



Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Kura Pūkenga Tangata

Executive Summary: Evaluation of Multisystemic Therapy Alcohol and Other Drug Services

As a response to service planning and policy initiatives, the establishment of two new community based alcohol and drug services were chosen for provision within the Multisystemic Therapy (MST) model, franchised through MST New Zealand. The intention of the new services was to provide intensive, home based treatment for young people/rangatahi aged 10 – 17 who were at risk of out of home placement and out of school placement, were involved in the youth justice system and were using alcohol or other drugs. These two new services joined the existing eight MST services already established in New Zealand/Aotearoa with the difference that there was an identification of alcohol and/or drug use as a key criterion. One of the teams was established within a Māori kaupapa service provider, and employed 3 therapists and a supervisor who were Māori.

This evaluation of the new services followed the development of the services for the first 24 months of implementation from June 2007 – May 2009, as well as an evaluation of a comparison site which also provided community based alcohol and drug treatment. There were a total of 110 interviews with MST therapists, MST supervisors, MSTNZ, 23 families/whānau and young people/rangatahi who received the service, stakeholders and comparison site participants – families/whānau, young people/rangatahi and therapists, as well as feedback on key findings from 4 ‘expert stakeholders’. As MST adopts a systemic approach to therapy, the evaluation team clustered interviewees together around the young person/rangatahi to get as many perspectives as possible about process and outcomes. The evaluation team included peer evaluators, who were young people/rangatahi with experience of mental health services who interviewed the young people/rangatahi who received the service to gain better access and data.

Key findings:

In the process evaluation, the recruitment of the MST therapists took longer than was anticipated, and the therapists proved difficult to recruit because MST is relatively unknown in Aotearoa/New Zealand, and because therapists did not have a single disciplinary background from which to recruit. This was particularly true of recruitment of Māori therapists, which was an aim for both teams. The development of the teams was a lengthy process, and the support received from MSTNZ and supervisors was effective in building teams who were quickly able to work with families/whānau. Across the two teams, 73 families/whānau received MST from June 2007 – July 2009 (including ongoing cases) despite initial delays in implementation.

The referral and pathway processes worked well and the young people/rangatahi who MST worked with presented with the following, usually multiple, issues:

- Alcohol use
- Drug use – cannabis, hallucinogens, ecstasy, petrol sniffing
- Dealing or possession of cannabis
- Physical violence or aggression to family members or within local community or school
- Verbal aggression towards family members and/or at school
- Not attending school
- Facing expulsion from school or attending an activities centre
- Court procedures often for aggression or stealing
- Living out of home, sleeping rough
- Residual mental health issues such as previous suicidal ideation, previous psychosis related to substance use or self harm
- Vandalism and damaging property

The MST therapists were required to take clinical lead whilst providing the intensive 20 week therapy. For some stakeholders this brought into contention professional boundaries and some negotiation about continuing involvement and working in a way which enhanced rather than compromised the MST objectives was required. The stakeholders who referred into the therapy had often been working with the families/whānau for considerable periods of time, welcomed the intensive nature of the therapy and the 24 hour availability of the service to the families/whānau. Successful outcomes with families/whānau who were described as ‘difficult to engage’ encouraged confidence in the service and generated referrals.

Through the process evaluation, it became clear that the families/whānau that the MST teams worked with had complex needs and problems and at times required longer than the 20 week involvement. Of the 23 families/whānau who participated in the evaluation, 19 reported positive outcomes which included decreased drug and alcohol use, increased attendance at school or a course, decrease in involvement of youth justice agencies, living at home and improvement in family/whānau functioning. Of the four families/whānau who did not report positive outcomes, one young person had joined a gang and was not living at home; one rangatahi had been taken into the care of Child Youth and Family and was not living at home; one rangatahi had moved to live with other whānau; and whilst one young person had reduced drug and alcohol use they were not at school and this was not considered a success by the parents, despite quite dramatic improvements. The programme was found to be effective with Māori and non-Māori service users. The key element of MST effectiveness with Māori whānau was the consistency with whānau ora, in the engagement of multiple whānau members in the implementation of the approach.

Outcomes as told by families/whānau

Outcome	Number of families/whānau
Improved family/whānau functioning	20
Building parental/caregiver strengths	20
Living at home	18
Decrease in drug use	18
Decrease in alcohol use	17
Decreased violence in family/whānau	17
No further criminal charges	16
Increased attendance at school or activities centre or employment	15
Pro social peers	10
Ongoing service involvement	9
Decreased violence in the community	6
Removal from 'at risk' registers such as for suicide	1

Follow-up interviews were undertaken with stakeholders involved with six of the young people/rangatahi who received the service one year after the initial evaluation interviews, and one other young person was no longer living at home. The reasons for leaving home for the young people/rangatahi were diverse, such as increasing

independence – getting a job and flatting (n=1); joining a gang (n=1); moving to live with other family/whānau members (n=3).

At the end of therapy there were a number of agencies who continued to be involved:

- School guidance counsellor
- Child, Youth and Family counselling
- Strengthening Families
- Young parent schooling
- Marae involvement for whānau
- Drug and alcohol counselling
- Mental health services

Completion of the programme was influenced by factors which were not in the control of MST services. If the young person/rangatahi was nearly 16 and if the parent was unlikely to engage with the programme then there was less likelihood of programme completion. Successful outcomes were dependent on good referrals and careful selection, and where there were established relationships with stakeholders who understood MST and supported the programme it was more likely that referral and selection led to successful outcomes.

In the comparison site, the major difference was that the young people/rangatahi agreed to the referral, or were required to attend through youth justice services. The service also had a harm reduction and resilience philosophy. About 1000 young people/rangatahi received the community based service over a 12 month period, which operated with less intensity than MST. The service was popular and effective with the young people/rangatahi who engaged in it. In the comparison site, feedback suggested that their service would have benefited from access to a more intensive service, such as that offered by MST, for those clients who did not engage well with, or respond to community treatment.

There is a need for increasing service provision and provision of intensive community based services for Aotearoa/New Zealand young people/rangatahi, which recognise the complexity with which young people/rangatahi present, and suitable responses which are effective in meeting complex needs. The positioning of one service within a Māori provider was consistent with capacity building as recognised by policy.

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