TE WHĀNAU POU TORU

Findings from a Randomised Controlled Trial (RCT) of
Te Whānau Pou Toru Whānau/Whanaungatanga Kōrero - Māori Adaptation of the
Primary Care Triple P Positive Whānau/Parenting Discussion Groups

TE RIPOATA — REPORT TO THE MINISTRY OF HEALTH

Prepared by

Louise Keown, Matthew R Sanders, Nike Franke, Matthew Shepherd

Whānau/Parenting Research Group, Faculty of Education, The University of Auckland

In partnership with the Ngāti Hine Health Trust

Whānau, Whanaunga, Ngā Pepe, Ngā Tamariki, Kuia and Kaumatua

Address for Correspondence:

Dr Louise Keown
Whānau/Parenting Research Group
Faculty of Education
University of Auckland
Private Bag 92601
Symonds Street,
Auckland 1150

KO HINEAMARU TE TUPUNA

KO TAUMARERE TE AWA

KO NGĀTI HINE TE IWI

NGĀTI HINE PUKEPUKERAU

Ko tā mātou whakahaere tēnei, ko tā ēnei uri o Hineamaru e noho nei i raro o ēnei puke e rua, o Motatau o Hikurangi, kua oti hoki te whakatauki, tū te ao tū te po, kia rite hoki ki te kōrero o te ture nui o Ingārangi.

"This is how we intend to act, these descendants of Hineamaru, who reside beneath these two hills of Motatau and Hikurangi, of whom it is said, stand both day and night, in concordance with that which is said are the great laws of England."

Ko te tino tikanga kia kotahi tonu whakahaere a te Māori. Kaua e rere ke atu i runga i te tikanga. Me titiro ki te upoko, ko Hineamaru te pou hei herenga, hei pupuri hoki i te tikanga a ngā uri o Hineamaru mo te whenua papatupu, apiti iho ko te whakakotahitanga a ngā uri o Hineamaru.

"The intention is that Māori conduct themselves with single purpose. That it should not vary in practice. When you look to its head the figure that binds, is Hineamaru. She is the repository of all customary practice, which the descendants of Hineamaru might utilise in respect of these customary lands. And thereby ingrain the unanimity of Hineamaru descendants."

TE ROHE WHENUA O NGĀTI HINE:

Te Porowini o Ngāti Hine I rohetia e Maihi i tēnei takiwa hei Rohe Tangata mo Ngāti Hine i te tau 1878: "Hikurangi titiro ki Pouerua, Pouerua titiro ki Rakaumangamanga, Rakaumangamanga titiro ki Manaia, Manaia titiro ki Whatitiri, Whatitiri titiro ki Tutamoe, Tutamoe titiro ki te Tarai o Rahiri, Te Tarai o Rahiri titiro ki Hikurangi ki ngā Kiekie whawhanui a Uenuku."

'This area was identified by Maihi Kawiti as the 'Te Porowini o Ngāti Hine' or the 'Province of Ngāti Hine'.

Mamai Aroha

ROB COOPER CNZM
(18th October 1939 – 20th June 2016)

E hoki muri ana ngā whakaaro
ki ngā tini whanaunga
kua ngaro atu ki te Po
Na reira
Haere Koutou
Haere Atu
Haere Atu

The passing of Rob Cooper on the 20th June 2016, was really sad, and a great loss indeed to all of us, not just Ngāti Hine but to our Nation - Aotearoa. Rob's many contributions in Health, Education and helping to shape Government policy are well known as was his skill for building collaborative relationships among people from all walks of life. A champion supporter of this project, Te Whānau Pou Toru and Te Tiriti Arohatinopumau Ki Ngā Tamariki Katoa. We were enriched by his resilience to shift mind-sets that had negative impacts on Māori capacity and capability and embraced his confidence and sense of integrity that Māori could achieve their full potential by having unique relationships and collectivizing our wisdom and talents. A wonderful legacy for the next generation.

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Ngā Mihi — Acknowledgements

The Ngāti Hine Health Trust and the Whānau/Parenting Research Group in the Faculty of Education at The University of Auckland wish to acknowledge the valuable contribution of the whānau/parents and practitioners who participated in the hui/focus groups and gave their kōrero/views on the relevance and acceptability of the Kaupapa- core principles, strategies, resources and delivery methods of the Primary Care Triple P Program to Māori whānau.

This project was able to be developed through collaboration between Dr Erana Cooper and her late father, Rob Cooper, CNZM, former Chief Executive of the Ngāti Hine Health Trust.

Te Mata Rehu - He toa kei te kokiri – hei hapai I te oranga o te iwi.

"Through our combined strength and unity of purpose, the well-being and development of our people is assured."

The Trust has long held a vision for the wellbeing of all whānau and partnering with this project presented an opportunity to enhance resources and skills available to whānau to be the best parents for their tamariki. Thus, a research partnership was established between the Whānau/Parenting Research Group and the Ngāti Hine Health Trust, resulting in a strong foundation upon which this project has been built.

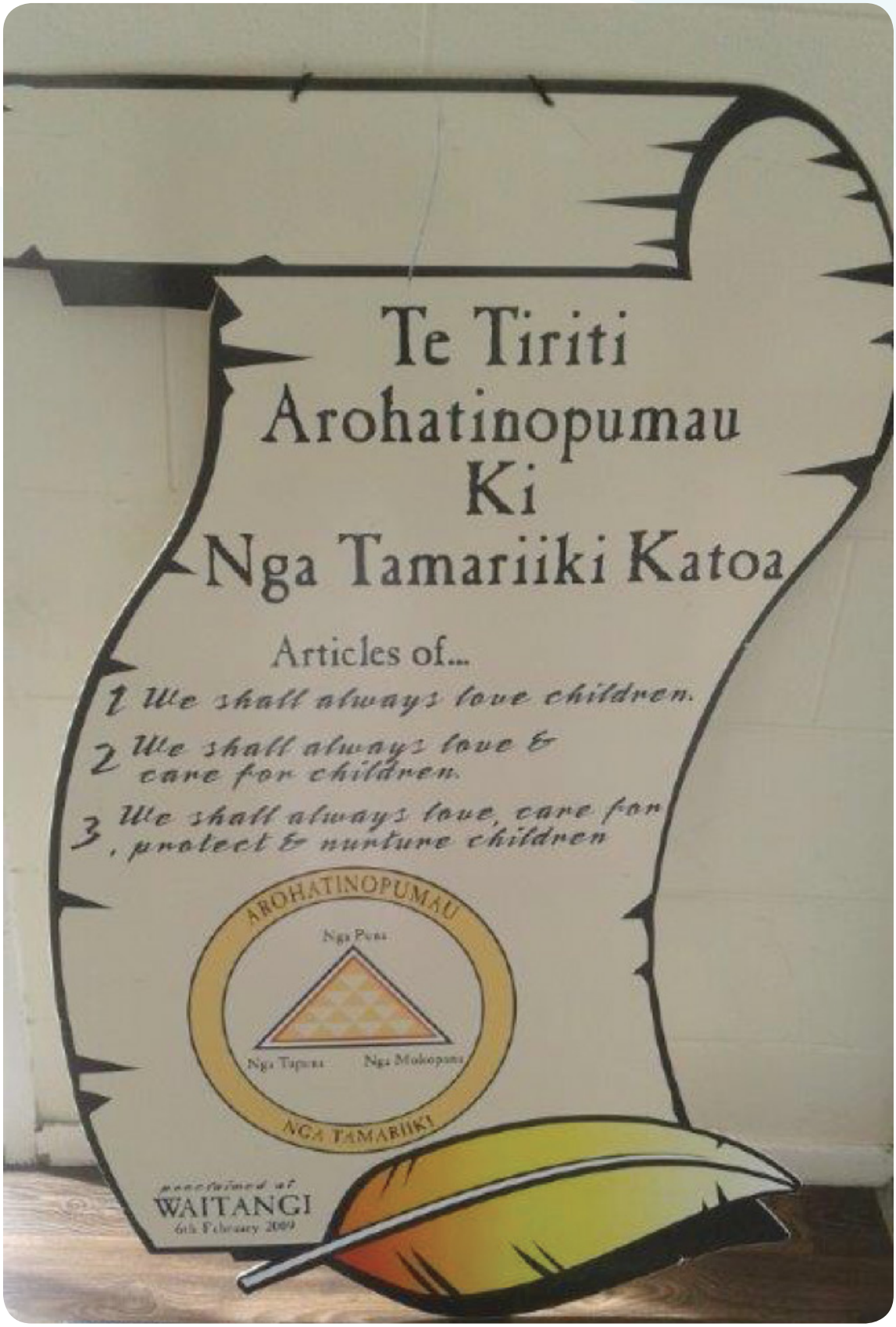
The Board Chair Gwen Tepania-Palmer for the Ngāti Hine Health Trust acknowledges the unwavering support of Ngāti Hine Whānau and the wider community, the Whānau/Parenting Research Group, the Māori Reference Group, and the understanding of the Ministry of Health throughout the time of this exciting project. Finally, to our Kuia and Kaumatua we thank you for continued guidance, wisdom and tautoko.

Dr Erana Cooper with her late father Rob Cooper

Nau te rourou, naku te rourou, kia ora ai te iwi e.

"Through united efforts our people will prosper"

Te Tiriti Arohatinopumau Ki Nga Tamariiki Katoa



Developed 2009 – Ngāti Hine Health Trust

Whakarapopotanga — Executive Summary

Timatanga Kōrero — Introduction

He aha te mea nui o te ao?
He tangata, he tangata, he tangata.

"What is the most important thing in the world?
It is people, its people, it is people."

Kōrero-o- muri — Background: Te Ripoata

This report describes the outcomes of a randomised controlled trial (RCT) evaluating the effectiveness of *Te Whānau Pou Toru*, a culturally adapted version of the Primary Care Triple P - Discussion Groups. The project was the result of a collaboration involving the Whānau/ Parenting Research Group in the Faculty of Education at The University of Auckland, the Ngāti Hine Health Trust and the Whānau/Parenting and Whānau/Family Support Centre at The University of Queensland in Australia.

He aha tenei Kaupapa — What is this initiative about?

Te Whānau Pou Toru is a brief, low intensity preventive early intervention programme for whānau/parents of young tamariki/children experiencing difficulties with managing tamariki/children's behaviour. The process of adaptation was based on a Collaborative Participation Adaptation Model (CPAM) a process to enable evidence based parenting programmes to be effectively deployed with culturally diverse groups of parents around the world. CPAM involved extensive hui/community consultation with whānau/parents and practitioners as end users, the project team and programme developers. Programme resources were reviewed to identify specific cultural adaptations in both the content and process of delivering Triple P at hui and with discussion groups that would enhance the Māori worldview, inclusive of whakapapa, tupuna stories, wairuatanga, and tikanga that reflect Māori traditional ways of doing things together. Plainly speaking in Tau Iwi terms of cultural acceptability, relevance and effectiveness of the programme with a broad range of Māori whānau as the Taonga or Treasures as they came together generously sharing their views. This process involved preserving the integrity, session structure, and all core procedures and activities that are part of the original Triple P Discussion Groups. No programme content was removed although ways of enriching the process of delivery through Tikanga principles and Karakia and the sharing of whakawhanaungatanga, illustrating, explaining and demonstrating it were modified to reflect principles/ values of all that is the best of things Ngā mea Māori, Ngā Tikanga o tenei Hui, Pono and Tika known as what is right and what is proper.

Evaluation approach

The evaluation used a mixed methods approach. This included conducting a two arm randomised controlled trial (RCT) that compared Triple P Discussion Groups (TPDG; the intervention group) to a Waitlist Control condition (WLC) at pre-intervention, post-intervention and at six-month follow-up. Programme outcomes were assessed using a range of standardised child, whānau/parenting and whānau/family measures. In addition, in-depth individual interviews were conducted with a third of participants who received the intervention.

What was involved: Seventy parents of young tamariki/children (age 3-7 years) experiencing concerns with conduct-related problems participated in the study. In four of these families a second caregiver also attended the parenting groups. Parents of the target child were randomly assigned to either a Triple P Discussion group condition (n = 41, TPDG) or to a Waitlist control condition (n = 29, WLC). Minimal restrictions were placed on who could participate to ensure a diverse range of families could be involved and to reduce any stigma associated with participating in a parenting programme. The main requirement to participate was having a child in the 3 to 7-year age group and having some concern about their child's behaviour. Parents participating in the TPDG condition attended two, 2-hour discussion groups *Being a Positive Parent*; and *Dealing with Disobedience*. Participants were reassessed 5 weeks after the intervention and again at 6-months post intervention.

What was found?

Randomisation produced equivalent groups prior to intervention as there were no baseline differences between conditions on any socio-demographic or outcome variables. An Intent to Treat (ITT) analysis of the effects of the intervention at five-weeks post intervention and again at follow up showed that the TPDG produced a range of positive and sustained intervention effects on child, parenting and family adjustment outcomes. On the primary outcome variable of child disruptive behaviour there were significantly lower levels of conduct problems on the Eyberg Child Behavior Inventory (Intensity score, d = .60 and Problem score d = .63) immediately following the intervention. Parents in the TPDG reported significantly lower levels of child functional impairment on the Strengths and Difficulties Questionnaire Impact supplement (d = .54). On the secondary outcome variables of interparental conflict there was significantly less conflict on the Parent Problem Checklist (PPC; Extent score, d = .88; Problem score, d = 1.18), and greater improvements in partner relationship quality (d = .85).

The immediate post intervention effects were largely maintained or improved further at follow-up. There were significantly lower scores favouring the TPDG on the ECBI Intensity and Problems scores (d = .53 and d = .71 respectively), the SDQ Emotional symptoms (d = .88), and Peer problems (d = .82). Additionally, there were greater improvements in parenting confidence (PTC Setting self-efficacy d = .44; PTC Behaviour self-efficacy, d = .44), and lower levels of overreactive parenting practices (d =.46), and partner conflict on the PPC (Extent, d = .54; Problem d = .72). There were also greater time effects from Time 1 to Time 3 for the TPDG for all subscales and total score of the Parenting Scale (range d =. 64 to .82), than for the WLC group (d =.17 to .65). There were no significant condition differences at follow-up for parental distress on the DASS. Scores for both groups on all DASS subscales remained in the normal range throughout.

Semi-structured interviews following the intervention highlighted a wide range of positive benefits from the programme for parents and their tamariki/children, the helpfulness of the whānau/parenting strategies learnt for managing their child's behaviour, positive reports about improvements in tamariki/children's behaviour, and an appreciation of the culturally adapted content.

Conclusions

The collaborative partnering process of culturally adapting an existing evidence-based whānau/parenting intervention (Triple P Discussion Groups) for Māori whānau was effective in producing a brief, high quality, culturally acceptable and effective whānau/parenting intervention. As the programme participants included a wide range of parents of tamariki/children with various levels of severity of child problems, (mild-to-severe) the programme appears to be a valuable 'light touch' prevention intervention that can be readily deployed as a universal early intervention programme to reduce behaviour problems, promote self-regulation in tamariki/children, parental self-efficacy and reduce overreactive parenting practices and whānau/family conflict. Programme effects were demonstrated with a Māori population in Northland living in areas known to have higher rates of risk factors (for example; unemployment, single parenthood, parents receiving various types of government assistance, large whānau/family sizes, and substance abuse). As the intervention is a brief low cost programme (2 x 2 hour sessions) involving minimal investment of practitioner and parent time future economic analyses are likely to show it is very cost effective as an intervention.

Detailed recommendations relating to the implementation of Te Whanau Pou Toru have been provided to the Ministry of Health under separate cover.

1 Tīmatanga kōrero — Introduction

1.1 Kōrero-ō-muri — Background

In 2011, the Government developed "Addressing the Drivers of Crime (DoC) Workstreams" as part of their work towards implementing a multi-level response to tamariki/children's conduct and behaviour problems. Part of the DoC Workstreams Agreement involved contracting services to enhance Primary Care Triple P for Māori, and to trial the Māori adapted version with Māori whānau.

In 2013, a contract for the project was signed between the Ministry of Health and Auckland UniServices Limited, dated 3rd December 2013 expiry January 2017. The project is a collaboration involving the Whānau/Parenting Research Group in the Faculty of Education at the University of Auckland, the Ngāti Hine Health Trust in Te Tai Tokerau and the Whānau/Parenting and Whānau/family Support Centre at the University of Queensland in Australia.

Te Reo Manatunga- The giving of a name creates a sense of significance. The Project-Te Whānau Pou Toru (name given by Ngāti Hine Health Trust) aims to explore the cultural appropriateness of the Triple P-Positive Whānau/ Parenting Programme (Primary Care Triple P discussion groups) for Māori whānau as a brief preventive early intervention programme. The name 'Te Whānau Pou Toru' refers to three pillars of Positive Whānau/Parenting Practices. The project team has applied Māori values and practices at hui to ensure appropriate consultation and a participatory research process involving whānau/parents as end users in hui consultation with programme developers. The purpose was to identify specific adaptations in both content and process of delivering Triple P discussion groups that might enrich the programme's Māori centric qualities that display Māori acceptability, relevance and effectiveness with a broad range of Māori whānau. This project provided opportunities for Māori whānau to expand their whānau/parenting capabilities and recognise improved health, social and educational opportunities for their tamariki/children, enwrapped in the korowai of Whānau Ora, Whanaungatanga, Wairuatanga and Whakapapa

The objectives of this project were:

- To determine the cultural relevance and acceptability of Primary Care Triple P methods and resources to Māori whānau.
- To inform the development and release of a Māori adapted version of the Primary Care Triple P Programme, known as Te Whānau Pou Toru - Positive Whānau/Parenting Practices.
- To evaluate the efficacy of the adapted programme with Māori parents of tamariki/children with behavioural difficulties in the 3- 7-year age range.

1.2 Te oranga o te pā harakeke — Māori whānau and well-being of tamariki/children and young people

While there has been significant progress made for Māori over recent decades, Māori in general are over represented in an array of negative education, health and well-being statistics (Ministry of Social Development, 2010). Government policy has attempted to address these issues, nevertheless, the social, economic and health gaps between Māori and non-Māori in New Zealand exist (Ministry of Social Development, 2010).

A recent initiative by the New Zealand government has targeted inequalities for Māori through whānau ora (Kara et al., 2011). This approach maintains a traditional Māori perspective which is to view the world in a collectivist way. Māori culture places an emphasis on the individual acting in a way that would seek to put the whānau (extended whānau/family) and iwi (tribe) needs before their own needs (Health Research Council, 2008; Smith, 1999). Incorporating this worldview into any programme that seeks to bring about change for Māori must be focused on the whole whānau, hapū and iwi systems.

Western psychological models have tended to focus on an individual's internal psychological state, for example, a change in one's thoughts and feelings leads to improved mental health. In contrast, Māori culture emphasises

the importance of being connected to extended whānau/family (whānau), genealogy going back many generations (whakapapa), tribe (hapū and iwi), environment (land, rivers, seas, and mountains), and spiritual (wairua) and physical health (Durie, 1994; Durie, 2001; McNeill, 2009). Each of these dynamics means that mainstream Western therapeutic approaches might have limited appeal or limited therapeutic power with Māori young people and their whānau. Western psychological models with their analytic focus on individual thoughts, behaviours, and feelings, without processes of cultural connection, might be considered antithetical to Māori worldviews.

Moreover, Māori youth are over-represented in areas of high deprivation and consistently experience worse health and well-being outcomes than Pākehā young people (Crengle et al. 2013; Helu, Robinson, Grant, Herd, & Denny, 2009; Ministry of Social Development, 2010). For instance, Māori youth have higher obesity rates, report greater mental health concerns and substance use, less consistent use of contraception, reduced access to health services, and greater exposure to violence. They are also less likely to report that their teachers treat them fairly (Crengle et al., 2013; Helu et al., 2008) and are more likely to leave secondary school with lower educational qualifications than their Pākehā counterparts (Ministry of Social Development, 2010).

These inequalities require attention and reinforce that Māori youth and whānau have unique needs that must be considered. Ethnic minority populations are largely missing from the efficacy studies that make up the evidence base for psychological treatments. This is often due to the inclusion of small samples, which limit the accuracy of statistical inferences (Bryant & Harder, 2008; Miranda et al, 2005). Similarly, few studies capture qualitative information because of the small number of ethnic minority participants in studies to date. Ethnic minority opinions (including the perspectives of indigenous people in colonised countries who are often in a minority) are therefore missing in relation to the development of interventions. There are implications for those that design therapeutic psychological programmes, in that the evidence base that they draw from to inform these therapies is fairly limited for ethnic minority groups, with a review of therapeutic programmes for adults highlighting that future research in the field needs to specifically assess the acceptability amongst indigenous minority groups (Tito, 2007). Therefore, this current study, Te Whānau Pou Toru, is much needed as it is exploring the efficacy of a behavioural change programme (Triple P Positive Whānau/Parenting Programme) for Māori whānau and tamariki/children. One, thus, cannot assume that psychological theories will be applicable in the same way that they are for non-indigenous people as they are for indigenous minority groups. A major focus for this project has been to have a clear consultative process with whānau, hapū and iwi that are currently involved in this trial. These people have become the voice, which has informed a ground up process where their thoughts and opinions have assisted in the design of Te Whānau Pou Toru.

1.3 Te urutau o ngā hotaka taunaki ki ngā ahurea kanorau — The adaptation of evidence-based programmes to diverse cultures

There is a growing literature on the effectiveness of evidence-based whānau/parenting programmes when they are used in different cultures. This work has included evaluation studies where whānau/parenting programmes developed in one country, typically an English speaking western country (e.g. the US, UK or Australia), have been tested and shown to be effective in another country, language or region (e.g. Northern and South East Asia, Middle East).

The core principles of positive parenting based on social learning theory and cognitive behavioural principles have been shown to be remarkably cross culturally robust. For example, research into the cultural acceptability and effectiveness of Triple P outside Australia and New Zealand where Triple P was developed has shown various versions of the programme are also effective with Asian parents from Japan (Fujiwara, Noriko, & Sanders, 2001), China (Guo, Morawska, & Sanders, 2016), Singapore and Indonesia (Sumargi, Sofronoff, & Morawska, 2015); in various European cultures including the UK, Germany, the Netherlands, Belgium, Switzerland, Sweden, Greece and Turkey; in North America (USA and Canada), and recently in Central and Latin America (Panama, Chile).

A recent meta-analysis by Gardner, Kerr and Montgomery (2015) counter intuitively found that larger effect sizes were reported in studies conducted outside the original country where the programme was developed and first trialled. Two other meta-analyses have shown that the positive effects are not dependent on developer

involvement where similar effects sizes were found for studies that involved or did not involve the developers of Triple P (Sanders, Kirby, Tellegen, & Day, 2014) and the Incredible Years (Menting, de Castro, & Mattys, 2013).

In Australia, Triple P has been shown to be effective with Aboriginal and Torres Strait Islander families of preschool aged tamariki/children and it has been used effectively with a diverse range of parents from Asian, Middle Eastern, Latin American and African backgrounds.

By and large most studies examining the cross-cultural robustness of evidence-based programmes have shown them to be remarkably effective with relatively minor changes or adaptations being required (e.g. Mejia, Calam, & Sanders, 2015a, 2015b). When changes have been made to core programme resources it has entailed translation of resources, voice dubbing or reshooting video material depicting parent-child interactions, the selection and use of practitioners from the same cultural background as parents participating in the programme, and selection of culturally salient examples that are relevant to the target group.

These principles of tailoring or customisation of delivery to an appropriate target audience are well understood by experienced clinicians working with a diverse range of families that is typical in most Western countries including New Zealand. However, there has been no specific study examining the views of Māori parents and practitioners on the cultural acceptability of Triple P and no randomised trials have been conducted to establish the efficacy of Triple P with Māori whānau. The present study aims to fill this important gap.

1.4 Whakāturanga Tauira urutau o Triple P mo te Māori — Description of a Collaborative Participation Adaptation model for adapting Triple P for Māori

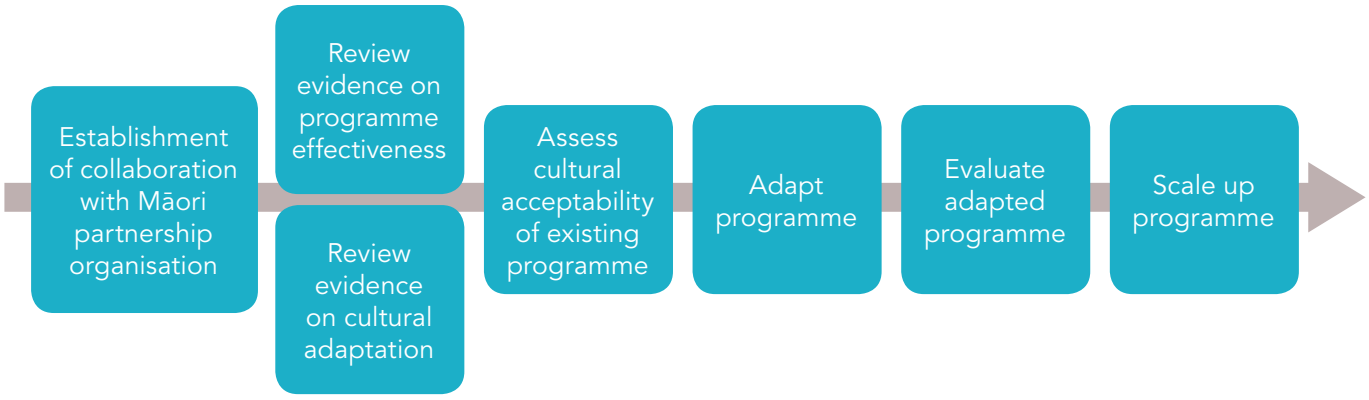


Figure 1: Collaborative Participation Adaptation Model culturally adapting Triple P

We employed a collaborative participatory adaptation model (Sanders, 2015; Sanders & Turner, 2016) to determining the extent to which changes were needed to the original programme to be consistent with fundamental Māori values and to evaluate the effectiveness of the culturally adapted programme. The approach blends a collaborative partnership process involving the continuous and ongoing input of both parents as consumers and end-users and a rigorous process and outcome evaluation as part of a continuous quality improvement process (Sanders & Kirby, 2014).

This blending of perspectives from multiple informants is particularly important for preventative programmes offered universally within a population health framework so that programmes have adequate population reach and have a better ecological fit to unique circumstances of modern Māori whānau raising tamariki/children in New Zealand.

The CPAM process begins by forming a project team with a particular interest in ensuring a version of Triple P is available that might address the needs of Māori whānau. This project team decided on the scope and focus of the project including which Triple P programme to focus on, the target age group and the region of NZ to conduct the work. Once this had been decided, a Māori Reference Group was established to advise the project

team on cultural issues related to conducting the research. The model involved reviewing relevant international literature on the topic of cultural adaptation and evidence concerning the efficacy of culturally adapted programmes. Both parents and end-user practitioners were asked to review and give their opinion about the relevance and cultural acceptability of the non-adapted programme resources and materials and to make suggestions for how the programme could be strengthened to meet the needs of Māori whānau. The project team, in consultation with the Māori Reference Group, reviewed recommended adaptations and prepared recommendations for the consideration of the programme developers, including an estimate of any costs that might be incurred by developers in making the proposed changes to the programme.

Kaumātua and Kuia from Ngāti Hine suggested the Māori name for Triple P be Te Whānau Pou Toru (TWPT). This name reflects the practices of Positive Whānau/Parenting, whilst retaining the quality and integrity of the Triple P – Positive Whānau/Parenting Program. The name Te Whānau Pou Toru (TWPT) brings together the whānau as a whole, working together with the strength, support and sustenance of Positive Whānau/Parenting Practices.

The research team, (Auckland University, Ngāti Hine and Kaumātua and Kuia [from Ngāti Hine]) derived the Te Whānau Pou Toru graphic (Appendix A). The Kaumātua and Kuia from Ngāti Hine developed a word document that explained the tikanga within the TWPT graphic (Appendix B). The TWPT graphic states how the Triple P principles and the tikanga of Ngāti Hine can both work together to teach whānau/parenting skills. This is considered a cultural adaption of the Triple P resource but it also highlights a partnership approach to whānau/parenting.

The revised culturally adapted programme, Te Whānau Pou Toru, has been subject to a careful evaluation in the form of a pragmatic randomised clinical trial using a mixed method evaluation approach involving both quantitative and qualitative data. The trial has produced positive findings and the adapted version has been shown to be effective and culturally acceptable. Therefore, consideration should be given to funding the scaling up and wider dissemination of Te Whānau Pou Toru.

1.5 He pātai — Key research questions

The key research questions related to the effectiveness of Te Whānau Pou Toru/Triple P Discussion Groups on child, parent, and inter-parental relationship outcomes.

Our primary outcome variable related to the effects of the programme on child conduct problems. We hypothesised that compared to a waitlist control group (WLC) parents receiving the Triple P intervention would report significant reductions at post intervention in child conduct problems on the Eyberg Child Behaviour Inventory (ECBI).

Our secondary outcomes variables related to changes in child emotion and peer problems, and child functional impairment, whānau/parenting practices, whānau/parenting confidence, teamwork around whānau/parenting and parental adjustment and partner relationship satisfaction. Specifically, we predicted that compared to parents in the WLC group, parents in the Triple P intervention group would report significant reductions at post intervention in (a) child emotional and peer problems and child functional impairment and (b) reductions in ineffective whānau/parenting practices and conflict with their partners over child rearing. In addition, it was hypothesised that parents in the intervention group would report greater improvements in their confidence in managing their child's behaviour, their own well-being and their partner relationship satisfaction.

Our exploratory questions related to the cultural acceptability and perceived value of Te Whānau Pou Toru Triple P for Māori mothers, fathers, and whānau.

Parent's awareness and understanding of:

- Age appropriate behaviours
- Child's needs as paramount
- Importance of parent's consistency
- Importance of parent's working together
- Importance of whānau support

2 Te huarahi — Method

2.1 Ngāti Hine hei māngae, Ngāti Hine hei hoa hāere — Ngāti Hine as partners and participating voices

Whānau Haere mai –
Whakarongo -Titiro -Kōrero mai

"Listen observe then make comment to our
Whānau and communities
This an important part of our organisational culture"

The Ngāti Hine Health Trust was registered as a Charitable Trust in 1992 and subsequently re-registered under the Charities Act of 2005 in June 2008.

Amongst the key roles set by the Trust are to act as "change-agent", "champions" and/or "best-practice exemplar" of activities which are expected to improve the status of all peoples resident in the Ngāti Hine rohe.

Listening to our whānau/communities is an important part of our culture. It is through these voices and the interactions that we truly understand the hopes and aspirations that guide us as an organisation through our best endeavours to work side by side so Whānau-communities can live better, healthier and set the direction for lives that hold a brighter future that shines full of hope.

Ngāti Hine and the wider whānau have established the delivery of a comprehensive range of mobile nursing, residential and community health services, and through the recognition of the underlying social determinants of health, the Trust expanded to encompass social, disability, education and training, and media services; and actively seeks to collaborate with other services and sectors. The Trust is now among the largest of the Māori health providers in Aotearoa New Zealand.

The Trust employs approximately 140 full time and 270 part-time staff most of whom are Māori. Skills of staff include medical qualifications, specialist nursing for cardiovascular, diabetes and asthma, dental, podiatry and mental health interventionists, qualified social workers and educationalists. The Trust runs an ongoing workforce development programme that includes residential care, disability support, community alcohol and drug services, health promotion, media services, education and training. The Trust is an accredited Quality Provider and has a dedicated Continuous Quality Improvement policy.

Ngāti Hine is proud to participate in this developmental project with our whānau, tamariki, and mokopuna. The Trust has a vision (He Mata Rehu) "He toa kei te kōkiri, hei hāpai i te oranga o te iwi" ~ Through our combined strength and unity of purpose, the well-being and development of our people is assured.

Some key guiding principles for this project

- Ngāti Hine Tikanga Māori – The knowledge of Ngāti Hine Māori protocols
- Te Reo Māori o Ngāti Hine- Acknowledgement and use of Māori Language an official language of Aotearoa/ New Zealand
- Rangātiratanga o Ngāti Hine –The principle of autonomy
- Kanohi ki te Kanohi- Face to face interaction and having accountability
- Ngāti Hine Manaakitanga – reciprocity being caring and considerate hosts.
- Whanaungatanga- importance of relationships, kinship, whānau/family, geneology
- Aroha ki te Whānau me ngā Tangata- displaying warmth and respect to whānau/family and all people gathered.

2.2 Whakaaturanga o ngā whānau me ngā mātua I whai wāhī — Description of parent participants

The demographic characteristics of the 70 parents of young children (age 3-7 years) who participated in the study are displayed in Table 1. The mean age of the target children was 4.5 years (*SD* = 1.44), the majority of whom were male (*n* = 44; 62.9%). Twenty-seven (38.6%) parents reported a second ethnicity for their child in addition to Māori, with the most (*n* = 21) common being NZ European or other European descent. The average age of the parent participants was 35.4 years (*SD* = 9.26) who consisted of 56 (80%) mothers, eight fathers (11.4%), and six (8.6%) grandmothers. Twenty-three (32.9%) caregivers reported a second ethnicity in addition to Māori for themselves, with NZ European or other European (*n* = 17) the most frequently given. With regard to marital status, in 54.3% (*n* = 38) of families, parents were either married (*n* = 10; 14.3%) or living with their partner in a defacto relationship (*n* = 28; 40.0%). The number of children per household under the age of 16 years ranged from 1 to 10 (*M* = 3.99; *SD* = 1.78), while the number of people per household over the age of 16 years ranged from 1 to 9 (*M* = 3.31; *SD* = 1.37). The most frequently reported caregiver educational qualification was a post-secondary certificate or diploma (*n* = 26; 37.1%) followed by any school qualification (*n* = 18; 25.7%). These patterns were similar for caregivers' partners with a post-secondary certificate or diploma specified for 55.3% (*n* = 21), followed by any school qualification (*n* = 7; 18.4%). Most caregivers were currently not employed (*n* = 50; 71.4%). For caregivers with partners, 50% (*n* = 19) of their partners were not in paid employment. There was a range of family income within the sample with 16 (22.9%) earning less than $20,000, 25 (35.7%) families earning between $20,000 and $50,000, and five (7.1%) families earning more than $50,000 a year. Twenty-four (34.3%) families did not know their annual income before tax. The majority (*n* = 59; 84.3%) of families received some type of financial help from the government. The most common type of benefits received were Sole Parent Support (*n* = 24; 40.7%), Jobseeker Support (*n* = 12; 20.3%) and Working for Families Tax Credit (*n* = 8; 13.6%).

Table 1: Demographic Characteristics of the Sample

	Intervention (*n* = 41)		Waitlist control (*n* = 29)	
	M	*SD*	*M*	*SD*
Child age	4.49	1.57	4.52	1.27
Caregiver age	35.20	9.16	35.66	9.54
	n	%	*n*	%
Child gender				
Male	24	58.5	20	69.0
Female	17	41.5	9	31.0
Child second ethnicity				
NZ European	10	58.8	6	60.0
Other European	4	23.5	1	10.0
Pacific Islands	2	11.8	2	20.0
Other (African American, Australian)	1	5.9	1	10.0
Caregiver				
Mother	30	73.2	24	82.8
Father	5	12.2	2	6.9
Foster mother	2	4.9	0	0
Foster father	1	2.4	0	0
Grandmother	3	7.3	3	10.3
Caregiver second ethnicity				
NZ European	11	66.1	2	40.0
Other European	4	22.2	0	0

	n	%	n	%
Pacific Islands	2	11.1	2	40.0
Other (African American, Australian)	1	5.6	1	20.0
Marital status				
Married	6	14.6	4	13.8
Defacto	16	39.0	12	41.4
Separated	7	17.1	4	13.8
Married/defacto and now living apart	3	7.3	2	6.9
Single/never married or never defacto	7	17.1	5	17.2
Divorced	1	2.4	2	6.9
Widower	1	2.4	0	0
Number of children within household (<16yrs)				
1	1	2.4	1	3.4
2	11	26.8	3	10.3
3	8	19.5	8	27.6
4	7	17.1	3	10.3
5	7	17.1	7	24.1
6-10	7	17.1	6	20.7
Missing	0	0	1	3.4
Number of people within household (>16yrs)				
1	1	2.4	0	0
2	9	22.0	8	27.6
3	17	41.5	12	41.4
4-9	14	34.1	9	31.0
Qualification caregiver				
No qualification	7	17.1	3	10.3
Any school qualification	12	29.3	6	21.4
NZ certificate/ diploma	11	26.8	7	24.1
Local polytech/ diploma	3	7.3	5	17.2
Bachelor degree	3	7.3	2	6.9
Other	1	2.4	1	3.4
Don't know	4	9.8	4	13.8
Missing	0	0	1	3.4
Qualification partner[a]				
No qualification	1	4.5	1	6.3
Any school qualification	5	22.7	2	12.5
Trade/ Advanced trade certificate	4	18.2	1	6.3
NZ certificate/ diploma	2	9.1	4	25.0
Local polytech/ diploma	3	13.6	4	25.0
Technicians certificate	1	4.5	0	0
Teachers certificate/ diploma	2	9.1	0	0
Other	0	0	1	6.3
Don't know	4	18.2	3	18.8
Currently employed — caregiver				
Yes	12	29.3	8	27.6
No	29	70.7	21	72.4

	n	%	n	%
Currently employed — partner				
Yes	14	36.4	8	50.0
No	8	63.6	8	50.0
Annual gross family income				
< $20,000	9	22.0	7	24.1
$20,000 – 30,000	7	17.1	5	17.2
$30,000 – 50,000	6	14.6	7	24.1
>$50,000	4	9.8	1	3.4
Don't know	15	36.6	9	31.0
Government benefit				
Yes	34	82.9	25	86.2
No	7	17.1	4	13.8
Type of benefit				
Sole Parent Support	15	44.1	9	36.0
Jobseeker Support	5	14.7	7	28.0
Working for Families Tax Credit	5	14.7	3	12.0
Sickness	0	0	2	8.0
Accommodation Supplement	1	2.9	1	4.0
Supported Living Payment	2	5.9	3	12.0
Student Allowance	2	5.9	0	0
Unsupported Child's Benefit	2	5.9	0	0
Child Support	2	5.9	0	0

[a] Intervention *n* = 22, Waitlist control *n* = 16

2.3 Huarahi kimi tangata — Recruitment methods

Participants were recruited in the Kawakawa and Whangarei areas via approaches to a wide range of services, agencies and organisations that worked with tamariki/children or caregivers. These included schools, child care and early childhood centres, GPs, child health centres, social service agencies (e.g. Whānau/family Works, Barnados, Plunket), and Ngāti Hine Health Trust services, who were contacted for assistance to circulate the study advertisement. The study was regularly promoted by Ngāti Hine FM radio who shared the pānui on their community notices. Study advertisements were also displayed in shop windows and distributed via letter box drops in Kawakawa and Whangarei.

Parents who indicated their interest in the study took part in a face-to-face screening interview to assess eligibility. Eligibility criteria included: (a) child aged between 3 to 7 years; (b) parent report of concerns about the behaviour of their tamariki (assessed by the question "is the behaviour of your tamariki causing you concern?"); (c) parent was not receiving services for their child's behaviour problems or for their own psychological difficulties; and (d) the child did not have a developmental disability. In total 136 families were screened for participation. Twenty-one did not meet the inclusion criteria (e.g. child outside the age range, did not have a concern about their child's behaviour), and another 45 families were unable to participate for a range of reasons such as whānau/family circumstances and other commitments. Figure 1 displays the flow of participants through each stage of the study.

The study was a 2 (condition: intervention vs. waitlist control) x 3 (time: pre-intervention, post-intervention, 6-month follow up) randomised controlled trial. Ethical approval was obtained from the University of Auckland Human Research Ethics Committee on 31 March 2015. Once deemed eligible for participation, parents completed informed consent forms and the pre-intervention questionnaire measures as described below.

Randomisation to group was conducted after completion of pre-intervention questionnaires. A simple randomisation procedure was used, which involves allocating to group using a computer-generated list of random numbers. Simple

randomisation is considered to be a robust method and is easy to undertake (Torgerson & Torgerson, 2008). A key limitation of simple randomisation is that an imbalance may occur in the number of participants allocated to groups, particularly on key variables such as marital status and location (Torgerson & Torgerson, 2008). In order to reduce the impact of any potential imbalances, allocation to condition was stratified by the location in which the participants resided (Whangarei or Kawakawa), and household configuration (one-parent vs. two-parent household) and blocked randomisation occurred within each strata. The allocation was stratified in this way to ensure that there would be a balance of participants in both groups at each location and to reduce the possibility of single parents being overrepresented in one group.

Participants from both groups completed the second set of questionnaire measures (T2) approximately five weeks after the intervention group had participated in the programme and the third set of questionnaires (T3) at 6-months post intervention. Parents were offered assistance with completing the questionnaires and 11 parents indicated they would like assistance. Twelve parents from the intervention group participated in post-intervention interviews after post-intervention data was collected. These twelve parents consisted of eight mothers, two fathers, one grandmother and one foster mother.

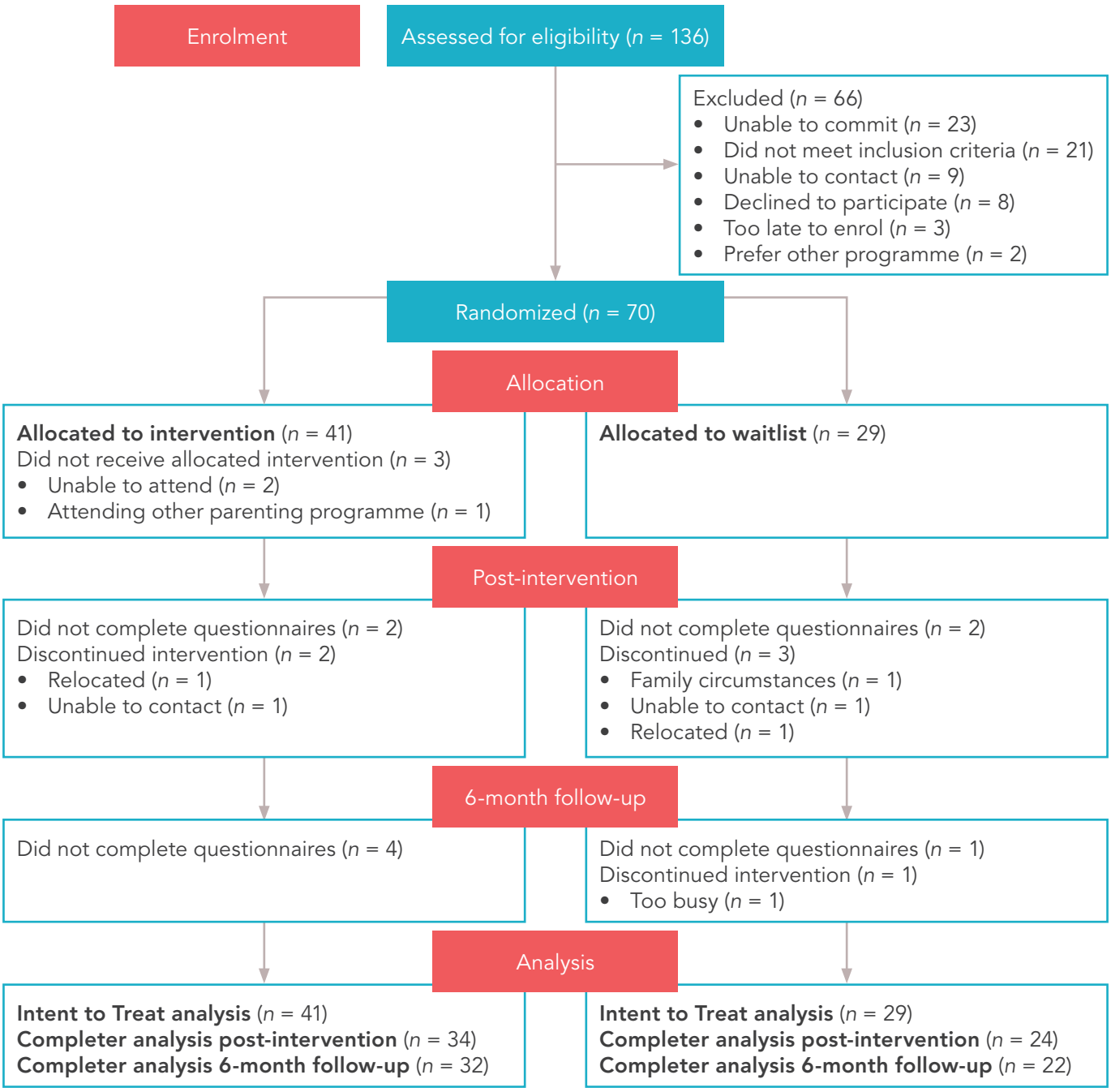


Figure 2: Flow of participants through each stage of the study and reasons for discontinuation.

2.4 Ngā Mēhua - Measures

Whānau/family Background Information

Demographic information collected at pre-intervention included questions about parent and tamariki/children's gender and age, parental marital status, employment details and education, and whānau/family composition and financial status.

Parents who were participating in the study completed the following questionnaire measures at each time point (pre- and post-intervention and 6-month follow-up). The internal consistency of each measure in the current sample was calculated at each time point using Cronbach's alpha coefficients. The results are reported below for each measure.

Child behaviour

The Eyberg Child Behavior Inventory (ECBI) is a 36-item multidimensional measure of parental perceptions of disruptive behaviour in tamariki/children aged two to 16 years (Eyberg & Pincus, 1999). It incorporates a measure of the intensity of disruptive behaviours (Intensity score) rated on 7-point scales with 1 being 'never' and 7 being 'always', and a measure of the number of disruptive behaviours that are a problem for parents (Problem score). Scores on the intensity scale range from 36 to 252 and on the problem scale from 0 to 36, with higher scores indicating greater difficulties. Across the three time points internal consistency of the two scales was high ranging from α = .93 for ECBI Problem to α = .94 for ECBI Intensity.

Parents perceptions of their child's emotional and peer problems and prosocial behaviour were measured using the Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) subscales. Each subscale consists of 5 items that are rated on a 3-point Likert scale to indicate how much each behaviour applies to the child. Across all assessments, mean reliability coefficients were moderate, with α = .52 for Peer problems (range: .35 to .69), α = .58 for Prosocial (range: .43 to .67), α = .60 for Emotional symptoms (range: .50 to .69).

Child functional impairment was assessed using the SDQ impact supplement (Goodman 1999), which asks parents to rate whether s/he thinks their child has a problem with concentration, behaviour, or being able to get on with people. If so, parents were asked to indicate which areas their child has problems with and further questions, rated on a 4-point Likert scale, are asked about the chronicity, distress to the child, social impairment, and burden to others, associated with the problem(s). Items on distress and social impairment are summed to generate an impact score that ranges from 0 to 10. Mean reliability for the scale across the three assessments was α = .85 (range: .81 to .88).

Whānau/Parenting and Whānau/Parenting Confidence

Inappropriate discipline practices were measured using the 30-item Whānau/Parenting Scale (Arnold, O'Leary, Wolff, & Acker, 1993). Each item contains a less effective and a more effective anchor, and parents rate on a 7-point scale the extent to which each end is typical of their disciplinary response. Higher scores indicate the use of more dysfunctional whānau/parenting practices. Scores can be summed to yield a total score and three sub-scale scores; Laxness, Overreactivity, and Verbosity. Across the three time points, the mean alphas were α = .87 for Laxness (range: .84 to .88), α = .81 for Overreactivity (range: .78 to .85), α = .44 for Verbosity (range: .34 to .61), and α = .88 for the Parenting Scale total score (range: .86 to .90).

The Whānau/Parenting Task Checklist (PTC) is a 28-item measure that was used to assess how confident parents feel in managing specific child behaviours and in different settings (Sanders & Woolley, 2005). Parents are instructed to rate their level of confidence for each item on a scale from 0 ('certain I can't do it') to 100 ('certain I can do it'). Two subscale scores, behavioural self-efficacy (e.g. refuses to do as told, constantly seeks attention) and setting self-efficacy (e.g. travelling in the car, speaking with another adult), are derived by averaging parents' responses on the 14 items on each subscale. The possible range of scores on each subscale is 0 to 100, with higher scores indicating greater whānau/parenting confidence. The mean alpha coefficients across the three time points were high, with α = .91 for the Setting scale (range: .89 to .94) and α = .96 for the Behavioural scale (range: .95 to .97).

Parental Adjustment and Relationship Functioning

The Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995) consists of 21 items assessing symptoms of depression, anxiety and stress in adults. Items are scored on a 4-point scale ranging from 0 = did not apply to me at all, to 3 = applied to me very much, or most of the time. Across the three assessments mean alpha coefficients were α = .87 for Depression (range: .79 to .91), α = .85 for Anxiety (range: .73 to .86), α = .88 for Stress (range: .81 to .91), and α = .93 for the DASS Total (range: .90 to .96).

Parents who were married or in a cohabiting relationship completed the Parent Problem Checklist and the Relationship Quality Inventory. The Parent Problem Checklist (PPC) is a 16-item questionnaire measuring interparental conflict over child rearing (Dadds & Powell, 1991). It provides an index of the number of disagreements, as well as the frequency of occurrence of such disagreements, rated on a 7-point scale with 1 being 'not at all' and 7 being 'very much'. Scores range from 0 to 16 on the total problem scale and from 16 to 112 on the extent scale, with higher scores indicating a greater level of inter-parental disagreement. Mean internal consistency coefficients across the three time points ranged from α = .84 for Problem (range: .74 to .90) to α = .92 for Extent (range: .88 to .95).

The Relationship Quality Index (RQI) consists of six items measuring relationship quality and satisfaction (Norton, 1983). Five items rated on a 7-point scale, with 1 being 'very strongly disagree' and 7 being 'very strongly agree,' assess various aspects of partner relationships and one global item, rated on a 10-point scale, assesses the happiness of the relationship. Scores range from six to 45, with higher scores indicating greater relationship quality. Across the three assessments mean reliability of the scale was high, with α = .94 (range: .90 to .96).

Programme Satisfaction

At Time 2 only, parents in the intervention group completed a 13-item Client Satisfaction Questionnaire (CSQ; Sanders, Markie-Dadds, Tully, & Bor, 2000). Items were rated on a 7-point scale with higher scores reflecting more satisfaction with the discussion groups. The questionnaire contained items related to the quality of the service provided; how well the programme met the parent's and child's needs and decreased the child's problem behaviours; and whether the parent would recommend the programme to others. Scores range from 13 to 91. Internal reliability at T2 was α = .94.

2.5 Te Wawaotanga — The intervention

The intervention consisted of two x 2-hour whānau/parenting discussions groups *Being a Positive Parent*; and *Dealing with Disobedience*. The *Being a Positive Parent* discussion group introduced the principles of positive whānau/parenting and taught skills to enhance tamariki/children's competence and development and skills to build positive parent-child relationships. The *Dealing with Disobedience* discussion group covered reasons for disobedience and taught skills to encourage cooperation with parental instructions and to manage disobedience. The information is presented in variety of ways: parents watch video-modelling of strategies, complete within session exercises, are given the opportunity to practice their skills in session, and discuss the strategies with other group members.

Parents in this study were also given the Te Whānau Pou Toru graphic (Appendix A) and a word document that explained the tikanga within the Te Whānau Pou Toru graphic (Appendix B). The Te Whānau Pou Toru graphic states how the Triple P principles and the tikanga of Ngāti Hine can both work together to teach whānau/parenting skills and this connection was explained to parents during the discussion groups. In addition, practitioners used culturally appropriate examples to illustrate within session exercises. Participants were welcomed into the group through the use of karakia, mihi whakatau and whakawhanaungatanga. Kai was provided for participants during the discussion groups.

The discussion groups were delivered by accredited Māori Triple P practitioners with the support of Kuia from the Ngāti Hine Health Trust. Since June 2015, four sets of discussion groups have been run in Kawakawa and eight in Whangarei at Ngāti Hine premises or in community organisation meeting rooms. Groups were timetabled once there were sufficient parents recruited to run a group. The first and second discussion groups

were held in consecutive weeks. Transport assistance and child care at the meeting location were provided where needed to enable parents to attend the groups. The waitlist control groups received the intervention following the completion of Time 3 measures (at 6-month follow-up).

All discussion groups were video-taped to monitor practitioner fidelity of programme implementation. Checklists created by the intervention developers were used to monitor intervention fidelity and provided a measure of the proportion of content covered in each group. Adherence to the intervention protocol was high with an inter-rater agreement of 98% between the ratings provided by the practitioner and those provided by a second independent rater.

Between Time 2 and Time 3, eight intervention group families and nine waitlist group families sought additional help for their child's behaviour or for their family. Services that were accessed included health care professionals, such as child health specialists (n = 10) and other types of child and family support programmes (n = 7).

2.6 Uiui Waowaotanga a muri — Post intervention interviews

The post intervention interviews took place via Skype with parents located at Ngāti Hine premises in Whangarei or Kawakawa and the interviewer located at the whānau/parenting research rooms at the University of Auckland. The interviews were conducted by interviewers who were accredited Triple P practitioners. The interviews took approximately 40 minutes during which time parents were asked to comment on the benefits of the programme to them and their child, the whānau/parenting strategies they found helpful, and the fit of the whānau/parenting strategies with Māori tikanga and values. Interviews were audiotaped and transcribed by a professional transcriber and then prepared for thematic analysis. Interview transcripts were subsequently coded by a member of the research team with the help of a research assistant. The first step involved close reading of the transcripts to identify participant responses to the interview questions. Summaries of responses, with illustrating quotes, were then created.

3 Ngā karere — Results: Key findings

3.1 Statistical analysis

To increase generalizability, preserve statistical power, and prevent bias from drop-outs an intent-to-treat approach was used for all analyses, with the Expectation–Maximisation (EM) (Gupta, 2011) method used to estimate missing data. A series of ANCOVAs (analysis of covariance) were used to examine differences between the intervention and waitlist control groups at post-intervention using the pre-intervention scores on each measure as covariates. ANCOVAs were also used to analyze the between condition effects at 6-month follow up using the pre-intervention scores as covariates.

Effect sizes were standardised differences, calculated by subtracting the pre- to post- intervention change in the control group from the pre- to post-intervention change in the intervention group and dividing this total by the pooled pre-intervention *SD* (Morris, 2008), and reported as Cohen's *d*. This approach allows a comparison of change over time across the groups from pre- to post-intervention which increases the precision on estimates of treatment effects and can statistically account for pre-intervention differences between groups (Morris, 2008). Pre- to follow-up effect sizes were also calculated to examine change over time for each outcome measure for each of the groups separately. Cohen's *d* was derived by dividing the difference in mean pre- to follow-up scores by the pooled pre- and post-intervention standard deviation (Cohen, 1992). Ninety-five percent confidence intervals were calculated on the pre- to post-intervention and pre-intervention to 6-month follow-up effect sizes. To avoid missing any effects that may be clinically important, given the small sample size, no statistical controls were applied for possible chance effects and an alpha level of .05 was used to identify statistically significant findings (Jaccard & Guillamo-Ramos, 2002).

3.2 Arohaehae Hukihuki — Preliminary analyses

At Time 1 less than 1% of the data was missing. Out of the parents randomised to condition, 17% did not complete post-intervention questionnaires and 23% did not complete 6-month follow-up measures. These non-completion rates include parents who had discontinued their participation (see Figure 1 for non-completion and discontinuation details).

Preliminary analyses revealed some statistically significant differences in family demographics, and pre-intervention measures between those who completed and those who did not complete outcome measures at post-intervention and 6-month follow-up. Among parents who did not complete post-intervention measures, there were less frequent disagreements about child rearing on PPC Extent pre-intervention scores. Parents who did not complete 6-month follow-up assessments were more likely to be single parents and to have higher baseline rates on the DASS stress and DASS total score.

At pre-intervention, there was a wide range of scores within the sample on the Eyberg Child Behavior Inventory (ECBI), which measures parental perceptions of disruptive behaviour in children. Scores for the ECBI Intensity scale ranged from 50 to 120 and from 0 to 33 for the ECBI Problems scale. Although the mean scores for both groups were below the clinical cut-off for both scales, scores for 43.9% of parents in the intervention group and 48.3% of parents in the control group were in the clinical range for the Intensity scale. These percentages were 41.5% and 34.5% respectively for the Problems scale. On the Whānau/Parenting Scale measure, on average parents in both groups reported moderate to moderately high levels of lax, overreactive, and verbose whānau/parenting practices. In families where the caregiver had a partner, in both groups the mean scores for the number of areas of conflict between partners over childrearing were in the clinical range.

3.3 Pānga Wawao: I mua, a-muri hoki — Intervention effects: Pre- to post-intervention

Table 2 displays the means, standard deviations and effect sizes of all outcome variables for both groups at each time point. Time 1 to Time 3 within group effect sizes are also shown. Following participation in the discussion

groups parents in the intervention group reported significantly fewer and less severe child behaviour problems than waitlist control parents. Medium effect sizes were found for ECBI Intensity F (1, 68) = 4.87, d = .60, p = .018 and ECBI Problem F (1, 68) = 9.26, d = .63, p = .003. Intervention group parents also reported significantly lower levels of child functional impairment on SDQ Impact scores (F (1, 68) = 6.65, d = .54, p = .013). For inter-parental conflict over child rearing the intervention group parents reported significantly fewer problems (PPC Problem (F (1, 30) = 15.52, d = 1.18, p < .001) and less severe disagreements (PPC Extent (F (1, 30) = 12.74, d = .88, p = .001). Intervention group parents also reported a significantly greater increase in partner relationship quality (RQI (F (1, 30) = 6.34, d = 0.85, p = .017). There were large effect sizes for the difference between intervention and waitlist control group scores on these measures. There were no significant differences between the intervention and the waitlist control groups for reductions in the level of dysfunctional parenting on the Whānau/ Parenting Scale, or for improvements in parenting confidence (PTC), and parent well-being (DASS).

Completer analysis

The ANCOVAs were repeated to examine the short-term condition effects using only the sample of parents who completed post-intervention outcome measures. The results were very similar to the Intent to Treat (ITT) sample results.

3.4 Pānga Wawao: Whai ake — Intervention effects at 6-months follow-up

Results of the analyses show that the significant differences between the intervention and waitlist control group for decreases in child behaviour problems and improvements in partner relationship quality were maintained at the 6-month follow-up assessment.

In addition, significant effects were found for several measures that were not found at T2. With regard to child behaviour, large effect sizes were detected for SDQ Emotional symptoms F (1, 68) = 13.87, d = .88, p < .001, and SDQ Peer problems F (1, 68) = 5.81, d = .82, p = .019. Intervention group parents reported significantly greater reductions in overreactive parenting practices F (1, 68) = 6.50, d = .46, p = .013 and larger improvements in parenting confidence on the self-efficacy scales PTC Setting F (1, 68) = 4.22, d = .33, p = .044 and PTC Behavioural F (1, 68) = 4.20, d = .32, p = .044, compared to the waitlist control group parents.

Across time (from pre-intervention to 6-month follow-up), when within-group changes were examined there were a greater number of significant time effects for child behaviour problems, parenting practices, parenting confidence, and inter-parental disagreement, showing improvement from pre-intervention to six-months follow-up, in the intervention group than in the WLC group. These included significant reductions (medium to large effect sizes) in the level of child behaviour problems on the ECBI Intensity (d = .62), ECBI Problem (d = .88), and SDQ Emotional (d = .52), subscale, as well as reductions in overreactive (d = .70) and lax (d = .64) parenting practices on the Whānau/Parenting Scale, parenting confidence on the PTC scales Setting self -efficacy (d = .73) and Behavioural self-efficacy (d = .68), and inter-parental disagreement on the PPC Problem scale (d = .78). Pre- to 6-month-effect sizes for these outcome measures in the waitlist control group were small and some were negative.

Completer analysis

The ANCOVAs were repeated to examine the long-term condition effects using only the sample of parents who completed 6-month follow-up outcome measures. In contrast to the ITT findings, the condition effects for parenting self-efficacy across behaviours (PTC Behavioural self-efficacy) and settings (PTC setting self-efficacy), interparental disagreements over childrearing (PTC Behaviour, PPC Extent), and overreactive parenting practices (PS Overreactivity) were not significant among the completer sample, although the effect sizes were very similar in both samples. For all other variables, the results were similar to those in the Intent to Treat (ITT) sample.

3.5 Programme satisfaction

At Time 2, the mean programme satisfaction score for parents in the intervention group was M = 72.59 (SD = 11.98), indicating a high level of satisfaction with the quality of the service provided and how well the programme met the parent's and child's needs and decreased the child's problem behaviours.

Table 2: Intervention effects at T2 and T3

Measure	Intervention (n = 41)			Waitlist (n = 29)			Post-intervention treatment effect		Follow-up treatment effect		T1-T3 time effect	
	Pre	Post	Follow-up	Pre	Post	Follow-up					Intervention	Waitlist
	M(SD)	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*p*	*d (CI)*	*p*	*d (CI)*	*d*	*d*
ECBI												
Intensity	123.76 (37.84)	95.47 (30.24)	100.02 (27.84)	115.64 (37.80)	110.43 (30.98)	112.32 (31.91)	.018	0.60 (0.12-1.08)	.025	0.53 (0.06-1.01)	0.62	0.09
Problem	12.59 (8.91)	5.74 (5.81)	4.59 (5.31)	11.34 (8.98)	9.88 (8.24)	9.43 (7.00)	.003	0.63 (0.15-1.11)	<.001	0.71 (0.22-1.19)	0.88	0.17
SDQ												
Emotional symptoms	2.83 (1.79)	2.16 (1.60)	1.89 (1.46)	2.55 (1.86)	2.70 (1.85)	3.23 (2.00)	.117	0.45 (-0.03-0.92)	<.001	0.88 (0.39-1.37)	0.52	-0.36
Peer problems	3.13 (1.57)	2.74 (1.58)	2.69 (1.63)	2.62 (1.82)	2.83 (1.79)	3.57 (2.37)	.368	0.35 (-0.12-0.83)	.019	0.82 (0.33-1.31)	0.27	-0.51
Prosocial	7.13 (1.89)	7.66 (1.58)	7.91 (1.75)	7.59 (1.50)	7.46 (1.31)	8.16 (1.33)	.205	0.38 (-0.10-0.85)	.760	0.12 (-0.35-0.59)	0.40	-0.37
Impact	1.59 (2.46)	0.41 (1.42)	0.91 (2.32)	1.38 (1.84)	1.42 (2.57)	0.95 (1.81)	.013	0.54 (0.06-1.02)	.884	0.11 (-0.36-0.58)	0.27	0.23
PS												
Laxness	3.51 (1.34)	2.90 (0.97)	2.64 (1.02)	2.94 (1.11)	2.66 (0.77)	2.57 (0.69)	.823	0.26 (-0.21-0.73)	.533	0.40 (-0.08-0.87)	0.64	0.32
Overreactivity	3.10 (0.93)	2.63 (0.90)	2.45 (0.80)	3.08 (1.11)	2.91 (0.91)	2.89 (0.73)	.119	0.30 (-0.17-0.78)	.013	0.46 (-0.02-0.94)	0.70	0.17
Verbosity	4.21 (0.81)	3.67 (0.78)	3.61 (0.91)	4.10 (0.89)	3.60 (0.70)	3.51 (0.78)	.847	0.05 (-0.42-0.52)	.818	0.01 (-0.46-0.48)	0.73	0.65
Total	3.49 (0.79)	3.05 (0.72)	2.83 (0.77)	3.26 (0.72)	3.01 (0.60)	2.94 (0.57)	.593	0.25 (-0.23-0.72)	.131	0.44 (-0.03-0.92)	0.82	0.43
PTC												
Setting self-efficacy	78.92 (14.76)	83.88 (15.57)	89.97 (9.04)	78.87 (15.75)	86.24 (10.12)	84.91 (12.71)	.442	-0.16 (-0.63-0.31)	.044	0.33 (-0.15-0.80)	0.73	0.37
Behavioural self-efficacy	68.78 (23.88)	80.12 (19.08)	85.37 (15.27)	69.34 (24.26)	80.26 (17.06)	78.05 (17.89)	.997	0.01 (-0.46-0.48)	.044	0.32 (-0.15-0.79)	0.68	0.35

Measure	Intervention (n = 41)			Waitlist (n = 29)			Post-intervention treatment effect		Follow-up treatment effect		T1-T3 time effect	
	Pre	Post	Follow-up	Pre	Post	Follow-up					Intervention	Waitlist
	M(SD)	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*M(SD)*	*p*	*d (CI)*	*p*	*d (CI)*	*d*	*d*
PPC[a]												
Extent	35.95 (15.12)	25.85 (11.96)	28.22 (13.96)	40.47 (18.51)	45.23 (21.00)	41.85 (21.66)	.001	0.88 (0.22-1.53)	.039	0.54 (-0.10-1.18)	0.49	-0.07
Problem	7.05 (3.23)	4.18 (3.08)	4.45 (2.57)	8.12 (3.79)	9.44 (5.07)	8.06 (4.63)	<.001	1.18 (0.50-1.86)	.007	0.72 (0.07-1.37)	0.78	0.02
DASS												
Depression	8.59 (11.91)	4.06 (5.59)	7.00 (10.29)	9.66 (10.42)	4.85 (4.82)	6.64 (5.43)	.572	-0.02 (-0.49-0.45)	.757	-0.12 (-0.60-0.35)	0.13	0.28
Anxiety	8.41 (9.38)	3.18 (5.18)	6.59 (8.54)	7.10 (6.82)	4.08 (3.76)	6.09 (6.38)	.309	0.26 (-0.21-0.73)	.959	0.10 (-0.38-0.57)	0.19	0.14
Stress	12.54 (11.92)	6.29 (6.22)	9.59 (10.28)	15.24 (11.20)	8.14 (5.79)	10.18 (7.40)	.290	-0.07 (-0.54-0.40)	.966	-0.18 (-0.65-0.29)	0.24	0.44
Total	29.27 (28.25)	14.00 (18.83)	22.59 (26.39)	32.62 (25.93)	17.41 (12.36)	23.18 (17.02)	.363	0.00 (-0.47-0.47)	.949	-0.10 (-0.57-0.37)	0.23	0.35
RQI[a]												
Total	38.16 (5.77)	39.10 (6.00)	39.18 (6.81)	35.92 (5.91)	31.80 (9.89)	33.75 (9.46)	.017	0.85 (0.19-1.51)	.112	0.54 (-0.11-1.18)	0.17	0.35

Note. DASS = Depression Anxiety Stress Scales; ECBI = Eyberg Child Behavior Inventory; PPC = Parent Problem Checklist; PS = Parenting Scale; PTC = Parenting Task Checklist; RQI = Relationship Quality Index; SDQ = Strengths and Difficulties Questionnaire.

[a] Intervention *n* = 22, waitlist control *n* = 16

3.6 Uiui Wawaotanga a muri: Ngā kitenga matua — Post-intervention parent interviews: Key findings

3.6.1 Managing child behaviour.

The majority of participants were positive about the Te Whānau Pou Toru programme and thought it was helpful in relation to managing tamariki/children's behaviour. It was thought that participants were taught effective whānau/parenting strategies. Parents and caregivers also had the opportunity to share and learn from others about whānau/parenting and managing tamariki/children.

> *"I found that it worked, like the sticker charts…… we've got into a routine where they're just doing it, we don't need the sticker chart. So, it was, I think, the sticker chart that really helped them to just do it for themselves. It's sort of small things, like where your clothes go, put your clothes in the wash, just all the little household things"*

Te Whānau Pou Toru allowed for the sharing of whānau/parenting ideas and the opportunity to learn from other participants about how to manage tamariki/children.

> *"I got to hear other parent's issues and how they dealt with whānau/parenting and some different styles…it was good hearing …very similar issues in terms of whānau/parenting and constructive whānau/parenting".*

One parent mentioned gaining a better understanding of what constitutes normal child behaviour.

> *"The main thing, if she was misbehaving I would take it as if she was purposefully being mean to me. And so, then I'd respond in that way, but then, when we were having the discussion group, just rethinking, she's just being a normal kid."*

3.6.2 Helpful whānau/parenting strategies.

The participants mentioned a range of whānau/parenting strategies that were helpful when caring for their tamariki/children. These included the use of behaviour charts, providing clear instructions, the use of praise, spending quality time with tamariki/children, providing clear consistent directions for expected behaviour, and managing challenging behaviour as it arises, through the use of time-out and learning how to say no effectively to their tamariki/children.

> *"I found all of it absolutely helpful, like the positive reinforcement, like praising them for good behaviour and ignoring the bad behaviour, which is really hard, you know. But then through Pou Toru it made me realise that I'm just giving him attention, lavishing attention on him at the wrong time. So, nobody says to your child, because he's sitting there nicely watching TV and goes oh really, really good, you know, sitting down and being quiet".*

> *"Quality time with my children. I talk to my kids all the time, show them affection. Using descriptive praise. I always give them attention, otherwise they play up."*

> *"For me to follow through on what I said I was gonna do. So, those are the two main ones, is making sure I gave him a clear instruction and one instruction at a time, and then following through with that instruction and the consequences if need be."*

> *"So, telling my boy twice and then it's time out. The time out strategy worked really well. He's learnt now that as soon as I go to time out it means business and he calms down a lot quicker."*

For some parents, there was new learning that occurred in order to assist the child with their challenging behaviours.

> *"Time out, the way you give time outs and the way to approach, what do you call it, well let's say discipline. Yeah, I didn't know how to do it".*

3.6.3 Changes in child behaviour.

Overall the participants commented that since attending the TWPT group their tamariki/children appeared to be happier, their tamariki/children's ability to listen to and follow instructions had improved, there were far less tantrums, and school behaviour had also improved.

> *"He's happier, pleasant…"*
>
> *"Yes, I have to say, he's more obedient'.*
>
> *"One of the issues we had was she would get really upset about going to kindy, …It was the whole going to kindy thing, and since doing the programme, there's been not a tear. So, she says, bye mum, kiss and a cuddle, and is gone. It means no stress in the mornings, and she's happy".*

One participant reported that a stronger bond became more apparent between herself and her child since completing the Te Whānau Pou Toru programme.

> *"I feel that (child's name) we're more connected. With this child, in particular, I feel like I've bonded a little bit more with him"*

3.6.4 Most often used whānau/parenting strategies.

Participants were able to state which whānau/parenting skills they most often used. Parents and caregivers stated that creating a daily routine for the child and/or whānau was an important skill. Some parents commented on the use of behaviour charts to encourage positive behaviour changes. Several parents mentioned the use of quiet time and time-out to manage misbehaviour. Participants described how helpful it was to learn to give instructions only twice and then to take action by following through with consequences. Giving clear calm instructions was proving to be effective coupled with praising and giving attention to good behaviour and ignoring other negative behaviour. Stopping and listening to the child when they are trying to communicate to their parent was another key skill that was often used.

> *"So far I've worked out that having a routine does help him. …this course has helped me heaps with developing my son into a better boy."*
>
> *"The time out, the listening, …it's nice to see another way to do it, for me it's always like a refresher, something else to come into the kete."*
>
> *"If someone's misbehaving, just to remove them from the situation and give them some time to calm down, rather than me stepping in and yelling and screaming. And then just bringing them back in and like okay, you know, carry on. So, you feel better now, go have fun, rather than what I was doing, which wasn't working."*
>
> *"Listening to my son when he's there. I realised a lot of the times he's there saying Dad, Dad can I have a drink…. like just little things and I'm not actually hearing him. Or Dad, Dad I want to watch this. So now I stop what I'm doing and it doesn't matter how annoying it is to me. I realise that it's really important to him, and that he needs to be heard and he's really responded to that"*

3.6.5 Whānau/parenting skills still in use.

The majority of participants stated that they were continuing to use the skills that they had learnt while attending Te Whānau Pou Toru. Participants liked the fact that these skills presented an alternative to other whānau/parenting strategies that they had used in the past such as 'smacking' their child.

> *"Well I think when I was growing up, when we used to not listen you'd get a smack. So, that's a big change for me, that's why I use some of this information."*

3.6.6 Further assistance required?

Participants were able to state whether or not they needed further parental assistance. Some participants stated that they did not require further assistance. Reasons given were that they thought they had gained more control over their child's challenging behaviours. One parent mentioned the usefulness of the whānau/parenting workbooks that the participants received while attending TWPT. It was stated that the workbooks can be referred to time and time again if and when needed.

> *"Well to tell you the truth these little books are really good and helpful enough for me. So, I probably won't need to go any further where his behaviour is at."*

Alternatively, one participant wanted to receive further assessment for her child because the participant was not clear about why they were behaving the way they were. Several participants thought that because there were some changes coming due to developmental

maturation they would need further support for the target child or their older siblings.

> *"So, he's getting older, so he's transitioning, he's pushing boundaries now and he's coming into a different age".*

> *"Not really, not with her (target child). My two boys, because they're coming up to being teenagers, you need one (parenting programme) for a higher age group."*

3.6.7 Benefits of Te Whānau Pou Toru for parents.

There were many benefits of Te Whānau Pou Toru highlighted by the participants. Participants stated that TWPT had assisted them to experience less stress, to be more confident and to develop greater personal awareness by remaining calm. There was an emphasis placed on learning effective strategies to manage their child's behaviour. Parents and caregivers reported that they were able to work more effectively with their partner when caring for their tamariki/children. It was also important for participants to learn about how to take care of one's self and to take time out to do this. The ability to share with other parents and caregivers assisted in normalising the whānau/parenting process, which includes all the challenges that accompany this task.

> *"I feel great, really. I feel more confident. Me and my husband both feel confident, cos my son used to play us off and we were both unbalanced with our whānau/parenting skills. Now we're more of a team than two parents, individuals trying to raise a whānau/family."*

Through the discussion groups participants were able to normalise the difficult experiences that they had with their tamariki/children's challenging behaviours.

> *"Again, it's hearing from other people about their issues … it reaffirms that you're not the only one. It makes you feel a little bit better about yourself. I'm thinking I'm a bad parent, … then someone else has a similar story, and it's like well I'm not that bad, it's quite normal, we just don't know, we haven't been taught."*

Having more quality time together was mentioned as an important benefit for one parent.

> *"Definitely less yelling in my house, less fighting. So, we've got more time to spend together doing fun stuff. I'm not spending as much time trying to break up arguments and settle the fighting that they have."*

3.6.8 Benefits of Te Whānau Pou Toru for tamariki/children.

Participants highlighted the benefits of TWPT for their tamariki/children. Participants stated that their tamariki/children were taking more responsibility for their behaviours and that they were using self-control. Several parents mentioned the value of an increase in positive attention and consistency from the parents or caregivers for their child.

> *"I went away to Auckland and we went into a dairy, and my son came in late and he just went to the shelf and grabbed what he wanted. But we had already paid for our groceries, and all I had to say was no son, we've already paid for our stuff, I'll get you something on our next stop. So, he went back to the shelves and put all his stuff back and said okay Mum, I'll wait. I had strangers commenting on his behaviour, and applauding him for how he reacted to the no …and then my Dad was so surprised at how far he has come… my whānau/family has appreciated his company more so now since I've done this course than ever before."*

One noted benefit of parental positive attention was an increase in the closeness and bond between the child and their parent.

> *"…he hugs me and kisses me now. Where we never had that connection, and it just shows me how much he was watching and listening…it's the whole praising thing. That's just awesome, I didn't know how much of an impact praising your child can do, and that's what I've learnt through this course."*

There was also a decrease in negative attention towards the child, for example a participant reported that they swore less at their child now.

> *"I think he's become more confident because of the changes, he's become more confident and being able to talk to me, because there's not actually going to be any physical repercussions, or I'm not going to say you're being a little s….head. I think he's become more confident in speaking his mind when he doesn't necessarily agree with things. But he does it in a way that puts a smile on your face anyway"*

3.6.9 Barriers.

Overall participants reported minimal barriers to utilising the Te Whānau Pou Toru programme. The majority of participants responded that the programme was easy to follow and put into practice and that the workbook was a good guide. Participants stated that having a comfortable place to meet in, where transport to the course and childcare were arranged were fantastic supports in being able to attend TWPT. The meetings occurred during the day and this worked for some participants as their tamariki/children were at school and it was easier to meet without needing to worry about childcare issues. Praise was also directed towards the coordinator of the groups indicating she had completed a good job of organizing the groups.

When participants were asked about whether there were any barriers to attending TWPT, the overwhelming response was no.

> *"No, not at all. When you've got ladies like Val (course coordinator), well how could you not come?"*

One constraint was having the time to implement the TWPT programme because of an already busy life and other commitments that needed attending to.

> *"I suppose myself and my other commitments. Cos sometimes, like with my studies I've not be able to implement the programme as well as I'd like to have. But because I've got the tools I can always refer back to them and then keep using them and just make it part of our way we live".*

3.6.10 Fit with Māori tikanga and values.

It was acknowledged that the whānau/parenting strategies fitted appropriately with Māori tikanga and values. The majority of participants thought that TWPT aligned extremely well with Māori tikanga and values. The Ngāti Hine Kuia was an important resource in terms of explaining the tikanga and kaupapa to participants. A participant was able to articulate the importance of different aspects of the principles of Te Whānau Pou Toru. An example of this was when the Kuia discussed the concept of Manaakitanga and how this is important when caring for others and in being a role model to others (which can include being a role model to tamariki/children). In terms of Māori pedagogy one participant stated that more activity needed to be introduced into the teaching groups, that there needed to be more movement in order to cement the learning.

> *"I think most of it was pretty good (the tikanga). Most of it aligned really well, with the strategies".*

Another parent commented:

> *"Yeah pretty consistent, I think, whether it's Māori or Pakeha, or just any nationality, family is family. And those are core values of what we wanna be teaching our kids no matter where you're from I think."*

The input of Kuia was experienced by some participants as being an endorsement and support to what Te Whānau Pou Toru was seeking to teach.

> *"It's awesome because it's all wellbeing for the child, it's keeping them safe. It fits in very well. …the Ngāti Hine Kuia that came into our programme, she was relating the programme to kaupapa Māori. And then even listening to her way of putting the programme was really helpful. Cos I can relate more to things Māori than things Pakeha. So, for me it was easier to relate to the terms Māori and put it into context."*

However, two participants stated that they did need the tikanga to be explained further due to their own limited understanding. Key action points were also requested that would flow from the tikanga.

> *"It would be really nice to show examples of how that can be changed to tikanga. It's like yes we have this general version, now the way that you would change it to coincide with tikanga is you do this".*

3.6.11 Additional comments.

Participants expressed that the way they were welcomed into the group was extremely helpful as it encouraged them to make connections with others through the use of karakia, mihi whakatau and whakawhanaungatanga. The majority of participants thought that the welcoming processes were ideal and that it assisted them to feel welcome and to be able to connect with the other participants in the group. It was very important to have a Kuia present to support the organisers of the group. The use of kai was also an important aspect to assist with the overall welcoming process.

> *"I think that the whole mihimihi process and the pōwhiri, and the karakia, I think it just fits with bringing that group in together. You actually feel more like whānaunga rather than just a group, you know and it's like we're all here for the same reason."*

One participant stated that the use of an ice breaker could have been beneficial.

> *"I suppose for me, cos I facilitate groups, I would do probably an ice-breaker. So yeah, apart from probably adding an icebreaker, it was good."*

3.6.12 Sharing whānau/parenting skills with others.

Participants reported sharing the information that they had learnt from Te Whānau Pou Toru with extended whānau/family, carers, playcentre parents, and anyone that they came into contact with.

> *"You know, I've even taught my parents how to do some of the strategies in these two books because, they need to know too. … I educated my parents, my siblings who are older than me and have bratty tamariki/children. I've even educated their tamariki/children…"*

> *"I tell everybody. Strangers, people I meet in the park. And they're like oh who's this know it all parent."*

> *"I go to playcentre and so one of the mums was saying that she was having trouble with her oldest boy being a bit violent with the littlest boy. And I was like, at the positive whānau/parenting, they suggested dah, dah, dah - so I had a chat to her about it. Actually, it's come up in conversations with a few parents, so, it's been good".*

> *"I told my aunty, because she was so upset, her daughter was misbehaving, they'd just moved back in with her mother. So, she doesn't feel like she has any control whatsoever, and she said my daughter has become one of those kids that I can't stand. And I don't wanna be around her. I told her listen, I learnt something. She's not doing this to you, okay, she's just misbehaving, so you can hate the behaviour - don't worry, you don't hate your child. It never occurred to her that it was the behaviour and not her daughter, so I felt quite good I could share that with her."*

3.6.13 Expectations.

The participants had some key expectations of Te Whānau Pou Toru before they attended the programme. The participant's expectations were mainly about learning new strategies and whānau/parenting techniques. There were some big expectations of the course material and the programme was able to exceed some of the participant's expectations.

> *"I wasn't disappointed …It was really good to share with the other participants, like share, and listen, and give them support if they needed it. We did have one or two that needed support, it was really good."*

> *"Yes, when I went through the programme, I really enjoyed the principles and I could really see that they were beneficial and would work for our situation."*

4 Whakarapopototanga, kupu whakatepe — Summary and conclusions

An Intent to Treat (ITT) analysis of the effects of the intervention at immediate post intervention and again at follow up showed that the TPDG produced a range of positive and sustained intervention effects on child, parenting and family adjustment outcomes. Specifically, following the intervention parents reported significantly fewer and less severe levels of behaviour problems in their child and lower levels of social impairment and distress to the child due to behaviour difficulties. Parents in the intervention group who were married or in a cohabiting relationship reported significantly less interparental conflict over child rearing and more improvements in partner relationship quality than married/cohabiting parents in the waitlist group.

The immediate post intervention effects were maintained at 6-month follow-up for reductions in the number and severity of child behavior problems and less interparental conflict over child rearing. Further improvements were found favouring the TPDG, for reductions in child emotional symptoms, peer problems, and overreactive parenting practices, and increased parenting confidence. Across time (from pre-intervention to 6-month follow-up), when within-group changes were examined there were a greater number of significant time effects for child behaviour problems, parenting practices, parenting confidence, and inter-parental disagreement, showing improvement in the intervention group (TPDG) than in the WLC group.

Semi-structured interviews following the intervention highlighted a range of positive benefits from the programme for parents and their tamariki/children, the helpfulness of the whānau/parenting strategies learnt for managing their child's behaviour, positive reports about improvements in tamariki/children's behaviour, and an appreciation of the culturally adapted content. Parents also reported sharing the skills they had learnt in the programme with extended whānau/family and others in their communities. Participants reported that it was beneficial to have the tikanga protocols of mihi whakatau and whakawhanaungatanga included. There was consensus that the programme delivery and parenting strategies in the programme were consistent with Māori tikanga and values.

These parent comments provide insight into the determinants of cultural acceptability of evidence based parenting programmes for Māori parents. Specifically, having culturally adapted programme content, methods of programme delivery, and ways of welcoming that are consistent with Māori tikanga and values. These parent interview findings are consistent with similar data obtained from parent and practitioner focus groups run during phase 1 of this study (Cooper, Keown, Sanders, Shepherd, & Vaydich, 2015). Those groups were conducted to determine the cultural relevance and acceptability of Primary Care Triple P methods and resources to Māori whānau. Recommendations from the parents and end-user practitioners were used to inform the development and release of the Māori adapted version of the Primary Care Triple P Program, Te Whānau Pou Toru - Positive Whānau/Parenting Practices. The theoretical model for cultural enhancement of evidence based parenting programmes, the Collaborative Participation Adaptation Model (CPAM), that guided the consultation approach used in this study, is described in the introduction of this report.

There are a number of limitations to the current study. The sample was based on one iwi in New Zealand, Ngāti Hine. This raises the possibility that some aspects of the adaptation may not be entirely suitable to other iwi/rohe. However, many of the concepts are pan-tribal, for example, the value of rangatiratanga, whanaungatanga and therefore appropriate for other iwi. A larger sample size that includes other iwi and a study design with a longer follow-up would help to provide stronger evidence for the generalisability of the findings and their maintenance over time. All measures were based on parent report, which raises the possibility of self-report bias. However, the value of ratings by parents should not be dismissed, given their unique knowledge about children's behaviour and their own role as consumers (Pfiffner, 2014).

The collaborative partnering process of culturally adapting an existing evidence-based whānau/parenting intervention (Triple P) for Māori whānau was effective in producing a brief, high quality, culturally acceptable and effective whānau/parenting intervention. As the programme participants included a wide range of parents of tamariki/children with various levels of severity of child problems, (mild -to -severe) the programme seems a valuable "light touch" intervention that can be widely deployed as a universal early prevention intervention to reduce behaviour problems, promote self-regulation in tamariki/children, and reduce whānau/family conflict and stress. Programme effects were demonstrated with a Māori population in Northland living in areas known to have higher rates of risk factors (for example; unemployment, single parenthood, parents receiving various types of government assistance, large whānau/family sizes, and substance abuse). As the intervention is very brief (2 x 2 hour sessions) involving minimal investment of practitioner and parent time future economic analyses are likely to show it is very cost effective as an intervention.

The present findings are consistent with a wider body of local evidence from seven randomised trials (Chu, Bullen, Farruggia, Dittman & Sanders, 2015; Dittman, Farruggia, Keown & Sanders, 2016; Frank, Keown & Sanders, 2015; Franke, Keown,& Sanders, 2016; Palmer, Keown, Sanders & Henderson, 2016; Salmon, Dittman, Sanders, Burson & Hammington, 2014; Sanders, Dittman, Farruggia, & Keown, 2014) plus service based evaluations conducted in New Zealand. Collectively these studies have documented the effectiveness and acceptability of several variants of Triple P including Primary Care Triple P, Group Triple P, Standard Triple P, Self Help Triple P, Online Triple P and Teen Triple P. It is also supported by international evidence that shows a population based using the Triple P system can reduce population indices of child maltreatment, reduce social and emotional problems of children. It is likely to be a very cost effective way of increasing access to evidence-based parenting support to an entire population in a highly cost efficient and non stigmatising manner.

5 Papakupu — Glossary

Māori	English
Aroha	Caring, love, compassion, respect; a tenet of tikanga Māori
Haere	Go
Haere mai	Come here (towards me)
Hāpai	To lift up, raise
Hapū	Kinship group/tribe, sub-tribe; pregnant
Iwi	Extended kinship group/tribe; bones
Kai	Food
Kanohi ki te Kanohi	Face to face
Karakia	Prayer, spiritual stimulation
Kaumātua	Elder (male or female)
Kaupapa	Plan, proposal, topic, theme
Kete	Basket, kit
Kōrero	Talk, speak
Korowai	Cloak
Kotahitanga	Unity
Kuia	Elder (female)
Mana	Prestige, authority, dignity
Manaaki	To take care of, support, protect, look out for
Manaakitanga	Reciprocity being caring and considerate hosts
Mihimihi	Greetings, acknowledgements
Mokopuna	Grandchild
Ngā	The (plural)
Pākehā	New Zealander of European descent
Pānui	Notice, letter, read
Pōwhiri	To welcome
RaNgātiratanga	Chieftainship, autonomy, self determination
Reo	Māori language
Rohe	District, area, region
Tangata, tāngata	Person, people
Tapu	Sanctity; sacred, special, restricted
Te	The (singular)
Tikanga	Cultural principles, practices and customs
Titiro	Look
Wairua	Spirit, spirituality
Whakapapa	Geneology, descent
Whakarongo	Listen
Whānau	Whānau/family; extended whānau/family
Whanaungatanga	Kinship, relationships, social cohesion
Whakawhanaungatanga	The acts of establishing relationships, connecting

6 Tohu toro — References

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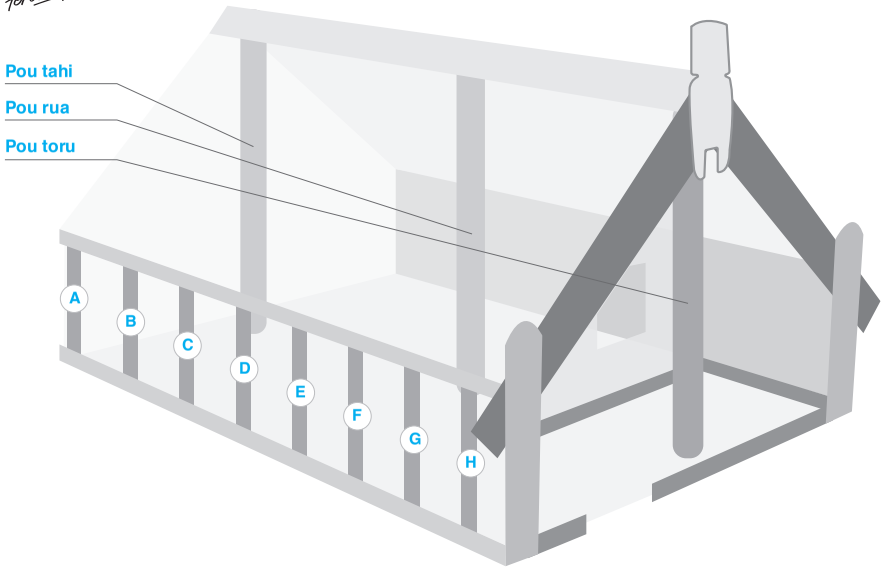
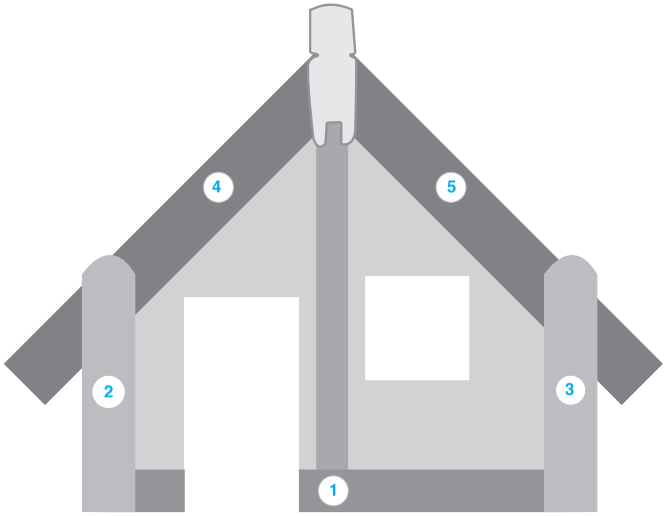
Te Whānau Pou Toru





A. **Whānau Motuhake** – Whānau are **autonomous** and self-managing.
Whānau use their strengths to achieve their goals and aspirations.

B. **Whānau Oranga** – Whānau are **healthy**.
Whānau work together to enjoy healthy lifestyles.

C. **Whānau Taki** – Whānau are **engaged** and participating in their environment.
Whānau are leaders within their communities.

D. **Whānau Manaaki** – Whānau are **nurturing**.
Whānau follow Māori values such as tika, pono and aroha which includes caring and learning.

E. **Whānau Haumi** – Whānau are **secure** economically.
Whānau are able to plan for and work towards meeting their wellbeing economically.

F. **Whānau Marama** – Whānau are **confident** in Te Ao Māori.
The Mana of Whānau and Whakapapa is secure and Te Reo me Ona Tikanga is valued and practised.

G. **Whānau Kaitiakitanga** – Whānau are **guardians** of the environment.
Whānau recognise the relationship between whenua and whakapapa.

H. **Whānau Matauranga** – Whānau are **knowledgeable**.
Whānau are life-long learners.

1. **Safe, interesting environment**
2. **Positive learning environment**
3. **Assertive discipline**
4. **Realistic expectations and boundaries**
5. **Taking care of yourself as a parent**

Note: *The contributions of Ngati Hine Kaumatua and Kuia, Ngati Hine Health Trust, New Zealand Ministry of Health, Parenting Research Group at The University of Auckland, and the Parenting and Family Support Centre at The University of Queensland in compiling this resource are acknowledged.*

7.2 Āpitihanga B — Appendix B: Explanation of the tikanga within the TWPT graphic

Te Whānau Pou Toru
The Three Pillars of Positive Parenting Practices

In consultation with Kaumatua and Kuia, the name "Te Whānau Pou Toru" reflects the practices of positive parenting and retains the quality and integrity of the Triple P – Positive Parenting Program®. Te Whānau Pou Toru brings together the family as a whole, working together with the strength, support and sustenance of positive parenting practices. Te Whānau Pou Toru contributes towards the following:

A. Whānau Motuhake

Whānau are autonomous and self-managing

Whānau use their strengths to achieve their goals and aspirations.

- ***Rangatiratanga*** – Parents are supported to make informed choices.
- ***Whakangahau*** – Achievements are celebrated by parents and tamariki.

B. Whānau Oranga

Whānau are healthy

Whānau work together to enjoy healthy lifestyles.

- ***Waiora*** – Parents' wellbeing is vital to care for their tamariki, for example:
- ***Te Whare Tapa Whā*** [1] – A balance between Hinengaro (mental health), Wairua (spiritual health), Tinana (physical health) and Whānau (family health).
- ***Te Wheke*** [2] – Eight tentacles that contribute towards waiora – Wairuatanga (spirituality), Hinengaro (mind), Taha Tinana (physical wellbeing), Whanaungatanga (extended family), Mauri (life force in people and objects), Mana Ake (unique identity of whānau members), Hā a Koro ma, a Kui ma (breath of life from forebears), Whatumanawa (the open and healthy expression of emotion).
- ***Te Pae Mahutonga*** [3] – The Southern Cross brings together elements of health promotion: Te Mana Whakahaere (autonomy), Nga Manukura (community leadership), Toiora (healthy lifestyles), Te Oranga (participation in society), Waiora (physical environment), Mauriora (cultural identity).

C. Whānau Taki

Whānau are engaged and participating in their environment

Whānau are leaders within their communities.

- ***Whānau Rangatira*** – Parents involve their tamariki in social and cultural activities.

D. Whānau Manaaki

Whānau are nurturing

Whānau follow Māori values such as tika, pono and aroha which includes caring and learning.

- ***Puna ki te Puna*** – Learning passes from grandparent to grandchild.
- ***Tuku Atu, Tuku Mai*** – Parents give to and receive from their children. Parents include love, caring, encouragement and participation with their children.
- ***Ngākau Māhaki*** – Parents and whānau give unconditional love for children.

E. Whānau Haumi

Whānau are secure economically

Whānau are able to plan for and work towards meeting their wellbeing economically.

- ***Whānau Nanakia*** – Parents are skilled and participate confidently in activities of their choice.

F. Whānau Marama

Whānau are confident in Te Ao Māori

The Mana of Whānau and Whakapapa is secure and Te Reo me Ona Tikanga is valued and practised.

- ***Mihimihi and Te Reo*** – Parents talk with their children with respect and understanding.
- ***Tikanga*** – Parents uphold values and communication.

G. Whānau Kaitiakitanga

Whānau are guardians of the environment

Whānau recognise the relationship between whenua and whakapapa.

- ***Tautoko*** – Parents are supported and encouraged by whānau, hapu and iwi.
- ***Whanaungatanga*** – These are relationships and links with whānau, hapu and iwi.

H. Whānau Matauranga

Whānau are knowledgeable

Whanau are life-long learners.

- ***Maramatanga*** – Parents are encouraged to continue learning in all features of life.
- ***Mohiotanga*** – Parents are building on their knowledge and learning new strategies.

[1] Durie, M. (1998). *Whaiora: Maori health development.* Auckland: Oxford University Press, 1998, pp. 68–74
[2] Pere, R. (1988). Te Wheke: Whaia me te Aroha. In S. Middleton (Ed.). *Women in Education in Aotearoa.* Allen Unwin, Wellington.
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7.3 Āpitihanga C — Appendix C: Explanation of the core principles

Core Principles and Parenting Strategies

Core principles of positive parenting

The Triple P system is based on five core principles of positive parenting:

1. Having a safe, interesting environment
2. Having a positive learning environment
3. Using assertive discipline
4. Having realistic expectations and boundaries
5. Taking care of yourself as a parent

Positive parenting strategies

These principles are reflected in the 17 positive parenting strategies (skills) that are taught to parents.

STRATEGIES FOR HELPING CHILDREN DEVELOP	
Developing good relationships with children	
Spending quality time with children	Spending frequent, brief amounts of time (as little as 1 or 2 minutes) involved in child-preferred activities.
Talking with children	Having brief conversations with children about an activity or interest of the child.
Showing affection	Providing physical affection (e.g. hugging, touching, cuddling, tickling, patting).
Encouraging good behaviour	
Using descriptive praise	Providing encouragement and approval by describing the behaviour that is appreciated.
Giving attention	Providing positive non-verbal attention (e.g. a smile, wink, pat on the back, watching).
Having interesting activities	Arranging the child's physical and social environment to provide interesting and engaging activities, materials and age-appropriate toys (e.g. board games, paints, tapes, books, construction toys).
Teaching new skills and behaviours	
Setting a good example	Demonstrating desirable behaviour through parental modelling.
Using incidental teaching	Using a series of questions and prompts to respond to child-initiated interactions and promote learning.
Using ask-say-do	Using verbal, gestural and manual prompts to teach new skills one step at a time.
Using behaviour charts	Setting up a chart and providing social attention and back-up rewards for appropriate behaviour.
Managing misbehaviour	
Setting clear ground rules	Negotiating in advance a set of fair, specific and enforceable rules.
Using directed discussion for rule breaking	Asking the child to state the rule and then practise the correct behaviour following rule breaking.
Using planned ignoring for minor problems	The withdrawal of attention while the problem behaviour continues.
Giving clear, calm instructions	Giving a specific instruction to start a new task, or to stop a problem behaviour and start an appropriate alternative behaviour.
Backing up instructions with logical consequences	Using a specific consequence that involves removing an activity or privilege from the child or the child from an activity for a set time.
Using quiet time for misbehaviour	Removing a child from an activity in which a problem has occurred and having them sit quietly on the edge of the activity for a set time.
Using time-out for serious misbehaviour	Taking a child to an area away from others for a set time when problem behaviour occurs.

Note: *The contributions of Ngati Hine Kaumatua and Kuia, Ngati Hine Health Trust, New Zealand Ministry of Health, Parenting Research Group at The University of Auckland, and the Parenting and Family Support Centre at The University of Queensland in compiling this resource are acknowledged.*

7.4 Āpitihanga D — Appendix D: Explanation of Kia Tupu Aki Ai

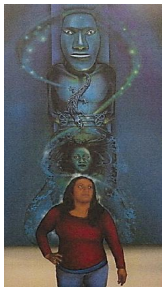
Nurturing whānau to grow and share their stories and their journey as they go through years of development.

7.5 Āpitihanga E — Appendix E: Explanation of Te Whare Rongoa/Healing Colours

Te Whānau Pou Toru

Concept – Te Whare Rongoa

Wairua

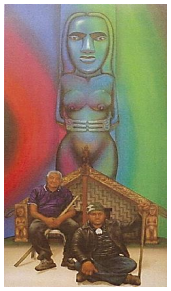


In the Maori creation tradition, all living things are descended from the first act of creation when Tane thrust his (earth) mother and (sky) father apart to create Te Ao Marama (the world of light). It is from this event that all life emanates and is therefore a particularly appropriate concept for a building designed for health and wellness.

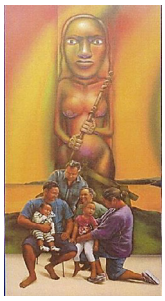
Rongoa is traditional Maori medicine. It comprises diverse practices and an emphasis on the spiritual dimension of healing. Rongoa includes herbal remedies, physical therapies such as massage, and spiritual healing.

Western medicine is slowly recognising the importance of treating the whole person – hinengaro (mind), tinana (body), whanau (family) and spirit (wairua). We believe it is vital that the concepts of Rongoa should be embodied in this iconic building, which will treat all cultures.

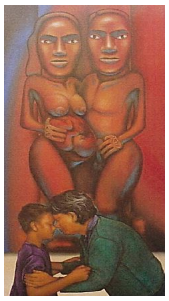
Hinengaro



Whanau



Tinana

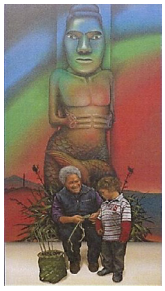


Kia Tupu Ake Ai

Te Whānau Pou Toru

Healing Colours for our Tamariki

Mauri

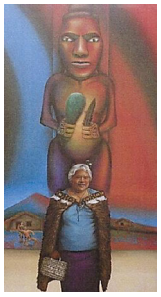


Waiporoporo or purple represents Whakapapa. Whakapapa represents the natural connections between Atua, Whenua, kai and yourself. Whakapapa is about genealogy, and your connection to your Tupuna.

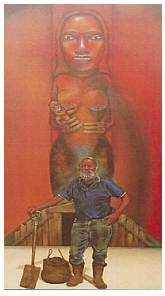
Kikorangi, kahurangi, or the colour Blue. Kikorangi represents Wairua, spiritual health and peace. Kikorangi represents truth, harmony and serenity, encompassing the space of dreaming and imagination.

Kakariki or Green represents Mana. Mana is about the autonomy of growing your own food and being able to feed yourself and your whanau. There is great Mana in takoha or giving Kai you have grown to your Kaumatua. Kakariki represents growth, regeneration hope and paradise.

Mana



Whenua

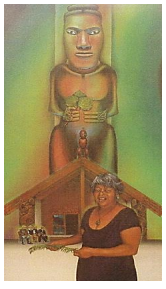


Karaka or orange represents Te Ao Türoa. Te Ao Türoa is the natural order of the universe where balance exists, connection between intellect and nature. Working with the natural world brings potency to one's self.

Whero or Red represents Mauri the vibrational energy for growth. Mauri represents life force, the energy of fertility and vitality to the health of one's self.

Ma or White represents Parakore, the place of infinite possibility and purity. A place where perfection is expressed, where joy and integrity reigns. The triumph of spirit over the physical is manifested in your creation of self.

Tikanga



Kia Tupu Ake Ai

Te Whānau Pou Toru The Project Team

Whaea
Kathy Diamond

Whaea
Isabelle Cherrington

Project Coordinator
Val Joyce


NGATI HINE
HEALTH TRUST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Te Whare Wānanga o Tāmaki Makaurau
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Triple P
Positive Parenting Program


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