasefika aiga, at 13 percent (two of the 15 cases who used the service). The rate is 43 percent for Pākehā families (six of the 14 who used the service).

The small number of completed cases means that quantitative analysis of the measured outcomes is suggestive rather than statistically derived. The quantitative results are corroborated with the qualitative analysis to strengthen the evidence base.

Table 2. Ethnicity and treatment status of clients

	Referred	Never began	Dropped out	Com-pleted	Active	Total number	Total (%)
Māori	1	30	6	7	3	47	**39**
Pasefika	1	11	13	2	4	31	**26**
Pākehā	3	7	8	6	12	36	**30**
Asian			2	1		3	**3**
Other	1			1	1	3	**3**
Total number	6	48	29	17	20	120	**100**
Total (%)	**5**	**40**	**24**	**14**	**17**	**100**	

Source: CSS data (1 Jun 2019- 23 Nov 2020). Accessed 30 Nov 2020.

1.1.2 Family cohesiveness

Increasing family cohesiveness through better communication

Management and therapists

Interviews with YH management and therapists all highlighted the importance of achieving the outcome of increasing family cohesiveness through improved communication. They also spoke about the importance of improving young people's perceptions of: family communication skills; caregiver or parenting skills and ability to supervise; family conflict level; and their own behaviour.

Management and therapists see these outcomes as essential markers on the road to success. They believe that achieving them will enable whānau and aiga to resolve conflict and prevent its escalation into offending.

> *We hope the service itself [is] really about young people and helping [their] families learn to deal with life and learn to deal with each other. The young people will then not offend anymore [and] will make different choices for themselves. (*IEW1 Management #6)

> *[The first thing] I'd like to see - an improvement in behaviour as viewed by the young person and as viewed by the family members. The second thing would be an improvement in the quality of the relationship between the members of the family, but particularly between the parents and the young person. A third benefit, which I think is hard to measure, … would be that the siblings also benefit from the intervention*. (IEW1 Management 4)

> *[The] FFT model allows for the space to address the interpersonal issues that our young people are having with families, such as communication breakdown. Introducing new skills or new ways of dealing with, or new ways of coping, for parents and a young person to regulate their emotions.* (IEW1 Cultural Advisor)

Therapists used the image of 'planting seeds' to describe the desired changes during the treatment with whānau.

> *Behaviour change results – we plant seeds that become powerful metaphors that lead to behaviour change…. We've all got a 'tool belt' and the tools we have help us to plant the seeds for change.* (IEW1 Therapist)

Whānau

Interviews with whānau revealed that they had similar expectations about reducing stress, tension, and in some cases violence, in their households. Whānau understood that this would be a long process that would require engagement and commitment from family members.

> *It was to have a violence free home. It was to work on communication between us, work around respecting each other, boundaries, like if I said to my son 'No, I do not want the person over here today' he would respect that. (IEW1 Mā #2)*

The most evident Māori whānau outcome has been the improvements in communication in the family. All whānau expressed their appreciation of their therapists for improving their ability to communicate.

A distinctive feature of Pae Whakatupuranga I FFT-CG is that both the index clients and their parents are involved in treatment, and all family members are encouraged to participate. This has enhanced communication among family members. One whānau pointed to this as a differentiation from other therapy.

> *I mean, we've been through therapy with other places, but it was like it was all aimed at [index client] Yeah, and not [index client's brother and sister]. It was all about [index client]. With [FFTCG therapist] it wasn't, it was the whole family, which was really good, she included everyone.* (IEW1 Mā #1)

This whānau also gave an example of how the therapist helped them handle negative feelings and develop understanding and positive feelings towards the young person. The grandparent and parent were able to realise through writing a journal that they had focused mainly on negative rather than positive feelings. This led to changes in their attitude to the young person.

> *[She] was doing all kinds of things [that] wasn't making me or her (mum) happy either. So, she [therapist] gave us this book and she told us to write in what [index client] had done and what [index client] had done that was really good. So, you know, you have the negative and the positive on top so you can actually see what was happening.* (IEW1 Mā #1)

The programme has helped parents to improve their communication skills by solving their own problems. Two parents reported that they had opened up to the therapists about their own feelings and how those feelings intruded into their relationships with the young people. Working through these issues with the therapist enabled the parents to be more open with their children.

> *I've acknowledged to the therapist that sometimes I pushed my kids away when they just want to say, Mom, we love you. It was what I've been through with my parents. Yeah, they weren't there, you know, so it was working on my own feelings as well.* (IEW1 Mā #2)

> *I actually told [the therapist] that I had to be open and honest to all my six children here … And I told her that I will be honest with them, the stress that I was under on this journey alone because I couldn't talk to them about it, because I always got negative every time we talk I got negative feedback. I reacted negatively. I think that were causing me stress.* (IEW1 Ma #4)

Another parent reported that the therapist calmed her and made her feel good about herself. This is very important for troubled whānau, as stressed parents tend to feel guilty and blame themselves.

> *She would always work with us and put us on a good level. I'm thinking when my kids will get into trouble, you know, doing the kind of thing and I didn't know, but she made it clear that we were just mums and just try and do the best you can as mum to their children. And it is okay to make mistakes.* (IEW1 Ma #5)

Improved communication enabled parents to recognise what triggered or mitigated anger in their children and what caused misbehaviour. For example, one parent had improved relationships by paying attention in conversation.

> *I had to take into consideration when he [index client] was talking to me that he liked the eye contact. He'd be talking to me and he'd make sure that I was looking at him. So that is attention. 'Why am I telling you this. You're not even looking at me, or you're not even listening to me.' And that's how he'd get angry as well, if he didn't have my full attention.* (IEW1 Mā #2)

Another whānau began to understand why their child kept running away and found a solution.

> *Most of the reasons, when she [index client] was taking off was that she had to go somewhere, do something and then she'd come back. But she'd forget to tell you where she was going. Now she doesn't go unless she talks to us.* (IEW1 Mā #1)

Therapists also helped the young people speak their minds and participate in the conversation. One whānau described how their young person gradually opened up to the therapist. At first, they did not respond much to the therapist. Later, when the therapist introduced communication skills and created a platform for whānau members, the son started to interact more with her.

> *I think that was also when [young person] started communicating better with her [therapist] because before that when she talked to him, it would be just like a yes or no answer or he shrugged his shoulders. And then when she introduced that [communication skill] part of the session, he started communicating better with her. He started interacting with her better. (IEW1 Mā #3)*

This whānau described this moment as a 'turning point,' because the whānau could communicate better about the cause of the young person's tendency to stay on the

streets and he gradually realised that was not what he wanted. The mother no longer felt the tension of 'hassling' her child.

> *I don't have to actually talk at all, you know, like have to hassle him. That's what I used to do.* (IEW1 Mā #3)

The result of improved communication and negotiation is a stronger whānau with closer ties among family members.

> *We have come a long way since we've been doing the therapy, you know, they're working with me and not against me now.* (IEW1 Mā #2)

> *I have the foundation now. So that's the start of my stability to bring my whānau back together.* (IEW1 Ma #4)

YH management also recognised this achievement. They believed the improvements captured in the data about the young people's behaviour were due to stronger whānau functioning.

> *What comes through very strongly is the family's ability to communicate and negotiate its way through issues. Yeah. You know that that's really been boosted. … The actual functioning of the family is what we know we're having an impact on. So, how they can communicate, how they work together, how they negotiate issues, how things are de-escalated. Those messages come through quite strongly in the data.* (IEW1 Management 1)

> *So, it seems that the young person reported improvement in their behaviour, what they're observing in terms of parenting skills with the parents, communication in the family, the level of conflict in the family…. The young people are reporting that they're better. So that's a really good outcome. And that's mapped pretty closely by what the parents are reporting as well.* (IEW1 Management 4)

The Pasefika Cultural Advisor similarly described how the therapists helped young people with difficult *talanoa* (communication) in their aiga. The young people were feeling that they were 'cornered' in their aiga. The therapy helped them overcome these feelings and become aware how they could change the dynamics of their aiga by changing their behaviour.

> *The work [of the therapists] helps young people to turn their pathway and strengthen them.* (IEW1 Cultural Advisor)

This corresponds to the generalisation stage of FFT, where whānau stabilise their cohesiveness and become resilient enough to withstand future tensions. A manager emphasised this important stage of achievement: life events will trigger moments of aggression among whānau, but with the skills they have acquired they will be able to recover and mend their relationships.

> *They are still experiencing interpersonal conflict. We're not a programme that's going to eliminate that, but it doesn't threaten them - shake them to their foundation as it would have earlier before the treatment…We say to them, you've learned these skills, you're practicing them, you've told us how you use them*

outside of sessions. That is the important piece. I think therein lies the resiliency like accepting that they [whānau] are going to flip the lid. But then, having a plan in place for how they manage when that happens. (IEW1 Management 3)

However, one whānau reported that they still had difficulty communicating with their child. Even though they tried to connect with the young person by involving him in the sessions with the therapist, they felt that it was impossible with the young person's attitude.

He [index client] would either come or we would have to go pick him up, bring him here [the caregiver's house] for the session.

Probably not [that zooming was part of the reason for the best results not being achieved]. Probably more just as his attitude, really. I think it was his way of saying things like 'not at all'. (IEW1 Mā #6)

This whānau did not totally agree with the therapist's approach. One of the parents described her approach as being 'patronising', possibly because the therapist was quite young and therefore it was hard for the parent's mother to take her advice.

Yeah. I mean, you might get …. a slightly different answer if you talk to [mum's name], because [mum's name] sometimes felt quite a bit patronised by her [therapist] because I guess her experience was a lot more and she [the therapist] was quite young and she felt that she was patronised [because] of some of the things she was saying to her, advising her. (IEW1 Mā #6)

This whānau also found efforts to compliment the child all the time did not work well, especially when the parents felt there were nothing to compliment them about.

She [the therapist] certainly tried to keep the communications open, sometimes to the detriment of what we wanted to say as well. …. she was sometimes so determined to keep things going with him that she would be, you know, rewarding him or saying that you have done this and that's really awesome. I would get quite sarcastic as that sounds like doing nothing. (IEW1 Mā #6)

Quantitative data

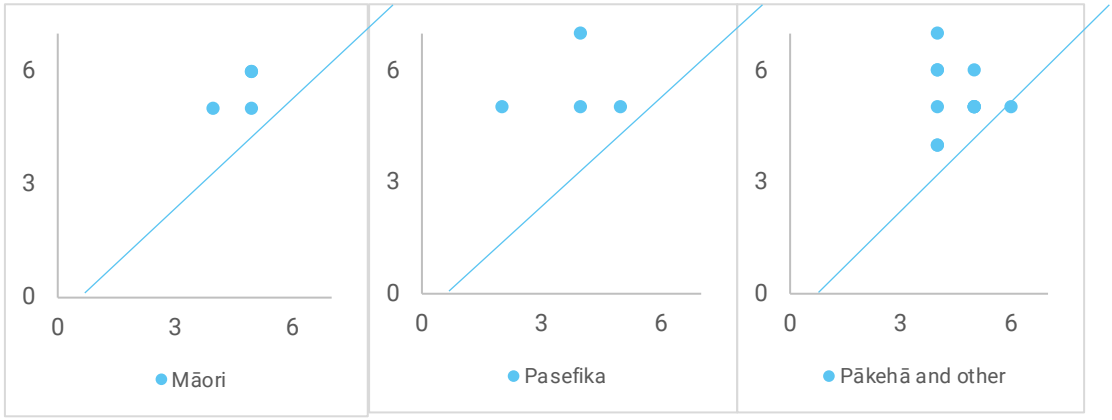
The data on self-reported family progress during treatment supports the qualitative analysis. Clients, their caregivers, and other family members were encouraged to complete the Family Self-Report (FSR) questionnaire throughout the treatment as many times as they were willing to do. The FSR gives information on how the clients evaluate themselves as treatment progresses. Because the FSR is voluntary and not required by the FFT procedure, very few clients completed the FSR questionnaire. However, those who gave their answers provided highly positive feedback.

Figure 3, Panels A and B, give the responses to the question 'How was the family doing before the first session?' (the horizontal line) and to the question 'How is the family doing now?' (the vertical line). The answers range from 1 (very bad) to 7 (very good). Only five clients did the FSR, two of whom completed treatment (one Pākehā and one other ethnicity) and three of whom dropped out (one Māori and two Pasefika).

Panel A gives the responses of the young people and their siblings. There are 22 data points in total (four data points for Māori, four data points for Pasefika and 14 data points for Pākehā and other). Some dots have more than one response on the same score point. The number of data points is larger than the number of cases because youth (and their siblings in case of Pasefika and Pākehā clients) completed the FSR several times.

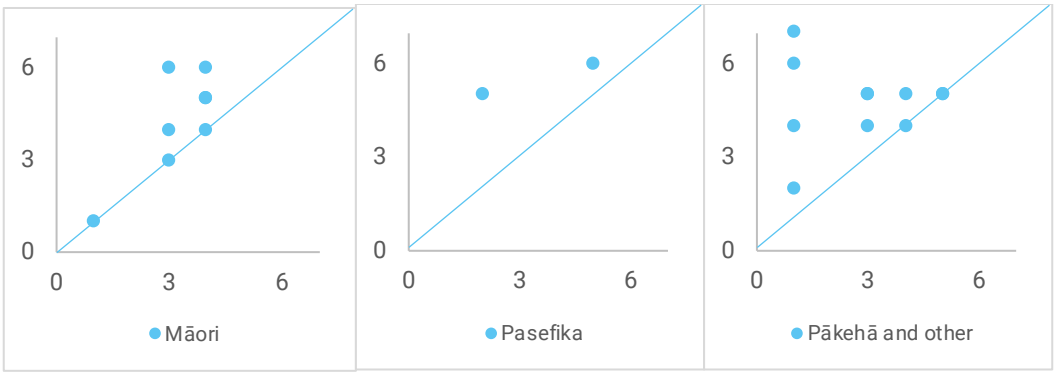
The diagonal line divides the graph into an area where there is improvement (above the line) and an area where there is deterioration (below the line). Data points on the diagonal line means there is no improvement: the situation is the same.

Figure 3: Family self-reported progress before, during, and after treatment



Panel A – Responses from young people (one Māori, two Pasefika, one Pākehā, and one other)

Panel B gives the responses of caregivers and parents. There are 21 data points in total (eight data points for Māori, two data points for Pasefika and 11 data points for Pākehā and other). Some dots have more than one response on the same score point. The number of data points is larger than the number of cases because the caregivers (two in the case of Māori and Pākehā) completed the FSR several times. Similarly, the diagonal line divides the graph into an area where there is improvement (above the line) and an area where there is deterioration (below the line).



Panel B – Responses from caregivers (one Māori, two Pasefika, one Pākehā, and one other)

Source: CSS data (1 Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

As can be seen, even though several dropped out, Māori whānau and Pasefika aiga made significant progress during the treatment. Most of the data points are above the

diagonal line in the graphs, implying that whānau and aiga felt that they were doing better after participating in the therapy.

Improving young people's behaviour

Whānau

Interviews with whānau show that the behaviour of the young people improved remarkably after participating in the programme. Misbehaviour such as running off (one whānau), swearing (one whānau), and living on the streets (one whānau) has stopped. The young people opened up to their whānau and were motivated to participate in productive activities.

> *Oh yeah, a lot [of improvements] yeah. I mean, [index client] doesn't run off anymore. It stopped. … That's a real biggie. In the beginning of COVID we were worried that we're going to have problems when COVID hit. And everybody had to be locked up. They couldn't go out anywhere. And we were worried about being locked down because I thought we're going to be in so much trouble. And she [index client] didn't even go out once. …. [we used to be] very worried, but now we've had no problems.* (IEW1 Mā #1)

> *It made my kids communicate to each other better, because my kids were always swearing at each other and calling each other names. It's made them think more. Okay, before this comes out of my mouth, I better watch out what I say. So it's made them think before they say it.* (IEW1 Mā #2)

> *Before everything was just about the street then. But that's what matters. He's just changed. And as dramatic changes, he's going back more back to the home life, like the whānau being around family, as opposed to being with the ones on the street that he used to kick around. He used to be quite bottled up. Now he is talking more.* (IEW1 Mā #3)

> *He's doing really well involved with the programme that we're in that he went through. He got a licence and he's come out of this quite a shy kid and it's gotten him out of his shell, made him more motivated and active. Yes, they got his licence and then he got a new job on Monday.* (IEW1 Mā #5)

The robustness of the core FFT process was appreciated.

> *FFT really allows the family to sort of come to know about different ways, different techniques and strategies to express their emotions in a way that is not volatile or cause that breakdown in their Va.* (Pasefika Cultural Advisor)

Interviews with management similarly identified definite improvements in parenting skills in dealing with young people's misbehaviour.

> *Truancy or school refusal has been part of the inter-personal family difficulties and arguments around that. I feel with we had success in terms of teaching skills that address that resistance.* (IEW1 Management 3)

> *[The families are saying] 'that helped improve how we function as a family. It gave us hope. It has really improved my young person's behaviour. It has helped our parenting.'* (IEW1 Management 1)

One whānau described how the treatment has helped the index client become a better son and brother. The client started as a person with bottled-up feelings and used to attack his sisters verbally and physically when he could not resolve his emotions. Now he was able to talk through his negative feelings and aim for a better course of life.

> *I found it really useful with the cards and just all of us sitting around and you know on the floor and saying how the week went or what our feelings were because [index client] used to bully my other daughter, as well as her sister. He used to like tease her about the way she looked, and he didn't realise that all the stuff he was saying, even though he said it was a joke. She [the therapist] helped with a lot of stuff. Even just getting him to talk, whereas before he would just lash out and not even talk about it. He would punch his sister. But now he's working a lot on his feelings.*
>
> *All his court stuff was all finished. And he's all clear. Well he might joke around that he's gonna steal another car, but he doesn't actually do it. He says, 'no, mum I'm growing up. I'm going to have a baby and I've got to think of better things to do.'* (IEW1 Mā #2)

This whānau is also a good example of the therapist's ability to engage other family members in resolving conflict. The sister who was attacked verbally by her brother was able to share her feelings about his actions.

> *Before my daughter wouldn't even talk up she'll just, you know, just leave it and just walk upstairs. But, [during treatment] she was acknowledging to him that what you said to me wasn't nice. It hurt my feelings and he said 'Oh, okay I was only joking', but it was hurting her. Yeah, she acknowledged her feelings as well.* (IEW1 Mā #2)

Quantitative data

Outcome data for all ethnicities measured by YOQ-SR (self-report Youth Outcomes Questionnaire), YOQ (Youth Outcomes Questionnaire), COM-A (Client Outcome Measure – Adolescent) and COM-P (Client Outcome Measure – Parent) strongly supports the statements above. Appendix 1 provides details of the questionnaires used in these outcome measures.

Figure 4 shows the scatter plot of YOQ-SR total scores of the eight completed cases that have both pre-treatment scores (horizontal axis) and post-treatment scores (vertical axis). They are three Māori, one Pasefika, three Pākehā, and one Asian.

Graphs for each of the four ethnic groups are presented to avoid having scatter dots with more than one response on the same score point making it difficult to see ethnic differences on the same graph.

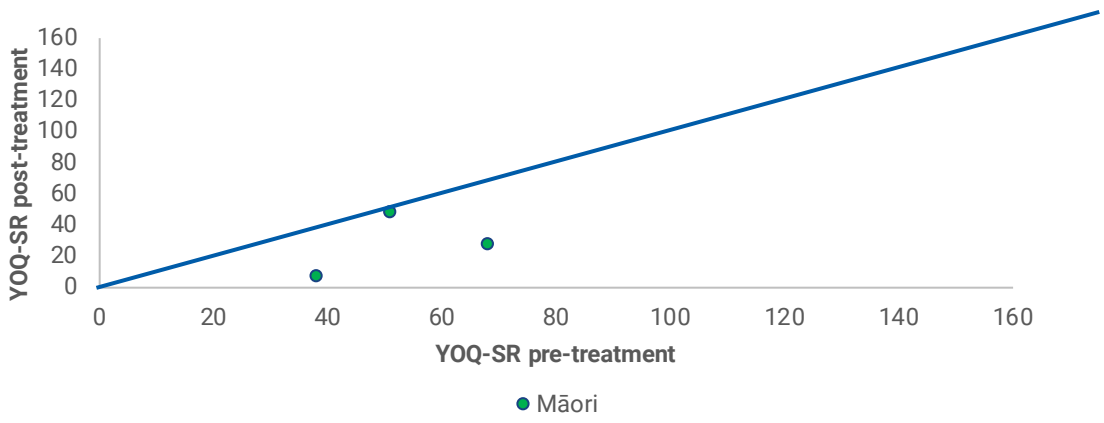
The YOQ–SR total scores were calculated using the YOQ-SR questionnaires completed by the young people who are under 18 years old about themselves. The total score is the sum of six sub-scores: critical items (those that may necessitate clinical follow-up); intrapersonal distress; physical and/or somatic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

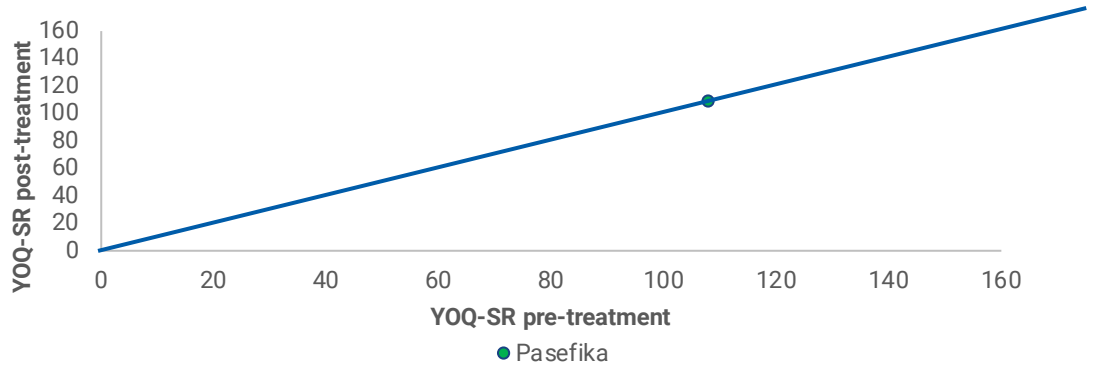
The higher the total score, the more critical the situation. The levels of distress are described as follows: moderately high is a score greater than 67; moderate is a score between 67 and 48; and low is a score less than 48. The cut-off point for clinically significant distress is a total score of 48.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

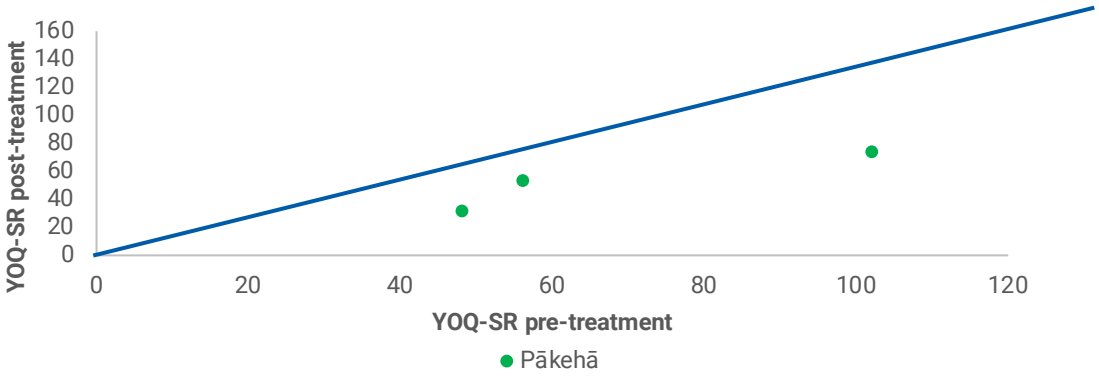
The diagonal line divides the graph into the area where there is improvement (below the line) and the area where there is deterioration (above the line). The diagonal line in each graph corresponds to the data point where post-treatment scores would be the same as pre-treatment scores and no change would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

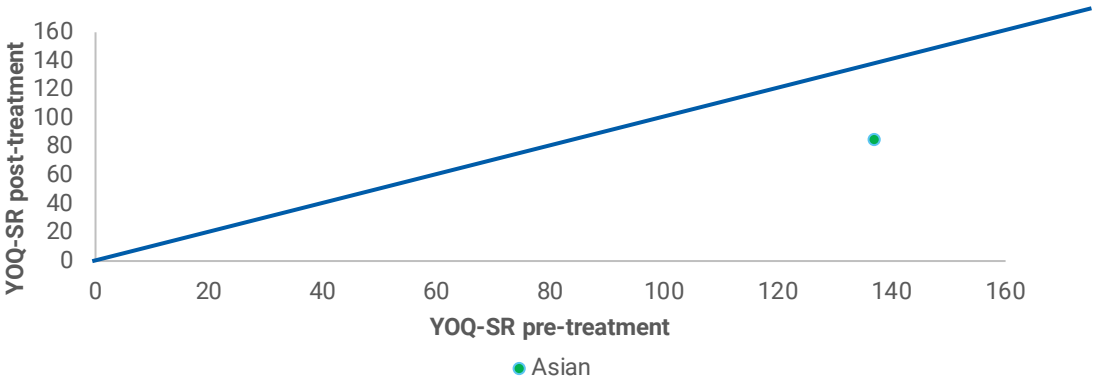
Given the cut-off of 48, the majority of the pre-treatment score observations (20 of 27) had moderate levels of distress that were considered to be clinically significant. The pre-treatment score data (the place on the horizontal axis immediately below each dot in figure 4) highlights the challenging circumstances and experiences of the programme's clients, which was also noted in the qualitative analysis.

Figure 4. YOQ-SR total scores before and after treatment (N=8)









Source: CSS data (1 Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

The data are indicative because only eight observations of the post-treatment YOQ-SR are available. The post-treatment YOQ-SR scores are all under the diagonal line except for one Pasefika case, indicating that the treatment has lowered distress levels among the index clients. The lower the data points, the more distress levels have been reduced and the better the behavioural outcomes.

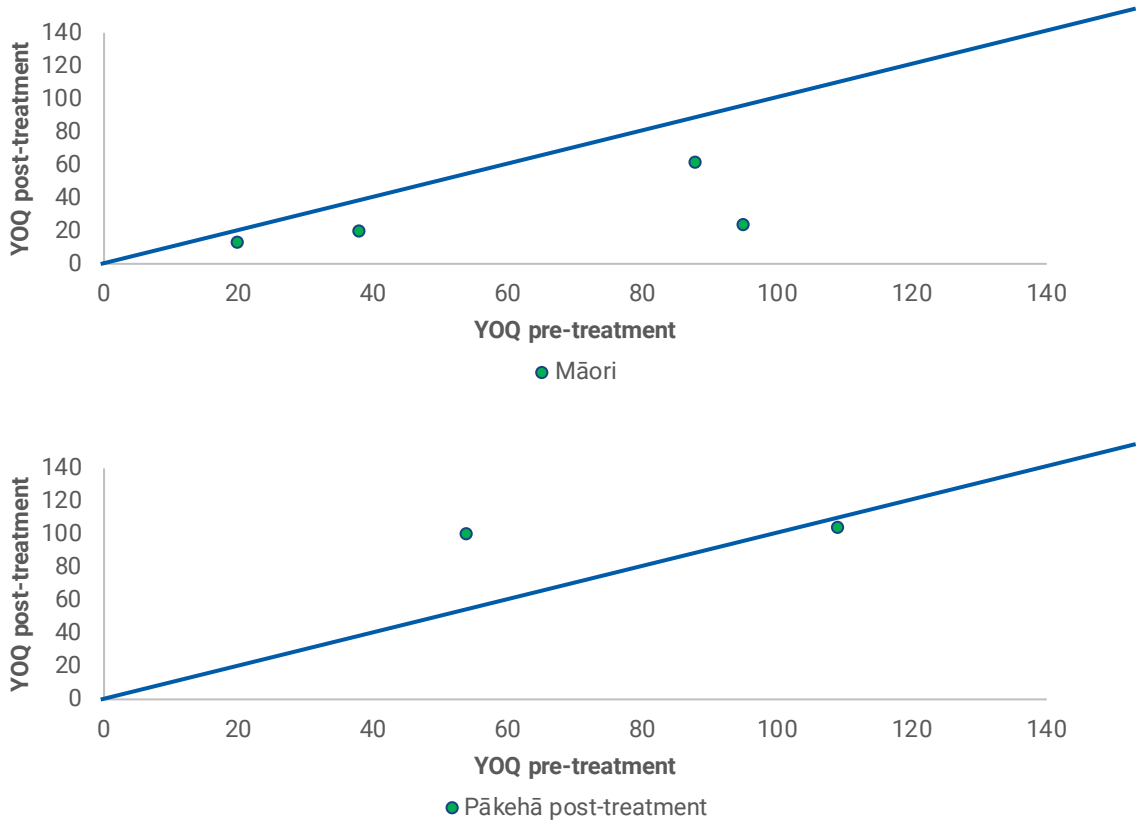
Figure 5 gives the data on YOQ total scores, reported by parents and caregivers about the behaviour of their children. The design of Figure 5 is the same as Figure 4, with graphs for different ethnic groups. Of the 17 completed cases, 11 recorded pre-treatment scores and only six of them recorded post-treatment scores (four Māori and two Pākehā). Pasefika and the Asian ethnic group have pre-treatment scores only and therefore are not shown.

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

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

The pre-treatment YOQ total score distribution (the place on the horizontal axis immediately below each dot in figure 5) is high with 17 out of 24 observations above the cut-off score of 48, similar to the YOQ-SR. Again, this highlights the challenging circumstances and experiences of the programme's clients, as was noted in the qualitative analysis.

Figure 5. YOQ before and after treatment (N=6)



Source: CSS data (1 Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

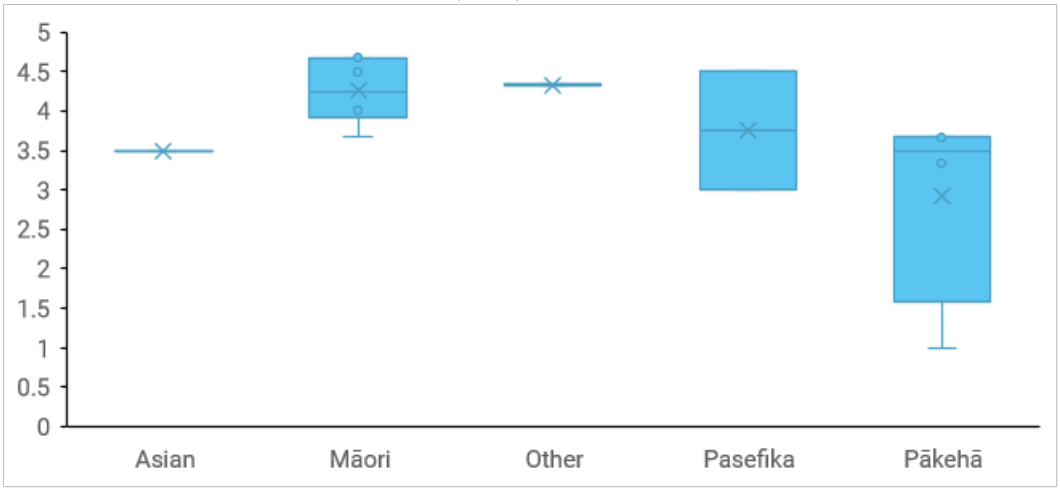
Only one client (Pākehā) displayed worse behaviour after completing the treatment (the data point is above the diagonal line), according to his/her parent/caregiver. The remaining Pākehā client and the four Māori clients were less distressed in their parents' perception. While the outcomes from the caregiver's viewpoint are more favourable for

Māori than for Pākehā, there would need to be more responses to be sure about any differences between cultural groups.

Figure 6 gives the Client Outcome Measure – Adolescent (COM-A) scores for the 15 completed cases (out of a total of 17) where the data was available. This questionnaire is completed by the index client just before discharge, and provides an evaluation across six dimensions: family status; family communication skills; youth behaviour; caregiver or parenting skills; caregiver ability to supervise; and family conflict level. The responses range from 1 (things are no different) to 5 (very much better). The final COM-A is the average of all responses to the six dimensions.

The data show very good outcomes, with average responses ranging from 3 (somewhat better) for Pākehā clients to about 4 (a lot better) for Pasefika and Māori. The length of the box indicates that the scores are not very different among Māori clients between 3.9 and 4.7 (N=6), more different among Pasefika clients between 3 and 4.5 (N=2), and most different among Pākehā clients between 1.5 and 3.7 (N=4). Only one Asian client and one client of 'other' ethnicity completed COM-A and their average scores are also very high.

Figure 6. Box plot of COM-A average score (N=15)



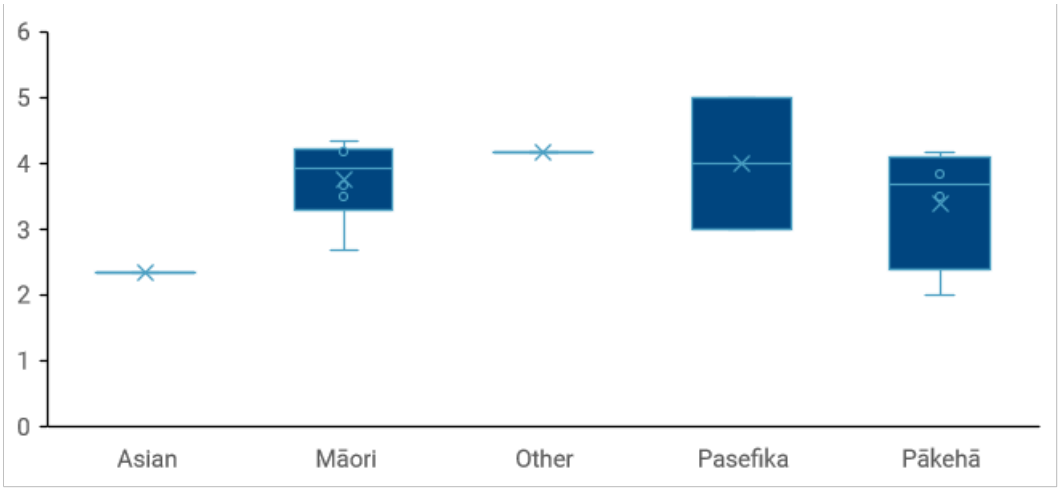
Source: CSS data (1 Jun 2019 to 23 Nov 2020). Accessed 30 Nov 2020.

Figure 7 gives the perception of the parents/caregivers about the behaviour of their children. The average scores are high, around 4 (a lot better) for Māori, Pasefika, and Pākehā parents.

There are slight differences between Figures 6 and 7, which indicate some differences in perception between parents/caregivers and their children.

The COM-P average for Māori whānau is lower than their COM-A of 4.3, possibly reflecting congruence with the qualitative analysis, which recorded positive responses from all but one Māori whānau.

Figure 7. Box plot of COM-P average scores (N=15)



Source: CSS data (1 Jun 2019 - 23 Nov 2020). Accessed 30 Nov 2020.

1.1.3 The therapy is culturally appropriate

YH has recognised the importance of cultural appropriateness through matching the functional dynamics of Māori whānau and Pasefika aiga – the ways in which family members related to each other, including cultural practices as they were employed in the particular family – in delivering the service. This was the key to engaging with whānau and aiga during the treatment process. Without engagement with whānau and aiga, none of the intended outcomes would have been possible.

> *I definitely think the cultural support has been really helpful, and that ongoing ability for therapists to receive supervision or support should they need it for the particular whānau.* (IEW1 Management 1)

> *When you did a really good match with a whānau, there's a good cultural understanding between the therapist and the family that assists in engagement and motivating the family, or increases the family's trust in the competence of [the] therapist, the trustworthiness of the therapist.* (IEW1 Management 4)

Māori whānau appreciated the therapists' cultural knowledge and respect. Whānau who completed the therapy were generally positive about their experience and particularly positive about the respectful and genuine nature of therapists. They gave examples of a therapist who is always humble, sensitive, genuine, and highly reliable.

> *And if she said something, she would say, um, I hope I didn't offend you, or was it the right way to kōrero or something like that ... She was always just herself. She always made us feel comfortable.* (IEW1 Ma #2)

> *She worked well with us, aye. That's a good thing. Like, yes. Automatic, the shoes thing. But then she even then left it up to us whether we do a karakia before it starts, you know, things like that. So she was culturally sensitive in that way which was good. She would be right at the top aye. She was pretty respectful. From the first day we met her. Five minutes to four [you will see her] just pull up the car and*

> *parked down the road.... And she always took off her shoes and she always greeted us. You know, yeah she would be right at the top mate. She was really good.* (IEW1 Mā #3)

Cultural activities were particularly enjoyed by whānau members. One whānau gave examples of how cultural understanding has helped the whānau engage in the therapeutic activity. Given that this whānau had limited treatment progress and disagreed with the therapist's approach of wanting to engage all whānau members, this positive feedback about cultural activities is remarkable and highlights the importance of cultural competence among the therapists.

> *I think halfway through the programme [therapist] could come around and we were doing a family tree and we were drawing a little drawing. And at the same time, we were doing whakapapa doing all that sort of stuff as a family. And he [index client] actually got quite interested in [it]. That was actually sort of the best things. And [the therapist] had lots of books to show us, a photographic Māori one which is really good ... a Māori type thing, a Māori type involvement. That seemed to hold his interest quite well.* (IEW1 Mā #6)

Another whānau appreciated the mahi done by the therapist, which enabled her to overcome the difference in ethnicity and connect with the young person.

> *Presumed because of skin colour but that mihi helped with [young person] taking notice of her .... because, you know, she did, I don't want to say it, but when you look at somebody's skin, it's different to your skin. .... I think that's what happened with my son. It wasn't until she actually spoke te reo then he listened. He wouldn't listen when she was speaking English just for real. But the acknowledgment was ah a grunt. Well, he's still listening, even though he's not looking. That's how we started. It eventually turned around that he was turning around looking at us.* (IEW1 Ma #4)

The Wave 2 Formative Evaluation[9], conducted in mid-2020, highlighted the need for more Pasefika cultural training and supervision. Interviews with the Pasefika framework creator and the Cultural Supervisor undertaken for this impact evaluation, showed significant progress in this respect. The Framework Creator described a shift of focus about Pasefika aiga and the Uputāua framework, which acknowledged that Pasefika and their aiga are unique, and it is inaccurate to assume that they are like Māori whānau. The Uputāua framework has been completed[10], and further Pasefika cultural training (including cultural experiences and interactions with aiga) and supervision sessions have occurred.

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[9] Family Centre Social Policy Research Unit (2020). *Pae Whakatupuranga: Functional Family Therapy Cross Generations (PW: FFT-CG) – Wave 2 Formative Evaluation Report*, Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

[10] The two cultural frameworks have been combined with the clinical manual in a practice manual titled *Te Huarahi o Te Rangatahi*. This manual is a taonga that draws together a therapeutic process informed by Te Ao Maori principles from Whaitake Whakaoranga Whānau and Uputāua. It was launched in late November 2020.

> *The Pasefika Cultural Training session started at 10 am and finished at 4 pm. It took place in Mangere. The architectural design of our buildings embodies our cultural concept and values for example,* fa'aaloalo *(respect). The therapists had direct experiences of Aiga, of Matai, and of New Zealand born members of the family. The parents are bicultural, Pākehā/Palagi, and Samoan. The New Zealand-born young person explained what it is like for him to live out Samoan values and concepts such as fa'aaloalo or respect, and teu le va [observing relational boundaries and taking care of relationships]. After the Family Conversation Session, we went on a walking tour to Maota Samoa, the Pasefika Art Centre, and some Pasefika Churches.* (IEW1 Pasefika framework creator)

The Cultural Advisor described special sessions that were held to enhance awareness of Pasefika culture within YH.

> *We run what we call Talanoa sessions, which is part of our Pasefika Language Week programme that we, as the Pasefika Committee, deliver for our staff. It's like professional development activities for our staff. We have guest speakers from the different services come and they talk about what these services deliver and the relevance it has to our work. So that's really to widen the exposure of our therapists and our Pasefika therapists, to know what services are out there.* (IEW1 Cultural Advisor)

Success in providing culturally appropriate services was also noted by referrers. One commented on the enhanced capability of the therapists as a result of cultural training.

> *I think the cultural training of therapists was very well done. I think the therapists themselves felt a lot more confident to be able to go ahead and do work.* (IEW1 Referrer 6)

Tailoring the FFT model to be suitable for the Aotearoa/New Zealand context has entailed intensive training for the therapists, who have needed to fine-tune their approach so it is comfortable for clients from different cultural backgrounds. Therapists have needed time and practice to build their understanding, confidence, and competence, and face-to-face experiential training in Uputāua has happened only recently. One manager reflected that the process of building a confident, competent team has taken a year to date.

> *We were unaware that it takes a year for a team to come together and get to the spot where you're actually getting completions. You've got to give the therapist team time to be able to build confidence and become skilled.* (IEW1 Management #6)

Table 3 gives the average of responses to the cultural satisfaction form for the five ethnic groups and the whole sample. The form is filled out by the index client and separately by their parent/s or caregiver/s. Two survey forms were used, which has led to missing data in responses to several questions that appeared in the long form and not in the short form. The responses range from 1 (not at all) to 4 (very much) in response to questions about different aspects of cultural appropriateness. The evaluation shows a high level of cultural appropriateness among the therapists.

Table 3: Average scores of responses to the cultural satisfaction form

	Asian (N=3)	Māori (N=11)	Other (N=1)	Pasefika (N=2)	Pākehā (N=16)	Overall (N=33)
How satisfied are you that the therapist: respects your culture	3.33	4.00	4.00	4.00	4.00	3.83
Knows enough about your culture to help you feel comfortable	3.67	4.00	4.00	4.00	4.00	3.92
Gives information in ways that aid your understanding	3.67	4.00	4.00	4.00	3.33	3.75
Pronounces your names correctly	3.67	4.00	4.00	4.00	4.00	3.97
Takes time to find out about your family/ whānau values		3.57			3.77	3.70
Looks for common ground to connect with you	3.67	3.64	4.00	4.00	3.56	3.64
Shows respect for your culture		4.00			3.67	3.80
Works in partnership with you to achieve change	4.00	4.00	4.00	4.00	4.00	4.00
Takes time to find out about the family's beliefs and values	4.00	4.00	4.00	4.00	4.00	4.00
Respects things that are important to the whānau	3.67	4.00	4.00	4.00	3.88	3.91
Helps you feel comfortable to talk and share		3.50			3.54	3.52
Allows you to know who they are as a person		3.63			3.69	3.67
Acknowledges and respects your religious/ spiritual beliefs		3.88			3.86	3.87
Allows time in sessions for cultural rituals if you want them		3.71			4.00	3.78
Knows enough about your culture to help you feel at ease		3.63			3.64	3.63
Is willing to learn about your culture		3.63			3.50	3.57
Acknowledges when they don't know something about your culture		3.63			3.83	3.71

Source: Google form shared by YH. Accessed 30 Nov 2020.

1.1.4 Improving index clients' living situation and their education or employment

Living situation

> *If a young person is still in the family, the goal is to keep the child there, that's first and that's the best place for them if we're able to address some of the challenges that they're having inside the family.* (Pasefika Cultural Advisor)

Table 4 gives information about the living situation of 45 index clients before and after participating in the programme. The data are for all clients who have used the service (17 completed and 29 dropped out), except for one case whose data are not available.

A majority (34: 80 percent) of the 42 young people who were living at home before treatment continued to do so. Of the remainder, one client moved from living at home to independent living with a partner and one to living with a flatmate. Three who were at home moved to judicial residential settings - one to prison (a Pasefika client who dropped out after less than six sessions) and two to residential care (Māori clients who dropped out after two or more sessions). The living situation of three is unknown.

Three clients changed from independent living with partners or flatmates before treatment, to living at home after treatment.

Table 4. Improving clients' living situation

		Living situation after treatment						
		Living with parent(s) or whānau	Living with flatmates	Living with partner or spouse	Prison	Secure OT or YJ residence	Unknown	**Total before treatment**
Living situation before treatment	Living with parent(s) or whānau	34*	1	1	1	2	3	**42**
	Living with flatmates	2						**2**
	Living with partner or spouse	1						**1**
	Total after treatment	**37**	**1**	**1**	**1**	**2**	**3**	**45**

*Each of these cells show the number of clients who changed from the situation in the row to the situation in the column.

Source: HCC data reconciled with CSS (1 Jun 2019 to 23 Nov 2020) accessed 30 Nov 2020.

Overall, the programme has largely achieved its goal of helping young people to stay at home or move successfully to independent living. However, the three exceptions to this general pattern, who moved from home to judicial settings, are a signal that living situations post-treatment may need to be carefully investigated at the next impact evaluation to identify any correlations and likely causes of any negative outcomes.

Education and employment

Table 5 gives information about changes in the education and employment activities of clients. The programme has made a good start on achieving its goal of ensuring young people stay in school, return to education, or further their employment opportunities.

At the start of the programme 25 were in education, employment or training (EET).

After participating in the programme, 29 were in education, training or employment.

These included 16 of the 25 who maintained the same EET status.

Of the remaining nine (out of 25), one found employment, one moved to further study, three were no longer in education, training, or employment, and no information was available for the four remaining clients.

The three who were no longer in education, training, or employment, were three clients (one Pākehā, one Māori, and one Pasefika) who dropped out of their alternative or mainstream education after participating in the treatment. They did not complete treatment.

Finally, we do not have information on two clients before they started treatment, but after treatment we know that they were in employment, education, or training.

Of the 18 clients who were not in employment, education, or training before treatment, nine began education, training, or employment, seven remained without education, training, or employment, and no information was available for the two remaining clients. In total, we know that 10 were not in education, training, or employment after treatment (NEET).

Table 5. Improving education and employment

Before therapy	**After therapy**							
	Alternative education	**Main-stream education**	**Full or part-time paid employment**	**Training or work-based programme**	**Not in education, training, or employment**	**University**	**Un-known**	**Total before treatment**
Alternative education	4				2	1	2	**9**
Mainstream education		9			1		1	**11**
Full or part-time employment		1	2				1	**4**
Training or work-based programme				1				**1**
Not in education, training, or employment	5		3	1	7		2	**18**
Unknown		1	1					**2**
Total after treatment	**9**	**11**	**6**	**2**	**10**	**1**	**6**	**45**

Source: HCC data reconciled with CSS (1 Jun 2019 to 23 Nov 2020) accessed 30 Nov 2020.

1.2 What is helping or hindering progress towards outcomes?

1.2.1 Therapists' inexperience slowed expected progress during Year One

Therapists are a critical component of Pae Whakatupuranga I FFT-CG. Their interactions with Pae Whakatupuranga I FFT-CG whānau and aiga is decisive in the successful delivery of the service. Management considered that, in the first year of operation, the Pae Whakatupuranga I FFT-CG team had to learn many things, including understanding the clinical and cultural elements of the therapy, and understanding the clients referred to this specific programme. Therapists' lack of experience has resulted in low client loads for Pae Whakatupuranga I FFT-CG in the first year. Management strongly believed that the second year of operation will witness significant improvements as therapists are now more experienced in the delivery of their services.

> *It's probably the team experience. So, at first it was a hindrance but now it has become very helpful because the experience is getting better.* (IEW1 Management #6)

> *The biggest disappointment has been the rate of, the volume of, young people who have gone through to complete. Some of the [causal] factors will just materially be different this year. Now that we've got [a] more experienced team, and some of the training and supervision load that was put on [them] in the first year doesn't apply now. I'm really confident about getting a lift in both caseload and completion rates in Year Two.* (IEW1 Management #4)

1.2.2 Therapists' approach has helped progress

Therapists' approach to their clients has already been an important factor in the successful delivery of the programme. Pae Whakatupuranga I FFT-CG's clinical and cultural training has enabled most therapists to adopt a 'strength-based' approach to their clients.

Therapists discuss risk factors, and the family's likely positive (or otherwise) approach to having therapy, in a staff meeting on receiving referrals, before getting in contact with clients or the referrers. A positive approach was perceived by therapists as the key factor in working successfully with families and facilitating their resilience.

Therapists described their genuine belief in families' capability and their (the therapists') ability to translate that into strength-based relational statements that families can use to improve their lives.

> *Always looking for the positive. Reframing the struggle of the family to transform some of those professional perspectives on families, and that's the power of FFT. We have a genuine belief that families can do this. They are their strongest resource. We want to support that.* (IEW1 Therapist)

Several skills were particularly useful in approaching and working with whānau and the young person. First, therapists understand and respect whānau/family/aiga dynamics.

This requires the therapist to be open-minded and treat each family as unique, so the therapist can acquire a thorough understanding of the difficulties the whānau is facing and meet them on their ground. Only then can the actions proposed by the therapists make sense to the family.

> *You don't treat them the same as other people, because as soon as you do that, it's not going to work because all children and parents alike are all different. And they all manage the kids differently. If you can work with them the way that they are working with their family and say, 'oh, yes, you could try this and see what happens'. She [the therapist] took time to know us all, and she did understand what we have been through and everything with everybody else. She saw the difficulties that they were having yeah and realised, well, it's not going to work this way so let's try it on their level and see how they'll react.* (IEW1 Mā#1)

> *I think that all other whānau are individuals, everybody is different.* (IEW1 Mā #4)

Understanding whānau dynamics helped the therapist to be sensitive towards the parents and the young people and engage them in the appropriate way.

> *Like I told her [therapist] all the background that we had come from, where we came from a house where there was a lot of violence with my ex-partner who's in prison. My kids saw some of the violence. I explained all that to her and she took that all on board. She was very thoughtful about bringing up stuff that might trigger some of my kids' feelings. So she said, 'is that okay to talk like this around your kids'. She sort of has all that kind of respect, just taking into consideration what we had been through.* (IEW1 Mā #2)

Understanding the particular need of individual whānau/aiga/family could also help therapists speed up the treatment process. One parent wondered whether it would have been better if the therapist knew about the situation of the young person in advance, rather than wait until the young person opened up. In this example, the therapist took the time to befriend the young person so he could communicate with her and let her know his problems.

> *Because she didn't know about the girlfriend right at the start and I can't say it because I had to get [index client] to open up himself, to be honest with her [therapist], on what's happening with him. So, I cannot say anything. If in the beginning, if she knew about both of them, it might have been different. It may have changed all the questions she asked. She would have had different elements on the programme. That would help benefit not just him, but her too.* (IEW1 Mā #3)

Lack of attention to family dynamics occasionally led to the therapist having difficulty in connecting with the parents and the family achieving cohesiveness. For example, one parent reported that the therapist did not explore what she wanted to achieve for her family. She felt the sessions should have been tailored more to what they needed, not what the therapist thought necessary. She wished the therapist had asked her questions like 'do you think that we should do this?', 'do you think this is what would work, or should we do something different?', 'what is helping and what is not helping?',

or 'should we change the subject?' rather than saying 'we need to work on communication'.

> *I don't know if we got the opportunity to actually work on what we were wanting to achieve… Maybe having five sessions on an issue might just be wasting your time because you know your young person is not interested in it. So, maybe checking in, saying; 'Hey how's it going? Should we change it?' and not like when we have two more sessions to go, and then we will finish the sessions.* (IWE1 other)

Although the family acknowledged communication had improved and anger and conflict had reduced, the bond between mother and son needed more work.

> *In terms of the relationship between my son and I becoming closer, that hasn't happened yet. We are trying to get that trust bond going with us.* (IEW1 other)

Another important skill in the strength-based approach is therapists' ability to relate to young people by meeting them on their own ground. In one example, the therapist at first tried the normal techniques but could not get any reaction from the young person: the young people in this whānau had different needs and difficulties from most children. The therapist kept trying different techniques with no success. It was only when she asked about their interests and hobbies and changed the sessions into interactive play with the children that she got reactions from the children.

> *I like her because she played cards with me.* (Index client IEW1 Mā #1)

> *She [the therapist] kept trying things and then one day she just came in and she was like, 'so what do you like' and they told her their hobbies and interests. She actually got to know the kids and what they liked. And so, she would bring over something that they liked and interact with them that way and help them talk about things or get through things. And she said 'how about we do tasks with your things that you like' and they just took to it. So, I think every counsellor should get on to the kid's level and that's the way you're going to get communication out of them and to help the family as well.* (IEW1 Mā #1)

In another example, the therapist spoke to the index client in a way that he could understand and, given that the client was shy, began by talking about herself and playing puzzles.

> *She never spoke above his understanding. He knew what she was saying, what she was talking about. There was a few times and he looked a little bit dumbfounded, but then she asked if he understood what she meant [and if he didn't understand] she just repeated in a different way. Like I said before, [index client] was a quiet type, so it was hard for him to open up so she used to start by saying a little bit something about herself, even the game questions. Just different ways to get him to kind of open up.* (IEW1 Mā #3)

The ability to relate to young people also requires therapists to have a good sense of the client's autonomy, to understand what they want, and to respect their decisions. In the following example, the therapist suggested, rather than prescribed, a course of action for the young person.

> *Then [the therapist] made suggestions on how to better themselves instead of acting out. So, it was really family oriented: instead of just 'oh well this is what you should do', she suggested [something] for them to go and do.* (IEW1 Mā #1)

One parent gave an example of how she felt the session was not effective because the participation of the young person was forced on them rather than encouraged through engagement.

> *I felt my son just attended the sessions because he had to. That was sometimes very frustrating.* (IEW1 other)

A young person from another family felt that compulsory participation would not work for children, especially teenagers, because they did not feel any need to participate or foresee any benefits from participation.

> *You can call it the opportunity to come or not. I feel like if you said that the family has to be there, a lot of the children, mostly the teenagers, old ones, they feel trapped. They …. close up. But I think if they give them the opportunity to come or go, then they may go …. but they also may give it a shot and actually try a little bit. Well, I need to think of that, that would be beneficial to me. I need to help myself to go through these things and do them properly, basically. Because her [the therapist's] job is based on what we say in our responses and how truthful we are. So I try to do my best on my side so she can help us as a family.* (IEW1 Pāk #3 sibling)

This young person also commented on how the therapist could have talked more about herself to enhance connection.

> *Maybe [the therapist] perhaps could have introduced herself a little bit more. She did introduce herself, but she did a very small one, which I understand, because she's here to help us. I think it would have been nicer to know more about her.* (IEW1 Pāk #3 sibling)

Working with young people, whatever their age, requires the ability to meet them on their own ground and relate well to them. Therapists need to know what the young person wants and to engage in the right activities in the therapy.

The strength-based approach was also mentioned by the Pasefika cultural framework creator as the core principle for approaching Pasefika aiga. He emphasised therapists' curiosity about the importance of culture and religion, the need to think beyond the FFT-CG model, and the humility necessary in working with Pasefika aiga.

> *Rather than pushing [the] FFT-CG line only, ask Pasefika families for their solution to the challenges they face. Let families come through with their own solutions.* (IEW1 Framework Creator)

The Pasefika Cultural Advisor also emphasised that solutions and strategies must be led by aiga:

> *The Uputāua framework is saying we've got to make sure that the skills and the strategies that we're offering to Pasefika families are family-led. We identify*

> *Pasefika strategies and techniques and let them be led by families for what suits them and what matches their family dynamics.* (IEW1 Cultural Advisor)

The need for this approach was reflected in an interview with a Pākehā family. The family pointed out that the therapist did not really get the 'culture' of the family. She started therapy without a thorough understanding of family dynamics. The parent expected that understanding from the therapist, and when the understanding was not there, she felt she did not have a voice.

> *There was a number of times we had to point out that this is the [nationality of the family] way of doing things and there are a couple of other things and we thought she knew because with the [therapist's national] background, but no you don't.... So my children are mainly home schooled. They have been raised to have bit of an opinion and their opinions are important. That's part of my culture and that's how they've been raised, now I just felt a bit shut down. .... It's very important that they speak for themselves, as much as it was for my husband and I. ... . It was just like 'Hold on. You haven't taking a moment to find out who we were and our culture.'* (IEW1 Pāk #3 mother)

The index client pointed out that it would be difficult for a therapist without international experience.

> *Someone that has been to other countries will see that hey this is not a kiwi family.* (IEW1 Pāk #3 child)

When the therapist received this feedback, they quickly acknowledged their error and showed respect for the family, which was well received. This aligns with the principle described above by the framework creator.

> *But as soon as we raised it and say it is our [nationality of the family] way it was 'oh OK'. She respected.* (IEW1 Pāk #3 mother)

> *She's being respectful of others and possibly emulate the [nationality of the family] way, just like we do things with differences. I'd say she respected.* (IEW1 Pāk #3 index client)

'Genuineness without judgement' was identified as a common approach to both Māori and Pasefika cultural frameworks in the Wave 2 evaluation. Whānau appreciated the genuineness of the therapists and their non-judgemental sympathetic attitude towards the family's situation.

> *The way our counsellor approached us felt quite natural. And there weren't any moments of awkwardness where the counsellor was saying something or doing something or I felt 'hang on a minute that's not right'. It was never that. I think I think the approach is very gentle and it worked perfectly.* (IEW3 Pāk 2)

> *And this person making a judgement in one interview whereas [therapist's name] didn't do that. She wasn't judgemental at all.* (IEW3 Pāk 1)

One whānau described how the therapist approached them in a simple yet comforting manner, like a family member. The therapist shared her stories with whānau, got on well with whānau members, and elicited positive emotions.

> *She made us feel comfortable with her. She told us about her past experiences. Whenever she would come up, always have the hots for my kids. They would sit around the lounge and they would listen to what she said. I have two daughters that really took on board what she would say. She's just so nice and the way she dressed and everything was just welcoming and warming and just a cool person to hang around.* (IEW1 Mā #5)

Genuine care for the whānau during the COVID-19 lockdown really touched them.

> *When it was the COVID lockdown, we were just off work and had to stay at home and she was there. She was there for me and my family, just because we're going through this scary lockdown. She just always rang, just always ringing, she wasn't saying I am going to ring back at this time. She just rang.* (IEW1 Mā #5)

Therapists also need to be flexible and patient to stay on the journey with their clients.

> *The acknowledgement that this is a pilot and their families are still in contact with us and progressing and having sessions, or getting better at a slower rate. We're not just going to arbitrarily kind of say 'you're not tracking how we would expect, goodbye'. Certainly, that flexibility has helped.* (IEW1 Management 3)

> *Three families that I have closed had not successfully completed anything before and the only reason that they have is because I haven't let it go. If we just closed at the expected timeframe, then we're just another bad person that's given up on them.* (IEW1 Therapist)

Flexibility is also evident in the therapist's willingness to work around the clients and their convenience. All whānau and families interviewed agreed that having therapists come to their home rather than the families attending the therapists' office assisted in the effectiveness of the therapy, as therapists' workplaces often have negative associations. Conducting the sessions at home enables therapists to observe daily interactions among family members, reduces the burden on families, and helps them feel relaxed and open to the therapy.

> *The office was very artificial, very negative.* (IEW3 Pāk #1)

> *[Home is] the family's comfort zone. With younger children, if they were taken somewhere, it could be quite daunting, especially in a treatment environment.* (IEW3 Pāk #2)

> *It has been better in a home environment rather than going into a meeting room. I think having it in your own personal space enables the children of the family to be more relaxed .... it enables the person involved to see the true interactions.* (IEW1 Pāk #3)

One family noted that their therapist also chose suitable times to have sessions with the family. This is particularly helpful for families on low incomes, as it eliminates any fiscal trade-offs.

> *Working around family times – that's really awesome. I did not find myself having to take time off work.* (IEW1 other)

Cross-generational disagreement in families about the therapeutic approach and whether the treatment has been successful have occurred a number of times. They confront therapists with a difficult challenge. The Pasefika Cultural Advisor described this problem in the Uputāua context.

> *She was considered, you know, youthful when she's in the presence of the elders, and I mean of the parents of the family. Her challenge was how can she still be able to relate to the young person in that youthful way that you do as a Pasefika person to another Pasefika person, but not in a way that undermines the parents.* (IEW1 Cultural Advisor)

The problem is not unique to Pasefika aiga. Two Pākehā families experienced cross-generational tension during their interviews. One Pākehā parent disagreed with her child about whether participation in the treatment was voluntary.

> *Can I just disagree? As a parent, we can insist [child's name] stay the course. You are under 18 …. You're in [a] space [where] you did not want to be involved. You REALLY did not want to be involved. We said 'you have to because you're under 18'. We do believe you benefited from it.* (IEW1 Pāk #3 parent)

The young person of another Pākehā family thought that the programme helped him, not his dad, and disagreed with his dad about the type of improvements in the family.

> *It was able to help just me. That's the main thing. I don't want it just to help ME. I want it to help HIM too, because I don't think that I could improve if he can't. If I improve and he is still the same, I think I'll just bring it back to him*. (IEW1 Pāk #1 son)

This young person was not happy and experienced the service as targeting young people and not their parents, in contrast to the principle of involving the whole whānau/aiga/family in Pae Whakatupuranga I FFT-CG.

> *I feel because it is mostly specified on younger people. They've got to change young people, that's what they specialise in. So, they are good at that … I think I feel like it was specified on me, for me to improve…. I might be more polite to him, a lot more, the way he wanted me to be. That doesn't make me happier.* (IEW1 Pāk #1 son)

The solution to this problem suggested by the Cultural Advisor is based on the concept of 'family alliance' discussed by the Uputāua framework creator.

> *As a somewhat young person myself, I know that there are clear expectations on how to behave. When I'm behaving outside of that, I'm seen as difficult or rebellious. And so, one of the things is changing their [parents'] response to the*

> *young person in order for the young person to change [their] behaviour. Use the elements of FFT to highlight the fact that everyone has a role to play. And when everyone has the best interests of the young person at the centre of what they're doing then they're more likely to come on board with the behaviour change.* (IEW1 Cultural Advisor)

The Cultural Advisor gave an example of involving the young person in the activities of the Ekalesia (church) where the parents are active members. That will help the young person increase family quality time and strengthen the relational bond between the young person and the family. It will be satisfying for the parents because they're taking part in it and building a community connection.

Another parent was not happy with involving both parent and child at every session.

> *I actually thought there would be some one-to-one sessions. All our sessions were done together. Each time we met it would be my son, myself, and the therapist in the conversation …. Having more one-to-one sessions as opposed to having the youth there all the time will help. I know it's a family therapy thing, but parents need some time to be asked how things are going and also to be asked about what we need to talk about.* (IEW1 other)

1.2.3 Therapist cultural training and supervision have been very effective and helped progress

All interviews with management, therapists, and referrers highlighted the importance of cultural training and supervision in building the therapists' competence and confidence in approaching whānau/aiga/family. The dominant theme from interviews is that therapists connect with their clients more readily and more deeply after cultural training.

> *I mean, this particular programme has these frameworks wrapped around it. And the education and the training that they've done with the therapists have been really intensive. And I think as a result this particular team can connect better because they've got the training behind them.* (IEW1 Management #6)

The Pasefika framework creator gave an example of the aiga's reaction during the experiential training for the therapists (this training is described on pp 38 above). The aiga had varied responses when they saw the therapists trying on lavalava, ranging from a quiet witnessing of the therapists' attempts to giving permission to them to just be themselves and not have to wear lavalava. The aiga gave positive and honouring feedback to all the therapists when they witnessed their cultural sensitivity. The therapists' knowledge and application of Pasefika cultural practices made a good impression on the aiga, which created an entry point for connection. Further, allowing aiga to decide whether to continue with therapy, put the aiga in charge and empowered their decision-making.

The cultural training provided by Whaitake Whakaoranga Whānau and Uputāua went beyond teaching the therapists practices such as wearing lavalava or removing shoes. The intensive training enables therapists to understand the principles and values of Māori whānau and Pasefika aiga, so they can understand and respond appropriately to the needs of their clients.

> *Having the Uputāua model helps workers to navigate the cultural terrain. The response from the aiga was positive. They said that they respected the therapists' efforts to be culturally sensitive.* (IEW1 Pasefika framework creator)

One manager described how her cultural competence resonates with whānau, even though they are of different ethnicities. This experience has had an empowering effect on both the therapist and the whānau.

> *And I have to say for the first time ever, I'm having sessions [where] we were using whakataukī. We are talking about how to apply some of those to the family understanding of themselves and how do they build up this sense of whānau or, you know, what are their values, what strengthens and upholds the manner in a way that feels really comfortable to me. And in a way, I've never attempted [this] before because I've always keenly felt my 'Pākehā-ness' and not really felt entitled to have those conversations and they've responded so well. And although they themselves probably wouldn't identify as being fluent in te reo or as comfortable with tikanga, they have like soaked it up and really flourished.* (IEW1 Management 3)

Ongoing cultural supervision provides a platform for therapists to exchange their experiences, seek support, and share stories in understanding and applying cultural practices. One therapist mentioned that cultural supervision helped her to stay connected with the aiga during the restrictions imposed by the COVID-19 lockdown.

> *For me personally, [what is helping you in dealing with COVID] it is access to cultural supervision for Pasefika families. We were really having to navigate working with Pasefika families in this new environment without being able to meet in person and having access to cultural knowledge.* (IEW1 Therapist)

This experience was confirmed by a manager:

> *Enhancing the therapists' cultural confidence through knowing that they have regular supervision or a relationship now with a Cultural Supervisor who they can turn to and just ring up and be like, 'Hey, here's what I'm thinking' and get some support. I think it's made them more confident stepping into those spaces.* (IEW1 Management 3)

Other therapists explained that because every whānau/aiga/family is different, they are there to learn about their experiences and increase hope for their clients. Cultural supervision assists them along the journey where clients have a variety of backgrounds and cultures.

> *Cultural Supervision reminds me that I am not an expert on the family, I am there to learn about their experiences … We do that in a genuine way. We are able to do that more strongly with the backing of our Cultural Supervisor.* (IEW1 Therapist)

Cultural training and supervision are one of the distinct features of Pae Whakatupuranga I FFT-CG.

> *I think it would be fair to say that the cultural support and training has perhaps provided scope for families who may have through their own experience expected*

a type of practitioner that may not have been as thoughtful around their own family values. So, I think the model itself really encourages therapists to match to family culture and family function. (IEW1 Management 3)

1.2.4 Effective collaboration across all stakeholders has helped progress, though organisational complexity is sometimes an issue

Almost all agency interviewees expressed their deep appreciation of the committed participation from all partner agencies. There has been excellent buy-in from all the stakeholders that are part of the programme. Notwithstanding this, each partner organisation has their own priorities, interests, and pressures and operates a range of programmes and activities in their specialisation; this means it can be challenging to ensure smooth and ongoing participation from all stakeholders.

The Steering Group

One manager was very impressed with the participation of Steering Group members, who represent the three major agencies, the service provider, and FFT-LLC. There was good attendance and contribution of feedback and ideas. There was no holding back and everyone seemed to be up to date with the progress of the programme.

> *In the Steering Group, I get really good buy-in from Steering Group members. We just are really collaborative. When they do have input, they say it. When they don't, they're happy. And so far, it seems like we've all been on the same page. So that's been really helpful.* (IEW1 Management #6)

YH management strongly agreed with this view. The members of the Steering Group are at senior levels in their organisations and can drive the strategy forward in their own organisations. All are committed to ensuring that the project will succeed.

> *This is the most collaboration I've ever seen in a project where there is high degree of responsiveness by those that are involved in [the] Steering Group.* (IEW1 Management 4)

> *When the Steering Group comes together [there] is a lot of shared enthusiasm across the different agencies …. It seems that everyone's on board with it and committed and invested in it.* (IEW1 Management 2)

> *The partner agencies have been highly attentive to feedback of our experiences. Leadership are 100% committed to making this work. And Steering Group is very supportive.* (IEW1 Management 3)

The Referral Coordinator described the rapid responsiveness of senior management in the Steering Group as extremely helpful for someone without inside knowledge of other stakeholders' organisations.

> *It's anytime I want to speak to someone, 'hey, who do I need to speak to? How does this aspect of your organisation work?'. Because I'm not a former Oranga Tamariki social worker or former police, I don't know all the internal workings. There's always been someone very happy to answer any of my questions in that*

> *regard and that has been helpful in helping putting the programme in places.* (IEW1 Management 5)

Therapists similarly provided highly positive feedback about the Steering Group's support. They felt that the Steering Group understood what they were doing and encouraged their efforts, and this meant a lot to the therapists.

> *They [Steering Group members] are really supportive. They want the best for us. They see the reasons why we're doing this and why the model can be so beneficial.* (IEW1 Therapist)

Only one YH interviewee thought Oranga Tamariki took a dominant role in the Steering Group. They felt that it was not clear whether this dominance, mainly due to the ownership and funding of the project resting with Oranga Tamariki, was helping or hindering progress.

> *OT is leading it, so they have to push …. forward. So that's why I didn't give it a five [highest evaluation level] because it's not a fully collaborative model because Oranga Tamariki kind of owns it. We were involved, but they are the drivers*. (IEW1 Management 1)

All referrers except one expressed the same appreciation of the high level of cooperation in the Steering Group.

> *I've been to two of those board meetings. It's very collaborative. Everybody had a voice at the table: everybody had an opportunity to contribute.* (IEW1 referrer #2)

> *We continue to go [to] those Steering Group meetings because of the level of coordination, support resources that's being put into us. I feel like there are the right people at the table.* (IEW1 Referrer #5)

The one negative response came from a referrer who did not receive enough communication from YH about the client's progress. He thought this might be caused by a difference between management's understanding and the therapist's practice.

> *Management may have a different understanding about their practice or policy or strategy whereas [the] frontline clinician works differently.* (IEW1 Referrer #4)

In explaining his position, he said that the programme design is very good, but the lack of communication between the referrers and the therapists is a problem in its implementation. (This issue is discussed in more detail in section 1.4.4 below)

> *The programme itself, I don't think any problem. A problem is the way we implement that programme, the way we can't communicate between the social worker and clinician. Absence of communication. Absence of feedback from the clinician.* (IEW1 Referrer #4)

This is an example of how insufficient collaboration across referrers and YH could undermine progress at the first stage—referral. The referrer was primarily concerned about his responsibility with his client.

> *From my perspective, I always emphasise better communication and interaction with referrer and clinicians. As a referrer, I want to get an update and closer contact with a clinician, because as a social worker, I have to provide regular report to [the agency] which means I do need the input or feedback from clinician.* (IEW1 Referrer #4)

He communicated his opinion during a site visit by YH management. However, he still received the discharge report six months later than the actual discharge by YH. The referrer pointed out that better collaboration at ground level among whānau/aiga/family, the social worker, and the therapist will help resolve problems and achieve better outcomes.

> *Therapists and social workers and client families work collaboratively to achieve their goal. If one part fell out it doesn't work … [I wanted] more frequent contacts with a social worker and a clinician to know whether we are on the right track or off track. If a young person doesn't engage with a clinician, we should have been informed about the situation. And we [should] sit down together, find out how we sort out the situation rather than getting permission late in the process.* (IEW1 Referrer #4)

This referrer has stopped making referrals to Pae Whakatupuranga I FFT-CG because of his experience. Although this response is an exception, it highlights how important it is to have aligned collaboration across all stakeholders in the programme, from top management to front line therapists and referrers.

Organisational complexity can slow intake and time for treatment

Even with the exceptional commitment displayed by all the partners in the programme, significant time and effort has been expended in adjusting and aligning processes across the players at the different stages of treatment. For example, initially there was no position allocated the responsibility for coordinating referrals; the Referral Coordinator proved to be a critical point of contact for effective communication within the programme[11].

1.2.5 The challenges of socio-economic disadvantage and previous discrimination are likely to have hindered progress

Whānau/aiga/families are referred to Pae Whakatupuranga I FFT-CG by three organisations—Oranga Tamariki, Police, and Corrections—whose clientele often experience highly disadvantaged social and economic circumstances. Interviews with whānau and comments about aiga in interviews with therapists, the Cultural Advisor, the Pasefika Cultural Supervisor, and YH management highlighted how these disadvantages undermine the impact of therapeutic treatment. Pākehā families were less affected by socio-economic disadvantage than whānau and aiga.

[11] As noted above, the Intakes Specialist role has replaced the Referral Coordinator role.

Housing

Unstable and/or expensive housing is a systemic issue that affects the majority of low-income families in Aotearoa/New Zealand. Lack of stable accommodation can affect a client's ability to enter the programme, as the selection criteria include a requirement that the index client lives with the most significant adult person/s in their lives, usually their whānau/aiga/family. This issue was canvassed at some length in the Wave 2 Formative Evaluation Report.

If the client is accepted for treatment, housing challenges can destabilise progress. As an example, two whānau identified their housing situation as an important factor in achieving their whānau goals. The first expressed concerns about the next stage of transitional housing as the parent had a limited understanding about the situation. All she knew was that she and her children will stay in a temporary place for 12 weeks and, if everything is fine, they will get a social housing place. The temporary place has many social restrictions that could trigger tension among whānau members.

> *I still don't have a little bit of understanding about it…where they will house us for 12 weeks and then If we go by everything, we'll go into our own place. That's gonna be the hardest part though because this transition housing, you don't have visitors; there's no internet. They [the children] are going to be in my face all the time. So that's gonna be really tough.* (IEW1 Mā #2)

The other parent mentioned how relieved she is to be no longer in emergency housing and can now focus on improving relationships with her children.

> *Yeah, I'm in a bit of a better space now because I'm not in an emergency house. I was always on call to Work and Income [WINZ], like what I was doing and everything because I was in emergency housing. So, it was quite frustrating. But I'm in a place that I wipe that off my shoulders to focus on my priority, my children*. (IEW1 Mā #4)

One therapist described the challenges of engaging with whānau/aiga/families who do not have stable housing. Another described the difficulties in keeping contact with the family after they moved out of temporary housing.

> *There have been significant delays in being able to engage with them because they've kind of disappeared from the emergency housing. It's like 'where have they gone?'* (IEW1 Therapist)

Another therapist had a highly challenging client who had moved houses many times and had a history of disengagement.

> *I have one family they've moved about four times now. Every other service that was involved with them was closed because they just can't engage.* (IEW1 Therapist)

Accessing and coordinating other services

The Cultural Advisor pointed out that the therapy should recognise the impact of life struggles on aiga, because they are recurring and undermine the resilience of aiga.

> *We can't expect to support a family in isolation of the issues that impact on their lives. It's only maybe one hour a week or so that they are in therapy. And they go back into that reality of the struggles.* (Pasefika Cultural Advisor)

Therapists admitted that they cannot 'fix everything', because their clients' systemic issues are beyond the programme's capacity.

> *Like [if] the system around us supports functional family therapy to support families to live safe, happy, and healthy lives it would be much more effective… The system is not perfect, these families aren't perfect.* (IEW1 Therapist)

However, the Cultural Advisor felt an obligation to access social and economic interventions to help aiga, for example in relation to their housing problems.

> *They [therapists] have a role to play in helping the families at risk, the systemic issues that they come with. For example, if they pick up on a family that has housing issues, they have a role to support the family through a referral process to Pasefika housing initiatives.* (IEW1 Pasefika Cultural Advisor)

Similarly, one manager believed that referring agencies should be part of a web of social and economic services to ensure that clients achieve their desired outcomes in areas such as education and employment.

> *Like the Youth Justice coordinator, the team that surrounds that young person probably are highly involved in that space as well. I think it's like the sliding scale across the services of how intensively are we working in that space to create opportunities or connect young people to those services. How much have we initiated that versus wrapping around and supporting the momentum of what's going on in this space?* (IEW1 Management 3)

The involvement of other social services may also be a necessary condition for a family's success and the challenge of coordination across services is familiar to everyone who works in social service delivery. For example, one whānau completed Pae Whakatupuranga I FFT-CG but could not move forward because they were still waiting on the response from a social service. The therapist was keen to help the whānau but could not do anything, even though the service was provided by Oranga Tamariki.

> *Well, that's what Oranga Tamariki needs to be doing [arranging for the speech therapist], but we haven't heard anything. They came in with a big bang, 'we're going to do this like gonna do that' and we've gone on a couple of months and I, we had COVID-19 and that kinda slowed [things] down. But then it started up again and then it's just gone. And at the moment, we're just waiting on Oranga Tamariki so there's nothing actually anyone can do.* (IEW1 Mā #1)

Mental health support, similarly, is often difficult to access in a timely manner to assist young people in distressed whānau/aiga/families.

> *I feel like they [therapists] are still under-resourced to get those young people support when they need [it] or other family members as well when they need it and [I] understand that's a result, some of the mental health system is outside of this programme but additional support there I think would be good. Families*

> *would benefit from that additional support, whether that's because of ADHD or autism or an intellectual disability in the family.* (IEW1 Management 5)

These examples demonstrate that therapists need to be connected to a system of social, economic, and health support services in order to achieve good social and economic outcomes. This is a real challenge, both at the personal level of the therapist and at the organisational level of YH. YH management is of the view that resolution will require thorough discussion and planning with Oranga Tamariki.

> *…where it's [family problems] embedded in a much bigger piece of transformation for families around employment and housing, debt relief and so on, and I think we'd see more potent outcomes for specialist intervention like this effort seated within a broader context of change for the community …. if we want to make it very effective. That would benefit from …. being part of an integrated programme that supports the family.* (IEW1 Management 4)

Client motivation, 'life struggles', and requirement to participate may also impede progress

As mentioned above, clients are likely to experience social and economic disadvantage. They are also likely to have experienced similar services before. This situation presents real impediments to engagement, which is the key to successful completion of the treatment.

> *But I suppose the engagement aspect by either the young person or their parents or caregivers is a key aspect to it all.* (IEW1 Referrer #6)

> *I know how hard it is to get people to complete treatment programmes and group work and therapy and stuff like that with this kind of cohort, so I can remember thinking it's not gonna be that easy. (*IEW1 Management 2)

The challenge for Pae Whakatupuranga I FFT-CG is even greater, because the programme requires the engagement of all members of the family. For example, one family thought it was possible that the young person did not want to participate because another family member did not join the sessions.

> *Between my son and I, I don't know if it is to do with my partner because he wasn't involved in the family therapy, he didn't want to be involved. I don't know whether that was the case - maybe my son saw that my partner wasn't involved.* (IEW1 other)

All management interviewees recognised that motivating clients is the responsibility of the service provider. However, sparking the interest and motivation of the whānau/aiga/families can take many sessions.

> *If they [whānau/aiga/families] can do that through to completion, it [the model] feels like a really good fit as it teaches the right skills and it is sufficiently fluid to be able to accommodate different families' ways of being. But the tricky thing is getting them to do enough sessions to have that dose.* (IEW1 Management 1)

Clients' lack of engagement is evidenced in the high rates of drop-out and 'never began' cases (Tables 7 and 8).

Table 7: Reasons for clients never beginning treatment

	Never began	(%)
Criteria not met	13	27
Declined services	18	38
Never attended initial appointment	2	4
Not able to contact	8	17
Conflict with other treatment	6	13
Youth whereabouts unknown	1	2
Total	**48**	**100**

Table 8 below sets out the reasons for clients not completing treatment after beginning the therapy. In this evaluation, there is a marked increase from the previous two evaluation phases in the proportion of clients who did not complete treatment. The proportion of 'drop-out' cases for this wave is 24 percent and 40 percent for 'never began' cases. In the Wave 2 evaluation, the proportions were 11 percent for drop-out and 33 percent for 'never began'. In the Wave 3 evaluation, the proportions were nine percent for 'drop-out' and 36 percent for 'never began'.

The proportion of treatment failure in 'drop-out' cases has also increased from 40 percent in Wave 2 (four of ten cases) to 59 percent (17 of 29 cases) in this wave, almost the same proportion as Wave 3 of 60 percent (three out of five cases). Pasefika are most of the clients in this situation. The next impact evaluation will show whether these proportions are a result of the low numbers involved, or whether they continue to comprise a significant proportion of the client base.

Table 8. Reasons for clients starting but not completing treatment by ethnicity

	Not treatment failure				Treatment failure			
Reasons for drop-out	**Māori**	**Pasefika**	**Pākehā**	**Asian**	**Māori**	**Pasefika**	**Pākehā**	**Asian**
Administrative discharge*	1		2					
Juvenile Justice Placement	1							
Moved prior to completing the programme	1	2	2					
Quit after at least one session					2	9	3	1
Youth referred to other services		1	1	1				
Runaway					1	1		
Total	**3**	**3**	**5**	**1**	**3**	**10**	**3**	**1**
	12				**17**			

* 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.

Interviews with YH staff suggested several reasons for this situation. The first was the 'life struggles' of whānau/aiga/families, especially in relation to housing, discussed at the beginning of this section. In Table 8 above, five of the 12 who dropped out for reasons other than treatment failure moved before completing the programme.

> *There is a huge issue—housing. I've had two families drop out. Both were in emergency housing … We've got a family of five in a motel room. It's an awful way to experience living when you don't have a base to call home … Some [have] just moved out of the area because they can't get housing in Auckland. I still think about them and wonder what has happened to them.* (IEW1 Therapist)

> *It was no fault of their own there have been significant delays in being able to engage with them because they've kind of disappeared from the emergency housing.* (IEW1 Therapist)

Even when the clients remained in the same location, stress from housing problems often prevented them from engaging properly.

It is a barrier for us to engage families when these families [who] do not know where they are going to live when we expect them to meet and do therapy and to concentrate on that. It is hard. (IEW1 Therapist)

The second major cause was the reluctance of index clients and their whānau/aiga/families to participate in the programme. Management and therapists reported that most Corrections referrals did not begin treatment (58 percent of Corrections referrals). The largest proportion of Police referrals also do not begin the programme (37 percent).

The largest proportion of Oranga Tamariki YJ referrals dropped out (48 percent of YJ referrals).

Table 9. Pae Whakatupuranga I FFT-CG case status as at 23 November 2020

	Referred	Never began	Dropped out	Completed	Active	Total
Corrections	1	22	6	2	7	38
	3%	*58%*	*16%*	*5%*	*18%*	*100%*
Oranga Tamariki	1	5	12	5	2	25
	4%	*20%*	*48%*	*20%*	*8%*	*100%*
Police	4	21	11	10	11	57
	7%	*37%*	*19%*	*18%*	*19%*	*100%*
Total	6	48	29	17	20	120
	5%	*40%*	*24%*	*14%*	*17%*	*100%*

In terms of dropping out of the programme, the Referral Coordinator, a manager, and the therapists explained that the tendency for Corrections referrals to drop out was due to the Court's requirement for referrals from Corrections to attend family therapy for a short period only. The Referral Coordinator described this as a 'confounder', because the whānau/aiga/families would no longer be required to complete the therapy when the period expired.

Whatever requirement that they're under means that they no longer have to complete it, [they have] a lower level of motivation, and then those families tend to not get to that final completed stage. (IEW1 Management 5)

One manager described this short period of participation as 'tokenistic' because as soon as the agreed Family Group Conference (FGC) plan ended, clients did not want to complete.

All the messages we were getting was that things are okay, we [clients] are going to close this FGC plan and then then we don't need to do FFT anymore. We [therapists] have to take responsibility for building internal motivation to do treatment, but it's frustrating when the environment is kind of pulling away and affirming independence and families say 'well, we're done with everything'. (IEW1 Management 3)

This may also be the case for referrals from Oranga Tamariki YJ who attend as a result of an FGC. One manager cited examples from her experience of clients who had FCG plans that expired in three months as highly challenging to engage. However, the team

were willing to invest their time and effort to establish engagement. Those who had FCG plans that expire in one month were most likely to drop out of the service.

> *When we receive a Youth Justice referral and if there is an FGC plan that's expiring in three months, we make a commitment to trying to allocate that as soon as possible. That's the most responsive thing we can do. We're going to give it 110% and try our best to build that internal motivation. I would never condone going with only one more month on the plan. History tells us that they're going to drop out as soon as that plan is finished.* (IEW1 Management 3)

A further cause of non-engagement and non-completion is the effect on older clients of more years of difficult family relationships.

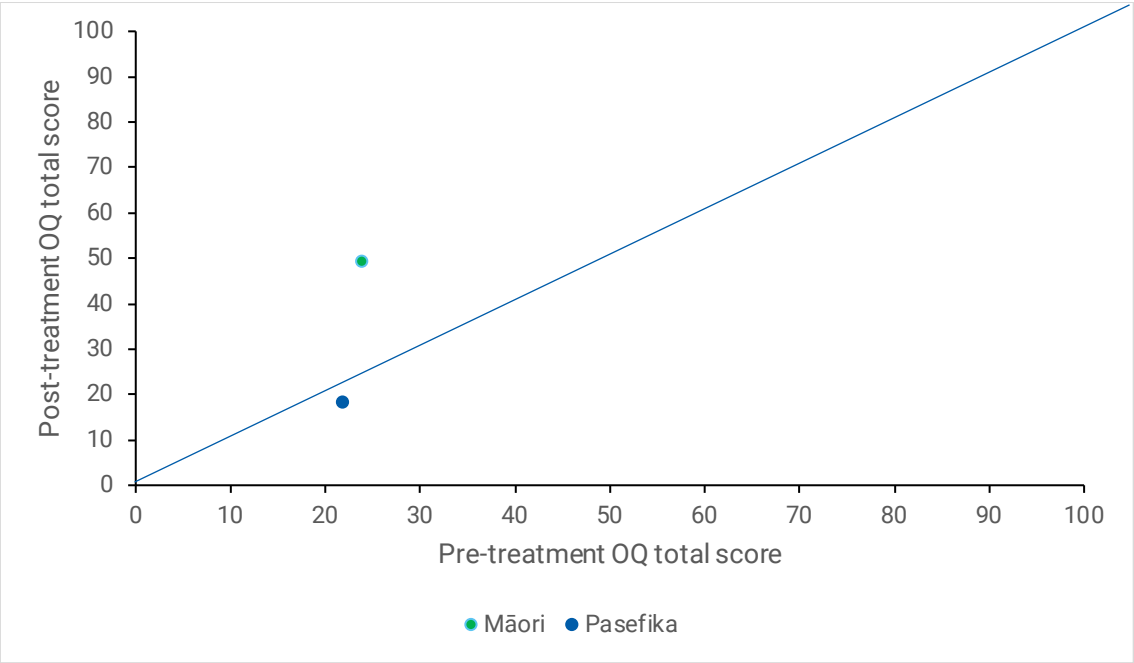
> *Some of the referees are of the older age range. If their recall [probation] date ends and if the special conditions do not include family therapy the clients are very difficult to motivate to join the FFT programme. If they were a bit younger it would have been more beneficial. As they are older its more difficult to repair broken relationships. It takes a lot more effort to get them on board through the engagement phase.* (IEW1 Therapist)

This was supported by data on outcomes for clients over 18 years old. Figure 7 gives data on OQ (Outcomes Questionnaire) total scores completed by young people over 18 years old. The OQ scores completed by their parents/caregivers are not available[12]. Levels of distress are described as follows: *high* is anything above 105, *moderately high* is between 83 and 105, *moderate* is between 64 and 82, and *low* is a score below 64.

Only two clients more than 18 years old have completed both questionnaires (one Māori young person aged 22 and one Pasefika aged 20). The Māori client had an increase in their OQ score from 24 to 49. The Pasefika client reduced their OQ score from 22 to 18. No generalisations are possible from this very small sample.

[12] The 41 data points of pre-treatment OQ total scores for parents/caregivers include parents/caregivers of two completed cases of clients aged more than 18 years old and other completed cases whose clients are aged less than 18 years old. However, the 10 data points of post-treatment scores only correspond to parents/caregivers of completed cases whose clients are aged less than 18 years old. There are no post-treatment scores for the parents/caregivers of those above 18 years old.

Figure 7. Total OQ score by young people over 18 years old



Source: OQ website accessed 30 Nov 2020.

The interview with a referrer from YJ highlighted the challenge of interacting with an individual who may wish to reject any further engagement with the state, which they may perceive as punishment rather than assistance.

> *Essentially it [a sentence case for referral] is one person on to us and they [young person] are the ones that have conditions to report to us, that engage with us. So that's a tricky one. It's not like they'll be willing sometimes. It takes us a while to engage with that young person and kind of convince them that we are with them and help them. (*IEW1 Referrer #2)

This referrer also described the pressure of engaging the young person sufficiently so they would accept the suggested referral in the constrained time before the sentence expired.

> *So, it is about us building up our engagement and then getting them to the point in their sentence whether or not they've got enough time in this sentence for us to kind of build enough support to refer them so they are successful. With young people, it takes some time to build that rapport.* (IEW1 Referrer #2)

In other cases, the whānau/aiga/family may no longer be willing to engage. One manager stated that the clients from YJ were more challenging than the others, because the intra-family conflicts were so entrenched the parents had lost any incentive to participate in therapy. The parents may feel that the young person's offending

behaviour is their fault, rather than a family responsibility. The parents do not exhibit the same level of investment in engaging and changing family dynamics as other families that YH is more familiar with.

> *I think too often families have experienced the strain of a young person's offending behaviour through Youth Justice as intolerable over time and [are] less invested in trying to help the young person. They [have] often reached the end of their tether. (IEW1 Management 4)*

Interviews with one whānau supported the analysis above of the challenges posed by uninterested whānau/aiga/families.

> *Providing the families are open, open with the therapist because not everyone will be like how we are. We were open to it. We haven't experienced that before but we were going for anything that could help. But not every family will be like how we are. Not every parent will agree to it. Some are frightened to make the step.* (IEW1 Mā #3)

From a management perspective, unmotivated whānau/aiga/families strained the whole system: they consume scarce resources that could be used with more motivated clients.

> *Because the stakes are high, they [therapists] are really trying to keep engaging them. But of course, that means that family who is really not engaging fully holds a space that could be for another whānau that you might be able to progress with.* (IEW1 Management 1)

This presents a dilemma for the service provider.

> *There's tension during the intervention between to take on the most reluctant, not very well engaged young people and families because that [they] often are the ones that need it the most; and really being present and persevering to get them engaged; versus being a bit more selective about which families and young people, you select to work with ones who would be more engaged and therefore more likely to be successful and more likely to attend all meetings. I don't [It doesn't] quite get landed where we want to be.* (IEW1 Management 4)

1.3 Unintended consequence

1.3.1 Acquiring transferable knowledge and skills

The programme has added to YH's knowledge and skills across several dimensions.

Cultural responsiveness: YH as an organisation has worked hard over many years to increase its responsiveness to Māori; Whaitake Whakaoranga Whānau is giving their managers and therapists the skills to oversee and deliver family therapy in a way that accommodates and incorporates Te Ao Māori. Uputāua is teaching and training staff in understanding and incorporating Pasefika worldviews in the management and practice of family therapy for Pasefika clients. Uniquely, YH therapists will be able to weave

together the three main cultures in Aotearoa New Zealand. One manager was sufficiently impressed with the competence achieved through the accommodation of Māori and Pasefika cultural worldviews that she has suggested incorporating cultural training and supervision in all other FFT programmes.

> *I know I jump ahead of myself all the time. I think they [YH] could actually roll it [the interweaving of Māori and Pasefika cultural frameworks into] all of their FFT teams. It would be really helpful….. I'd like to see the same level of support and training for all their therapists.* (IEW1 Management #6)

Inter-agency understanding and cooperation: Implementing the programme has given YH a greatly increased understanding of the operations of three major government agencies in the areas where their work touches YH. It has also given YH a much deeper insight into the subtleties and complexities of engagement with a cohort of whānau/aiga/families whose multiple disadvantages and challenges require nuanced attentiveness and developed self-reflection on the part of the therapists who work with them. One manager considered these skills would improve the quality of other YH programmes.

> *The things we've learned about how we can do things better, how we approach our service delivery in terms of weaving cultural frameworks, and how we work with other agencies. All those things. I mean, they're not intended consequences. You learn new stuff about things you can apply elsewhere.* (IEW1 Management 2)

1.4 Improving programme effectiveness

Suggestions in this section are drawn largely from interviews conducted for this evaluation. They bring together the issues that have already been canvassed in the material above.

1.4.1 Refine the selection of therapists

Therapists are a critical component of Pae Whakatupuranga I FFT-CG. The intensive training and special requirements of weaving Māori and Pasefika cultural frameworks together with FFT Standard have been a real challenge for the therapists. Turnover is reasonably high for the programme.

> *I think if you can somehow sort of retain staff. That [turnover] is what seems to sort of upset the apple cart. A weeper is when you have to change therapists.* (IEW1 Referrer 6)

Interviews with YH management have highlighted the need to recruit 'the right people for the job' who have persistence, knowledge, and commitment. Suitable therapists need to be familiar with the cultural worldviews of Māori and Pasefika. Therapists and the Cultural Advisor agreed that the cultural supervisor who provides ongoing support for the therapists should have both clinical experience and cultural competence.

> *I think there needs to be more in-depth questioning of the applicants around the commitment [and] strong cultural worldview knowledge would be helpful.* (IEW1 Management 1)

> *I think that we could try and recruit therapists who are more culturally strong and value that equally to their therapeutic experience or background on academic knowledge.* (IEW1 Management 2)

The Pasefika framework creator also suggested an increase in the number of frontline Pasefika workers to strengthen the team's overall cultural competence.

> *The effectiveness of FFT-CG is to increase Pasefika therapists and to support building the Pasefika team in the organisation.*

> *The best people to work with cultures are the people from those cultures, and I mean not having a singular worker or two workers of a certain culture to work with people of their culture. There needs to be cultural teams with workers of the same cultures to support each other.* (IEW1 Cultural Framework Creator)

The Cultural Advisor supported this view, noting that a Samoan therapist had recently been recruited for the Pasefika Cultural Supervisor position.

> *Once we have an experienced Pasefika therapist on board, she'll be able to work at the level in which the Māori therapist and the team is doing that for Whaitake Whakaoranga [Whānau]. [There] needs to be Pasefika staff working with Pasefika families, and a Cultural Supervisor or advisor in order to ensure responsiveness to Pasefika families. …. They've recruited a Samoan therapist. I'm not sure that she's had experience in delivering FFT previously [but] her therapeutic experience will really be helpful for delivering Uputāua within FFT.* (IEW1 Cultural Advisor)

The point that the best people to work with cultures are people from those cultures was also made strongly in the previous Formative Evaluation Wave 2[13] by both Māori and Pasefika participants. It was noted that recruitment of such therapists would not only enhance the quality of the cultural work and connections with families, but also reduce the substantial early cultural burden on Pākehā therapists. The current model expects them to become deeply responsive to three cultural world views in a short space of time. Appointing Māori and Pasefika therapists would allow them to develop their therapeutic skills and cultural competence more naturally alongside colleagues from these cultures.

It is not always easy to attract Māori and Pasefika candidates who are trained in the social sciences, therapeutically competent and well-grounded in their culture, because every other smart organisation also wants that sort of capable person on their staff. Recommendation 1b. in the previous evaluation report stated, *"Seriously consider recognised cultural knowledge and experience as whānau or aiga support people within*

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[13] Family Centre Social Policy Research Unit (2020). *Pae Whakatupuranga: Functional Family Therapy Cross Generations (PW: FFT-CG) – Wave 2 Formative Evaluation Report*, Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

their cultures as having equivalent importance as mainstream therapeutic training."[14] There are numerous examples throughout New Zealand of very competent people from these cultures who work really effectively in non-government organisations (NGOs) like YH, with whānau and aiga who are not educated in the Western tertiary sense but are well recognised as being 'go to' people for help with their whānau/aiga problems.

Retaining therapists is also a challenge, but a shift to marketing the role's unique opportunities may assist.

> *Recruitment is really hard when we are up against the cost the salaries …. it's about why would a therapist come to us or to another organisation to deliver this very challenging model, what would they get out of it? …. it's really thinking through what the benefits are to the therapists.* (IEW1 Management 1)

The recent appointment of an advisor to strengthen YH's recruitment strategy is a promising step.

> *We now have a dedicated FTE for what we call the Principal Advisor. This role has just come in to place about three months now …. her role is focused on really building, strengthening, our recruitment strategy for the organisation, and she and I have had a number of discussions about what that means for us.* (IEW1 Cultural Advisor)

1.4.2 Review treatment length and consider some limited post-treatment contact

Two whānau and two Pākehā families thought that treatment length and pace could have been more closely tailored to their needs. The two whānau felt that they would have benefited from a longer treatment.

> *Well our family has been a lot better. It [the therapy] would have been good if it had been a little bit longer. It would have helped more.* (IEW1 Mā #1)

This is especially true when the index client is moving to a new life stage.

> *I would have liked to have worked on him [the index client] a little bit more because now he's gonna be a father. I don't know what he's gonna be like with his anger, it might escalate. I would have loved to have done a little bit longer.* (IEW1 Mā #2)

One Pākehā index client also thought more sessions would have helped him to handle conflicts in his family.

> *With these problems that have gone on this long, it needs to be longer. I think it needs longer.* (IEW1 Pāk #1 son)

In these examples, family members have begun to engage with their therapists and are learning how to navigate conflict. However, they have not yet mastered the skills they

[14] Ibid p.8.

need, or become sufficiently confident to use those skills without support from the therapists. More positive measurable outcomes, such as participation in training/employment, may result from extended treatment.

Members of one Pākehā family had differing opinions about the length of their treatment. The sibling of the index client believed that it was shorter than was needed.

> *I believe it was cut short a little bit. And [the therapist] decided that, hey, let's complete this before [the index client] goes to university. Because at times I felt like that it can't be kind of crammed a lot of things in a very short amount of time.* (IEW1 Pāk #3 sibling)

Treatment did not cover the 12 weeks[15] expected by the client, and was unevenly paced.

> *She didn't have the twelve weeks…. There are some weeks where she would do only like very light stuff for a short time; other weeks she'll cram a lot of heavy stuff altogether. I think it would've been better if you just made sure it was all evened out.* (IEW1 Pāk #3 sibling)

The mother disagreed, and thought the pace of the treatment was in line with the family's progress.

> *Sometimes that's just how it pans out…. it's not about being easy, but maybe there's a hiccup in us in particular that we've had to stay home growing this one little bit and then next week [therapist is] going to try and catch up with you little bit. So that's just a work perspective.* (IEW1 Pāk #3 mother)

The family came to the agreement that it would have been better if the treatment was longer than 12 weeks but was tapered so that the family could practice the skills they had learnt and call on the therapist for support when needed.

> *.. I mean, she has always said she was there if we needed to call her. We think it would help other families maybe to get fortnightly sessions after the twelve weeks period and then maybe one month and then just depending on the assessment of the family.* (IEW1 Pāk #3)

It is not uncommon for therapists to keep in touch with their clients even after the treatment had completed.

> *[Therapist name] keeps in touch with us so it's good. She said if we need to top up on other any time [top up at any other time] just give her a call and she'll come back*. (IEW1 Mā #1)

Most whānau would welcome 'check-ins' with therapists every few months, or as needed by whānau. Therapists also gave examples of their engagement after treatment.

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[15] Youth Horizon's website: "The programme consists of 10-12 sessions, typically taking place over three months." https://www.youthorizons.org.nz/our-services/functional-family-therapy/

> *I've had a family that has completed, but I've gone to see them again just to make sure that they're doing okay. Or if they need support, they can ring me.*
>
> *Even though I'm not actively involved with them. I can still be of support for them.* (IEW1 Therapist)

This sort of follow up is clearly helpful for some families. We consider there is an opportunity for the service to encourage referrers to offer post-treatment contact with interested clients for a six-month period, as well. Referrers will have ongoing contact with a number of the clients and could be drawn in to enhance the post-treatment period.

At this stage of the pilot programme insufficient data have been generated to establish a general trend for time to complete treatment. This will become clearer during 2021, as the current therapists continue to gain experience and new recruits join a well-established programme with sequenced training, experienced supervisors, and more experienced referral agencies.

1.4.3 Expand support: link to external services and creating a client support network

Access to support services

Several clients and therapists had seen first-hand the difficulties index clients and families faced in accessing local services that could help them overcome factors that were blocking their progress through treatment.

> *If it [therapy] was coordinated with something else like that, it'd be quite good. It might be really quite effective. He had left high school and he was on a course that was alternative education. He's been trying to get back to the course he was doing to find it is completely full. There's a waiting list. That's a problem.* (IEW1 Mā #6)

The Cultural Advisor gave an example of proactively assisting aiga in need by connecting them to support services.

> *I developed a list of community support services that are operating across the country. If they [the aiga] do need further support, I can help them to contact those agencies.* (IEW1 Cultural Advisor)

As the programme matures, sites may be able to develop databases of available local support services they have found useful for their clients, so they can be shared among their therapists. We suggest that improving clients' and families' access to critical support, especially housing, should be explored at the national level.

Client support network

Many clients and therapists value the support some therapists provide once treatment is completed. One whānau suggested an alternative approach - a support network for whānau/aiga/families who have completed treatment where they could share experiences, giving and getting help from each other.

> *It would be good if there was a group that he [index client] could go to or a group that we could go to, to share, like a Support Group. They can have support there all the time.* (IEW1 Mā #2)

Creating and maintaining support networks is time-consuming, and best done at arm's-length from the service provider. If support for such a network is raised again in future evaluation interviews it may be worth further exploration.

1.4.4 Streamline and enhance the referral process

Clients, referrers, and therapists would all benefit from greater flows of relevant information from referral to treatment and beyond.

Referrers play a significant part in the programme. They are the first point of contact with clients and the first opportunity to collect information about them. The more knowledgeable they are about the programme, the more motivated they will be to make referrals and the better they are at providing useful information to clients and therapists.

> *Personally, the best referral source that I've had dealings with are those [referrers] that understand and believe in the model.* (IEW1 Therapist)

Interviews with management for this evaluation demonstrate that YH is aware that referrers may lack basic information about the programme, and have not yet realised that the programme has the potential to reduce their workloads.

> *Things can be enhanced in terms of connecting with our referrers and upscaling their understanding of the model so that when they have conversations with their clients, people are coming in knowing what the programme is. We were still receiving referrals we when we reach out that they're coming back and saying, 'Are you here to help us with WINZ, or are you here to help us get a job'. They don't really know what we do. So, we kind of start on the back foot*. (IEW1 Management 3)

> *It feels to me when I have interactions with them [probation officers], they believe in it. When I've done site visits to do meets and greets and explain the programme, they have been the most enthusiastic and welcoming.* (IEW1 Therapist)

The Referral Coordinator pointed out that referrers will determine the interest of whānau/aiga/families in coming to the programme.

> *I'd say, making sure that there was a close relationship with any referral organisations that were around. I think that's going to be the biggest determinant of success in terms of getting established because you need buy in from those families. They [referrers] are going to be the ones that are selling the service to the families and really doing the real frontline work of convincing them that it's worthwhile …. That initial step is going to need to be taken by those referrers and they need to be enthusiastic about it*. (IEW1 Management 5)

A Corrections referrer also acknowledged the appealing features of Pae Whakatupuranga I FFT-CG to whānau/aiga/families need to be communicated to the

young people and their whānau/aiga/families by the referrers themselves, and home visits to explain the programme to the whole whānau might assist.

> *Bringing a whānau into [a] civil service centre is not comfortable for them as well. Trying to talk to them about something that we see is very positive can just be counted out simply from the environment……We came up with introducing the programme or the idea of the referral to that young person at home, in their own environment with their whānau's presence.* (IEW1 Referrer 2)

One manager suggested that tino rangatiratanga should be encouraged before making referrals so that whānau/aiga/families feel in charge of changing their own lives. This requires a thorough motivating conversation with whānau/aiga/families before referral to the service.

> *We need to be really coming together with whānau pre-referral and having really authentic conversations with them around changes and what will benefit them, to really empower them to think about if this is something that they want to do as a family. And getting like not like a 'Yay. You're coming at long last', but being more attentive to those pre referral conversations so that families feel involved and that this is a decision that they have.* (IEW1 Management 3)

Several suggestions were made for increasing referrers' confidence in the programme, thus increasing referrals.

Site visits

> *All we can do at this point as [is] really try to continue investing in the relationships with referrals and going out for site visits.* (EW1 Management 3)

Though this will require more presenters than the Referral Coordinator from YH.

> *I know that [doing presentations at site] has been put on [YH Referral Coordinator], but I just wonder whether we need somebody else to be doing that as well to get around multiple sites. It is impossible to get two or three sites together* (IEW1 Referrer #24)

Such visits would be useful across all referral agencies.

Provide more information/education for referrers and client background information to therapists

The comments below illustrate referrers' interest in having more information they can access to both understand the benefits of the programme and to increase their ability to 'sell' the programme to potential clients.

> *If from the beginning, we implemented some support through the practice leader, a pathway … and ensure that our practitioners [referrers] have a really good understanding of what the advantages are for them and for those people they are working with…. They didn't understand that if you refer them and they're working in treatment, then they can be assured that they're doing some work and don't have to worry so much about them.* (IEW1 Referrer #29)

> *We have talked with referrers. They have to trust [the] workers that they are going to refer the families to. That trust takes time to build. The referring agencies need to know what FFT-CG is about. It is important to provide training for the referral agencies. It is important that these [this] training be face to face.* (IEW1 Framework Creator)

> *People open up the intranet and first thing that comes up …just to give them some exposure, because I know what they [the programme] offers, it's pretty awesome. We just need to keep it in front of their [referrers] face, to remind them that it's there.* (IEW1 Referrer #24)

> *They've only got one brochure and it's really aimed at the young person, so we suggested that they probably need a series of brochures, one for the referrer, one for the adults and the whānau, one for the young person that's going to participate* (IEW1 Referrer #28)

> *Maybe even doing something specific for Corrections…those brochures … like a synopsis of: these are the criteria; this is the content; the suitability we require.* (IEW1 Referrer #24)

Referrers also need feedback about treatment progress, to flesh out their understanding of the programme and its impact on their clients. Four of the six referrers who were interviewed identified the need to have feedback on clients' treatment progress.

> *A police officer might refer a kid to the programme, to their family, but also they don't necessarily step away. A sort of subtle monitoring is going on…. I think you can always be better in that regard. You work as a referrer; you need to be reassured that the time and effort you put into the referral is working for that young person and their family. And you reassure that's happening so that you could do more referrals*. (IWE1 Referrer #28)

> *It would be nice to get some email that, once a month, twice a month or whatever.* (IEW1 Referrer #28)

Clarify the referral form

> *Just to make it clear what they are looking for, because it is a lot of time…. I know it's just completing a form, but in the life of the Probation Officer, that's a lot of time to complete the form.* (IEW1 Referrer #24)

Probation officers often did not understand what information was required, so they put in basic information. Therapists need more information about cultural affiliations and family dynamics (below); the referral form should clearly identify what information is required.

Therapists need to know more about family dynamics when they receive a referral. The Referral Coordinator, who works to ensure the best possible timely match between the client and their therapist, is clear from her interactions with therapists that this will help therapists in their first session with a new client.

> *How aware they are of the family situations? It really helps therapists [to] know what kind of dynamic they are walking into during that first session. 'Okay, I know this family's values a bit. I know where the conflicts are. The young person is not going to buy in, Nan might not buy in and whoever it is', they can at least have that knowledge. I think that really helps them.* (IEW1 Referral Coordinator)

Therapists and the Cultural Supervisor are of the view that therapists also need cultural information so they are well prepared to work with the family from the outset.

> *When the referrals were made with very little information on the young people and the families, [therapists] have to go back a few steps to try and obtain that information. When therapists make that first point of contact with the families, they at least know what island group they're from and use it as a point of connection with them, e.g., greet them in their language. And it's just having an understanding around the engagement, the relational protocols for establishing relationships with this family. So that was often something that came through in some of the talks with the therapist around it being a challenge, not having that information.* (IEW1 Cultural Supervisor)

Therapists would welcome continued communication with referrers for information.

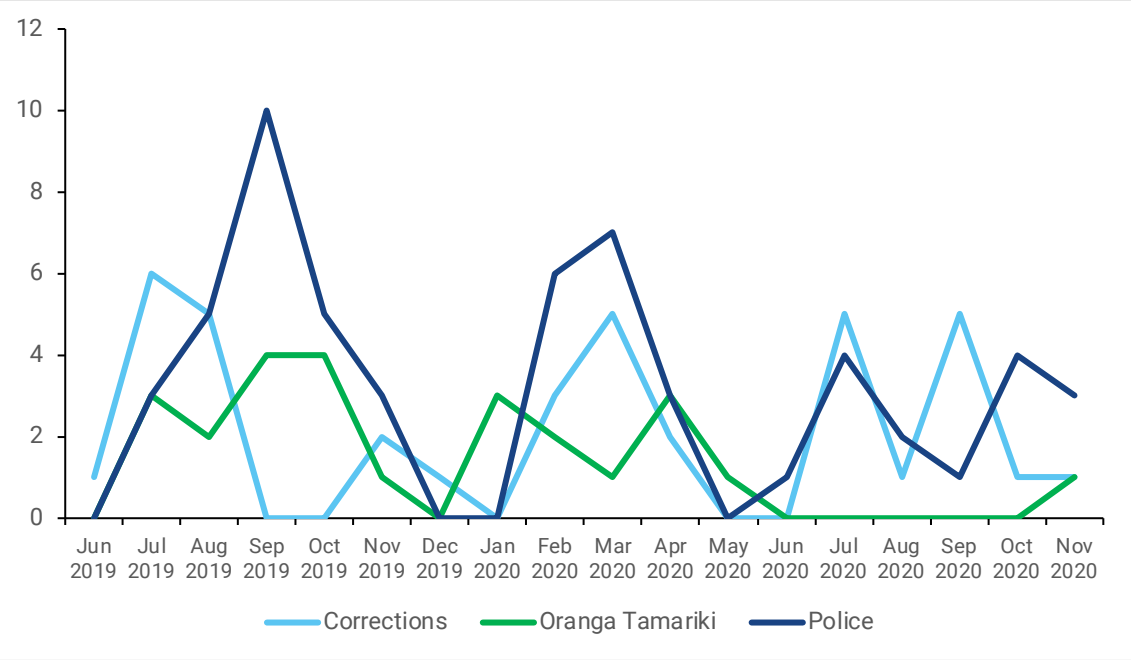
> *We need to have some expectations of our agencies' referrers about feeding back to us and giving us the correct information.* (IEW1 Therapist)

Improve information flow, and tailor information to each referral agency

Problems with information flow are not the same across all agencies. The data show that Police tend to have a larger share of referrals than YJ or Corrections (Table 9 above). Figure 10 complements that data showing the monthly flow of referrals over time by the referring agency. The Police team has an advantage as they already have an established relationship with the YH team and information has been exchanged extensively between the two teams, especially in fine-tuning the process for choosing potential clients for the programme.

> *And I think they [referrers] need to understand what was required from Youth Horizons around how to gather the information, who were the right people. So that took a while. We already had people in the right position to do this on a day-to-day basis because it's what we do as a part of our Youth and Community team. It was an easy fit for us. And Youth Horizons and our teams were really flexible around the criteria. So initially they set up the criteria. And a couple of months it was really clear that it was probably a little bit too strict. And a lot of that came back from the coordinators and the staff that were working with the youth and making their referrals. So I think they [Youth Horizons] really adjusted the criteria and then we could refer more families.* [IEW1 Referrer #27]

Figure 10. Number of referrals by agency and month



The process was not as smooth with the other two agencies. Interviews with the therapists clarified the issues. The first issue with Corrections was the limited interaction between staff and the young person, because of the nature of their work.

> *Police are pretty good and are very motivated because they're on the front lines saying how this [the therapy] could impact on a day-to-day basis. Probation has these special conditions and they can't really identify what the family would benefit from.* (IEW1 Therapist)

Police officers are more likely to have contact with the whole whānau/aiga/family, whereas probation officers' contact tends to be limited to the young person.

The second issue is high caseloads in Probation and YJ.

> *That belief in the programme doesn't feel like it's there on the frontline level [with Probation Officers]. It's like a disconnect. I wonder if that's just because of their overwhelming caseload. And the same probably with Youth Justice.* (IEW1 Therapist)

> *Probation Officers' work [hours] are just crazy, and they need a lot of support in getting and following up those referrals.* (IEW1 Referrer #29)

The impact of time constraints is exacerbated by referrers' unfamiliarity with the programme. The Corrections referrer, who is also a member of the Steering Group, described their unsuccessful attempt to increase referrals.

> *I actually assigned one of my staff the job of going through every single case load of [location name] at every single site and go up to every single Probation Officer and saying 'you need to make this referral'. And they did it. But I mean three months later she went back and double checked how many of them should be followed up and very few.* (IEW1 Referrer #2)

The therapists believed this was because the Probation Officers were not convinced by the programme.

> *They've been told by their manager that we need more referrals to this programme, so they've just referred them to us [but they] lack belief in what we do.* (IEW1 Therapist)

> *They [referees] become non-compliant or they've gone to prison or, they've moved out of the area. So we [Corrections referrers] made the referral, but we didn't follow up or withdraw the referral.* (IEW1 Referrer #29)

> *I think of a case a Pasefika family. I had really good motivation sessions and then they dropped off. The Probation Officer had never met the family. She hadn't gone and spoken to the family about the programme. She couldn't really identify the goals of treatment for the young person.* (IEW1 Therapist)

Suggestions for improving two-way communication included more frequent briefings to deepen each agency's knowledge of the work of the other agencies. A referrer gave the example of a noho marae where all stakeholders discussed the issue of young people in secure care. Representatives from Corrections and Police explained what happened to the young people in secure care and what support or influence therapists could have in that situation. They explained Youth Courts and the relevant legislation and what opportunities existed for the programme while the young person was in secure care.

Another referrer mentioned the strong impact of cultural training on enhancing YH staff capability in working with whānau/aiga, and pointed out that the referrers have yet to experience that impact.

> *In the noho marae, the wānanga they had, and just the experience that the Youth Horizon staff have had in gaining more knowledge - it's made a huge difference to working alongside Māori and Pasefika whānau, just gaining that extra understanding … We're yet to see some of the influences from it.* (IEW1 Referrer #27)

Building referrers' cultural competence and familiarity with therapeutic practices would take considerable time and resources. Therapists suggested establishing a role of 'intake worker' who can provide the initial interaction with whānau/aiga/families to understand family dynamics and motivate their engagement. The therapists believed an intake worker would be able to identify those who would be the 'never-began' and 'drop-out' cases and save subsequent YH time and effort. However, this would add an extra step in the referral-engagement process, which may increase the chance of disengagement. If this role were accepted by Oranga Tamariki, it may require three such workers to engage with the different ethnicities among clients[16].

> *So maybe if we had an intake worker that when we received referrals, we triage the families and we'd go out and meet with them. In the triage stage a cultural match is completed and consent signed. This person's job is to have the clinical*

[16] As noted above, the Intakes Specialist role has replaced the Referral Coordinator role.

> *experience working with families and the understanding of the model and be able to build that relationship with them to get them on board. And they could weed out the ones that maybe aren't quite ready for this. And then the first session could just get them on board, build that relationship with them.* (IEW1 Therapist)

Different suggestions were put forward about ways to increase referrals from Corrections. One referrer suggested putting the programme forward in the Youth Court so it could be considered as an alternative to giving a sentence.

> *But I think the main issue for our referrals has been the lack of engagement or the lack of willingness from that young person. If they have a special condition and …. the Judge said specifically, you need to engage in …. X, Y, Z programme, that makes it a whole lot easier for not only the young person, but for the practitioner. We have managed to encourage young people through these special conditions saying, 'hey, look, if you if I participate in this, then you will meet that special condition'.* (IEW1 Referrer #29)

Another referrer from YJ suggested putting the programme to the FGC.

> *It is over to the coordinator to actually put this [FFT-CG] in front of the [family group] conference …. It's not really for the Youth Court to decide whether or not it's appropriate. It's a decision made by the conference of the group*. (IWE1 Referrer #28)

1.5 Conclusions

During the one-and-a-half-years of operation (July 2019 to November 2020), the pilot programme of Pae Whakatupuranga I FFT-CG has delivered initial positive outcomes in the wellbeing of young people and their whānau/aiga/family. The programme has made a good start on achieving its goals as set out in the initial plan. However, there are substantial 'never began' and 'dropped out' rates, and recruitment to the programme has been slower than expected. To be fair though, many of these families are difficult for any helping agency to engage. A considerable proportion of families struggle with serious housing, health, and other poverty related issues, while others have had previous encounters with the justice system. Completion rates have improved in recent months as the impact of COVID-19 has receded.

Qualitative analysis shows that family cohesiveness has been enhanced, with more open communication between parents and their children; conflict levels have been reduced, and whānau have become more resilient in handling conflicts. Quantitative analysis shows similar positive results across whānau, aiga, and Pākehā families, with improved youth behaviour and distress levels, as shown by YOQ, YOQ-SR, COM-A and COM-P. The data also show young people mostly continue to live with their parents or caregivers, and maintain their engagement in education, training, or employment.

However, success is still in the early stages, with limited data to draw concrete evidence on the impact of the programme due to the few programme completions. Many factors have contributed to this limitation, including the inherent challenge of implementing an innovative therapeutic approach that combines a Western worldview with Māori and Pasefika worldviews. The cohort of clients referred to Pae Whakatupuranga I FFT-CG

from Oranga Tamariki YJ, Police, and Corrections tend to be more socially and economically disadvantaged than the clients of other FFT programmes, with more critical issues and have complex lives. Building the team of therapists, refining the referral process, adjusting as necessary the pace of treatment, and building strong connections with other social support agencies are needed to lock in future success.

2. KEY REQUIREMENTS FOR ANY FUTURE EXPANSION

What lessons can we learn for implementing the programme in other locations and its ongoing development?

We have learnt three major lessons for implementation and development:

(i) set realistic expectations about expected outcomes and the time needed to achieve them

(ii) have the project and implementation design and documentation ready, especially in terms of cultural frameworks, with skilled therapists appointed and trained, referral agencies and the referrers well informed about the programme and its benefits, and supportive management processes

(iii) prepare for unexpected risks, such as the COVID-19 pandemic, that may disrupt engagement efforts. Each is described in more detail below.

2.1 Set realistic expectations based on robust information

Expectations form the basis for planning and organising resources in implementation. Realistic expectations help management to establish realistic plans and avoid unnecessary pressure to achieve the programme's goals. The Pae Whakatupuranga I FFT-CG pilot will inform how any other locations establish a realistic pathway for implementation in terms of time taken to achieve full caseload and outcomes for clients and their families. Interviews with YH staff and other stakeholders have highlighted two major issues that acted as barriers to initial expectations. These are (1) the greater challenges faced by participants in this programme than those faced by other client cohorts and (2) the culturally-based therapeutic approach to whānau/aiga/families, which has taken time to become fully operative.

After a year in operation, YH staff found that clients referred to Pae Whakatupuranga I FFT-CG were different from other client cohorts. A significant proportion of clients referred from YJ, Police, and Corrections tend to be socially and economically disadvantaged and their family situations tend to be more traumatic than other streams of referral. It is not uncommon to find criminality, drug use, or child developmental issues among the whānau/aiga/families. The young person's issues are more challenging, as they have already experienced justice sector (YJ, Police, or Corrections) involvement prior to their referral. Clients have frequently had experience of other social services before and after referral and are wary of further engagement.

> *Mother: All the organisations out there we've probably been through 80 percent of them*

> *Nan: And they all tell you the same thing. So when [therapist name] came on, we thought, oh you know it's just kind of the same.* (IEW1 Mā #1)

> *We're getting very challenging cases, who are very fatigued by institutional involvement.* (IEW1 Management #1)

Others are coping with trauma.

> *I got six children here and [index client] has only just been home one week. He left due to arrest. He had a horrific car accident which has put a spanner in the works and he went on the run.* (IEW1 Mā #4)

> *I couldn't protect my little boy from getting assaulted. I took him home and he would be screaming, don't take me back. It was this horrific.* (IEW1 Pāk #1)

Management and therapists all realised that there were more challenges with this cohort of clients. One manager noted the complexities were beyond the expectations of all partner agencies.

> *The Police, and Oranga Tamariki, Corrections - they didn't really realise the progression, with the progression of offending, you also get the progression of complexity for those families.* (IEW1 Management #6)

Two managers pointed out the whānau/aiga/families have been traumatised by hardship and past experience of unsuccessful services.

> *The fact that their lives have been so drenched in historical trauma and the fact that their day to day lives are very chaotic. …. They are just clients who are going to take longer.* (IEW1 Management #3)

Another manager explained the challenges of working with young people who are at a transitional stage of looking to move to greater independence and become involved with Police, YJ, or Corrections. Their whānau/aiga/family relationships are more tenuous and the ability to influence the behaviour through family intervention is more challenging, even for an organisation with 10 years' experience like YH.

> *I think that accounts for some of the surprise and underestimating of the challenge of this project, and because we had 10 years of experience working with a different population where that wasn't such a challenge for us.* (IEW1 Management #4)

The culturally-based therapeutic approach to whānau/aiga/families has also taken time to become fully operative.

> *It has been an ambitious and innovative approach to addressing some really challenging needs in our community. Commitment to weave together cultural frameworks with [a] Western approach in a way which is honouring and respectful of…. the three knowledge bases.* (IEW1 Management #4)

> *This is a pilot programme and it has taken a lot of time. There has been extra learning that we have had on top of FFT-CG training* (IEW1 Therapist)

> *[It is difficult to engage] even on an individual basis, so when you need to get groups of them together it's even harder* (IEW1 Management #2)

Given these challenges in implementing the model, it is important to have realistic expectations about the timeline and outcomes of the project. Interviews with the management and therapists show that progress was taking longer than initial expectations.

> *We need to be willing to accept that this is just going to take longer because of all the myriad of complexities* (IEW1 Management #1)

> *I think having a clear understanding of the challenges is really helpful, and realistic expectations of what's possible to achieve within the time frame, it's really helpful* (IEW1 Management #2)

> *We had to remind ourselves that this is a pilot and it is working with a new cohort of families and people. It reflects the complexity of the challenges the families were facing. However, some of them were able to complete. It took a lot of time to get there.* (IEW1 Therapist)

This view was supported by interviews with other stakeholders and clients. One father acknowledged the improvement in communication to be a big achievement for his family, and highlighted the realistic expectations needed.

> *She didn't change the world for us. I think that's impossible. It was too a good start and it might lead to more therapy for us, so I would say the communication was pretty good. I didn't expect it to fix the intense problems. I expected and hoped it would help us deal with them better.* (IEW1 Pāk #1 father)

Another whānau expressed their agreement with the slow but sure approach of the therapist.

> *It's only slow little steps at the moment. We've only just got him back from Oranga Tamariki and it's only been one week… As long as we keep going forward, that's where we want to be. I don't want to go to two steps forward and tens back.* (IEW1 Mā #4)

Some managers felt that the emphasis of the programme for the first year should be on building a robust and effective system.

> *Encouraging a new provider to set realistic expectations of the funder programme in the first year. By year, two, and three, we're showing some really good results but if you lose heart after the first year because of the low volumes. Well Youth Horizons hasn't lost heart because we know that [the] standard can work out successfully. But if we hadn't had that experience we'd be like, God, I don't know if this is doable* (IEW1 Management #4)

> *I would say a focus on supporting and encouraging the therapists and protecting them from conversations around efficacy, which increase their own sense of self-doubt and concern around being observed.* (IEW1 Management #3)

The goals of treatment completion and achieving the programme's outcomes for a full complement of clients may be better delayed until the end of the pilot. As explained by two managers, low volumes in the first year of operation could be discouraging and conversations around efficacy could cause self-doubt in inexperienced therapists, which creates unnecessary pressure on YH and its staff in staying motivated and consistently engaged with their clients.

2.2 Have the team ready with clear comprehensive documentation

2.2.1 Have clear, comprehensive project documentation in place

As intended, the pilot Pae Whakatupuranga I FFT-CG has identified and resolved many issues in implementation. Many processes have been built from scratch, such as cultural training and supervision, referral processes, and the operation of the Steering Group. Project documents have been developed, such as referral forms and the Pae Whakatupuranga I FFT-CG clinical manual that interweaves cultural worldviews. All remain as working documents that continue to be refined and updated.

> *Having business cases and things like that [are] all in order before you get started. …. I guess for me, I would want to make sure that those initial projects, start-up scenes are really tight before hopping into the next programme…. Just like the kind of project planning documentation.* (IEW1 Management #6)

Having a clear plan for the set-up and implementation of the programme in new locations will enable the scalability of Pae Whakatupuranga I FFT-CG. YH's senior manager suggested breaking the programme into separate stages, so that it can be rolled out successfully. The more detailed the documentation, the easier it will be to scale up the programme, or to set it up and implement it in another location.

> *It's almost like a staging or simplification process that needs to happen now for it to be scaled up. I don't think I find quite the right words because it's a really rich set of knowledge bases. We do need to find ways to make it more scalable by providing the right support in place* (IEW1 Management #4)

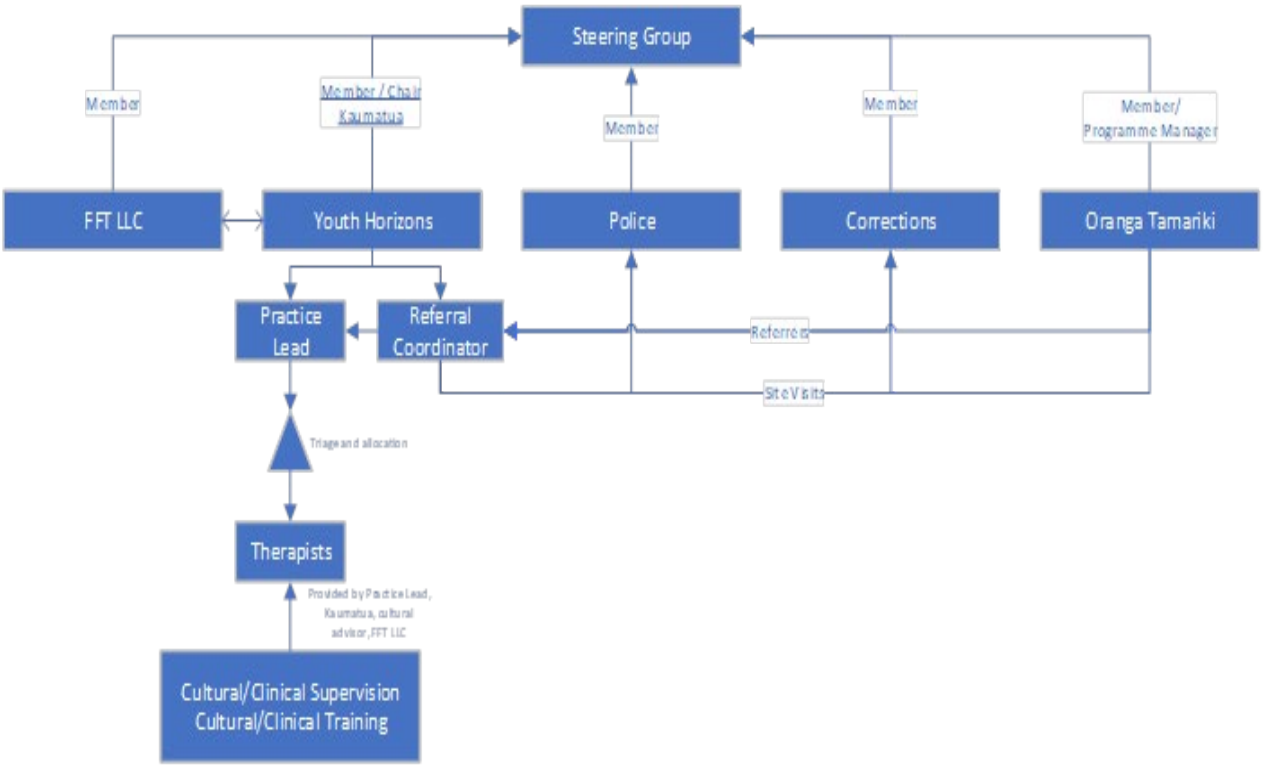
2.2.2 Match implementation teams and support structures to the programme's scale and locations

The programme requires good coordination among different agencies in transferring clients from referral to treatment to ensure that clients stay engaged and information flows from management to frontline workers and back, and to and from key stakeholders such as referral agencies at the programme's location.

Figure 11 shows the programme's current management structure that has evolved during the pilot. The management team, which began with the Steering Group, now includes positions to provide therapists with cultural training and clinical and cultural

supervision, and a coordinator[17] to improve the flow of referrals from referral agencies to the therapists.

Figure 11. Project structure



It is likely the current project structure will undergo further development and refinement to meet the evolving needs of the programme as it expands in client numbers and, possibly, across locations in the future. If the programme is rolled out, there may also be a need to set up smaller local implementation teams[18] tailored to the scale and location of sites. It may also be appropriate to appoint cultural supervisors in different sites in Auckland as the volume of work increases. These issues will be explored in more detail in the Wave 4 Impact Evaluation in 2022.

The senior manager at YH emphasised the need for significant management resources for implementation.

[17] As noted above, the Intakes Specialist role has replaced the Referral Coordinator role.

[18] 'Implementation team' denotes the members of the programme who oversee and coordinate activities to ensure that operations in any new site are well established and performance is on track for outcomes to be achieved.

> *I think it takes much more senior management resource than one would imagine to get it set up and to bring a project management framework, or an implementation framework.* (IEW1 Management #4)

Current management, therapists, and referrers highlighted the qualities needed for effective implementation. It is important to have committed team members with appropriate responsibilities to drive the establishment of the programme in a new location. YH staff on the implementation team would need deep knowledge about the programme and its history, and the ability to interact well with people both inside and outside YH.

> *Having someone like [the current manager], it's been critical. I think she's got really detailed oversight of the different bits. Having a project manager like that is really important when you've got so many different people involved in, what needs to happen next and people on top of action points.* (IEW1 Management #2)

Managers and therapists also stressed that it is not just about having representatives from partner agencies: the collaborative nature of the programme means that it needs representatives from partner agencies and YH management with the drive, the motivation, and the time to put energy into it.

Several interviewees were concerned about the possibility of the programme being contracted out to a new service provider. They made the following observations about this possibility.

- The service provider needs to have organisational features compatible with the model. YH has been recognised as a suitable agency for delivering this service because of its experience with and commitment to improving the wellbeing of whānau/aiga/family, especially in terms of engaging and building trust with their clients. YH also has experience in working with government agencies.

  > *I really think that Youth Horizon[s] was the right group to take on a youth and family project like this. And it's purely around their intent. They are there for whānau, you can see its history, all that they have done. If you're going to make change, if you're going to support family to achieve their own aspirations, then you need a service like that to take the lead to help the families that are in stress* (IEW1 Re #27)

  > *It's got to have the capability, not just somebody [who] put their hand up and be given it. I think Youth Horizon[s] is well trusted in government circles for this type of work. So the organisation is going to be very well structured and very well managed to achieve the outcomes.* (IEW1 Re #28)

  > *I do worry about that this programme going to another organisation that doesn't have the core values that we have, and a culture and the level of supervision and support that we do have.* (IEW1 Therapist)

- The programme's innovative approach requires cultural appropriateness and the service provider needs to have in-house expertise in cultural knowledge that can support the therapists in challenging situations.

> *I think ideally the funder would select an organisation that has really robust clinical governance, with a real commitment to honouring Tiriti o Waitangi* (IEW1 Management #4)

> *You can't run this programme unless you have a Kaumātua and a Pasefika supervisor.* (IEW1 Therapist)

2.2.3 Recruit therapists with appropriate experience

The therapists are the key to the programme. Current therapists are well equipped with clinical skills and determined to achieve results.

> *They [FFT LLC] feel the team is progressing at a clinical pace that we would expect, and that there's no red flags in terms of practice that we would need to design specific training around to address…. I think they're highly reflective practitioners and I think those so determined and committed to the pilot that are really throwing everything they have at it.* (IEW1 Management #3)

As discussed above in section 1.1.3 the current therapists have successfully built their cultural competence in approaching whānau/aiga/family. However, it has taken a lot of time and resources to reach this point. One manager described the situation at the start of the pilot.

> *So right at the very beginning, we were just struggling with just getting therapists on board …. I wish I would have been able to …. dive a little bit deeper and get some real understanding to know when and how long does it take a therapist to become competent.* (IEW1 Management #6)

The pilot has helped the management understand that clinical development within Pae Whakatupuranga I FFT-CG takes time, which requires strong commitment from the therapists. Recruitment of the right therapists and on-going support for them plays a critical part in preparing for implementation.

> *Be aware that you're looking for staff who are going to give you two or three years, if not the rest of their life, who are committed to learning and who are able to sit in the unknown, adapting and trying again and not having the [their] confidence overwhelmed.* (IEW1 Management #3)

2.2.4 Ensure cultural frameworks are accompanied by appropriate training

The pilot Pae Whakatupuranga I FFT-CG has experienced considerable challenges in establishing processes for accommodating Māori and Pasefika worldviews in the original FFT model, for example, therapists and other YH staff commented strongly in the Wave 2 Formative Evaluation on the intense and exhausting nature of training simultaneously in FFT therapeutic delivery and practice and the application of Whaitake Whakaoranga Whānau concepts, and a further approach, as Uputāua training began.

Managers are also aware of the importance of being culturally sensitive, not just in terms of ethnicity but also in terms of location.

Management emphasised the need to have cultural training and supervision available for therapists when the pilot is rolled out to new locations.

> *And I would say, certainly, including the cultural training and the cultural experts and supervisors to walk alongside the team.* (IEW1 Management #3)

> *The cohorts of people in Christchurch versus some people in Auckland would be different. You couldn't just pick up the cultural framework easily and just pop it into another one.* (IEW1 Management #6)

From the experience of developing Whaitake Whakaoranga Whānau and Uputāua, management and therapists have recognised the need to pace the training appropriately, though views differed on the best approach. Suggestions from management included that training be staged as in FFT practice so that the therapists would not feel overwhelmed.

> *We tried to do the cultural frameworks training and supervision too quickly too much. I think it needs to be sequenced in a thoughtful way …. it's to be staged so that the focus for [the] therapist is the therapeutic model first so they can really get confident and grounded enough. We just run the risk of overwhelming people* (IEW1 Management #4)

Another manager acknowledged that the break between the clinical and cultural training was helpful for the therapists.

> *The break from the really intensive cultural support and the cultural training has actually been really helpful for the therapists because they can get their head to the into the details of the therapy.* (IEW1 Management #1)

The interweaving of Māori and Pasefika worldviews into the clinical FFT model made one manager consider the possibility of interweaving the three training processes so that they are not clinically and culturally separate.

> *So I am thinking how you might weave a bit more of the cultural training into the FFT training, which is still quite separate because of the restrictions around FFT International. The models are very tightly designed so the cultural and the clinical are a bit separate. I would like to see going forward that that's a bit more integrated* (IEW1 Management #1)

If this idea was implemented successfully, it would save a lot of time and effort by the therapists.

2.2.5 Cultural supervision

A therapist suggested that cultural supervision should be available as soon as the therapist contacted the client, especially when they have different ethnic backgrounds. Training should not be organised at the same time as delivery of service to clients.

> *I would recommend that this cultural supervision [be] available for the first couple months for families that were not of the same ethnic background, maybe to go for support, but maybe hold off on all of the training happening when you first start. If you're expected to keep that caseload up and the intensity of working with the families, then you've got no brain juice. Sometimes I say 'I can't hear you right now. I need to decompress. I can't listen right now because it takes a lot of your brain, your energy'.* (IEW1 Therapist)

Finally, the therapists and the Cultural Advisor agreed that the cultural supervisor who provides ongoing support for the therapists should have clinical experience and cultural competence.

> *One of the things that I've really appreciated from the Māori framework is having [the Cultural Supervisor] because she's an effective practitioner, but also a Cultural Supervisor for that model.* (IEW1 Therapist)

> *One of the therapists who provides the ongoing cultural supervision was one of the people on the Whaitake Whakaoranga team. She's also done postgraduate qualification and diverse cultural supervision. She's got a really good, strong skill set and then being able to provide that ongoing cultural support for the therapists in terms of embedding the knowledge and practice.* (IEW1 Cultural Advisor)

2.3 Prepare for disruptive events

The COVID-19 pandemic and the resulting lockdowns were a disruption unforeseen by management that interfered significantly with the pilot's progress. COVID-19 has had an impact on the duration and possibly the success of therapy. Telephone contact with therapists was appreciated by whānau/aiga/families, and indicative of therapists' genuine concern, but this was not a satisfactory medium for conducting whānau or aiga therapy.

COVID-19 lockdowns have highlighted the need to be prepared for situations where face-to-face engagement with whānau/aiga/family is not possible. Although the Wave 2 Formative Evaluation uncovered some unexpected benefits from contacting clients through video or phone, the long-term impacts on treatment progress are not encouraging. For example, the only whānau who did not achieve much progress during treatment pointed to the lack of interaction in sessions on Zoom compared with face-to-face meetings.

> *The Zoom ones were unusual because we'd sit there in front of a laptop and see [therapist], and make sure he [index client] was out of video reach. She couldn't really see him. He didn't want to be in the camera, and so that was kind of odd. It was definitely better when he sat there and she could come here.* (IEW1 Mā #6)

A Pākehā family found that face-to-face sessions were more interactive because they could all join in activities and these human interactions motivated family members to communicate more.

> *Because of quarantine we had Zoom. There wasn't much that could be done except talking. [During face-to-face sessions] we spoke a lot more and we talked more as a group than when we were on Zoom. Because of Zoom and in quarantine, not much was done.* (IEW3 Pāk #3)

These situations, where there is significant difficulty in maintaining communication with the therapist and among members of whānau/aiga/family, require therapists to employ finely-honed skills to help clients and their whānau/aiga/family open up online.

Clients who have had issues with verbal conflict, however, may find an online platform, where only one person can speak (and be heard) at a time, a helping factor in making each family member listen to the others.

COVID-19 has also created practical difficulties in maintaining the connection between therapists and their clients, who did not always have or use technology for communication. While COVID has exacerbated these difficulties, they are frequently found in areas without connectivity and families without technology.

> *COVID has been hard when many families don't have the resources to do Zoom, or even feel comfortable to do a phone call. It has been a real challenge to keep motivation when you've got a significant period when we haven't had sessions. The pandemic has made it really difficult. The relationship that you built becomes changed and difficult. We do so much chasing around. I'm not sure how we would cope with another level 4 closedown.* (IEW1 Therapist)

The therapists identified many cases where COVID-19 delayed their clients' progress. One could have completed earlier but Level 4 lockdown made them unable to reach the next level without face-to-face sessions. Another could not engage during COVID-19 because they were unable to make phone calls, as their short attention span meant phone calls were not a good match. The delay in treatment led to the client being discharged from YJ without further treatment. Another client simply disappeared during lockdown and the therapist had no way to contact him.

The referral process has also been affected. Figures 9 and 10 above show the marked reduction in referrals made to the programme since April 2020.

> *It [the process] really just stopped. I feel for the coordinator involved in this stuff because they couldn't get out and do their jobs. I don't think a lot of that information [on the referrer's reflection on the service] is being filtered through the referrals. I just think maybe it's because during COVID things really shut down* (IEW1 Referrer #27)

> *We've got no control over the COVID aspect. That really upset the apple cart because that really negated the ability to do face-to-face work and really stalled the whole programme.* (IEW1 Referrer #28)

Cultural training was also disrupted.

> *The lockdown was also negative. It moved our Pasefika Cultural Training from a face-to-face approach to online training. Face-to-face explanation not only works on the rational level but it becomes experiential and holistic. The learning is not*

> *only experienced in the mind but it [it's] also experienced through the senses and the heart. It provides a real people connection.* (IEW1 Framework Creator)

Two managers expressed deep concern about the impact of COVID-19 and the need to be prepared for such events.

> *We could see the four months where COVID happened and what kind of engagements and completions and things like that happened in those months. I didn't realise what a big impact it was in terms of COVID.* (IEW1 Management #6)

> *I've seen twice now therapists' entire caseload stopped because not one of them had capacity to do anything other than a phone check-in weekly. And so treatment pacing was completely blowing out. I think services across New Zealand need to think about this too.* (IEW1 Management #3)

Work remains to be done on assessing the risks and actioning risk mitigation strategies to minimise the disruptions caused by such events. As an example, a manager suggested consideration be given to providing whānau/aiga/family with appropriate technology so communication between families and their therapists can be maintained.

> *I think that if we're going to be living in a world where we might go back into lockdown, even at lower levels where we have to either wear masks or do video conferencing, we need to start really considering how we are going to equip families to continue to stay involved. We buy tablets or some kind of device …. to give to those families who don't have a laptop or a computer. I think that's probably the most sensible thing that we can start preparing for in a world of COVID.* (IEW1 Management #3)

The Cultural Advisor noted that it was not clear whether YJ, Police, Corrections, or all three, would provide tablets or laptops for online connection.

> *But one of the things that I noticed was that with Oranga Tamariki, Police, and Corrections, it was discovered that they didn't have the resources to do that* (IEW1 Cultural Advisor)

YH may have sufficient spare capacity to provide the equipment in the short term, but there needs to be a process set up to ensure confidentiality is not breached.

> *I found that we had devices that our therapists already have on hand that we weren't being used during that time. It was really just a matter of giving them that permission with approval from our leadership so that I.T. checks to make sure that when the devices are being given over to families, they don't hold any private or confidential information.* (IEW1 Cultural Advisor)

Therapists also highlighted the need to establish clear guidelines for their practice during such events. They continued to reach out to connect with their clients during lockdown, for example checking in on them through texts or giving them a call to let them know that the therapists were thinking about them. One even delivered food parcels to their clients to make sure they could survive; the therapist could see the clients face-to-face (but contactless) to keep communication going even though it was not a therapy session. These practices clearly resonate well with what the therapists

have learned during clinical training and cultural training. Standard Operating Procedures (SOPs) will maintain therapists' confidence that they are doing all they can to help their clients at such times.

> *It would also be helpful that the organisation was clear around guidelines of what we should and shouldn't be doing around that period. Having clear guidelines around each of the levels and having clear boundaries would also make the families clear.* (IEW1 Therapist)

Finally, therapists and the organisations they deal with, would be well-advised to refine the necessary skills for maintaining the flow of referrals and engaging with whānau/aiga/family when face-to-face interaction is not possible. At the least, resources for online learning should be developed in the short term.

2.4 Conclusions

Pae Whakatupuranga I FFT-CG is an innovative family therapy that was designed to meet the needs of whānau/aiga/families coming into the system through Oranga Tamariki YJ, Corrections, and Police. The trauma of these whānau/aiga/families and the lack of trust in the system due to past experiences require a therapeutic approach that engages both parents and young people in a way that resonates with their cultural worldviews. To achieve that aim, a strong clinically and culturally competent therapist team is required, which in turn requires a high level of coordination and support from the implementation management team, especially in developing cultural competence. This process takes time and effort and therefore needs to be realistically paced to avoid unnecessary stress. The COVID-19 pandemic highlights the need to be prepared for extreme situations where face-to-face engagement is impossible.

3. RECOMMENDATIONS

Recommendations

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

1. Streamlining and enhancing the referral process

- Create greater flows of relevant information from referral to treatment and beyond.
- Consider encouraging pre-referral discussions so whānau/aiga/families feel in charge of changing their own lives.
- Increase referrers' confidence in the programme, thus increasing referrals, through:
    - nurturing close relationships between the programme and referral organisations to deepen each agency's knowledge of the work of the other agencies
    - providing referrers with brochures for parents and caregivers, in addition to the present brochure which is aimed at the young person, and providing brochures in culturally appropriate languages
    - clarifying the referral form so referrers know what information is useful to the programme; therapists would benefit from knowing more about family dynamics and cultural affiliations when they receive a referral, so they are well-prepared to work productively with their client
    - feeding summary information about the treatment progress of their clients back to referrers so they are aware of the programme's benefits.
    - Inviting Steering Group members from Police, Oranga Tamariki, and Corrections to consider cultural training for their referrers, to enhance their capacity for working with whānau and aiga.
- Explore options to increase referrals from Corrections, including the feasibility of putting the programme forward in the Youth Court so it could be considered as an alternative to giving a sentence and putting the programme to the FGC where this is not already happening.

2. Improving programme effectiveness

- Refine the therapist selection criteria. Future recruitment needs to continue to find people with persistence, knowledge, and commitment. Suitable therapists should be well-grounded in the cultural worldviews of Māori and Pasefika.
- Continue to recruit cultural supervisors with both clinical experience and cultural competence.

- Increase the number of frontline Māori and Pasefika workers to strengthen the therapist team's overall cultural competence, sufficient to meet the cultural proportion of client whānau and aiga.
- Review treatment length in 2022, when the general trend for time to complete treatment will be clearer as current therapists gain experience and new recruits join a well-established programme.
- Consider encouraging referrers to offer post-treatment contact with interested clients for a six-month period.

3. Outreach for socio-economic support

- We suggest partner agencies work with others to improve clients' and families' access to critical support, especially housing.
- Expand access to local support services through establishing databases of services for clients.

4. Lessons for any future expansion

- Set realistic expectations about expected outcomes and the time needed to achieve them.
- Have the project and implementation design and documentation ready, especially in terms of cultural frameworks, with skilled therapists appointed and trained, referral agencies well informed about the programme and its benefits.
- Prepare for risks, such as the COVID-19 pandemic, that may disrupt engagement efforts.
- Regularly review the need for further development and refinement of management structures and in-house support as the programme expands in client numbers and, potentially, across locations.

APPENDIX 1. ANALYSIS AND OUTCOME QUESTIONNAIRES

The quantitative analysis interrogated both administrative and qualtric[19] data stored in different databases. The following describes the quantitative data and the analyses used in measuring progresses of the project's intended outcomes.

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

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

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

We analysed data collected on clients who used the services and have closed their cases, either via completion (completed) or dropping out of the service (dropped out). Data on other situations are either not collected (e.g., outcome data on clients who never began the service) or are not suitable (e.g., outcome data on clients who are still using the service – active cases). Each observation for each outcome measurement corresponds to one completed questionnaire. Table 2 shows the small number of available observations, which is due to the long-time taken to complete a case.

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

Table 10. Sample for Wave 3 impact evaluation quantitative analysis

Outcome data	Completed by	Frequency	Sample size	Database
Youth Outcomes Questionnaire (YOQ)	Parents to assess youth 10 to 17 years old	Twice: pre-treatment (completed by third session) and post-treatment (completed at discharge)	24 observations of pre-treatment scores (13 dropped out and 11 completed); **6** of the 24 observations had post-treatment scores (6 completed)	CSS[20]
Youth Outcomes Questionnaire self-reported (YOQ-SR)	Youth aged 10 to 17 years old to self-report		27 observations of pre-treatment scores (14 dropped out and 13 completed); **8** of the 40 observations had post-treatment scores (8 completed)	
Client Outcome Measure for Adolescent (COM-A)	Youth 10 to 17 years old	Once: At discharge	**15** observations (completed)	
Client Outcome Measure for Parent (COM-P)	Parents to assess youth 10 to 17 years old	Once: At discharge	**15** observations (completed)	
Outcome Questionnaire (OQ)	Parents and youth over 18 years old to self-report	Twice: pre-treatment (completed by third session) and post-treatment (completed at discharge)	8 observations of pre-treatment scores for young people (two completed and six dropped out); **2** had post-treatment scores (completed)	OQ Analyst Website[21]
Cultural Satisfaction Form	Parents and young people	At discharge	**12** observations from parents and their young people (completed) with the *short form* and **21** with the *long form*	Excel sheet extracted from Google
Living Situation	Therapists	Twice: pre-treatment and after treatment	**45** (28 dropped out and 17 completed)	HCC
Education, Employment and Training (EET)	Therapists	Twice: pre-treatment and after treatment	**45** (28 dropped out and 17 completed)	HCC

Due to the small sample size (less than 30) of available data on the measured outcomes (see the table above), tables and graphs were used as follow:

- For outcomes measured before and after treatment (OQ, YOQ, YOQ-SR) we used a scatter plot to compare the outcome scores before and after treatment. Each

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

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

case is represented by a dot on the scatter plot and the values of the dot correspond to the scores completed before treatment (horizontal axis) and after treatment (vertical axis).

- For outcomes measured after treatment (COM-A, COM-P) we used a box-plot graph to visualise the distribution of the scores completed by the clients.
- For the Cultural Satisfaction Form, we present a table of average scores for each cultural aspect covered by each question asked in the form.
- For Living Situation, we used tabular analysis of living situation before and after treatment, with each cell giving the number of clients who either stayed in the same living situation, which can be either at home (with parents and/or whānau) or independently (with flatmates or partners/spouses) or in other situations, or change from one living scenario to another.
- For Education, Employment and Training (EET), we similarly used tabular analysis of EET before and after treatment, with each cell giving the number of clients who either maintained the same situation of EET (alternative or mainstream education, training or work-based programme, full or part-time employment) or changed from involvement in one form or EET to another, or stopped EET (not in education, training or employment).

Cultural Satisfaction Form

Short form

How satisfied are you that:

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

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

Long form

How satisfied are you that:

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

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

Source: Youth Horizons

Youth Outcome Questionnaire

Youth Outcome Questionnaire (Y-OQ®2.01)

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

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

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

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

PLEASE COMPLETE BOTH SIDES

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

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ID	S	IR	SP	BD	CI
XXX					

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

ID	S	IR	SP	BD	CI
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Source: Project Documents

Youth Outcome Questionnaire – Self Report

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

Name _____ ID# _____ Today's Date _____

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

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

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

PLEASE COMPLETE BOTH SIDES

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

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ID	S	IR	SP	BD	CI

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

ID	S	IR	SP	BD	CI

TOTAL = _____ **SUBSCALE TOTALS (Sum of Subtotals)**

Source: Project Documents

Client Outcome Measure – Adolescence (COM – A)

Instructions:

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

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

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

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

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

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

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

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

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

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

_____ 3. How much has your behavior changed?

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

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

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

Please stop here. THANK YOU for your help

Source: Project Documents

Client Outcome Measure – Parent (COM – P)

Instructions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Please answer the following questions according to events that have occurred SINCE you began counseling.

7. How many times has your adolescent been charged with the following types of crimes since counseling began?
   - Misdemeanor crimes _____ Number of times
   - Felony crimes _____ Number of times

8. How many times has your adolescent been charged with crimes involving the following since counseling began?
   - Weapons _____ Number of times
   - Drugs _____ Number of times
   - Violence _____ Number of times

9. How many times has your adolescent been to detention since counseling began?
   _____ Number of times

10. How many times has your adolescent run away since counseling began?
    _____ Number of times

11. Is your adolescent attending school? (please check one)
    ☐ Yes
    ☐ No

12. How many times has your adolescent been kicked out of school since counseling began?
    _____ Number of times

13. Alcohol use by your adolescent since counseling began? (please check one)
    ☐ None
    ☐ Use
    ☐ Use that disrupts daily functioning

14. Drug use by your adolescent since counseling began? (please check one)
    ☐ None
    ☐ Use
    ☐ Use that disrupts daily functioning

Please stop here. THANK YOU for your help

Source: Project Documents

Outcome Questionnaire (OQ)

Outcome Questionnaire (OQ®-45.2)

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

Name:_____ Age:____yrs.

Sex

ID#_____ M☐ F☐

Session #_____ Date____/____/____

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

DO NOT MARK BELOW

For More Information Contact:
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Source: Project Documents