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

Formative Evaluation Report – Wave 1

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
16 March 2020

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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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Published: May 2020

ISBN: 978-0-9951307-9-1

If you need this material in a different version, please email us at research@ot.govt.nz and we will provide it for you.

Citation guidance: This report can be referenced as *Family Centre Social Policy Research Unit (2020). Pae Whakatupuranga: Functional Family Therapy Cross Generations (PW: FFT-CG) – Wave 1 Formative Evaluation Report*, Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

Acknowledgements: The Family Centre Social Policy Research Unit wishes to thank all those who generously shared their knowledge and experience of the development of Pae Whakatupuranga: Functional Family Therapy Cross Generations during its first six months of operation. This included key members of the Steering Group; the Youth Horizons Kaumātua, therapists and managers; and referrers from the New Zealand Police, Department of Corrections and Oranga Tamariki. We also wish to acknowledge the Oranga Tamariki Evidence Centre for their review of drafts of this formative evaluation report. Tēnā rawa koutou katoa i tautoko mai i tēnei o ngā kaupapa rangahau.

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1 Executive summary

Pae Whakatupuranga: Functional Family Therapy Cross Generations (PW: 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.

PW: FFT-CG is an adaptation of the original Functional Family Therapy (FFT) model, which is designed and owned by FFT LLC[1], but has been adapted in order to be suitable for the Aotearoa context with regards to cultural appropriateness. It is funded by Oranga Tamariki under its Reducing Youth Offending programme of work. The service involves two other agency partners - Department of Corrections (Corrections) and New Zealand Police (Police).

Youth Horizons (YHT), a contracted third-party provider of the PW: FFT-CG service, has been implementing the pilot service in Auckland since July 2019.

The Family Centre Social Policy Research Unit (FCSPRU) is undertaking a multi-year evaluation of PW: FFT-CG (July 2019 to June 2022). This evaluation has three overall high-level objectives:

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

This evaluation report prepared by FCSPRU is largely a baseline report about the first six months of the programme's operation. It focuses on the first evaluation objective and is an early part of the formative evaluation that is taking place from July 2019 to December 2020. (The formative evaluation will be followed by an impact evaluation.)

A mixed-method evaluation strategy utilising both qualitative and quantitative methodologies was used, which included *document review, individual interviews, a focus group* and *data analysis*. The three tikanga approach of FCSPRU ensures that all research is conducted from cultural perspectives, with Kaupapa Māori theory and practice and the Pacific Fa'afaletui methodology used. Interviews were carried out with staff and key stakeholders alongside a review of the monitoring data generated from three databases: the CSS (clinical services system) database created by the FFT programme (FFT LLC); the YHT HCC (healthcare community client) management database; and the YHT Googleform database for cultural satisfaction survey data.

In general, the programme is heading in a positive direction with a strength based, in-home, in-depth, broad family/whānau/aiga service. The complexity of the model and the multiple partnerships involved are outlined in the following sections of the Results chapter (Chapter 5): *Conceptual and contractual framework; governance and management; referrals; YHT PW: FFT-CG clinical delivery;* and *therapeutic training and processes.*

Māori and Pacific frameworks are being incorporated into PW: FFT-CG to make it culturally appropriate in the Aotearoa/New Zealand context

At the conceptual level, the pilot PW: FFT-CG model specifically seeks to incorporate culturally responsive therapeutic understandings and approaches in relation to Māori and Pacific

[1] More information about FFT LLC can be found at https://www.fftllc.com/.

worldviews and value systems, with a therapeutic model originating from a Western epistemological base. The model has a 'phase-based' progression of engagement, motivation, assessment, behaviour change, and generalisation of index clients[2] and families/whānau/aiga, rather than a prescribed therapeutic delivery template. Many young people and families who YHT engage with identify as Māori and/or Pacific, so YHT is implementing Whaitake Whakaoranga Whānau (WWW), the Māori cultural framework developed for YHT, within the PW: FFT-CG pilot. Training in the framework has been provided to YHT therapists. A Pacific framework is currently being developed.

Intellectual property agreements are in place in relation to the frameworks. The clinical model is the property of FFT LLC and the Māori cultural framework is the property of YHT and the kaitiaki of the YHT Kaumātua. The US-based FFT LLC is the original owner and Licensor and the monitoring data is fed back into their system as well as being accessible to the service. It is not clear to the reviewers who owns the intellectual property rights, kaitiakitanga, and copyright matters relating to the incorporation of WWW (or elements thereof) within the Clinical Training Manual and control of the 'cultural data' that is collected in the monitoring system (e.g. all the assessment information and case notes that are entered into the FFT LLC CSS database).

The Steering Group provides strategic advice on operations, YHT senior managers lead the service and Kaumātua contributes cultural leadership

At the Governance and Management levels, the Steering Group provides a central role in advising on the effective operation of the programme. Stakeholders from the three partner agencies (Police, Corrections, and Oranga Tamariki) and the programme provider organisation (YHT) are members of the Steering Group. Steering Group members bring valuable knowledge of their agency's systems, structures, cultures, lines of authority, and decision-making processes to the table.

The relationships between Oranga Tamariki, Police, Corrections, and YHT have developed positively. These strong relationships enable a high degree of flexibility and adaptability in developing and implementing the model, as illustrated by the partner agencies' openness and cooperation in the Steering Group.

The Senior Managers in YHT, in the main, lead the service and facilitate learning and active communication among the therapists. There is a sense of unity within the service and a strong belief in the effectiveness of the FFT model. The Kaumātua of the service, one of the developers of the WWW framework and trainer for therapists, contributes strong cultural leadership and understanding. The therapists are committed to learning a complex and hopefully effective model of practice and enjoy the stimulation. The inter-accountability of the group structure enables processes to be implemented in relation to feedback from different levels of the service. Respect is a major value both internally and towards client families.

All referrals come from the three collaborating agencies, the referral and allocation processes have been clarified and strengthened, but challenges remain for successful service take-up

Referrals are made by the three collaborating agencies, most commonly from youth aid officers, case social workers, or probation officers, because of their direct contacts with clients. Each agency has appointed a site champion to promote the PW: FFT-CG programme within their agency/site and to provide a point of contact for the Referral Coordinator at YHT.

The Oranga Tamariki programme manager and YHT staff have put considerable effort into ensuring that criteria for referrals are well understood. Many improvements have been made

[2] YHT uses the term 'index client' to refer to the young person in a whānau who the PW: FFT-CG referral mainly relates to.

to promote good quality referrals, including the straightforward and 'to-the-point' pamphlet for client families/whānau/aiga, YHT leading small group presentations with potential referrers (staff who refer potential clients to the programme) in the collaborating agencies, and the fact that therapists can contact referrers directly to gain further information prior to meeting clients and family/whānau/aiga. Most contacts with clients are conducted at their home or marae.

The YHT Practice Leader and the Referral Coordinator have important roles in assessment, triaging, and allocation of referrals to ensure safety and suitability of clients in matching with therapists. The differences in the client groups of the three agencies lead to different referral rates. The higher rate of Police referrals, than Corrections or Oranga Tamariki referrals, probably stems from the younger age of their index clients and the rapport with families/whānau/aiga in the Youth Aid scheme.

There are challenges however in the referral process. Fewer than half the cases allocated become and remain active. This is not necessarily a failure of the service, or the referrer, because the service relies on consensus with the clients and many have experienced very difficult lives with anti-social histories. The matter needs to be studied though, to understand how the bridging process between referrer and successful take up of the service can be strengthened.

The therapeutic process is at an early stage of delivery, therapists are strongly committed to their client families/whānau/aiga, and there are positive team dynamics among therapists

The therapeutic process is in its early stages, with five therapists, and no clients who have reached the final therapeutic phase yet. The therapists are committed and persistent in their efforts to gain the trust of family/whānau/aiga. It is clearly the key to successfully delivering PW: FFT-CG, but the process is quite time consuming. It is not uncommon for therapists to make numerous visits to the family/whānau/aiga, or to meet family members separately, prior to bringing them together. There is a strong culture of respect for client families/whānau/aiga and there are positive team dynamics among the therapists. They are also comfortable with meeting families/whānau/aiga in their homes and outside normal business hours, and appear highly committed to promoting the successful delivery of the service.

With the Steering Group's help, confidentiality policies have been developed that require a therapist to report incidents that may present a danger to the client, themselves or the public, but do not require them to report incidents that should be kept confidential in a therapeutic setting. This nuanced policy assists therapists to establish and maintain trusting relationships with clients and their family/whānau/aiga.

Programme training is in the early stages of development and delivery

A three-day noho marae has been held for the five therapists that covered the first two phases of the FFT model of therapy. Two further noho marae have been held and there has been substantive training in the WWW framework. The training was well received with positive feedback on the content and the support therapists have received from their supervisors.

Therapists are required to commit to a substantial amount of reporting and paperwork because of the robust FFT monitoring system. The volume of paperwork and its complexity is challenging for some, but generally appears to be considered acceptable and part of the procedure. It is important that the monitoring aspect is facilitated by YHT Managers and not compromised, because it is one of the pillars of the model and should prove to be very useful for therapists, families and the service. The transparency it produces, if used well to improve practice, should help lift the level of positive outcomes.

The YHT information monitoring instruments are comprehensive and fit-for-purpose, but the management and accessibility of data require improvement

Monitoring data, namely information on client cases, is recorded throughout the referral and therapeutic processes. The information is stored on three databases: the CSS database/client management system created by the FFT programme (FFT LLC); the YHT HCC case management system; and the YHT Googleform database for cultural satisfaction survey data.

At the end of the first six months of operation, 56 cases were allocated to a therapist in the CSS database, 25 of which are active cases. The small number of observations recorded in the databases limits the analysis of trends. However, an early trend has emerged of Māori, who comprise the largest proportion (52%) of total referrals and make up the highest percent of the active cases (44%), having the highest rate of non-engagement in the service: 85% of those who were allocated to a therapist, but never signed a consent form or participated in an FFT session, were Māori. This result, despite the strength of the WWW cultural framework that is central to YHT's training and rationale, raises questions about what is really needed to create a more welcoming bridge for Māori young people who find themselves in social and legal difficulties. Caution is needed interpreting these findings from the small numbers in this early period, but it is fair to say the current approach is clearly working for some but not for others.

Our review of YHT's information monitoring system shows that the data collected is comprehensive and fit-for-purpose, with a range of measurements that can be used to quantify the difference before and after treatment. Current data tools are useful, especially the monitoring dashboard, in providing a summary of progress or otherwise, and the number of contacts therapists make for allocated and active cases is reported on in the monitoring dashboard. However, concern was expressed by some therapists that failure/success categories in the monitoring data may not reflect the engagement efforts made with whānau/aiga/family. This could be a fine-tuning matter.

While the data collection instruments are fit-for-purpose, the management and accessibility of the data is not. As measurements are located in three separate databases the accessibility of the total body of data for a comprehensive analysis of processes and outcomes is limited. The outcome measurements in CSS include the Family Self Report, Outcome Questionnaire (OQ), Youth Outcome Questionnaire (YOQ), Youth Self Report (Y-OQ-SR), Client Outcome Measure Adolescent (COM-A) and Parent (COM-P), and Therapist Outcome Measure (TOM). The YHT HCC database has data from the Outcome Assessment Form and the YHT Googleform database has data from the Cultural Satisfaction Form. It is recommended that a unified, easily accessible database be developed that is adequate to meet the reporting needs of the programme.

Recommended next steps

The findings in this evaluation should be seen as baseline data for the overall evaluation. The small numbers involved, and the fact that no active cases had been completed at the time of the evaluation, suggest that at this stage only a small number of foci are worth considering.

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

1. It is recommended that the partner agencies implement a process that enables them to understand the circumstances of families, particularly whānau Māori, who decide not to take part in PW: FFT-CG therapy after they have been allocated a therapist, and their reasons for not proceeding.

2. Related to 1 above, according to the data, around a third of referrals cannot be contacted for follow up. This may be because they change their contact details without notifying the referring organisation/YHT or they do not answer their

phone/email/door. It is recommended that the referrers and the service consider solutions such as:

a) developing supplementary processes for maintaining contact details of clients who have been referred, particularly those who may be more mobile or transient. 'Follow up back up' in service agencies and longitudinal research organisations often includes collecting contact details of clients' significant others (e.g. a close relative, neighbour or other associates) in case clients change addresses, so that they can still be contacted
b) developing an agreement between YHT and referrers that YHT therapists contact the referrer when they are unable to contact a client and the referrer follows up to renew/review/withdraw the referral
c) developing a protocol that requires the referrer, client whānau and YHT therapist to meet together in the first instance. This would involve the referrer introducing the young person and whānau to the therapist enabling direct contact from the outset.

3. The current data collection process could include additional items that record the gaining acceptance and building trust activities that therapists undertake prior to the young person and family/whānau/aiga becoming an active case, as this is an important component of the PW: FFT-CG approach.

4. Develop a unified easily accessible database from the three separate databases currently being used, to better meet the needs of the programme.

5. Clarify the ownership of the intellectual property rights, kaitiakitanga, and copyright matters relating to the incorporation of WWW (or elements thereof) within the Clinical Training Manual and control of the cultural data that is collected in the monitoring system (e.g. all the assessment information and case notes that are entered into the FFT LLC CSS database).

The staff, Steering Group, Kaumātua, and participating agencies should all be acknowledged and encouraged for what they have achieved to date in a positive and cooperative manner. A new and innovative service in an area where success has been hard to achieve in the past, is well underway, is running smoothly, and is well governed. Success breeds success and this early achievement should be recognised and encouraged.

2 Introduction

An independent external team of the Family Centre's Social Policy Research Unit (FCSPRU) was contracted by Oranga Tamariki to deliver a high quality, multi-year evaluation (July 2019-June 2022) of the Pae Whakatupuranga: Functional Family Therapy - Cross Generations (PW: FFT-CG) pilot programme. The mixed methods evaluation has been designed by FCSPRU in collaboration with the Oranga Tamariki Evidence Centre.

YHT is implementing the pilot PW: FFT-CG programme. FFT has been operating nationally through YHT for over 10 years, giving YHT a full understanding of traditional FFT. This evaluation is concerned with the implementation of the cross-generation adaptation of FFT with a wider age range and adaptations to the New Zealand situation. YHT as service provider is present at all levels of governance, management, and service provision. YHT is contractually accountable to Oranga Tamariki, and to FFT LLC to whom it is also a Licensee. YHT is also accountable to the Steering Group, on which it sits and holds a Co-Chair position. In addition, YHT is responsible for meeting the data collection, reporting, and accountability requirements of the multiple stakeholders to whom it has contractual or other ties.

The evaluation has three overall high-level objectives:

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

There are two parts to the evaluation. The formative evaluation will take place in three waves and the impact evaluation in two waves. All waves of the evaluation will involve quantitative and qualitative data collection. This report concerns wave one of the formative evaluation and examines early indicators pertaining to objective one above. The views and experiences of staff, stakeholders, and Steering Group members involved in the PW: FFT-CG pilot were obtained, along with a range of monitoring data and documents. The researchers sought to elicit and analyse information on the strengths and challenges of the pilot programme to date. The wave one evaluation covers the programme's conceptual and contractual framework, governance and management, referrals, therapists, training, and monitoring data. It is essentially a baseline evaluation, and does not encompass client reports or effectiveness analysis, given that there are no programme completions at this early stage of the pilot.

The PW: FFT-CG pilot is complex, in part because of the multiple stakeholders and multiple issues inherent in the pilot. The collaborative initiative aims to meet the different but over-lapping goals of three agencies. This evaluation is concerned with process elements around the collaboration between three agencies, each with their own distinct systems, structures and organisational cultures.

In addition to the processes around the formation and pilot operation of a collaborative initiative between agencies and YHT as the service provider, the project also involves the piloting of a new adaptation of FFT. This brings another stakeholder into the picture, the FFT LLC – the developer, owner, and Licensor of FFT programmes.

The therapeutic model is also unique because of the anticipated amalgamation of culturally specific (Māori and Pacific Nations) therapeutic approaches. This is being achieved through ongoing training around the cultural frameworks.

Hence the evaluation canvasses organisational structures, systems, and relationships; culturally specific and embedded approaches to families/whānau/aiga, people and values; and the new adaptation of FFT. The adaptation (PW: FFT-CG) is being delivered by a newly constructed team of therapists with a range of supports in place.

3 Background

3.1 Desired outcomes of the PW: FFT-CG

The PW: FFT-CG therapeutic programme is designed to decrease criminogenic risk and increase protective factors amongst index clients, including addressing eco-developmental and contextual environmental factors, specifically family/whānau/aiga functioning. Desired outcomes have been identified as:

- Reduce risk of re-offending
- 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.

In addition, PW: FFT-CG as it is practised in Aotearoa/New Zealand aims to explicitly include Māori and Pasifika culture-centred therapeutic approaches.

3.2 PW: FFT-CG Aotearoa/New Zealand pilot

The PW: FFT-CG pilot programme aims to "break the intergenerational cycle of justice involvement for youth"[3] through reducing reoffending by facilitating positive change in family systems. This is posited to reduce risk and increase protective factors related to offending or re-offending.

The PW: FFT-CG pilot is a collaboration between Oranga Tamariki (Youth Justice), Police, and Corrections. Oranga Tamariki is funding the pilot programme and evaluation under its Reducing Youth Offending programme of work.

YHT is a third-party provider of the PW: FFT-CG programme in New Zealand. Oranga Tamariki has contracted YHT to pilot PW: FFT-CG in Auckland for two years from July 2019. If early indications are the service is effective then it might be rolled out gradually to other locations, starting in July 2021.

Oranga Tamariki (Youth Justice) has provided a resource in the form of a programme manager for the pilot. The programme manager plays a significant role in the preparation and implementation of effective communications, including face-to-face meetings between stakeholders.

3.3 Scope of pilot programme

YHT is piloting PW: FFT-CG in the Greater Auckland region (including Franklin to the south, Waiheke Island and Wellsford to the north). YHT has five trained PW: FFT-CG therapists, one Practice Supervisor, and one Referral Coordinator. Referrals for the pilot are made by Oranga Tamariki (10 to 17-year olds), Corrections (18 to 24-year olds) and the Police (10 to 24-year olds). The pilot is governed by a Steering Group comprising representatives from all the partner agencies and key YHT personnel. The pilot runs for two years, from 1 July 2019 to 30 June 2021.

YHT uses the term 'index client' to identify the young person who is referred to PW: FFT-CG. If a parent or an entire family is referred, then the young person with the greatest need is identified as the index client. When that is not clear, the oldest person aged 17 years or under is the index client. YHT collect and organise their monitoring data in relation to the index client.

To qualify for entry into the pilot, the index client has to have some involvement with the justice system and be living with their family of origin. The family of origin must include at least one caregiver, that is, a person with significant influence in the index client's life.

Exclusion criteria from PW: FFT-CG include: sexual offending when it is the primary reason for the referral; if the index client has serious other charges pending; if the index client has acute mental health episodes requiring a health intervention; index clients whose comprehension of therapeutic interventions would be compromised, for example, those who have developmental delay; and where the index client has experienced incidences of family

[3] INFO by Design. (2019) *Information Sharing for Functional Family Therapy – Cross Generations: Privacy Impact Assessment.*

violence with acute palpable terror and the perpetrator is suspected to have ongoing contact with the family.

In total, 56 clients were referred from the beginning of the pilot to 16 December 2019:

- Twenty of these were classified as never beginning treatment (36%)
- Five as having dropped out after beginning treatment (9%)
- Six as being referred but not yet having begun treatment (11%)
- Twenty-five active cases receiving treatment (44%).

A note of caution. These figures point to areas that are illustrative of the pilot, however the numbers are too small to predict the performance of the programme in its final form.

4 Methodology

4.1 Research aims

This report concerns wave one of the formative evaluation. Priority questions include:

- How is the PW: FFT-CG programme being implemented?
- What is working well or not working well during the implementation? What are the reasons for this?
- How could the implementation be improved, if at all?

4.2 Research methodology and cultural values

In order to determine whether the PW: FFT-CG pilot is being implemented as intended, it is necessary to examine the nature of the PW: FFT-CG therapeutic model and the key intentions associated with it.

In addition, given the inequitable (over) representation of whānau Māori and Pacific Peoples in offending statistics, together with the specific inclusion of cultural aspects into the PW: FFT-CG programme, the team considered that cultural theory and methodology should permeate the research process as a whole, from design to data collection, analysis, and reporting. This is enabled by the three tikanga (Māori, Pacific, and Pakeha/European) approach of the FCSPRU.

The therapeutic model and values behind the Māori and Pacific approaches, which differ from mainstream Western approaches, are summarised briefly below. Further detail about the approaches is provided in Appendix A.

PW: FFT-CG therapeutic model
PW: FFT-CG is an adaptation of FFT, a family-based treatment designed to address young people's behavioural problems and the family contexts within which they occur. FFT was "specifically designed to address the needs of a range of problem families, especially the most challenging ones"[4]. FFT targets adolescents aged 11-18 with moderate to severe conduct problems and offending. Two earlier adaptations of FFT expanded the age range, to 0-18, and to 18-24, respectively.

A philosophical and conceptual framework that focuses on therapists establishing respectful relationships and a family-centred environment (based on client and family perspectives),

[4] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc.) Seattle, WA. p3.

together with "an appreciation of the individual, family, and socio-cultural systems"[5] is common across the FFT adaptations.

Core principles of FFT are a therapeutic approach that is:

- Respect-based
- Phase-based
- Integrated and multi-systemic
- Evidence-based and data-driven.

For FFT to work, all members of the index client's significant social network (often household or family members) should participate in the therapy. Members of the extended family/whānau/aiga are also welcome to participate.

FFT therapies utilise five components (known as 'phases') of change. Therapists are required to work through the five phases with index clients and families/whānau/aiga achieving the goals identified with each phase in order to complete a programme. The five phases are: engagement, motivation, relational assessment, behaviour change, and generalisation when behaviour changes are extended into other areas of the family's life.

A key variation in the PW: FFT-CG adaptation from the existing FFT approaches is the age range of 10-24 years, which requires developmentally appropriate elements from existing FFT adaptations. In this sense, PW: FFT-CG may be more demanding than existing FFT adaptations. The PW: FFT-CG Clinical Training Manual states a programme usually consists of 10-12 sessions over three months. However, the view of YHT is that five months is a more likely period, given the greater range of problems presented by clients across childhood, youth, and early adulthood, compared with YHT's experience with the standard programme.

Kaupapa Māori and Pacific Fa'afaletui research methodologies

Kaupapa Māori theory and practice

The FCSPRU Māori research team was guided by the knowledge gained through the 'acts' of research characterised under kaupapa Māori, tikanga-a-iwi and the broader Mātauranga Māori methodologies. Kaupapa Māori is not a new research methodology, but rather the application of longstanding values, worldviews, ethics and processes to modern research contexts[6]. Māori approaches tend to involve looking outwards and developing relationships and connections with the aim of gaining the whole (holistic) picture. This method of engagement was also employed by PW: FFT-CG.

Pacific Fa'afaletui research

The Pacific *relational person* consists of three core elements: the spiritual, physical, and mental. The Pacific relational person has meaning within the *four primary relationships*: relationship with Atua; with the environment; with ancestors and heritage; and with others, aiga, and extended family[7]. *Fa'afaletui* methodology was developed for research with indigenous people to avoid the marginalisation of their cultural differences in mainstream studies[8].

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[5] Robbins, Michael, S. (2019) *Functional Family Therapy: Cross Generations. Clinical Training Manual.* Functional Family Therapy (FFTllc/FFTinc.) Seattle, WA. p7.

[6] Smith, L.T. (1999). *Decolonising methodologies: Notes from Down Under*. London; Zed Books

[7] Tamasese, K, Parsons, L, Sullivan, G & Waldegrave, C. (2010) "*A Qualitative Study into Pacific Perspectives of Cultural Obligations and Volunteering."* Family Centre Social Policy Research Unit, Lower Hutt, Wellington

[8] Tamasese K, Peteru C and Waldegrave C (1997) *Ole Taeao Afua, The New Morning: A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services*. The Family Centre, Lower Hutt, Wellington

Whānau Narrative Inquiry
Narrative Inquiry is a qualitative research methodology[9] that takes the approaches of narrative enquiry and integrates them within indigenous cultural frameworks. Whānau Narrative Inquiry places participants and their stories or narratives at the heart of the research process.

Fa'afaletui Inquiry
Fa'afaletui Inquiry includes individual and fono group inquiries. The fono group method facilitates systematic comparisons of an individual's experience with those in their group[10].

4.3 Research methods: qualitative data collection and quantitative data analysis

Semi-structured interview schedules were co-designed by FCSPRU and the Oranga Tamariki Evidence Centre. Whānau Narrative Inquiry was guided by interviewers to maintain the focus on priority research questions, while providing for participants to generate their own narratives and interpretations around the broad questions. The interview schedules varied according to the roles and specialisations of the participants, but all interviews sought descriptions of interviewees' roles and processes, and their assessment of what was working well and where the challenges lay. Likert scale ratings were collected during the qualitative interviews to provide contextual internal quantitative ratings of aspects of PW: FFT-CG (e.g. the referral process). Further details about qualitative data collection are provided at Appendix A.

Administrative, monitoring, and assessment documents were provided to the research team. These documents provided information on the entry into and uptake of the PW: FFT-CG programme, including referral pathways, eligibility assessment, uptake, early exits, and completions.

YHT collects administrative and outcome data through a range of forms and questionnaires. They provide information about the programme's implementation, the characteristics of its participants, and the outcomes achieved for and by the participant families and youth.

The data generated by the forms and information sources is held in three databases:
- CSS database/client management system created by the FFT programme
- YHT HCC case management database
- YHT Googleform database for cultural satisfaction survey data.

The data serve two broad reporting and monitoring purposes: process and outcome. Process monitoring and reporting focuses on the movement of participant families and youth into, through, and out of the PW: FFT-CG process, and participants' evaluations of the process and their therapists. Outcome monitoring and reporting focuses on the quality of participants' engagement with the PW: FFT-CG process and the behavioural changes achieved.

We examined the available documentation and data to assess the fitness-for-purpose of existing documents and make recommendations to improve data quality.

Our quantitative analysis of the monitoring data provided an initial evaluation of service implementation.

Tamasese K; Peteru C and Waldegrave C. (2005) "*Ole Taeao Afua, The New Morning: A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services."* Australian and New Zealand Journal of Psychiatry. Vol. 39 (4) April, p.300-308

[9] Clandinin, D. J., & Rosiek, J. (2007). Mapping a Landscape of Narrative Inquiry: Borderland Spaces and Tensions. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (p. 35–75). Sage Publications, Inc

[10] Kreuger RA. (1988) *Focus groups: a practical guide for applied research.* Newbury Park, CA: Sage

4.4 Ethics

YHT informs young people and their families/whānau/aiga about the evaluation when they begin PW: FFT-CG, and seeks their consent for routine information about them to be used for evaluation purposes and to being contacted to be asked to take part in other evaluation activities.

A member of the Oranga Tamariki Evidence Centre ethics panel reviewed an ethics assessment for the overall PW: FFT-CG evaluation.

All those who were invited to take part in wave one were adults participating in their professional capacity and the information collected focused on their experience of how well entry into and uptake of PW: FFT-CG is working, so the likelihood of participants experiencing emotional harm and/or disclosing risk of harm or illegal behaviour was very low.

All participants were provided with FCSPRU and Oranga Tamariki Evidence Centre co-designed information sheets outlining the purpose of the evaluation and given the opportunity to ask questions. Participants were asked to complete a consent form and were given the option of refraining from answering questions or discontinuing their interview at any stage.

Young people and their families were not invited to take part in wave one because none had completed, or nearly completed, PW: FFT-CG at the time the fieldwork was undertaken. Consequently, the submission of the ethics application to the Oranga Tamariki Evidence Centre ethics panel for these interviews was delayed until the start of 2020.

5 Results

This section examines how the PW: FFT-CG pilot is being implemented at this early stage, six months from its commencement. The pilot has several inter-linked and overlapping components, hence the analysis has some level of complexity. For clarity, five broad elements of the pilot are examined, however it is acknowledged that these elements are inter-woven to a considerable extent:

1. Conceptual and contractual framework
2. Governance and management
3. Referrals
4. YHT PW: FFT-CG clinical delivery
5. Therapeutic training and processes.

5.1 Conceptual and contractual framework: how is the PW: FFT-CG programme being implemented?

Conceptual framework

FFT programmes have an emphasis on a 'phase-based' progression of index clients and families/whānau/aiga through a therapeutic behaviour change process, as opposed to a prescribed therapeutic delivery template. Therapists are "not trained to follow a specific behavioural template."[11] This provides the space for therapists to approach therapy from a range of worldviews, and to utilise culturally specific concepts and motivators according to what is most consistent with client cultural contexts.

FFT LLC has developed several adaptations of the foundational FFT model to accommodate various providers and client populations. For example, Functional Family Therapy-Child Welfare (FFT-CW®) is designed for referrals from child welfare agencies, Functional Family

[11] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc) Seattle, WA. p3

Probation/Parole (FFP®) is designed for clients referred through probation and parole services and FFT-G® is designed for clients with gang associations. In each case, FFT LLC staff have modified the FFT training manual and training materials to directly address issues that are likely to be salient in the identified client group. These modifications retain the basic components and approaches of the full FFT model. FFT LLC provides training in the PW: FFT-CG therapeutic model to YHT therapists.

A range of 'techniques' are available for use within FFT adaptations. They may be utilised primarily in relation to particular phases of therapy and in response to the specific requirements of index clients and family/whānau/aiga. They are designed as tools to be utilised by therapists in response to the specific needs and circumstances of the families/whānau/aiga they are working with. However, the progression of families/whānau/aiga through 'phases' of treatment, together with the 'balanced alliance' concept and core therapeutic values[12] form the backbone of FFT approaches.

The approach taken to the common therapeutic technique of 'matching' is also worth noting here. It is not simply about matching therapist and clients based on gender, ethnicity, or other variables. Using family/whānau/aiga therapeutic approaches, FFT endeavours to generate and maintain a 'balanced' alliance with multiple participating clients. 'Matching' in an FFT context is understood as **matching interventions** to the unique qualities of each family and family member. These qualities include "culture, history, developmental considerations, family structure, gender identities and preferences, and a range of co-occurring physical, emotional and psychological challenges."[13,14] Within this context, FFT LLC trains therapists in culture-centred therapeutic approaches that 'match' with the primary cultural contexts of families/whānau/aiga.

The pilot PW: FFT-CG model specifically seeks to incorporate culturally responsive therapeutic understanding and approaches in relation to Māori and Pacific culturally constituted worldviews and value systems, with a therapeutic model originating from a Western epistemological base. While the application of culturally responsive PW: FFT-CG therapy to Māori and Pacific client groups will be examined in detail in wave two of this formative evaluation, the integration of cultural frameworks into contractual agreements, training and practice warrants some initial consideration at a conceptual level.

Whaitake Whakaoranga Whānau (WWW) is the Māori cultural framework developed for YHT. WWW is being implemented within the PW: FFT-CG pilot, with training in the framework already having been provided to therapists. A Pacific framework is currently in development. Pacific cultural aspects are reported to have been acknowledged in the PW: FFT-CG training through the involvement of Pacific cultural advisors and staff. Therapists also have regular access to cultural supervision.

Contractual framework
Agency Partners
The government agency partners in the PW: FFT-CG pilot initiative are:

- Oranga Tamariki, specifically the Youth Justice division in terms of the operation of the pilot
- Corrections, including but not limited to the probation, parole and community sentencing functions
- Police, including but not confined to the Youth Aid Division.

[12] Ibid p.15
[13] Robbins, Michael, S. (2019) Functional Family Therapy: Cross Generations. Clinical Training Manual. Functional Family Therapy (FFTllc/FFTinc. Seattle, WA. p2.
[14] This differs from some other types of therapeutic 'matching', where the emphasis is on matching therapist and client characteristics such as gender, ethnicity and/or age.

Oranga Tamariki provides the operational funding for the PW: FFT-CG pilot programme and may be considered the Lead Agency within the agency partnership.

YHT is contracted to Oranga Tamariki to deliver the pilot. Key positions in relation to the pilot include:

- Referral Co-ordinator
- On-site Practice Leader (also serving as Clinical Supervisor)
- PW: FFT-CG therapy team (five therapists)
- Kaumātua.

Additional cultural supervisors within and outside YHT also engage regularly with the therapy team.

FFT LLC and FFT Associates are the owners of FFT models of therapy. They are separate companies with common intellectual property rights to FFT materials and research. FFT LLC is the primary owner and Licensor of the FFT programmes delivered by YHT. All FFT services operate with a licence issued by the company.[15]

Licensed organisations delivering various FFT programmes (including YHT) are required to use the FFT LLC data collection tools and thus contribute to the international data pool. The YHT Agreement with FFT LLC includes providing FFT programmes that meet the international requirements and standards of FFT, including participating in and contributing data to the FFT LLC reporting and monitoring database.

In contractual arrangements with Oranga Tamariki, YHT and the developers of WWW retain ownership of the intellectual property associated with the WWW framework and grant limited rights to Oranga Tamariki for the duration of the PW: FFT-CG pilot only. The draft FFT-CG Clinical Training Manual and materials anticipate including the WWW framework (or elements thereof) in the FFT-CG Training Manual. This is a unique development for the FFT LLC, and for the creators of WWW. To date, FFT training materials and manuals have been clearly copyrighted and owned by FFT LLC.

Arrangements for the ownership, kaitiakitanga, and copyrights relating to the incorporation of WWW (or elements thereof) within the Clinical Training Manual are not, at this stage, clear. This review has also raised questions about the intellectual property rights of the cultural data collected in the monitoring system, which includes all assessment information and case notes which are entered into the FFT LLC CSS database.

What is working well?

Flexibility during the development stage

Communications and relationships among stakeholders are pivotal in a multi-stakeholder arrangement such as the PW: FFT-CG pilot, where rigorous examination of progress together with a degree of flexibility and adaptability are desirable. This is particularly so for the PW: FFT-CG pilot where elements of the therapeutic model and the Pacific cultural framework are works in progress.

YHT's relationship with Oranga Tamariki, and that between YHT and FFT LLC, appear to be working well, with regular and clear communications, an apparently high degree of trust, and the willingness of parties to consider some adaptation of their own practices to accommodate the combination of PW: FFT-CG and cultural models in a pilot.

[15] Information sourced from http://fpmcic.com/functionalfamilytherapy.php

FFT LLC are viewed by YHT management and therapeutic staff as understanding and providing effective support and adaptations to fit both the YHT organisational culture and the local client group needs.

> *"Developers/trainers [of the FFT model] have a good relationship with YHT and are supportive of how YHT works."*

Collective rather than individual approach to therapy
Some Steering Group members commented that they were inspired by the approach of the therapeutic team. There was strong support for the collective (family/whānau/aiga) approach as opposed to an individual counselling approach that had been more commonly employed. The PW: FFT-CG collective model was a positive and suitable model to assist in rehabilitation.

> *"It is a great way of working and I hope that in time this will be the future direction of our rehabilitation programmes – focusing on the collective not the individual."*

Room for improvement

Ownership arrangements for components of PW: FFT-CG beyond the pilot programme
There is a question about the long-term ownership of the intellectual property, particularly pertaining to the cultural frameworks that are being developed and applied within the PW: FFT-CG model. Issues of ownership and copyright of the cultural data generated in the new PW: FFT-CG model, including assessment data and case notes, are also not yet clear.

Differing perspectives on collaboration in the development of the therapeutic model
While a collaborative partnership to implement the PW: FFT-CG multi-agency pilot is certainly underway, there are different perspectives about how collaborative the initial process was in regard to the therapeutic model, and the degree of ownership felt within some agencies.

One view was that there was strong collaboration from all partners right from the start.
Another view was that YHT got a contract from Oranga Tamariki and purchased the programme from FFT LLC, while there was no Steering Group or partner input into the construction of the therapeutic model itself.

> "*I do not believe that this was genuine co-design of a programme, it was still a programme designed by FFT LLC in the USA, purchased by YHT to meet a (albeit loosely defined) contract from Oranga Tamariki."*

5.2 Governance and management

Background
The contracting organisations provide a level of oversight and guidance through their contractual and collegial relationships with YHT as the programme provider organisation. However additional governance and management of the pilot project is shared between the three partner agencies (Police, Corrections and Oranga Tamariki) and the programme provider organisation (YHT) through a Steering Group. Agency representatives on the Steering Group have clear lines of reporting and accountability to their respective partner agencies.

The Oranga Tamariki programme manager is a Steering Group participant and co-chair. The programme manager drives, monitors and facilitates multi-agency collaboration, communications, pilot project progress and troubleshoots as required.

Within YHT, there are several staff who provide leadership at managerial levels to support the pilot programme implementation, most of whom also participate actively on the Steering Group. YHT members on the Steering Group and their specific areas of expertise are outlined below:

- *Kaumātua* – the Kaumātua is a developer of the WWW framework. He is also a trained FFT therapist, provider of cultural supervision, and respected member of mana whenua iwi.
- *Outcomes and Evaluation Manager* – responsible for data management, measures and tracking, and reporting. This role requires the planning, organisation, collection, and analysis of data sets required to meet contractual obligations as well as data required to monitor pilot programme progress across a range of domains and to inform best practice. This role also works across YHT and FFT LLC management and pilot programme governance to ensure processes facilitate best practice and successful outcomes on the ground.
- *Clinical Supervisor/Practice Lead* – The clinical supervisor is an experienced FFT therapist who is also accredited as a Site Supervisor and trainer with FFT LLC. In the role of clinical supervisor, she provides regular individual and group supervision with the therapy team. While there is a consultant "practice lead" from FFT LLC, the YHT Clinical Supervisor also acts as the on-site "secondary practice leader." This involves monitoring outcome and ratio adherence, therapeutic progress and therapist and whānau plans. Further, the Practice Lead was central to the selection of YHT's five-person inaugural PW: FFT-CG therapeutic team and plays a significant role in the triage of referrals, and allocations to therapists.
- *Referral Coordinator* – A Referral Coordinator position was established for the PW: FFT-CG pilot to facilitate referrals from partner agencies to the YHT therapy team. Components of the Referral Co-ordinator role include:
    - Establishing and maintaining relationships with referrer agencies
    - Triaging referrals
    - Assessing clients' suitability and matching clients/families with therapists
    - Administration, and entering and reporting on monitoring data
    - Participating in the Steering Group
- *Cultural Supervisor* — The Cultural Supervisor supports the therapists to integrate WWW into their therapeutic processes. Fortnightly team sessions connect the WWW training with FFT skills and approaches.

Steering Group members have the authority within their organisations to effect change directly, including to influence or to progress requests relating to the PW: FFT-CG pilot to the required level of seniority within their agencies. In this respect it is intended that Steering Group members can bring about changes that may be needed to facilitate the effective operation of the pilot programme, including responding to feedback from the contracted provider and their own organisations. The Steering Group monitors referrals across agencies and progress of the PW: FFT-CG pilot implementation. Members report on the progress of PW: FFT-CG pilot programme directly to senior management, leadership teams and working groups within their respective agencies.

What is working well?

Steering Group composition

Steering Group members bring valuable knowledge of their agency systems, structures, cultures, lines of authority, and decision-making processes to the table. Steering Group members from government agencies hold relatively senior positions within the regional hierarchies of their respective agencies. Steering Group members described their roles in part as:

"Providing a [agency] perspective, supporting the outcomes of the pilot through referrals."

"To provide knowledge of the [*agency's] system, practices and policies in the design and pilot of the programme while also providing the link to local sites and managers in the Auckland region."*

Steering Group leadership
Steering Group members reported that leadership of the Group by the Oranga Tamariki programme manager was effective. The programme manager was described as committed to the project, and an excellent communicator and co-Chair of the Steering Group. Steering Group operation was described as:

"Very effective with good leadership [from programme manager]."

Internal Steering Group communication and collaboration
The role of the programme manager as a consistent point of contact was beneficial. Steering Group members considered that communication between them and the programme manager was working well.

"[Programme manager] is a consistent point of contact."

"Effective communication between members and via email."

"The team seems to gel well with good support to each other and the trial."

Although it was noted that the inter-agency collaboration was still 'developing', Steering Group members expressed satisfaction with the progress of collaboration and communications at meetings. A Steering Group environment that was described as 'safe' enabled discussions that were robust, effective and collaborative to occur.

"Collaboration between agencies is still developing…"

"Good collaboration... on the whole everyone contributes and provides input."

"The [Steering Group] collaborative relationships and professionalism."

"I think that the Steering Group is working very effectively as a group."

Supportive environment
Most participants in this evaluation considered that YHT did a good job of providing a safe and supportive environment within which issues about staff and the pilot could be safely raised.

"Team meetings… am allowed to have weaknesses and not be judged but instead feel supported. YHT incredibly friendly, welcoming experience that is different. It has a heart of its own."

"Think of it as dynamics within whānau…. it's the same as dynamics within the team… If the therapist team didn't work well together the programme wouldn't work well"

Upward and parallel reporting and accountability lines of Steering Group members
Agency Steering Group members were clear about both their parallel and upward reporting and accountability roles within their respective agencies, and their accountabilities to partners on the Steering Group.

Regular attendance of YHT therapists at Steering Group meetings
The programme manager is keen to keep the Steering Group well informed about the operations of the pilot. The team of YHT therapists meet regularly with the Steering Group, attending a portion of Steering Group meetings. Some Steering Group members appreciated this direct line of communication between operations and governance as an opportunity hear success stories and better understand the therapeutic approach. Steering Group members described this as:

> *"The approach the therapists use with whānau is inspiring and we can really see the benefits with some of our success cases."*

Therapists and other YHT staff felt they were listened to by Steering Group members and appreciated the opportunity to attend Steering Group meetings to raise issues that required direction from the Steering Group, and present their recommendations for any changes or modifications that they would like the Steering Group to consider. There was feedback that therapists and other YHT personnel were satisfied that issues raised by them were addressed effectively by the Steering Group.

> *"We feel listened to by Steering Group…. Proactive."*

> *"So, SG decide. So far they have been favourable … generally adopt our recommendations."*

Steering Group initiates change to facilitate pilot programme success
Steering Group members identified an important part of their role as being:

> *"…to also see potential risks and troubleshoot these where appropriate."*

A notable example of making change in agency protocols to facilitate the successful operation of PW: FFT-CG relates to an area of risk identified by therapists. Therapists communicated to the Steering Group that the reporting requirements of agencies were sometimes conflicting with their ability to establish and maintain trusting relationships with clients and their family/whānau. For example, a condition of a client's bail may require no alcohol but s/he may be having a beer when they went to see them. The therapists explained that reporting could lead to index clients and whānau identifying therapists as 'agents of' or primarily aligned with Police, Corrections or other government agencies that index clients tended to view negatively or distrust. This in turn negatively impacted the levels of trust that therapists were able to establish with index clients and whānau, and their willingness to engage.

Therapists sought assistance from the Steering Group to be exempted from some of the reporting requirements of agencies, in order to clearly delineate their role from that of the referring agencies, and more effectively build therapeutic alliances. It was explained that for index clients and whānau:

> *"...the distinction of who you are and what your role is, is important."*

The Steering Group emphasised that reporting was necessary if there were incidents that presented a danger to the client, the therapist or the public, but did not require them to report incidents that should be kept confidential in a therapeutic setting. This nuanced policy assisted therapists to establish and maintain trusting relationships with clients and their family/whānau/aiga.

(There is) "*No offence reporting requirement unless there is an immediate risk of harm to selves or others…. in fact, whānau knowing that there was no requirement for therapists to report helped establish relationships."*

In addition to facilitating index client/whānau engagement and trust in therapists, the Steering Group's advice on reporting enabled therapists to operate more consistently within the PW: FFT-CG model that emphasises prioritising whānau needs and working alongside whānau.

"Whānau needs are prioritised, which tells them they are important...make it easy for them to say yes to participate in therapy."

A programme emphasis on early identification, prevention, and early intervention, strongly supported by therapists and YHT staff, is also operating. Police can refer youth and whānau who are deemed "at risk of offending" to PW: FFT-CG, as opposed to waiting until youth enter the system as offenders.

Data collection and reporting to enable effective pilot programme management and assist pilot development

The current pilot PW: FFT-CG will undergo rigorous evaluation before it is approved for full implementation, and the evaluation will rely on robust data and information gathered at the pilot stage. The pilot is also designed as a learn-as-you-go programme – data is continuously gathered and reported to the Steering Group so the Group can gauge progress and discuss issues as they arise. Participants assess the data collection and reporting as functioning effectively – "*information necessary to achieve model fidelity for contract purposes"* is being collected; the data collection is "*manageable and systematic – not just adding new measures*" and management are continuously "*looking at what our staff are collecting and what we are doing with it"* with the aim that, if issues arise, there will be "*clinical and cultural support in place."*

Monthly dashboard reports to the Steering Group are constantly reviewed and refined to maximise their utility, and Steering Group members were appreciative of the report's continuous improvement. Variations in data across sites and/or agencies give the Steering Group the opportunity to explore the reasons behind the differences and possible modifications to their agency's processes.

Room for improvement

Communications between agency representatives on Steering Group and on-the-ground staff, particularly potential referrers

While communications upward (reporting and accountability) appear to be working well among agency representatives on the Steering Group, there is a question around how effectively downward communications to on-the-ground staff, particularly from site champions, site managers, team leaders, and potential referrers, are operating. This was particularly the case in relation to the Oranga Tamariki (Youth Justice) and Corrections personnel, with some suggestions that there was room to: *"improve communication strategy to front line practitioners to increase quality referrals"*.

Suggestion for improvement

One point of contact for communications within YHT PW: FFT-CG team

A communications manager and/or a shared calendar so all YHT staff members involved in PW: FFT-CG know where to go for information may alleviate the frustration and feeling of being overwhelmed by communications that some participants expressed. This would allow staff to focus on their respective roles and respond to specialised queries.

"It would be good to have like a programme manager, one person that passes information/event information onto the relevant people…. tracking what's happening across the different domains… one point of contact – Māori, Pacifica, FFT Training, Noho – one person tracking all that…What would be good would be an overall team calendar so everyone knows what is going on and where potential times are available to schedule things like training etc."

5.3 Referrals

The referral process

Several personnel and agencies are involved in the PW: FFT-CG referral process for clients/families/whānau/aiga. Referrals are taken from Police, Oranga Tamariki, and Corrections, most commonly from a youth aid officer, case social worker, or probation officer who has direct contact with a potential candidate. Each agency appoints a site champion from staff to promote the PW: FFT-CG programme within their agency/site and to provide a point of contact for the YHT staff.

The Referral Coordinator liaises directly with potential referrers in the partner agencies, with site champions and with potential referrers, to ensure that criteria for referrals are understood and to encourage referrals of appropriate clients. The Referral Coordinator will discuss the possible referral with a client and their whānau/family and seek preliminary agreement for referral. If the client or family is interested, they are offered the PW: FFT-CG explanatory brochure, which also provides a Freephone number to enable clients to contact YHT personnel directly.

Referrers highlighted several factors that contributed to their decision-making about client suitability for PW: FFT-CG. Dysfunctional families/whānau/aiga, who would benefit from improving their communication skills and relationships qualify, as do families with a history of parent/caregiver powerlessness in the face of the teen's lack communication or co-operation. Some youth and their families/whānau/aiga are heavily engaged in gangs and reside at known gang houses, and this was not seen as precluding referral. PW: FFT-CG clients and families/whānau/aiga experiencing parent/child conflict, cultural issues, or drug and alcohol abuse are potential PW: FFT-CG candidates. Some referrers delve quite deeply to understand the nature of their client's issues.

"We try to see how they are using [drugs]. Is it to deal with deeper issues, trauma, pain?"

Factors which might make referrers decide against referring to PW: FFT-CG include a point-blank refusal by index clients or their families/whānau/aiga to countenance the programme. Risk to the therapist is also seen as a barrier for some, and safety is considered in the assessment process, in line with YHT practitioner policies. In some circumstances, referrers were concerned with over-loading index clients and families/whānau/aiga

"If the young person is already involved in other interventions...If mental health professionals are involved – It may be too much."

Where a client and family/whānau/aiga meet the criteria and are considered suitable, the Referral Co-ordinator works closely with the YHT Clinical Supervisor/Practice Leader in assessing and triaging referrals. There is often consultation with the referrer to assist in allocation of the most appropriate therapist to the client/family concerned.

Therapists will normally contact referrers directly to gain further information prior to contacting the client and family/whānau/aiga to engage them directly. If a therapist finds it difficult to

engage clients, they may contact the referrer and plan together how to get the family engaged. Referrers noted though, that overall, the therapists "don't give up easily."

The Referral Coordinator role
The Referral Coordinator appears to be integral to the successful implementation of PW: FFT-CG. They lead the development of relationships with referral agencies and sites and aim to gain acceptable referrals from all agencies. Referrers consistently spoke well of the Referral Coordinator, the link they have with her, and the confidence they place in her guidance. This linkage is very important to the success of inter-organisational connections and consequential to good client family/whānau services. While Police referral rates are considerably higher than those for Oranga Tamariki and Corrections, the Referral Coordinator has already taken actions that are likely to even out the referrals across the agencies in the future.

YHT management members who were involved, along with the Referral Coordinator, in the initial promotion of the PW: FFT-CG programme to referral agencies, noted that agencies were more receptive and likely to refer if the contact was tailored to agency goals and consistent relationships were established. The Referral Co-ordinator had established a regular presence at some sites and delivered tailored presentations to small groups or key individuals within agencies. Feedback indicated that small group presentations to specific teams and individuals were much more effective than large group presentations. Sitting in at a regular time at sites, increasing visibility and providing an opportunity for agency staff to talk about potential referrals, was also judged as increasing referral rates.

> *"What's working particularly well is the [Referral Coordinator] engagements with the people onsite. …having access to the sites, sitting in for one to two hours, building the relationships with the people on the site."*

> *"We managed to deal with smaller groups – site champions and practice leads or team by team… which meant that we could achieve those sorts of outcomes…tailored information…It is much more work for us, but it's more pleasant and more effective…We have seen an improvement as a consequence."*

The Practice Leader role
The Practice Leader is experienced and believes in the FFT model. The Practice Leader has a major role in the assessment, triaging, and allocation of referrals. She works closely with the Referral Co-ordinator and has responsibility for ensuring the safety and suitability of the client/therapist match. The Practice Leader has used the FFT model extensively with various populations such as whānau involved in gangs and others.

The Practice Leader and Referral Coordinator have established effective ways of communication and collaboration. While their collaborative work could theoretically be conducted via email, the mutual agreement has been to meet weekly to *"work through lists of issues in person."*

Police referrals
Referrals come from the three stakeholder agencies (Police, Corrections, and Oranga Tamariki (the Youth Justice section). They employ different internal referral systems and processes. The three agencies and sites within the agencies have client groups who differ in significant respects. This is important because the age and stage of index clients and their families/whānau has a significant effect on the perceived suitability of clients for referral, the rates of referrals to PW: FFT-CG, and the willingness of index clients and families/whānau/aiga to engage in therapy.

The monitoring data shows that Police referral rates are considerably higher than those for Oranga Tamariki and Corrections. Several factors may be behind the relatively high rate of

Police referrals. Police referral ages for index clients are 10–17 years, so these clients are likely to have become involved with the justice system only recently. This means they are still in the early stages of offending behaviours so Police have options to keep them out of formal and irrevocable involvement in judicial systems, and families/whānau are still motivated to help the young person.

> "*Police are….at the front end – (the) young person could be deemed as moving into offending behaviour…families are good because they really want to support that young person…they really want to see what supports are out there to help the young person change their behaviour – not only within the family but also behaviour that may be happening in the school...This is the front end, this is before they are getting entrenched in the YJ [Youth Justice], Corrections space…It's the willingness…that's coming from the families because they really want to support their son or their daughter… The parents are motivated and not too discouraged at this point."*

Further, the young person is usually already involved in a youth intervention in which they and often the family/whānau/aiga are required to participate. Police Youth Aid officers try to work on any difference in views between the parents and the young person about entering therapy prior to putting through a referral – as noted above, families may be well motivated to help but the young person may consider therapy a waste of time.

What is working well?

Overall ratings of *how the referral process is working for the referrers* are very good indeed (see Table 1). Referrers find the referral process easy with good communication at the outset. They admire the persistence of the therapists and understand that if no progress appears to be being made in the early phases of therapy, change can still occur in the middle and later stages. All respondents who were interviewed thought PW: FFT-CG had potential to improve the lives of index clients and their families.

Table 1: Referrers' responses to critical questions

	Very well	Well	Mixed	Not very well	Not at all well
How is the referral process working for referrers?	4	1			
How do you think the referral process is working for families?		5			

The consensus from referrers about *how the process is working for the client families* is positive (see Table 1). They consider families, overall, appreciate the support they receive from YHT, based on their feedback. The PW: FFT-CG pamphlet is appreciated by clients and referrers as it is straightforward and to the point. Referrers were impressed with the continuous refinement and improvement of the referral process and forms, a consequence of collaboration by the Clinical Supervisor/Practice Leader, who works primarily with the therapeutic team, and the Referral Co-ordinator, working with referral agencies and on-site personnel. This is thought to have led to increased rates of appropriate referrals, and high levels of satisfaction on the part of referrers.

Respondents assessed the referral process as slightly less positive for clients than for themselves because, for example, a parent might be very happy with the support they were

receiving but the young person may consider turning up for therapy a nuisance, so different family members might assess the programme differently.

Aspects of the programme that referrers considered were appreciated by families included: early engagement with the therapist; clients' ability to choose where they engaged with the therapist, whether at home or elsewhere; and the clarity about the duration of the sessions (a maximum of 20 sessions of 45 minutes). Referrers also considered that clients feel safe and respected in this collaborative process which aims to improve relationships within families. Referrers were not aware of any negative comments about the service that families received.

When *the therapists were asked about how the referral process was working*, their responses were mixed. The responses in Table 2 are much more positive about the referral allocation process than the initial referral process. This has been a consistent response throughout the evaluation, as noted above.

Table 2: Therapists' response: referrals

	Very well	**Well**	**Mixed**	**Not very well**	**Not very well at all**
How do you think the referral process is working overall?					
Initial referrals	1	1	3		
Allocation/distribution of referrals	1	4			

Therapists, sometimes facilitated by referrers, met with families/whānau/aiga to discuss what the therapy would involve and what benefits it might bring if they chose to participate. The voluntary nature of the programme is likely to increase client's commitment to the process, especially when clients and their families are well informed before agreeing to take part.

> *'…. have been given the opportunity for therapists to meet the families beforehand to see if it's suitable – family buy in, is it right for the young person."*

Room for improvement

Communications: feedback in the referrals process
The primary challenge identified by referrers (and identified by managers – see *Room for improvement* in *Governance and management* above) is providing feedback to referrers over time. There are complexities about sharing information among organisations, but it is likely that partner agencies and YHT could develop an agreed list of progress indicators (both for overall progress and for specific concerns) that do not compromise the privacy of the family/whānau, nor the confidentiality expectations of the therapist.

Referrals from Oranga Tamariki and Corrections
There are several plausible explanations for the comparatively lower rates of referrals coming from Oranga Tamariki and Corrections. Oranga Tamariki clients are the same age group as Police referrals (10-17 years). However, Oranga Tamariki clients typically have a significant

documented history of anti-social and/or offending behaviour. They, and often their families/whānau/aiga, are already in the justice system. This can make it more difficult for ongoing engagement with the youth and their families/whānau/aiga:

> *"It's a difficult one…we get the referral coming through and then we find that they reoffend, are back in youth residence…so the engagement there has been a little bit challenging for the therapists."*

In contrast, Corrections' referral ages are 18-24 years, where the young person/index client is becoming an adult or transitioning to independence. Young people in Corrections' services may not be living with family/whānau/aiga, they may have their own partners and children, and relationship with their family/whānau/aiga of origin may not be primary in their lives. This group of young people is often well entrenched in offending behaviours and government justice systems, have strong relationships with criminal associates, and can be quite unmotivated to change.

Further, the PW: FFT-CG is a voluntary programme, often recommended on top of many other mandatory requirements, and this may reduce the number of Corrections referrals.

> *"People who are involved in Corrections have extensive plans in place [already] to achieve objectives and are already overwhelmed and have required KPIs [key performance indicators] to address… Some Corrections whānau have so much going - FFT ranks where? FFT may be able to be like an entry point first choice. Remove the necessity for a Corrections referral to go to, for example, anger management."*

Several suggestions for improvements in the Oranga Tamariki and Corrections referrals processes are outlined below (see *Suggestions for Improvement* below).

Feedback to referrers and client confidentiality during therapy
Referrers suggested that providing therapists with information specific to the young person could be helpful especially if it related to youth offending. They suggested that red flags could also be flown while therapy is progressing if the youth shows a lack of empathy toward their family, for example. Referrers hold a lot of private information about the individuals from psychological reports, so they tend to consider more clarity about the youth concerned could be helpful for the therapist. This view needs to be weighed carefully against the privacy concerns set out in the *Information Sharing for PW: FFT-CG Privacy Impact Assessment* document and the views of therapists in YHT, including the risk that receiving information might bias their views of the young people.

A further concern expressed by one referrer was that the inadequate communication between the therapist and the referrer has at times led to referrals to other groups or agencies, creating the possibility of overburdening families/whānau with people working with them.

Large group presentations to potential referrers
Small group presentations and a regular presence by the Referral Coordinator at various sites are effective strategies for engagement; however, large group presentations are less effective. In some agencies there is considerable choice of programmes to refer clients to, and referrers may be overloaded with presenters pushing their programmes. YHT staff found that in large group situations the attention of audiences was likely to wane.

> *"Our ability to whakatau and whakawhaungatanga was hindered when we had to present to a huge group at different sites. It felt like people were checked out when we were presenting… It felt like the groups were too big to engage meaningfully."*

"What hasn't worked so much, when you go in there and you're presenting….to about 30 odd people…and a lot of what you're saying can get lost in translation….and what I've also noticed… disinterest, it's "oh not another service coming to pitch their programme"…at one site we had the audience rolled their eyes….I'm not going to say all of them coz that wouldn't be fair…but we saw it…"

Referral Co-ordinator's need for familiarity with the PW: FFT-CG model

The Referral Coordinator did not attend the initial therapist training. However, the benefit of the Referral Coordinator being thoroughly familiar with the therapeutic model, so they can convey deep knowledge of and well-founded enthusiasm for it and use some of the model's principles in his or her work, has since been recognised.

Suggestions for improvement

1 Review referral age/process/conditions

Several suggestions were made in relation to youth involved in the Oranga Tamariki Youth Justice Service and the Corrections system to increase the numbers of appropriate referrals and the engagement of index clients and family/whānau/aiga. They included:

I. Completion of PW: FFT-CG programmes being a condition of bail, parole, diversion, discharge conditions.
II. Engage young people and family/whānau/aiga early, for example as part of Family Group Conference processes.
III. Reduce the age limit for Corrections clients.

"It would be beneficial to review the cohort we refer and perhaps open it up to parents of children who meet the index age. Those on sentence with a parenting course or make (completion of) the programme a special condition."

"…. getting agreements for FFT to be considered a [Corrections] KPI and …. confirmation that FFT will reduce some of their hours…:

2 Retain the Referral Co-ordinator role

The Referral Coordinator role was uniformly seen by participants as pivotal to the success of the pilot. The role has evolved over time, with the Coordinator taking on much of the site champion's role in some cases, and establishing a regular on-site presence at most referral sites. There appears to have been a misunderstanding about whether the Referral Coordinator role would continue into the second year of the pilot. There was consternation in some quarters as some informants understood the Referral Coordinator role was a short-term position; they did not view the referral rates from Oranga Tamariki and Corrections as stable enough to warrant dis-establishment of the Referral Coordinator role. Others were clear that this role would be carried over to year two of the pilot.

3 Introduce guidelines for sites and agencies

Although there are commonalities across referral agency goals and PW: FFT-CG aims, there are many differences in agency operations and processes

"*All agencies are very different, different in the way that they work... That ability to tailor [the referral] approach to different agencies is really, really important."*

"Different sites and referrers have different practices …Corrections' sites all work differently…..'

4 Revisit the implementation of site champions

The efficacy and involvement of site champions was variable. While the goal of these roles is clear and positive, implementation has not always met expectations and needs to be revisited.

Agency representatives on the Steering Group have communicated clear expectations of site management and site champions, and seek to facilitate a clear and standard process across agencies and sites. Where clear information and directives have not been provided to site champions and site management staff, the Referral Co-ordinator can be dependent on the attitude and interest of individual managers to PW: FFT-CG. This variability exists between agencies and sometimes sites within agencies.

5.4 YHT PW: FFT-CG Clinical Delivery

Background
To gather information about the current delivery of the therapeutic component of the programme, the five members of the therapist team were interviewed in a focus group about their roles. Feedback was also sought from other staff members of YHT, the referrers, and the Steering Group about their observations about the operation of the model to date.

Overall, the therapist's role is to engage the young person and their whānau/families and deliver the PW: FFT-CG therapy; it is too early in the process to consider outcome data, as no index clients and families/whānau/aiga have completed the PW: FFT-CG programme to date.

As noted previously, FFT therapies are based on a therapeutic approach that is:

- Respect-based
- Phase-based
- Integrated and multi-systemic
- Evidence based and data driven.

The therapists are undertaking the PW: FFT-CG training as a phased process. At the time of interview, they had completed only the first integrated phase of the training: engagement and motivation. Therapists identified two components of their overall role *(gaining access and trust* and *establishing a family/whānau/aiga led process)* as particularly important at this early stage of the therapeutic process.

Gaining access and trust
Therapists stressed that it was essential to gain access to and trust from the family/whānau/aiga, as well as the index client, in order to deliver PW: FFT-CG successfully. This process tended to be time-consuming. Therapists aimed to meet with clients in their homes, and numerous visits to the family/whānau/aiga home were sometimes undertaken. Where the index client and significant family/whānau/aiga members resided separately, multiple meetings with different members were sometimes required before bringing members together. Gaining access to index clients and families/whānau/aiga could be an uphill battle. As previously noted, the requirement to report imminent risk of harm to the person or others, and the clarification of the therapist's role as distinct from those of Police, Corrections or Oranga Tamariki youth justice staff, was a key plank in therapists' efforts to gain access and establish trust.

> *"If the therapist feels compelled to report something, we tell the whānau and try and get them on board in that process."*

Establishing a family/whānau/aiga-led process
The PW: FFT-CG model requires therapists to work alongside clients and actively involve them in problem-solving and identification of therapeutic priorities. In order to do this, therapists' approach to their index clients and families/whānau/aiga is conducted in accordance with their training in the early phase of the FFT model.

> *"Meeting with whānau, not being judgemental, not trying to change whānau dynamic, coming in alongside and not over the top of whānau, seems to be effective. Building hope, optimism, not blame or negative."*

Developing a balanced alliance
PW: FFT-CG uses a cross-generational approach to emphasise the establishment of a trusting relationship between the therapist and the family/whānau/aiga as a unit. This is the foundation of the FFT's 'balanced alliance'. This, together with the greater effort put into the initial engagement, was described by therapists as a somewhat more time-consuming process than in other approaches. However, therapists firmly believe that the extra expenditure of time building the alliance was likely to be worthwhile as the therapeutic process progressed.

> *"Develop relationships and engagement with families in the best way for them. … Always looking for what sits beneath the symptom or issue and work with that."*

The therapists considered that the nature of the relationship that they sought with index clients and their families/whānau/aiga was very different to that of staff typically operating within a government agency environment.

> *"Our priority isn't to elicit information it's to establish relationships... the goal is to have relationships with the whole whānau, as a whole not individually – have a balanced alliance."*

Team dynamics
Therapists tend to work in and around the areas in which they reside. They do not work full-time from the offices of YHT and therefore do not necessarily have daily contact with other YHT staff. Efforts have been made to maintain strong team contact and promote positive relationships, and these appear to be working well. Formal support, in the form of scheduled supervision, including group supervision, is valued by the therapists, with the Clinical Supervisor/Practice Leader's availability specifically highlighted. Less formal support networks, in particular an online group chat facility, was also appreciated by the therapists.

> *"Peer support – those social media sites are awesome for that… we are on there all the time… it's not just for if you're struggling either… lots of positive stuff, encouragement…at the moment there are just lots of cat GIFS going back and forth. … Also having [Clinical Supervisor/on-site Practice Leader] from FFT standard is great, can go to her and we do a lot."*

Therapy team selection
The team of therapists and YHT management were positive about the team that had been selected. Although it is unclear how much input cultural advisors had in selection, there was a specific emphasis on finding the right people to deliver the PW: FFT-CG model to the anticipated client group. This included consideration of cultural and general openness.

> *"The selection of the therapists especially was an important aspect of ensuring effective service delivery and maintenance of the YHT organisational culture, given they would be working directly with clients... It was a careful recruitment process. [We] weren't concerned about numbers, more interested in getting the right people…. It was*

critical for this pilot to get the right people despite pressure from various areas to get therapists on board."

Therapists' overall perspectives

Therapists were asked to give tick box responses to questions about relevant aspects of their tasks. Table 3 sets out the first set of questions and their responses. Their responses to questions about participating in training and engaging clients were confident and positive. Comments above highlighted difficulties therapists had engaging some clients who were more reluctant to start, suggesting these responses on engaging probably refer to their total client load where a good proportion engage willingly. There was less unanimity and confidence around delivering the PW: FFT-CG model, and difficulty for some with the volume and complexity of the paperwork. These are early days in the programme and some baseline scores are likely to change over time.

Table 3: Therapists' response: training, paperwork, engagement, model in practice

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult
How did you find the training overall?		5			
How do you find the information, consent and reporting processes (paperwork) with clients and whānau/family/aiga?			3	2	
How do you find engaging with index clients and whānau/family/aiga using the PW: FFT-CG model?		5			
How do you find delivering the PW: FFT-CG therapeutic model in practice?		3	2		

When the therapists were asked a question about the effectiveness of the PW: FFT-CG therapeutic approach in engaging with index clients and whānau/family/aiga compared to other approaches, their assessment was unanimously very positive, as shown in Table 4.

Table 4: Therapists' response: therapeutic approach

	Very effective	Effective	Neither effective nor ineffective	Ineffective	Very ineffective
How do you find PW: FFT-CG in relation to other therapeutic approaches you have used in the past?	5				

What is working well?

Therapeutic approach: attention to engagement and respectful processes
Therapists were positive about the respectful family/whānau/aiga-led nature of the PW: FFT-CG approach. They were comfortable with meeting families/whānau/aiga in their homes and outside of normal business hours and accepted the need for persistence in gaining access and building trust. They also appreciated that the sometimes chaotic nature of life for struggling families/whānau/aiga made their ability to get together for family therapy sessions problematic at times.

> *"We listen and don't judge their past actions; we take them as they are and don't talk at them."*

Room for improvement

Engagement phase not reflecting numbers/work
The nature of the PW: FFT-CG model, especially the emphasis on building trusting relationships in the engagement phase, can contribute to a sense that the numbers actively engaged in treatment are low; for example, many clients are allocated but are logged as not starting treatment. Therapists and others interviewed were concerned that the (low) numbers of clients identified as 'engaged' in therapy can look like failures when they are not. There is a significant amount of work being undertaken by the therapist to get the family to participate in the service and measures could be developed to record this.

> *"Numbers might be or seem down because of the time it takes for engagement, but there's lots of work going on behind the scenes."*

A suggestion for a data collecting process that that could help address this problem is outlined below under suggestions for improvement.

Communication with referrers
Referrers noted that communication with the Referral Co-ordinator was going well or very well; however, most referrers would prefer more communication from therapists working with the client families/whānau/aiga that they had referred. Referrers would like to hear directly from the therapists and suggested a short email with salient indicators of progress would be helpful. They noted,

> *"Some therapists let us know what is going on. Others I've not heard from."*

This has led to a lack of clarity amongst referrers about what they could expect in terms of reporting from therapists once they had referred clients to therapy. Some referrers were not at all sure what feedback arrangements existed. Referrers were aware that the therapists probably had legitimate privacy concerns and that it may not be appropriate to share details with the referring organisation while the therapy is in progress. However, referrers noted that they may need to write reports (for example a report for the Court) and having access to as much salient information as possible was helpful. This is an area that needs clarification.

Suggestions for improvement

1 Progress reports to referrers
There are several issues regarding reporting to referrers on the progress of therapy that could be profitably worked through. Some of those interviewed believed that reports to referrers should simply notify referrers when the various phases of therapy were completed. Others

have advocated for a more open and collaborative working relationship between referrers and therapists.

2 Additional data collection to reflect time spent in engagement and trust-building stage
FCSPRU recommends that the current data collection process include additional items that record the *gaining acceptance and building trust* activities of the early phases of the therapeutic process, as this is an important component of the PW: FFT-CG approach.

5.5 Therapeutic training and processes

Training and supervision
The training of therapists for the PW: FFT-CG pilot began with a three-day noho marae covering the early phases of FFT therapy. Training was marae-based and incorporated lived experience and learning aspects of the WWW cultural framework. The FFT LLC primary trainers from North America travelled to Aotearoa to deliver the training and full use is made of technology, with refresher training using audio-visual technology. The PW: FFT-CG Training Manual is still in draft form as it is evolving during the early stages of the pilot programme.

Therapists described their first experiences of PW: FFT-CG training and refresher training as:

> *They've tried to coincide training with where you are at with your whānau, integrating training and practice."*

Therapists and other YHT staff reported a full complement of supervision and support for the therapy team, including weekly individual supervision by the YHT Clinical Supervisor/on-site Practice Leader, regular professional cultural supervision, a supervision and mentorship resource in the form of the YHT Kaumātua, and peer supervision.

What is working well?

Phased training
Therapists and senior management considered that the FFT training provided at this early stage of the pilot was:

> *"very systematic training" "great...amazing and regular."*

The phased approach worked well as it helped to prevent information overload, although some therapists described the training as exhausting because of the new aspects of practice and reporting they were taking on board. Most agreed that the fact that the *"training structure is in phases which paces it"* was vital to avoid being overwhelmed with information. Holding the initial training on a marae was appreciated as emphasising the integration of the WWW cultural framework throughout the PW: FFT-CG process.

One therapist commented that:

> *"the content of training is easy, but the learning really started when we are in the field coming into contact with whānau and cases where the terms, language, becomes relevant."*

Another participant described the training as embedded in a continuous improvement philosophy. Some therapists were hungry for more training, having found their previous training very beneficial.

Therapists expressed satisfaction with the amount of supervision and support that was available to them as they ventured out as inaugural providers of PW: FFT-CG therapy. In addition to weekly on-site supervision, they had regular cultural supervision, peer supervision, access to the on-line chat service and the ability to schedule calls and 'refresher training' with the internationally based PW: FFT-CG trainer.

Use of technology
Therapists described several technological aids in training, supervision, and development of their work in positive terms.

> *"We are having Behaviour Change training over video call from America."*

> *"...just did some second phase training over video chat."*

Interviewees commented on the use of tapes of the training as very useful for revision, and on the usefulness of audio-tapes of their meetings with clients for analysis in supervision (with client's permission).

Paperwork requirements
Therapists mentioned the large amount of paperwork that they and their clients were required to complete. Although they found it quite time-consuming, they accepted that the data collected was useful, and they sometimes found that getting alongside clients and completing the paperwork with them could be an aid to building alliances. Therapists also appreciated having access to data reports that showed them what they were achieving, including those that monitored the timeframes involved in engagement processes. As noted above, additional data that recorded activity in the engagement phase would be welcomed by therapists.

Suggestion for improvement

Include Referral Coordinator in training
We suggest that the Referral Coordinator attends therapy training from the outset in the future, in order to ensure that they are well informed about the therapeutic model, have a firm basis for promoting the therapeutic model, and gain additional engagement, motivational and behaviour change skills to use in their work. It is vital that a Referral Coordinator discussing the nature of the programme has an in-depth understanding of and enthusiasm for the model, as it is usually the Coordinator who is the first face of the programmes and the one to whom potential referrers initially go with their questions.

The Referral Coordinator has established a clear view of what works best and what does not. These lessons should be considered when designing the requirements and expectations of Referral Coordinators in the future.

6 Monitoring data

The aims of the review of the administrative and monitoring data are, broadly, to document current data collection and reporting, and recommend any changes in its quality, organisation, or the content covered, to improve the efficiency and effectiveness of the current processes and outputs. The monitoring and reporting of *process* tracks the movement of index clients and their whānau, and participants' evaluations of the process and their therapists. The monitoring and reporting of *outcomes* documents the quality of the engagement of clients and their whānau with the PW: FFT-CG process and the behavioural changes achieved.

6.1 Data recording forms

Numerous sets of recording forms are listed in the PW: FFT-CG outcomes measurement framework and the PW: FFT-CG documentation requirements. The cultural satisfaction form and the outcome assessment form are two measures YHT added to ensure assessment requirements for the pilot are met. All other forms are requirements of FFT teams, not solely PW: FFT-CG. The forms are summarised in this section, and more detail is provided at Appendix B.

1 Cultural Satisfaction Survey
This measures participant satisfaction with their therapist from a cultural perspective. It is geared towards adults and applied just prior to discharge.

2 Family Self-report
This report measures participants' feelings about aspects of their therapy sessions and their efficacy, interactions with their therapist, and how their family is doing. It is applied six times during participants' engagement with PW: FFT-CG.

3 OQ (Outcomes Questionnaire) adult reporting on self
The outcomes questionnaire measures distress, interpersonal relations, and difficulties in the workplace, school, or with home duties. It is geared towards adults and administered twice: once 'pre' the third therapy session, and once 'post' at discharge.

4 YOQ (Youth Outcome Questionnaire) parent reporting on youth
This can be used to identify and target particularly problematic areas for treatment. It is completed by parents about their youth aged 10 to 17, and with discretion about their youth aged 18. It covers parents' perceptions of how their child feels within themselves, how they are getting on with significant others, how they are coping with stress, and how they are performing in important life tasks, such as work and school. It can also assess change in paranoia, obsessive-compulsive behaviours, hallucination, delusions, suicide, mania, and eating disorder issues. It is administered once 'pre' the third therapy session, and once 'post' at discharge.

5 YOQ-SR (Youth Outcome Questionnaire Self-report)
This is used to identify and target particularly problematic areas for treatment. It covers the same areas of functioning as the Youth Outcome Questionnaire above, but is completed by the index client. It is also completed twice: once 'pre' the third therapy session, and once 'post' at discharge.

6 COM-A (Client Outcome Measure, Adolescent)
The measure assesses youth participants' perceptions of change in family functioning, communication, personal behaviour, parenting skills, parental supervision, and family conflict. It is completed by youth aged 10 to 17 just prior to discharge.

7 COM-P (Client Outcome Measure, Parent)
This assesses parent participants' perceptions of change in family functioning, communication, adolescent behaviour, parenting skills, parental supervision, family conflict, and misdemeanours since PW: FFT-CG began. It is completed by parents of youth aged 10 to 17 and youth aged 18+, if appropriate, just prior to discharge.

8 TOM (Therapist Outcome Measure)
This measure assesses the therapist's perceptions of change in family functioning, communication, adolescent behaviour, improved parenting skills, parental supervision, change in family conflict, and misdemeanours since PW: FFT-CG began. It records the

therapist's general impression of the outcome of a case. It is completed by the therapist about the family and their adolescent, just prior to discharge.

9 Managing Risk Form
This is completed by the therapist (Practice Leader) for all children and young people. It is completed at the beginning of treatment, updated at regular intervals during treatment, and finally on participants' discharge from the service.

10 Outcome Assessment Form
The data from the outcome assessment form is used to determine whether the PW: FFT-CG intervention has been successful for the participant. Success is achieved if the participant: has been maintained in the family home/avoided a higher level of care; is engaged in education, training or employment; has completed treatment (attended 8+ sessions); and has made moderate or significant progress.

YHT administrative data: therapist retention data, requests to train as PW: FFT-CG therapists, referral rates
These three types of data are collected and retained by the implementation group at YHT. Data relating to retention of therapists in PW: FFT-CG and requests to train as PW: FFT-CG therapists are not routinely reported. Referral rates are reported monthly by YHT to the PW: FFT-CG Steering Group.

6.2 Data-based outputs and reports

Two sets of data output are listed in the PW: FFT-CG outcomes measurement framework and the PW: FFT-CG documentation requirements. These are summarised below, and more detail is set out at Appendix B.

PW: FFT-CG pilot monitoring dashboard
The pilot monitoring dashboard facilitates reporting of monitoring data drawn from the HCC and/or the CSS, as appropriate. Recent examples of such reports cover the following aspects of PW: FFT-CG implementation over defined time periods:

- Referrals received
- Referrals allocated
- Volumes: progress of allocated cases
- Caseload
- Closure outcomes for clients who have started PW: FFT-CG
- Summary analysis.

Monitoring data to be accessed from Oranga Tamariki
It is anticipated that Oranga Tamariki will provide data that FCSPRU can use to monitor outcomes (e.g. number of index clients in out-of-home care). This data is not currently being provided.

6.3 Progress following referral

The following analysis uses data extracted from the CSS system. This data has been generated for the CSS database of allocated cases. It does not include all clients who are referred to YHT and are recorded on the YHT database. Once the referrals are triaged, accepted, and then allocated they then become 'cases' or 'referrals' on CSS.

Three reports were used: *Case Tracking, Case Demographics* and *Case Data*. As of 16 December 2019, there are 56 referrals. The analysis reveals the service flow, and characteristics of the service users.

Client participation
The documentation of the stages of clients' participation in the PW: FFT-CG process begins with their referral. The term 'referral' relates to the date when a client has been assigned or allocated to a therapist. The 'referral date' is the date of assignment to a therapist.

In total, 56 clients were referred from the beginning of the pilot to 16 December 2019:

- twenty of these were classified as never beginning treatment (36%)
- five as having dropped out after beginning treatment (9%)
- six as being referred but not yet having begun treatment (11%)
- 25 active cases receiving treatment (44%).

Figure 1 shows that 44 percent of referrals are currently active, which means they are having sessions with therapists. Of those who are active (25 cases), 10 cases have reached the behavioural change phase, and 15 cases are still in the engagement and motivation phase.

Thirty-six percent were allocated to a therapist, but the client/family consent was never signed and a PW: FFT-CG session never took place ("never began").

Nine percent dropped out. "Drop out" is used to describe the early cessation of therapy and is also known as "treatment failure" or "non-completed case", which corresponds to a case where treatment is interrupted, and the family does not complete all phases of PW: FFT-CG. Efforts to re-engage the family do not result in a subsequent session. Most of the drop-out cases are still in the early phases – engagement and motivation. Only one case had reached the behavioural change phase before the family dropped out.

Eleven percent (six cases) are categorised as "referred." This means that they have been assigned a therapist but have not yet started their sessions.

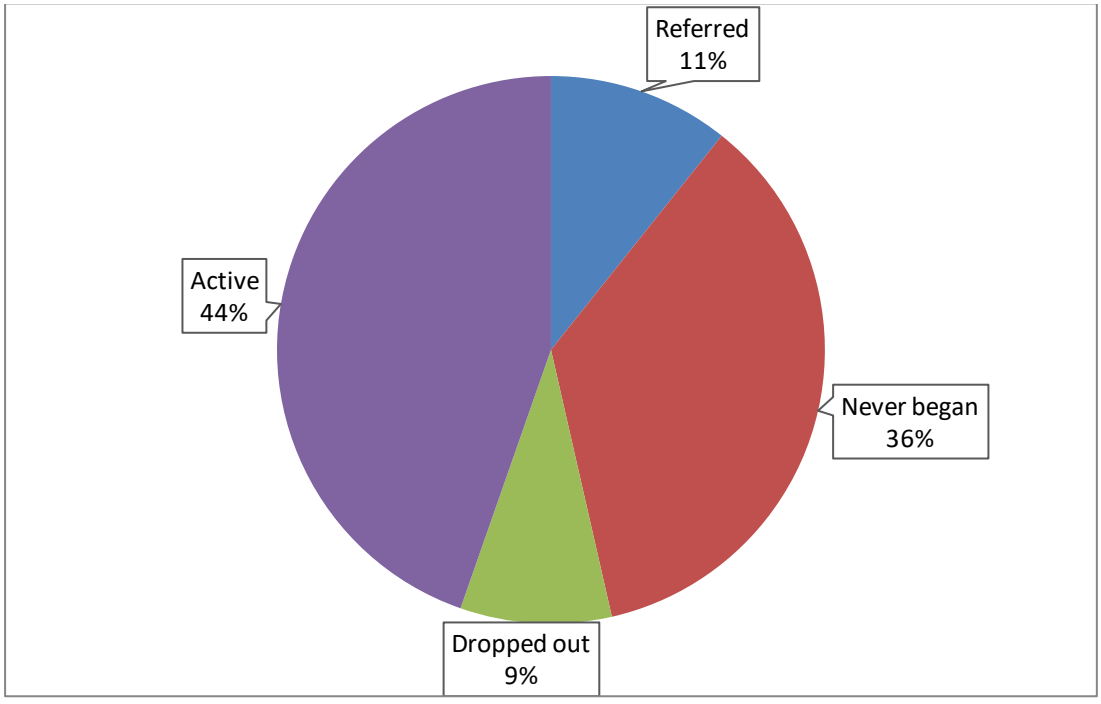

Figure 1: Case status

Figure 2 shows the proportion of cases categorised by the referring organisations. The three key collaborating organisations are Police with 17 cases, Corrections with 15 cases, and Oranga Tamariki with 13 cases. Ten cases are categorised as “other” and no identifiable information is provided.

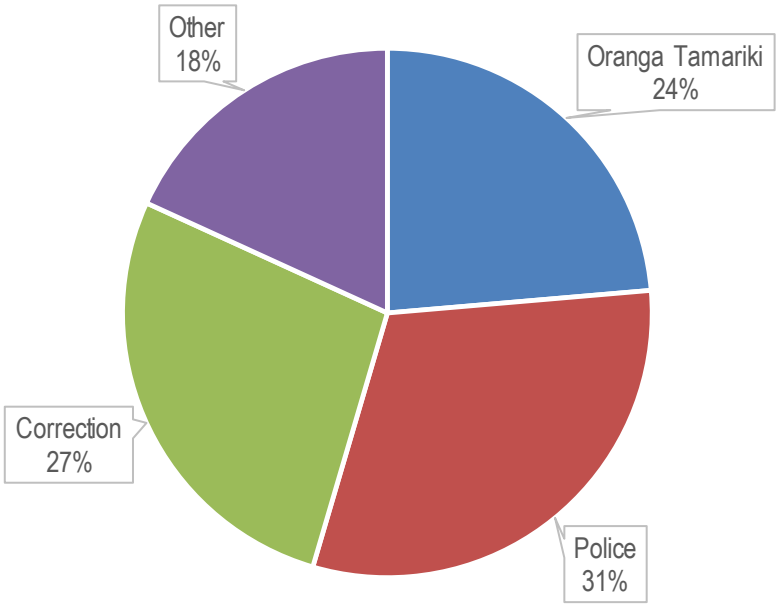

Figure 2: Case status by referring organisation

Figure 3 shows that the majority of referred clients are Māori, at 52% with 29 cases. The next common ethnicity is Pacific Peoples at 21% with 12 cases. Pakeha clients comprise 20%, with 11 cases. Other ethnicities comprise minor proportions. Figure 3 shows a serious over-representation of Māori and Pacific Peoples in the referral process, reflecting their over-representation in the youth justice system.

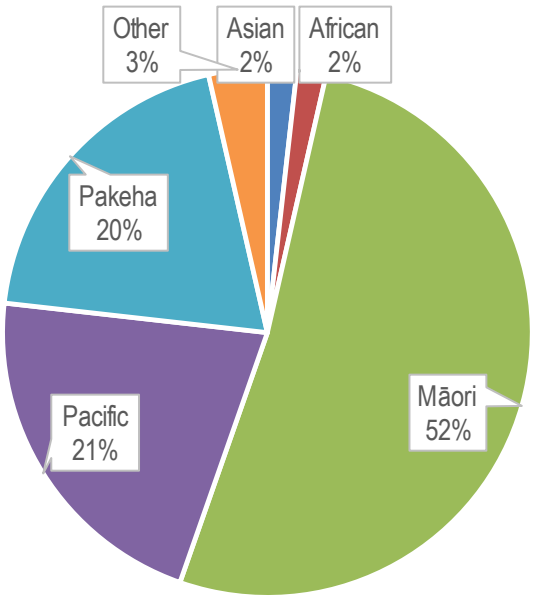

Figure 3: Case status by ethnicity

Clients who did not begin therapy
In this section we investigate the demographic characteristics of the index clients, the referring organisations, and the reasons why referred clients never began their PW: FFT-CG sessions despite their suitability.

Figure 4 shows that Māori are the main ethnic group that never began the PW: FFT-CG therapeutic treatment process, with 17 out of the 20 cases. Only two Pakeha clients and one Pacific client never began their treatment despite being referred. The Māori rate for not using the service after referral is 85 percent. The Pakeha clients and Pacific clients are the next groups, at 10 and 5 percent respectively. While the numbers for Māori are high, they should also be seen in the context of 11 of the 25 active cases (44%) that are Māori. Again, the small number of current cases limits the generalisability of the analysis.

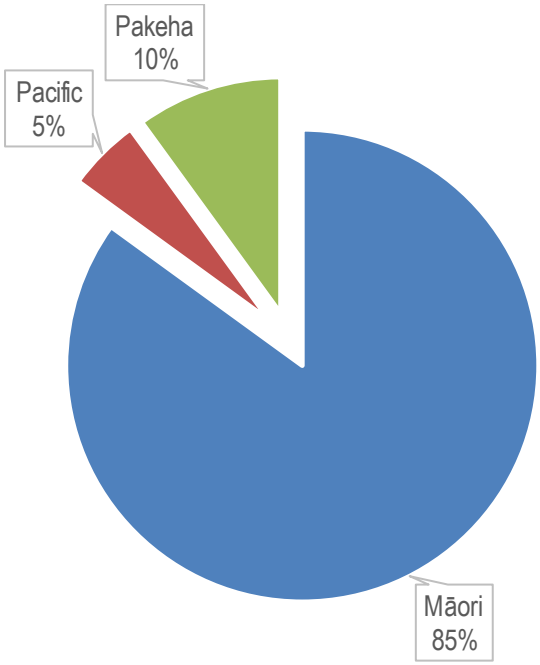

Figure 4: Ethnicity of "never began" clients

Table 5 shows the proportion of clients who never began treatment, by reason and by referring organisation. Overall, the largest single reason is clients declining the services of PW: FFT-CG (nine cases). This is followed by the service not being able to contact clients, including their whereabouts being unknown (six cases), and not meeting the criteria for PW: FFT-CG treatment (four cases).

Table 5: Reason for never beginning treatment by referring organisation

Referring organisation	**Reason for never beginning**				
	Criteria not met	Declined services	Not able to contact	Youth whereabouts unknown	Total
Oranga Tamariki	1	2	1	0	4
Police	0	3	4	0	7
Corrections	3	3	1	1	8
Other	0	1	0	0	1
Total	4	9	6	1	20

Table 6 sets out the referral problems for 'never began' cases. The most common problem for the referral of these 20 cases was delinquent behaviour (15 out of the 20). Other problems are mostly related to dysfunctional families, including family abuse and violence and youth/parent conflict. Only one case was due to family reunification.

Table 6: Primary referral problem by referring organisation for those never beginning

Referring organisation	Primary referral problem						
	Delinquent behaviour	Family reunification	Family substance abuse/use	Family violence (physical)	Runaway behaviour	Youth/ parent Conflict (verbal)	Total
Oranga Tamariki	3	0	0	0	0	1	4
Police	6	0	0	0	1	0	7
Corrections	5	1	1	1	0	0	8
Other	1	0	0	0	0	0	1
Total	15	1	1	1	1	1	20

Dropped out cases

In this section we analyse the ethnicity and reasons for dropping out, in addition to other information on treatment progress. The numbers are small and no clear trend or pattern is warranted. We use tabular form rather than visualisation to reflect this problem of data limitation.

Table 7 gives the reasons why cases dropped out. The current data show that Pacific Peoples have the largest proportion of dropping out (three cases) but the number is too small to warrant any clear trend.

Table 7: Drop out reason by ethnicity and referring organisation

	Drop out reason		
	Moved prior to completing programme	Quit after at least one session	Runaway
Ethnicity			
Māori	0	1	0
Pacific	1	1	1
Pakeha	1	0	0
Referring organisation			
Oranga Tamariki	1	0	0
Corrections	1	0	0
Other	0	2	1
Total	**2**	**2**	**1**

Table 8 gives the classification of treatment based on drop-out reasons. Of the three reasons given, the first reason 'Moved' is not considered a treatment failure whereas the two other reasons, 'run away' and 'quit', are considered treatment failure.

Table 8: Drop out reason by whether treatment is classed as a failure

Drop out reason	Treatment failure?		
	Yes	No	Total
Moved prior to completing programme	0	2	2
Quit after at least one session	2	0	2
Runaway	1	0	1
Total	3	2	5

Table 9 gives the primary referral problems for those who dropped out. Like 'Never Began' clients, delinquency is the most common referral reason for the drop-out clients with four cases. The remaining case was due to family violence.

Table 9: Drop out reason by primary referral problem

Drop out reason	Primary referral problem		
	Delinquency	Family violence	Total
Moved prior to completing programme	1	1	2
Quit after at least one session	2	0	2
Runaway	1	0	1
Total	4	1	5

Figure 5 shows the progress of treatment for 5 drop-out cases. The number is too small to warrant any trend analysis.

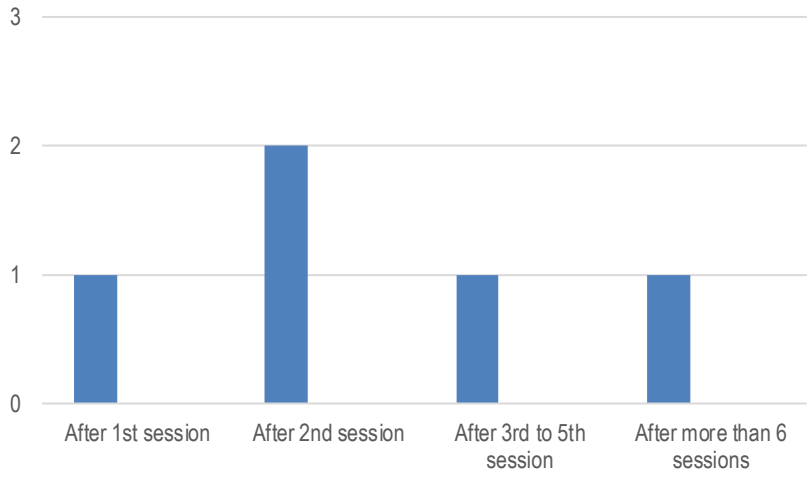

Figure 5: Treatment progress of "Drop-out" clients

6.4 Conclusions

Data collected
The range of data collected seems sufficiently comprehensive to monitor and report on: the movement of index clients into and through the PW: FFT-CG process; obtain the evaluations of the programme by therapists and clients; and measure the quality of outcomes achieved.

The data collected is relatively fixed given the requirements of the licensing contract with FFT LLC. However, thought needs to be given to four questions around the use of the data and reports generated from it:

- what is the most efficient and effective selection of data for analysis, given the extensive nature of the data collected
- whether less data would be more appropriate for use in reports, given the relatively small number of cases likely to be included in the programme in the future when compared with the number of cases in the Youth Justice system
- whether a different, more focused set of data would allow a more appropriate analysis of the programme during its pilot phase, in order to optimise the design of the programme prior to roll-out, e.g. collecting data that would give more specific information about the bridging process between referrers and therapists
- finally, it is not clear to the reviewers who owns the cultural data that is collected in the monitoring system (e.g. all the assessment information and case notes that are entered into the FFT LLC CSS database), and this question needs to be resolved before roll-out.

The entry and storage of the data in three separate databases limits the utility of the total body of data as a tool for comprehensive, combined analysis of all process and outcome related variables. Presently, any combined analysis of variables depends on the ability of the analyst to extract the variables from each database and combine them in a new dataset. This presents an unnecessary obstacle to running regular analyses to support routine monitoring of the programme and participant outcomes, particularly for therapeutic practitioners who do not necessarily have expertise in manipulating and managing data.

The FFT Clinical and Research Director, Dr Michael Robbins of the Oregon Research Institute, has indicated that they would be able to make the complete database of YHT pilot programme data available in a raw form. Once the complete CSS dataset is available in a raw form it would be possible to merge it with data from the YHT HCC case management system and YHT Googleform.

The creation of such a database would be a first, but not final, step towards making the data storage and retrieval system fit-for-purpose. The next stage would involve defining the range of report outputs required to cover all necessary monitoring tasks and designing user-friendly data query templates to enable non-data specialists to generate those reports. At the same time, the unified database would be available for the evaluators and other data analysts to conduct bespoke analyses using statistical software.

Progress following referral
The figures and tables in this section are illustrative of what can be gleaned from the case tracking database. The numbers are of course too small at this stage to draw conclusions, but over time outcomes and trajectories from larger numbers of participants will help provide a much more transparent picture of the effectiveness of the service.

The lack of therapeutic ‘take up’ between referrer and therapist or referring agency and YHT is quite substantial, in the range of a third to a half of all referrals depending how it is measured.

This certainly warrants attention and investigation. A study of the referral bridge may suggest other more effective ways of making connections.

Of concern is the high number of young Māori who are clearly not attracted to the service, despite the strong investment in a Māori cultural framework for the entire service. There may be ways of helping those specific connections in a manner that can reverse these early indications.

A lot of care has been taken in designing the monitoring data collection. No doubt some aspects can be improved in time, but it is our view the data collection instruments are fit-for-purpose and if the databases can be combined and become much more accessible, they will provide a rich vein of information for the service and beyond.

7 Future roll-out

7.1 Agency for roll-out

YHT has a decade-long history of relationship with the FFT developers and trainers, and a decade of experience in delivering FFT programmes. Some participants held concerns regarding an anticipated roll-out of the programme to other agencies that may not have the same experience of FFT, established relationships, supportive mechanisms in place for FFT therapists, or understanding of the delivery requirements within their organisational cultures.

> *"YHT has its own culture so transplanting the programme to another organisation may not work well as there would need to be maybe a lot of scaffolding and support to such organisations to get that culture right so that the FFT can be implemented successfully."*

> *"With a different organisation FFT may not be successful... If you were in an organisation that wasn't highly supportive the model would fall apart because you wouldn't be able to keep to it. You'd get burnt out."*

While the researchers are not aware of any proposals to do so, there was concern expressed by some participants that the PW: FFT-CG pilot may be considered by some government agencies as a precursor to a wider roll-out by agencies themselves or by contracted providers. The possibility that some government agencies may attempt to incorporate the PW: FFT-CG therapeutic model within their organisations was viewed as a risky option by some interviewees.

> *"We don't want other organisations to take the programme and then water it down."*

Some concern was also expressed that the sustainability and possible expansion or roll-out of the programme was questionable without the drive and commitment of the current pilot programme manager. They considered that role was central to the progress of the pilot:

> *"If we didn't have a [programme manager] I'm not sure how it would go..."*

7.2 Readiness for roll-out

Thinking ahead, several suggestions were made to address concerns about the potential roll-out of the PW: FFT-CG programme to other providers (whether government agencies or community organisations). Concerns were raised about whether other organisations would have the organisational culture to apply the PW: FFT-CG model successfully, and the danger

of adapting the PW: FFT-CG model to fit within their organisation's operational culture and timeframes.

There was a suggestion that a template for 'readiness assessment' be developed if the model is considered for implementation by other organisations in the future. This would help prepare the organisation.

> *"Organisational readiness assessment sort of needs to be developed."*

Developing a comprehensive implementation manual and providing clear guidance that included pilot learnings were also suggested. The 'manual' envisioned by participants differed from the PW: FFT-CG training resources, being focused on organisational and support requirements, timeframes and understandings for staff involved in delivery organisations.

> *"Set up a manual so that the requirements to deliver are really clear."*

Any future roll-out of similar multi-agency programmes may choose to engage a Steering Group in the selection and any negotiations about the therapeutic model that will be put in place, from the outset. The knowledge of agency representatives on the Steering Group of their client populations and of their agency processes, may contribute usefully to the shape of future programmes. Involvement of a multi-agency Steering Group from the outset may also strengthen agency buy-in to the initiatives.

7.3 In summary

In general, PW: FFT-CG is heading in a positive direction with a strengths-based, in-home, in-depth, broad family/whānau/aiga service. It aims to strengthen families who are referred to YHT to interact and communicate with each other in constructive ways, and to reduce the risk of young people reoffending while improving their wellbeing and the wellbeing of their family/whānau/aiga. As a pilot programme, it is successfully incorporating the WWW Māori cultural framework. The governance, management and service delivery functions constructively and flexibly and in a highly motivated manner. Stakeholders generally relate well to the service and the monitoring system is comprehensive and transparent.

It is too early to know whether the high level and challenging aims of the service will be accomplished because none of the 25 active cases have been completed. However, this evaluation has noted several foci worth considering if roll-out to other sites is to take place (as shown below).

- Despite much positive effort, a significant number of young people and their family/whānau/aiga who were referred to the service, did not actually reach the point of receiving the therapeutic services, and even though the numbers are small, Māori young people are disproportionately high among that group. This presents a potential future challenge that requires greater understanding and attention, because a Māori cultural framework has been incorporated into the heart of the programme, specifically to make the programme accessible to Māori young people and their whānau.
- The monitoring data shows that around a third of referrals that don't become active cases cannot be contacted for follow up. This may be because they change their contact details without notifying the referring organisation/YHT or they do not answer their phone/email/door. Developing alternative ways to contact these families/whānau/aiga may increase contact.
- Therapists are spending considerable time working in the interface between a referral and the young person or whānau becoming an active case, but their activities are not recorded fully, and hence not adequately recognised in the current data monitoring

system. Developing new measures that record this process more fully could be expected to provide greater information on therapists' engagement with clients and help further inform the matters raised in the bullet point immediately above.
- While the data contained in the monitoring data system is fit-for-purpose, the management and accessibility via three separate databases is not. It is recommended that a unified, easily accessible database be developed to better meet the needs of the programme.
- Finally, while much of the intellectual property matters are well addressed in the contracting arrangements, it is not clear to reviewers who will have control of the matters relating to the incorporation of WWW (or elements thereof) within the Clinical Training Manual and control of the cultural data that is collected in the monitoring system.

A resolution for these matters will put the programme in a strong position for future roll-out.

7.4 Recommended next steps

The findings in this evaluation should be seen as baseline data for the overall evaluation. The small numbers involved, and the fact that no active cases had been completed at the time of the evaluation, suggest that at this stage only a small number of foci are worth considering.

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

1. That the partner agencies implement a process that enables them to understand the circumstances of families, particularly whānau Māori, who decide not to take part in PW: FFT-CG therapy after they have been allocated to a therapist, and their reasons for not proceeding.

2. Related to 1 above, according to the data, around a third of referrals that don't become active cases, cannot be contacted for follow up. This may be because they change their contact details without notifying the referring organisation/YHT or they do not answer their phone/email/door. It is recommended that the referrers and the service consider solutions such as:
   - developing supplementary processes for maintaining contact details of clients who have been referred, particularly those who may be more mobile or transient. 'Follow up back up' in service agencies and longitudinal research organisations often includes collecting contact details of clients' significant others (e.g. a close relative, neighbour or other associates) in case clients change addresses, so that they can still be contacted
   - developing an agreement between YHT and referrers that YHT therapists contact the referrer when they are unable to contact a client and the referrer follows up to renew/review/withdraw the referral
   - developing a protocol that requires the referrer, client whānau and YHT therapist to meet together in the first instance. This would involve the referrer introducing the young person and whānau to the therapist enabling direct contact from the outset.

3. The current data collection process could include additional items that record the gaining acceptance and building trust activities that therapists undertake prior to the young person and family/whānau/aiga becoming an active case, as this is an important component of the PW: FFT-CG approach.

4. Develop a unified, easily accessible database from the three separate databases currently being used, to better meet the needs of the programme.

5. Clarify the ownership of the intellectual property rights, kaitiakitanga, and copyright matters relating to the incorporation of WWW (or elements thereof) within the Clinical Training Manual and control of the cultural data that is collected in the monitoring system (e.g. all the assessment information and case notes that are entered into the FFT LLC CSS database).

The staff, Steering Group, Kaumātua, and participating agencies should all be acknowledged and encouraged for what they have achieved to date in a positive and cooperative manner. A new and innovative service in an area where success has been hard to achieve in the past, is well underway, is running smoothly, and is well governed. Success breeds success and this early achievement should be recognised and encouraged.

7.5 The future of the evaluation

As noted above, this evaluation report is largely a baseline report about the first six months of PW: FFT-CG's operation.

The next report, to be completed in June 2020, will focus on the cultural appropriateness of the service in the Aotearoa/New Zealand context. FCSPRU will collect data about this from young people and their families/whānau/aiga. As the client base for whom the service has been set up, their perspectives are very important. Data will also be collected from YHT staff and an external cultural advisor.

The implementation of the WWW framework has been an important part of the initial phase of PW: FFT-CG. The responses of Māori whānau to the service and the monitoring data related to their progress through it, will provide important measures of the impact of the framework. Although the Pacific framework is not yet developed, the responses of Pacific families and the relevant monitoring data will be important to alert the service to their needs and inform the development of the proposed framework.

The longitudinal approach to the evaluation will allow the re-interviewing of Steering Group members, referrers, staff, young people and families/whānau/aiga alongside identifying trends in the monitoring data. The combination of both data sources will provide significant information on the successes and challenges of the service over time including: the extent of therapeutic achievement (i.e. behavioural changes and generalisations of index clients); strategic approaches to engaging hard-to-reach clients; more efficient ways to successfully complete cases; the cultural integrity of the service; and critical information for any planned roll-out of the service.

Appendix A: Research methodology

Kaupapa Māori theory and practice

There are basic differences between Western and Māori approaches to knowledge and consequently to preferred research methodologies. Durie[16] cited in Milne[17] described the difference as Western approaches to research tend to involve 'inductive' methodologies, meaning the object under examination is broken down into progressively smaller pieces and the individual parts examined. On the other hand, Māori approaches tend to involve looking outwards, developing relationships and connections with the aim of gaining the whole (holistic) picture. This is also the method of engagement employed by PW: FFT-CG.

Pihama has noted, "Kaupapa Māori Theory provides openings into analysis that can more readily explain and transform current inequities that face Māori people."[18] Given the inequitable (over) representation of whānau Māori and Pacific Peoples in offending statistics, together with the specific inclusion of cultural aspects into the PW: FFT-CG programme, the team considered that cultural theory and methodology should permeate the research process as a whole, from design to data collection, analysis, and reporting.

Pacific Fa'afaletui research

Pacific Fa'afaletui research is a component of the Pacific worldview as the Pacific relational person. The Pacific person consists of three core elements: the spiritual, physical, and mental. These elements are inseparable, integrated, and interdependent, just as the systems of the human body are inter-connected. Together, they constitute the whole Pacific relational person that is located within its relationships. The Pacific relational person has meaning within the four primary relationships; that is, the Pacific relational person in relationship with Atua; with the Environment, lands, forests, mountains, seas; with Ancestors and Heritage; and with others, aiga, and extended family.

Pacific Peoples are born into Aiga, Kopu Tangata, Kaiga, Magafaoa, Vuvale, and Kaaiga family structures and these unique structures form the human crucible that is both spiritual and physical. Within Pacific cultures there are clear protocols or etiquettes for behaviour at both intra-familial and inter-familial levels. These protocols and etiquettes ensure that relationships are life giving as well as spiritually and physically safe. All these familial arrangements are in familial structures that are unique to each Pacific culture and nation.

Fa'afaletui methodology was developed for research with indigenous people to avoid the marginalisation of their cultural differences in mainstream studies. Fa'afaletui is a Samoan concept that refers to a process of weaving (tui) together all the different levels of knowledge frames from within the 'houses' (fale) or group of collective representation. In the research context, this describes a method that facilitates the gathering and validation of important knowledge within a culture, from people indigenous to the culture and with direct knowledge and experience of it. FCSPRU applied this methodology throughout the research conducted with Pacific Peoples.

Whānau Narrative Inquiry

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[16] Durie, M. H. (1986). " Te taha hinengaro": An integrated approach to mental health. *Community Mental Health in New Zealand,* 1, 4-11.

[17] Milne, M. (2005). *Maori perspectives on kaupapa Maori and Psychology. A discussion document. A report prepared for the New Zealand Psychologists Board.* Wellington.

[18] Pihama, L. (2001). *Tīhei mauri ora: honouring our voices: mana wahine as a kaupapa Māori: theoretical framework,* PhD dissertation, The University of Auckland, Auckland. p. 9.[19] We were given the names of three people from Corrections. However only one was a referrer who was available and had made a referral.

Whānau Narrative Inquiry encompasses a range of methods designed to enable the validation of the voices and experiences of those holding the narratives or stories, as they interpret the significance of the narratives for themselves. The endpoint of Whānau Narrative Inquiry is a story or narrative that captures the meanings generated by the participants, rather than the researchers. Stories and narratives offer a way to experience and know the truth according to the reality of the story-teller as centred within the cultural contexts, key experiences, and interpretations that inform their stories or narratives. Whānau Narrative Inquiry places participants and their stories or narratives at the heart of the research process.

Fa'afaletui Inquiry
Fa'afaletui Inquiry includes individual and fono group inquiries. The fono group method facilitates systematic comparisons of an individual's experience with those in their group. The Fa'afaletui fono group context provides opportunities for clarification of responses, probing of opinions, and follow-up questions, all of which enable a full discussion of the topic and an airing of various points of view.

Qualitative data collection
A culturally rich mixed methods evaluation was developed specifically for this phase of the formative evaluation. A range of mediums were used depending on participant availability, preference, and timing. A small number of Likert Scale questions were used in each interview including the focus group.

- Focus group with the five YHT PW: FFT-CG therapists.
- Individual interviews with other YHT staff, including the Outcomes and Evaluation Manager, the Referral Co-ordinator, the on-site Practice Leader (also serving as Clinical Supervisor), the Kaumātua and cultural advisors involved in the programme.
- Individual telephone and audio-visual interviews with five Steering Group members.
- A sample of five referrers from the collaborating organisations were interviewed individually by telephone (Police (two referrers), Oranga Tamariki (two referrers), and Corrections (one referrer[19])).

Some preferred to write responses to questions.

Document and data analysis
Administrative, monitoring, and assessment documents were provided to the research team, including the programme's initial scope, planning documents, the intervention logic model (ILM) and current record keeping tools (e.g. existing YHT assessment tools, and cultural needs perception and measurement tool). These documents provided information on the entry into and uptake of the PW: FFT-CG programme, including referral pathways, eligibility assessment, uptake, early exits, and completions.

YHT collects administrative and outcome data through a range of forms and questionnaires, some of which are completed by the therapists and some by the participating parents and youth. They provide information about the programme's implementation, the characteristics of its participants, and the outcomes achieved for and by the participant families and youth.

The data generated by the forms and information sources is held in three databases:

- the CSS database/client management system created by the FFT programme
- the YHT HCC case management database
- the YHT Googleform database for cultural satisfaction survey data.

[19] We were given the names of three people from Corrections. However only one was a referrer who was available and had made a referral.

The data serve two broad reporting and monitoring purposes: process and outcome. Process monitoring and reporting focuses on the movement of participant families and youth into, through, and out of the PW: FFT-CG process, and participants' evaluations of the process and their therapists. Outcome monitoring and reporting focuses on the quality of participants' engagement with the PW: FFT-CG process and the behavioural changes achieved.

We examined the available documentation and data to assess the fitness-for-purpose of existing documents and make recommendations to improve data quality.

In reviewing the monitoring data for formative evaluation purposes, we:

- identified the elements of the administrative data collection and current reporting outputs
- described the sources and contents of those elements
- identified the intended purpose and fitness for purpose of each element
- described the ways in which the elements are combined in a database, or databases, to provide the basis for reporting programme implementation and outcomes
- recommended, where appropriate, changes to the data collection, integration, and reporting protocols.

Quantitative analysis of monitoring data provided an initial evaluation of service implementation. As the monitoring data is still in the preliminary stage of development with a limited number of observations, graphical illustration and cross-category tabular analysis were the primary analytical methods.

Appendix B: Data recording forms

Cultural Satisfaction Survey

Type: This is an ordinal scale measure of participant satisfaction with their therapist from a cultural perspective. The measure collects responses to 12 statements each of which expresses a different therapist quality. Participants are asked to rate their agreement with each statement on a four-point scale: Not at all; A little; Mostly; Very much. An additional Not Applicable response is also allowed for.

Purpose: This measure is applied to the parents of children aged 10 to 17 years and to youths aged 18 and above. It is stated to be geared towards adults.

Applied just prior to discharge.

Value: This is the only measure that specifically links the practice of therapists to the aims of the WWW PW: FFT-CG Cultural Framework developed by YHT for application in Aotearoa New Zealand.

Data generated from this measure is entered on a Googleform. It is not entered in the CSS database.

Source: The FFT-CG Cultural Satisfaction Measure was created by YHT for the PW: FFT-CG programme in New Zealand.

Family Self-report

Type: An ordinal scale measure of participants' feelings about: aspects of their therapy sessions and the efficacy of them; their interactions with their therapist; and how their family is doing. The measure collects responses to seven questions, each on a seven-point scale with responses ranging from negative to positive.

Purpose: This measure is applied to the parents of children aged 10 to 17 years and to youths aged 18 and above. It is applied six times during participants' engagement with PW: FFT-CG.

Value: This measure enables participants' assessments of their interactions with the therapeutic process, and the effects on their families, to be tracked longitudinally over the course of their engagement with PW: FFT-CG.

The scores are entered in the CSS database.

Source: This measure was created by FFT LLC.

OQ (Outcomes Questionnaire) adult reporting on self

Type: The Outcomes Questionnaire (OQ-45.2) is an ordinal scale measure covering 45 statements, each with a five-point scale ranging from Never to Almost Always. It measures three subscales:

1. Symptom Distress (or subjective discomfort; intrapsychic functioning with an emphasis on depression and anxiety)
2. Interpersonal Relations (loneliness, conflict with others and marriage and family difficulties)
3. Social Role (difficulties in the workplace, school or home duties).

The three sub-scale scores can be summed to produce an overall score.

Purpose: This measure is applied to the parents of children aged 10 to 17 years and to youths aged 18 and above. It is administered twice: once 'pre' by the third therapy session, and once 'post' at discharge.

Value: The subscale scores can be used to identify and target particularly problematic areas for treatment. The three areas of functioning represent a continuum covering how participants feel within themselves, how they are getting on with significant others, and how they are getting on with important life tasks.

The comparison of 'pre' and 'post' scores provides a basis for one measure of the PW: FFT-CG programme's effectiveness.

The scores are calculated by the specialist application OQ Analyst and entered in the CSS database.

Source: OQ Measures (http://www.oqmeasures.com)

YOQ (Youth Outcome Questionnaire) parent reporting on youth

Type: The Youth Outcome Questionnaire (Y-OQ 2.01) is an ordinal scale measure covering 64 statements, each with a five-point scale ranging from Never or Almost Never to Almost Always. It measures six subscales:

1. Intrapersonal Distress (emotional distress)
2. Somatic Distress (distress presenting physically)
3. Interpersonal Relations (relationship with parents, other adults, and peers)
4. Social Problems (socially-related problematic behaviours)
5. Behavioural Dysfunction (unhealthy behaviours)
6. Critical Items (flags need for those requiring immediate intervention beyond standard outpatient treatment).

The six sub-scale scores can be summed to produce an overall score.

Purpose: This measure is completed by parents about their youth aged 10 to 17, and with discretion, about their youth aged 18. It is administered twice: once 'pre' by the third therapy session, and once 'post' at discharge.

Value: The subscale scores can be used to identify and target particularly problematic areas for treatment. The six areas of functioning represent a continuum covering how parents' perceive their child feels within themselves, how they are getting on with significant others, how they are coping with stress physically and behaviourally, and how they are performing in important life tasks, such as work and school. The YOQ can also assess change in paranoia, obsessive-compulsive behaviours, hallucination, delusions, suicide, mania, and eating disorder issues.

The comparison of 'pre' and 'post' scores provides a basis for one measure of the PW: FFT-CG programme's effectiveness.

The scores are calculated by the specialist application OQ Analyst and entered in the CSS database.

Source: OQ Measures (http://www.oqmeasures.com)

YOQ-SR (Youth Outcome Questionnaire Self-report)

Type: The Youth Outcome Questionnaire (Y-OQ-SR 2.0) is an ordinal scale measure covering 64 statements, each with a five-point response scale ranging from Never or almost never to Almost always. It measures six subscales:

1. Intrapersonal Distress (emotional distress)
2. Somatic Distress (distress presenting physically)
3. Interpersonal Relations (relationship with parents, other adults, and peers)
4. Social Problems (socially-related problematic behaviours)
5. Behavioural Dysfunction (unhealthy behaviours)
6. Critical Items (flags need for those requiring immediate intervention beyond standard outpatient treatment)

The six sub-scale scores can be summed to produce an overall score

Purpose: This measure is completed by youth aged 10 to 18. It is completed twice: once 'pre' by the third therapy session, and once 'post' at discharge.

Value: The subscale scores can be used to identify and target particularly problematic areas for treatment. The six areas of functioning represent a continuum covering how participants feel within themselves, how they are getting on with significant others, how they are coping with stress physically and behaviourally, and how they are performing in important life tasks, such as work and school. The Y-OQ-SR can also assess change in paranoia, obsessive-compulsive behaviours, hallucination, delusions, suicide, mania, and eating disorder issues.

The comparison of 'pre' and 'post' scores provides a basis for one measure of the FFT programme's effectiveness.

The scores are calculated by the specialist application OQ Analyst and entered in the CSS database.

Source: OQ Measures (http://www.oqmeasures.com)

COM-A (Client Outcome Measure, Adolescent)

Type: The COM-A is an ordinal scale measure with six items, each rated on a 6-point scale from 0 (things are worse) to 5 (things are much better).

Purpose: The COM-A is completed by youth aged 10 to 17 just prior to discharge.

Value: The measure assesses youth participants' perceptions of change in family functioning, communication, personal behaviour, parenting skills, parental supervision, and family conflict.

The scores are entered in the CSS database.

Source: FFT Inc.

COM-P (Client Outcome Measure, Parent)

Type: The COM-P consists of an ordinal scale measure with six items, each rated on a 6-point scale from 0 (things are worse) to 5 (things are much better), and a further eight questions about their adolescent's criminal and other misdemeanours since therapy began.

Purpose: The COM-A is completed by parents of youth aged 10 to 17 and youth aged 18+, if appropriate, just prior to discharge.

Value: The measure assesses parent participants' perceptions of change in family functioning, communication, adolescent behaviour, parenting skills, parental supervision, family conflict, and misdemeanours since therapy began.

The scores are entered in the CSS database.

Source: FFT Inc.

TOM (Therapist Outcome Measure)

Type: The TOM consists of an ordinal scale measure with six items, each rated on a 6 point scale from 0 (things are worse) to 5 (things are much better), and a further nine questions about their best impression of the degree to which each of nine factors and qualities exist within the family after therapy finished.

Purpose: The TOM is completed by the therapist about the family and their adolescent, just prior to discharge.

Value: The measure assesses therapists' perceptions of change in family functioning, communication, adolescent behaviour, parenting skills, parental supervision, family conflict, and misdemeanours since therapy began. They represent the therapist's general impression of the outcome of a case.

The scores are entered in the CSS database.

Source: FFT Inc.

Managing Risk Form

Type: The managing risk form has three sections: 1. Demographic and background information; 2. Risk screening template; and 3. Risk management plan template.

The risk screening template has four sections: 1. Harm to self; 2. Harm to others; 3. Harm from others; and 4. Other (includes property damage and placement breakdown).

Purpose: The managing risk form is completed by the therapist for all children and young people referred to and accepted into PW: FFT-CG. It is completed at the beginning of therapy, updated at regular intervals during therapy, and finally on participants' discharge from the service.

Value: The information generated with the managing risk form is entered in and retained on the YHT case management system (HCC). It is not further entered in the CSS database. It has a clear value in supporting the management of the risks associated with the lives of the children and young people undergoing PW: FFT-CG, and for monitoring changes in their risk profiles during that therapy.

As this information is not entered in, or provided for, in the CSS database and is retained by YHT, it is unclear how, or if, it is presently used in the overall monitoring of the PW: FFT-CG programme.

Source: YHT.

Outcome Assessment Form

Type: The outcome assessment form collects basic KPI information for all participants who exit YHT services. It has three sections: Pre, Post; and Outcome. The Pre and Post sections each cover participants' age, date of entry or discharge, number of face-to-face sessions, living situation and engagement in education. The Outcome section covers: type of discharge, and outcome at discharge in terms of one of five categories: 1. Significant progress; 2. Moderate progress; 3. Minor progress; 4. No change; 5. Worse off.

Purpose: The data from the outcome assessment form is used to determine whether PW: FFT-CG has been successful for the participant. Success, as defined by YHT, is achieved if the participant has:

- been maintained in the family home/avoided a higher level of care (compare living situation pre/post)
- engaged in education, training or employment (engaged at post)
- completed treatment (attended 8+ sessions)
- made progress (assessed as having made moderate or significant progress).

Value: The information generated with the outcome assessment form is retained by YHT. It is not further entered in the CSS database. It has a clear value to YHT as a summary assessment of each participant's success in PW: FFT-CG.

As this information is not entered in, or provided for, in the CSS database and is retained by YHT for its information only, it is unclear how, or if, it is presently used in the overall monitoring of PW: FFT-CG.

Source: YHT.

YHT administrative data: therapist retention data, requests to train as PW: FFT-CG therapists, referral rates

These three types of data are collected and retained by the implementation group at YHT. Data relating to retention of therapists in PW: FFT-CG and requests to train as PW: FFT-CG therapists are not routinely reported. Referral rates are reported monthly by YHT to the PW: FFT-CG Steering Group.

This data does not seem to be involved in measuring participant outcomes, but could potentially reveal significant (positive or negative) associations between therapist retention rates and outcomes for participants.

Data based outputs and reports

Altogether, two sets of data output are listed in the PW: FFT-CG outcomes measurement framework and the FFT-CG Documentation Requirements. The sets of data output are described regarding their sources and types of coverage.

PW: FFT-CG Pilot Monitoring Dashboard

The pilot monitoring dashboard facilitates reporting of monitoring data drawn from the HCC and/or the CSS, as appropriate. Recent examples of such reports cover the following aspects of PW: FFT-CG implementation over defined time periods:

- Referrals received
- Referrals allocated
- Volumes – progress of allocated cases
- Caseload
- Closure outcomes for clients who had started PW: FFT-CG
- Summary analysis.

Monitoring data to be accessed from Oranga Tamariki

It is anticipated that Oranga Tamariki will provide data that FCSPRU can use to monitor outcomes (e.g. number of index clients in out of home care). This data is not currently being provided.

Reporting from the CSS system

The CSS database is equipped to generate 15 standard reports:

1. Weekly Case Report
2. Clinical Case Report
3. Therapist Report
4. Contact Data Report
5. YOQ Data Review
6. COM-A By Case Data Review
7. COM-A By Therapist Data Review
8. COM-A By Workgroup Data Review
9. COM-P By Case Data Review
10. COM-P By Therapist Data Review
11. COM-P By Workgroup Data Review
12. TOM Data Review
13. Case Tracking
14. Case Demographics
15. Data Review.

The areas covered by these reports are summarised below.

Weekly Case Report

- Case Number
- Begin Date
- Last Service Date
- Status
- Completion Status
- DO Reason
- Never Began

Clinical Case Report

This reports the scores for the YOQ questionnaire for responses by youth and up to two parent figures, by case, therapist and work group. The following items are scored:

- Intrapersonal Distress (emotional distress)
- Somatic Distress (distress presenting physically)
- Interpersonal Relations (relationship with parents, other adults, and peers)

- Social Problems (socially-related problematic behaviours)
- Behavioural Dysfunction (unhealthy behaviours)
- Critical Items (flags need for those requiring immediate intervention beyond standard outpatient treatment).

Therapist Report

This purely administrative information is reported by work group and covers the following categories:

- Workgroup
- Therapist Name
- Status
- Began PW: FFT-CG
- End PW: FFT-CG.

Contact Data Report

This purely administrative information is reported by work group and covers the following categories:

- Workgroup
- Therapist Name
- Case Number
- Date of Contact
- Type of Contact
- Location
- Session Number
- Duration
- Who Attended?

YOQ Data Review

This reports the pre- and post-treatment YOQ questionnaire scores for responses by youth and up to two parent figures, by case, therapist and work group:

- Workgroup
- Therapist Name
- Case Number
- Pre/Post
- Type
- Test Date
- Testee (respondent)
- Testee Description (Youth, Parent figure 1 and/or 2).

Scale scores:

- Intrapersonal Distress (emotional distress)
- Somatic Distress (distress presenting physically)
- Interpersonal Relations (relationship with parents, other adults, and peers)
- Social Problems (socially-related problematic behaviours)
- Behavioural Dysfunction (unhealthy behaviours)
- Critical Items (flags need for those requiring immediate intervention beyond standard outpatient treatment).

COM-A By Case Data Review

This reports the scores for the COM-A questionnaire by case, workgroup, and therapist with the following variables:

- Workgroup
- Therapist Name
- Case Number
- Test Date.

Scale scores:

- General
- Communicate
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score.

COM-A By Therapist Data Review

This reports the scores for the COM-A questionnaire by workgroup and therapist with the following variables:

- Workgroup
- Therapist Name.

Scale scores:

- General
- Communicate
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score.

COM-A By Workgroup Data Review

This reports the scores for the COM-A questionnaire by workgroup with the following variable:

- Workgroup.

Scale scores:

- General
- Communicate
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score.

COM-P By Case Data Review

This reports the scores for the COM-P questionnaire by case, workgroup, and therapist with the following variables:

- Workgroup
- Therapist Name
- Case Number
- Test Date.

Scale scores from Mother:

- General
- Communicate
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score

Scale scores from Father:

- General
- Communicate
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score

COM-P By Therapist Data Review

This reports the scores for the COM-P questionnaire by workgroup and therapist with the following variables:

- Workgroup
- Therapist Name.

Scale scores:

- General
- Communication
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score.

COM-P By Workgroup Data Review

This reports the scores for the COM-P questionnaire by workgroup with the following variable:

- Workgroup.

Scale scores:

- General
- Communication
- Adolescent
- Parent
- Supervision
- Conflict
- Average Score.

TOM Data Review

This reports the scores for the TOM questionnaire by workgroup, therapist and case with the following variables:

- Workgroup
- Therapist Name
- Case Number
- Test Date.

Scale scores:

- General - Change
- Communicate - Change
- Adolescent - Change
- Parenting - Change
- Supervision - Change
- Conflict - Change
- Average Score
- Parental - Love
- Parent Figure 2 - Relate
- Extended - Relate
- Female - Relate
- Male - Relate
- Parent Figure 1 - Relate
- No One - Relate
- Opportunity
- Conflict
- Supervision
- Control
- Punish - Appropriate
- Punish - Severe
- Punish - Insufficient
- Punish - Little
- Reward - Appropriate
- Reward - Over
- Reward - Protect
- Reward – Little.

Case Tracking

This template reports 35 average and/or total quantity statistics by worksite and therapist. The statistics cover the following variables listed below:

1.1 Number of Total Referrals: Computes the number of cases with a “Referral Date” within the reporting date range.
1.2 Number of Cases Remaining at Referral Status: Shows cases from 1.1 whose last CSS status prior to the reporting end date is “Referral.” Note: Entering a session moves the case to an “Active” status.
1.3 Average Number of Days from Date of Referral to First Contact Date: Computes the average number of days and provides the number sampled (Quantity), for referrals having a first contact entered.
2.1 Number of Cases Opened: Computes the number of cases with an “Open Date” within the reporting date range and not in “Referral” status prior to the reporting end date.
2.2 Average Number of Days from Referral Date to Open Date: Computes the average number of days between the “Referral Date” and the “Open Date” and provides the number sampled (Quantity), for those cases under 2.1.
2.3 Number of Active Cases: Counts the number of cases with an “Active” status as of the reporting end date.
3.1 Number of Cases Closed (Non-Active): Computes the number of cases with a “Termination Date” entered for the given time period. "Never Begans" are explicitly omitted.
3.2.1 Number of Completed Cases (grouped by Finished Result): Computes the number of cases with a “Termination Date” and a “Finished Result” selected from the CSS Termination Page’s “Section One-Finished Counselling” drop down box.
3.2.2a Youth Status at Termination - At Home?: This shows the number of youths remaining in the Home/with Family.
3.2.2b Youth Status at Termination - Enrolled?: Shows the number of youths enrolled in an educational/vocational school programme or working.
3.2.2c Youth Status at Termination - Violation Free?: Shows the number of youths violation-free since PW: FFT-CG treatment began.
3.2.3 Average Number of Sessions for Completed Cases: Computes the average number of sessions from the CSS “Sessions” page and provides the number sampled (Quantity).
3.2.4a Average Number of Engagement and Motivation Sessions for Completed Cases: Computes the average number of Engagement and Motivation sessions from the CSS “Sessions” page and provides the number sampled (Quantity).
3.2.4b Average Number of Behaviour Change Sessions for Completed Cases: Computes the average number of Behaviour Change sessions from the CSS “Sessions” page and provides the number sampled (Quantity).
3.2.4c Average Number of Generalisation Sessions for Completed Cases: Computes the average number of Generalisation sessions from the CSS “Sessions” page and provides the number sampled (Quantity).
3.2.5 Average Number of Days from Date of Referral to First Contact Date for Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that have a “Referral Date” and a first contact date entered.
3.2.6 Average Number of Contacts Between Date of Referral and First Session Date for Completed Cases: Computes the average number of contacts entered and provides the number sampled (Quantity), for those cases that have a “Referral Date” and a first session date entered.
3.2.7 Average Number of Days from Referral Date to Open Date for Completed Cases: Computes the average number of days between the “Referral Date” and the “Open Date” and provides the number sampled (Quantity).
3.2.8 Average Number of Days from Referral Date to First Session Date for Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that also have a “Referral Date” and a first session date entered.

3.2.9 Average Number of Days from First Session Date to Second Session Date for Completed Cases: Computes the average number of days, and provides the number sampled (Quantity), for those cases that have a first and second session date entered.

3.2.10 Average Number of Days from Second Session Date to Third Session Date for Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that have a second and third session date entered.

3.2.11 Average Number of Days in Programme for Completed Cases: Computes the average number of days between the “Open Date” and “Termination Date” and provides the number sampled (Quantity).

3.3.1a Number of Closed Cases Due to Non-Completion (Grouped by Phase and Reasons for Non-Completion): Computes the number of cases with a “Termination Date” in the reporting date range and "Case Dropped Out" indicated on the termination.

3.3.1b Number of Closed Cases Due to Treatment Failure (Grouped by Phase and Reasons for Non-Completion): Computes the number of cases with a “Termination Date” in the reporting date range and "Case Dropped Out" indicated on the termination.

3.3.1c Number of Closed Cases Due to Non-Treatment Failure (Grouped by Phase and Reasons for Non-Completion): Computes the number of cases with a “Termination Date” in the reporting date range and "Case Dropped Out" indicated on the termination.

3.3.1d Closed Cases Due to Non-Completion (grouped by Time of Dropout): Shows cases from 3.3.1a broken down by "Time of Dropout."

3.3.2a Youth Status at Termination - At Home?: This shows the number of youths remaining in the Home/with Family.

3.3.2b Youth Status at Termination - Enrolled?: Shows the number of youths enrolled in an educational/vocational school programme or working.

3.3.2c Youth Status at Termination - Violation Free?: Shows the number of youths violation-free since FFT treatment began.

3.3.3 Average Number of Days from Date of Referral to First Contact Date for Non-Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that have a “Referral Date” and a first contact entered.

3.3.4 Average Number of Contacts Between Date of Referral and First Session Date for Non-Completed Cases: Computes the average number of contacts and provides the number sampled (Quantity), for those cases that have a “Referral Date” and a first session date entered.

3.3.5 Average Number of Days from Referral Date to Open Date for Non-Completed Cases: Computes the average number of days between the “Referral Date” and the “Open Date” and provides the number sampled (Quantity).

3.3.6 Average Number of Days from Referral Date to First Session Date for Non-Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases under 3.3.1 that have a “Referral Date” and a first session date entered.

3.3.7 Average Number of Days from First Session Date to Second Session Date for Non-Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that have a first and second session date entered.

3.3.8 Average Number of Days from Second Session Date to Third Session Date for Non-Completed Cases: Computes the average number of days and provides the number sampled (Quantity), for those cases that have a second and third session date entered.

3.3.9 Average Number of Days in Programme for Non-Completed Cases: Computes the average number of days between the “Open Date” and “Termination Date”, the mode and provides the number sampled (Quantity).

4.1 Number of Never Begans (grouped by Never Began Reason): Computes the number of cases with a “Never Began Reason” selected from the CSS Termination Page’s “Section Three-Never Seen” drop down box for the given time period.

Case Demographics

This output reports four sets of administrative statistics by 10 demographic and other variables. Note: detailed ethnicity information is not collected in CSS. More detailed information is held on the HCC database, including the client’s iwi if known.

Administrative statistics:

01 Referrals: This section includes cases whose last status within the reporting date range was "Referral".
02 Active Cases: This section includes cases whose last status within the reporting date range was "Active".
03 Completed Cases: This section includes cases whose last status within the reporting date range was "Closed" and which have an Outcome listed.
04 Non-Completed Cases: This section includes cases whose last status within the reporting date range was "Closed" and which have a non-completion reason on the termination.

Demographic and other variables

Gender: This section breaks out client gender by state, site or therapist. It provides the user with a raw number and a percentage.
Age: This section breaks out client age by state, site or therapist. It provides the user with a raw number and a percentage.
Ethnicity: This section breaks out client ethnicity by state, site or therapist. It provides the user with a raw number and a percentage.
Family Status: This section breaks out family status by state, site or therapist. It provides the user with a raw number and a percentage.
Educational Status: This section breaks out educational status by state, site or therapist. It provides the user with a raw number and a percentage.
Referral Type: This section breaks out referral type by state, site or therapist. It provides the user with a raw number and a percentage.
Referral Source: This section breaks out referral source by state, site or therapist. It provides the user with a raw number and a percentage.
Primary Referral Reason: This section breaks out primary referral reason by state, site or therapist. It provides the user with a raw number and a percentage.
Secondary Referral Reason: This section breaks out secondary referral reason by state, site or therapist. It provides the user with a raw number and a percentage.
DSM Diagnosis: This section breaks out DSM diagnosis by state, site or therapist. It provides the user with a raw number and a percentage.

Data Review

This output reports 58 statistics combining demographic, administrative, and outcome variables.

Case ID
Work Group
Therapist
Therapist Id
Referred in Date Range

Referral Date
Referral Problem Primary
Referral Problem Secondary
Referral Type
Days from Referral Date to Open Date
Opened in Date Range
Termination Phase
Open Date
First Contact Date
First Session Date
Days from Referral to First Session
Days from Open Date to First Session
Contacts Before First Session
Sessions Phase 1
Reached Phase 2
Total Contacts
Total Sessions
Contacts in Date Range
Sessions in Date Range
Closed in Date Range
Outcome
Days in Programme
Case Never Began
Never Began Description
Case Dropped Out
Drop Out Reason
Age
Gender
Ethnicity
Status
Case Number
Opened Date
Date Closed
Sessions Phase 2
Reached Phase 3
Sessions Phase 3
Days from First Session to Second Session
Days from Second Session to Third Session
Second Session Date
Third Session Date
Drop Out Time
Youth Status Home
Youth Status Enrolled
Youth Status Clean
DSM Assessor Description
DSM Source Description
DSM Timeframe
DSM Dx
Family Status
Educational Status
Referral Source
Case Completed?
Treatment Failure?

Reporting from YHT's HCC database

Managing Risk Form

This output reports results from application of the risk screening template. It has four sections: 1. Harm to self; 2. Harm to others; 3. Harm from others; and 4. Other (includes property damage and placement breakdown). Two of the sections and their component elements are listed below.

Harm to self

- Suicidal behaviour
- Self-harm
- Unintended risk to self: substance use
- Unintended risk to self: risky sexual behaviour
- Unintended risk to self: running away

Harm to others

- Physical aggression / violence
- Psychological / emotional harm
- Harmful sexual behaviour
- Other offending e.g. theft/ dangerous driving

Outcome Assessment Form

This output reports data from the outcome assessment form that is used to determine whether the PW: FFT-CG intervention has been successful for the participant. Evaluation of success or failure is based on comparison of the following variables pre- and post-treatment.

PRE AND POST COMPARISON
LIVING SITUATION

- Exited to YHT caregiver permanently
- In foster care treatment service (TFCO, SCP)
- In residential treatment centre, non-secure
- In short term foster care
- In Teaching Family Home, non-secure
- Living alone
- Living independently in a hostel
- Living with flatmates
- Living with foster carer
- Living with parent/s
- Living with partner/spouse
- Living with whānau
- No fixed abode
- Prison
- Secure Oranga Tamariki or YJ residence
- Unknown

PRE AND POST COMPARISON
ENGAGED IN EDUCATION, EMPLOYMENT OR TRAINING

- Not in education, training or employment
- Special school (secondary)
- Mainstream/private high school
- Kaupapa Māori high school

- Boarding school
- Alternative education
- Alternative education in secure residence
- Residential/Behavioural school
- Correspondence School
- Charter school
- In full-time paid employment (over 30 hours per week)
- In part-time paid employment (under 30 hours per week and not studying)
- Parent receiving benefit to care for dependent child
- In Work-Based Learning (e.g. youth guarantee, industry partnership)
- In training programme (employment related, 30+ hours per week)
- At University or Polytechnic
- On another course
- Studying and employed part time
- Unknown

DISCHARGE TYPE ("TREATMENT SUCCESS")
Treatment success definition
Client completed minimum number of model sessions of PW: FFT-CG:

- All stages completed and
- 8 or more sessions attended.

OUTCOME AT DISCHARGE

- Significant Progress: All or most target outcomes met; significant improvement in functioning; and/or situation improved.
- Moderate Progress: Two or more target outcomes achieved; functioning improved; and/or situation improved.
- Minor Progress: At least one target outcome achieved; slight change in functioning, and/or slight improvement in situation.
- No change: Target outcomes not achieved; functioning remains unchanged; and/or situation unchanged.
- Worse off: Target outcomes not achieved; deterioration in functioning; and/or situation worse.

PW: FFT-CG Pilot Monitoring Dashboard

The pilot monitoring dashboard facilitates reporting of monitoring data drawn from the HCC and/or the CSS, as appropriate. Recent examples of such reports cover the following aspects of PW: FFT-CG implementation over defined time periods:

- Referrals received
- Referrals allocated
- Volumes – progress of allocated cases
- Caseload
- Closure outcomes for clients who had started PW: FFT-CG
- Summary analysis.

Reporting from YHT Googleform

Cultural Satisfaction Form

This output reports data about participant satisfaction with their therapist from a cultural perspective. The measure collects responses to 12 statements each of which expresses a

different therapist quality. Participants are asked to rate their agreement with each statement on a four-point scale: Not at all; A little; Mostly; Very much. An additional Not Applicable response is also allowed for. The statements are listed below:

How satisfied are you that your therapist:

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