

Care and Protection Secure Residences:

A report on the international evidence to guide best practice and service delivery

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A list of the people who were interviewed and consulted as part of this review is presented in Appendix A.

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Executive Summary

Young people admitted to Child, Youth and Family's (CYF) care and protection secure residences are some of New Zealand's most vulnerable and challenging. Secure residential placements are provided for children and young people with acute care and protection needs where it has been determined that other care alternatives within the community or family/whānau are deemed inadequate or inappropriate. Secure residential care is a highly specialised environment at the most intensive and institutional end of the continuum of services available to children and young people in need of CYF intervention.

The four care and protection secure residences in New Zealand provide secure residential care to young people who are generally aged 12 to 16 years and deemed to require such care. The objectives of practice for the care and protection population are to deliver high-quality services for the children and young people in the custody of the Chief Executive of CYF in a safe and humane environment, and in a culturally appropriate manner. The ultimate goal is to address their needs and make positive changes to the young people's lives and relationships in order to assist with their reintegration into their family, whānau, hapu, iwi and other groups responsible for their ongoing wellbeing.

This report reviews the international and national evidence-based literature regarding best practice and optimal service delivery in relation to CYF secure residences and the wider continuum of care for the care and protection population in New Zealand. CYF commissioned this report in December 2014 as an input into on-going work to ensure that CYF's care and protection secure residences provide the best possible care that improves outcomes for these young people while operating as cost-effectively as possible.

This report is one of two reviews commissioned by CYF regarding the international and national evidence-based literature concerning best practice and service delivery for CYF residences in New Zealand; the second report outlines literature and best practice in relation to the youth justice population in secure residential care. Although these reviews are presented as separate documents, given the similar backgrounds and needs of the care and protection and youth justice populations, there is cross-over in the content presented.

The care and protection population in New Zealand present with a range of complex needs, and the care and protection system is complex. As such, this report has not set out to provide a comprehensive overview of

all aspects regarding this population and service needs. Instead, this document summarises key conclusions and understandings from the national and international literature and evidence-based practice regarding the care and protection population in secure residential care.

These reviews were written with the philosophy in mind that the population of young people in secure residential care are a vulnerable group that we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care based on the literature and evidence-based practice presented in this review so that current service provision can be enhanced, consequently promoting best possible outcomes for this population.

Terms of Reference

This report is guided by several Terms of Reference. CYF requested a synthesis of the expert and evidence-based literature about current best practice in relation to:

1. When secure residential care is appropriate and necessary for children and young people with care and protection needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of children and young people to similar sorts of residences in other jurisdictions.
2. Whether there are effective alternative community care models for children and young people who currently enter care and protection secure residences that are more likely to provide better care, improve outcomes and/or constitute better value-for-money.
3. Where secure residential care is required, the right mix of services within Care and Protection residences that would:
 - a. improve short and long term outcomes and
 - b. ensure a safe and positive residential environment for children/young people and staff.

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

4. Where secure residential care is required, the optimal service delivery model for care and protection residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes. We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.
5. Effective social work transitions into and from care and protection residences so that young people are well supported when leaving and returning to the community.

Subsequently, the Terms of Reference were extended to include:

6. Broadening the literature review to inform transitions to and from residence (i.e., the use of assessment and the appropriateness of each assessment model).
7. Using the time a young person spends in residence to inform the next steps.
8. Commentary on the care and protection secure residences as a “service”, as part of the continuum of care services.
9. A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry of Social Development. This should include, for example, Ministry of Education specialist residential schools, forensic mental health facilities and examples of disability and other mental health residences/homes. This should include:
 - a. The model used
 - b. The staffing arrangements
 - c. The kinds of clients and their needs
 - d. The intervention programme offered
 - e. Information on the physical restraint approaches used.

Method of Data Collection

To meet the briefs and objectives for the care and protection residences literature review, information was primarily sought from two sources: (1) national and international literature, and (2) interviews with experts in the field of care and protection/child welfare.

1. Literature was searched for using internet search engines (e.g., Google, Google Scholar), electronic databases available through the University of Auckland library (e.g., PsycINFO, ERIC, MEDLINE), as well as documents and reports from CYF. Publications were restricted to include those published in English.
2. Interviews were conducted with national and international experts in the field of care and protection/child welfare. People interviewed as part of this review are listed in Appendix A.

The reviews were compiled documenting the evidence base, providing an overview of findings from the literature and interviews conducted, and outlining what “works best” to CYF with regards to the best practice and optimal service delivery of secure care and protection residences.

Review Structure and Summary

This report is separated into three parts, with each part comprising several chapters:

Part A: The Care and Protection Population and Secure Residential Care in New Zealand

Part A sets the context for the review, and comprises three chapters:

- **Chapter One:** overview of the care and protection population in secure residential care in New Zealand
- **Chapter Two:** overview of the New Zealand care and protection system and governing legislative and regulatory framework in which care and protection secure residences exist.
- **Chapter Three:** overview of the care and protection secure residences in New Zealand.

Part A discusses the myriad of difficulties and negative life experiences among the care and protection population in secure residential care. With regards to physical health, the main problems presented among young people residing in CYF secure residences are

asthma, skin problems, and sexual and dental health. Experience of trauma, including serious physical, mental or sexual abuse, is also common. In addition, those in the care and protection system have a high prevalence of psychiatric disorders, substance abuse, behavioural difficulties, and suicidal ideation. Furthermore, internationally, educational difficulties and intellectual disabilities are prevalent among those in placed in child welfare residences. In New Zealand, many young people in CYF secure residences have left education prior to admission, and 80% of those in CYF care leave school with less than Level 2 NCEA qualifications.

This population are some of the most vulnerable and at-risk young people in New Zealand. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care to best address the needs and improve outcomes for this population.

Part B: Secure Residential Care: National and International Research and Best Practice

Part B provides an overview of the national and international research and best practice regarding services for the care and protection population, and comprises the following chapters:

- **Chapter Four:** overview of international care and protection systems and continua of care
- **Chapter Five:** frameworks to guide secure residential care and protection services
- **Chapter Six:** models for care and protection secure residential care
- **Chapter Seven:** ‘step down’ care models for the care and protection population
- **Chapter Eight:** assessment for the care and protection population in secure residences
- **Chapter Nine:** therapeutic models for the care and protection population in secure residential care
- **Chapter Ten:** cultural models and considerations
- **Chapter Eleven:** education programmes and approaches

- **Chapter Twelve:** crisis management, including de-escalation and non-violent methods of intervention with young people in care and protection secure residences
- **Chapter Thirteen:** addressing the needs of the client types in care and protection secure residences
- **Chapter Fourteen:** transition from care and protection secure residences and aftercare.

Part B classified each framework, model, and rehabilitative programme examined by the report into seven groups, based on their current evidence of effectiveness. The rating scale used to evaluate the evidence of each framework, model, and rehabilitative programme was based on the California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale¹. The California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale was chosen for this summary review due to its international reputation, ease in usage, and breadth of criteria.

The rating scale (in brief) is as follows:

1. Well-supported by research evidence

These were frameworks, models, and/or rehabilitative programmes for which there was strong evidence of efficacy, i.e., two or more published, peer-reviewed rigorous randomised controlled trials (RCTs), with multiple site replication and follow-up (< 1 year post-treatment).

2. Supported by research evidence

These were frameworks, models and/or rehabilitative programmes that had good evidence of efficacy, i.e., one published, peer-reviewed rigorous RCT, with multiple site replication and follow-up (< 6 months post-treatment).

3. Promising research evidence

These were frameworks, models and/or rehabilitative programmes that have evidence of efficacy; however, the evidence-base does not include a rigorous RCT. i.e., one published, peer-reviewed study utilising some form of control group.

¹ More information is available at: www.cebc4cw.org/ratings/scientific-rating-scale

3a. Promising research evidence among comparable youth populations

These were frameworks, models and/or rehabilitative programmes that have good evidence of efficacy, i.e., one published, peer-reviewed rigorous RCT among non-youth justice populations who have behavioural and/or mental health difficulties comparable to those of the youth justice population.

4. Evidence fails to demonstrate effect

These were frameworks, models and/or rehabilitative programmes for which there was strong evidence to suggest the practice does not result in improved outcomes, i.e., two or more published, peer-reviewed rigorous randomised controlled trials (RCTs), with multiple site replication and follow-up (< 1 year post-treatment).

5. Concerning practice

These were frameworks, models and/or rehabilitative programmes for which the overall weight of evidence suggests the practice has a negative effect upon clients, including data suggesting risk of harm (that was probably caused by the treatment and the harm was severe or frequent) and/or the practice constitutes a risk of harm to those receiving it.

NR - Not able to be rated

These were frameworks, models and/or rehabilitative programmes for which there was no published, peer-reviewed study using some form of control group, and the practice does not meet criteria for any other level on the rating scale.

On the basis of the current review's rating scale criterion:

One model was identified as being *well-supported by research*:

- Multisystemic Therapy

Two models and programmes were classified as being *supported by research evidence*:

- Teaching Family Homes
- Therapeutic Foster Care (Multidimensional Treatment Foster Care)

Two models and programmes were classified as having *promising research evidence*:

- The Sanctuary Model
- Stop-Gap

Seven models and programmes were classified as having *promising research evidence among comparable youth populations*:

- Positive Peer Culture
- Aggression Replacement Training
- Trauma-Focused CBT²
- Dialectical Behavioural Therapy
- Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5
- Therapeutic Communities
- Positive Behaviour for Learning – School Wide

One programme was classified as having evidence *failing to demonstrate effect*:

- Alternative Education³

One model was classified as having *concerning practice*:

- Behaviour Modification – Token Economy and Point Level System

Thirteen models and programmes were classified as *not able to be rated*:

- Trauma, Attachment and Neurodevelopment Framework
- Neurosequential Model of Therapeutics (NMT)
- Children and Residential Experiences (CARE)
- Spiral to Recovery
- Seeking Safety
- Sensory Modulation
- Meihana Model (was considered a “sustained” programme by the Advisory Group on Conduct Problems (AGCP, 2013))

² Trauma-Focused CBT presents as a particularly promising programme for the care and protection population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

³ Note: concerns regarding Alternative Education, as reported in this review, were identified by the Advisory Group on Conduct Problems (2013).

- Te Pikinga ki Runga (was considered a “sustained” programme by the AGCP (2013))
- Te Hui Whakatika (was considered an “emerging” programme by the AGCP (2013))
- Prevent-Teach-Reinforce
- Non-Violent Crisis Intervention
- Therapeutic Crisis Intervention
- Intensive Aftercare Programme.

Please note that the Advisory Group on Conduct Problems (AGCP) used a different process to classify the effectiveness/efficacy of each programme reviewed in their 2013 report on Conduct Problems: Effective Programmes for Adolescents⁴. An overview of the AGCP’s process for classification and how it compares to the scale used in this review is provided in Appendix B.

Part C: What Works Best for the New Zealand Context

Part C summarises the aforementioned literature and best practice for the care and management of the care and protection population, and comprises:

- **Chapter Fifteen:** based on current best practice and evidence-based programmes and models, a summary of what “works best” for care and protection secure residences and the wider continuum of care.

What “works best”

The what “works best” summary is structured to address each of the Terms of Reference that guided this review:

Terms of Reference 1

When secure residential care is appropriate and necessary for children and young people with care and protection needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of children and young people to similar sorts of residences in other jurisdictions.

Drawing comparisons between New Zealand and international care and protection systems and the use of secure residential care is limited due to the differing standards and philosophies regarding the purpose of secure care and the availability of community-based alternatives.

Internationally, the literature recommends that secure residential care should be reserved only for the most high-needs and at-risk young people, be used as a last resort, and only for a limited amount of time. This is largely due to literature indicating a range of negative impacts young people experience while in secure residential care (see Lambie and Randell (2013) for an overview).

Terms of Reference 2

Whether there are effective alternative community care models for children and young people who currently enter care and protection residences that are more likely to provide better care, improve outcomes and/or constitute better value-for-money.

There is a shift internationally toward the use of community-based services as an alternative to secure residential placement, where possible. Community-based and evidence-based models of intervention that can be used as an alternative to secure residential care and as step-down homes (i.e., out-of-home care) that young people from secure residential placement can transition to, include Multidimensional Treatment Foster Care (MTFC) and the Teaching Family Model (TFM; see Chapter Seven, Sections 7.3 and 7.2 respectively). In addition, Multi Systemic Therapy (MST; Chapter Seven, Section 7.1) is another efficacious community-based multimodal treatment used to address serious social, emotional and behavioural problems in children and adolescents.

Terms of Reference 3 and 7 question what services should be implemented in residence, and request a commentary regarding how to best use the time a young person spends in residence to help inform next steps. Therefore, these TOR are addressed together below.

⁴ See: www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/effective-programmes-for-adolescents.html

Terms of Reference 3

Where secure residential care is required, the right mix of services within care and protection secure residences that would:

- a. improve short and long term outcomes, and
- b. ensure a safe and positive residential environment for children/young people and staff.

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

Terms of Reference 7

Using the time a young person spends in residence to inform the next steps (i.e., use of assessment and the appropriateness of each assessment model, programmes, and interventions).

To the best of the authors' knowledge, there is a lack of information regarding what interventions or combination of services help promote the short- and long-term outcomes of young people in care and protection secure residences. However, an overview of the literature and current best practice in relation to the assessment process, framework and model of care, rehabilitative programmes, cultural models and practices, education programmes, vocational skills development, crisis management, and physical environment are provided below, as well as what appears to "work best" in meeting the needs of the various client types seen in care and protection secure residences.

Length of Time in Secure Residential Care

At the time of writing this review, the reviewers were unaware of any clear guidelines regarding the maximum length of time a young person should be placed in secure residential care. However, the Stop-Gap model (see Chapter Six, Section 6.4) suggests young people should only be held in residence for up to 150 days.

Overarching framework and model of care

Here, a framework is described as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as guiding principles in the assessment and treatment process. A model of care is a therapeutic or rehabilitative model that can be implemented in residential services, and sits underneath the overarching framework. Implementing an overarching framework and model of care may help foster a common understanding between all staff and professionals as to the aims, goals and philosophies of the services provided to young people in residential care, consequently promoting consistency in approach between staff.

Utilising a trauma, attachment and neurodevelopmental framework (e.g., the Neurosequential Model of Therapeutics; see Chapter Five, Section 5.1.1) for guiding the assessment and rehabilitation/intervention of the care and protection population acknowledges the trauma experienced from histories of abuse and neglect that are common among this population. In addition, components of the trauma-informed Sanctuary model (see Chapter Six, Section 6.1) could be used as a model of care in care and protection secure residences.

Assessment process

Assessment of young people in care and protection secure residences has two purposes: to identify the immediate acute needs of the young person at admission, and to guide the individualised intervention/rehabilitation plan. Assessment should therefore begin when a young person first has contact with CYF services, with reassessment conducted periodically right through to the young person's exit from CYF services.

With regards to the assessment process for the young person's individualised plan, this should involve standardised identification of a wide range of risk and protective factors of the young person, their family/whānau, and other supports. In addition, each young person should be screened for physical and mental health problems, educational needs, cognitive deficits, substance use, and any immediate risks to self, including self-harm or suicidal ideation, and risks to others and from others. Such a systemic, holistic and comprehensive assessment acknowledges the childhood experiences and environment that may contribute to the young person's behavioural and mental health difficulties.

Implementing standardised assessment processes and measures can help facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. Standardised assessment tools identified in Chapter Eight include the MAYSI-2 and Strengths and Difficulties Questionnaire. For young people placed in care and protection secure residences who have engaged in offending behaviour, the assessment should also include identification of criminogenic risk and needs. One such standardised assessment tool is the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002).

Utilising a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

Rehabilitative programmes

To facilitate good outcomes for a young person post-residence, it is important to plan and implement appropriate, individualised and effective interventions which align with the young person's identified strengths and difficulties from assessment. This parallels practice implemented by the Kibble Education and Care Centre where the level of service a young person receives is determined based on the comprehensive risk and needs assessment.

Implementing multidimensional interventions and rehabilitative programmes, such as educational, mental health, cultural, medical, speech and language, and family-based interventions are important to ensure that the wide array of difficulties the young person may be experiencing are addressed. This is in line with strategies implemented internationally (e.g., Kibble Care; see Chapter Four, Section 4.3.1), and the step-down community-based care models such as MST and MTFC (Chapter Seven, Sections 7.1 and 7.3 respectively). Furthermore, working with family and caregivers, to whom the young person is likely to return post-residence, is accepted as essential to ensure that benefits obtained in residence are maintained in the long term (Caldwell & Van Rybroek, 2013).

Evidence-based rehabilitative programmes identified in this report included Aggression Replacement Training (ART), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), and Dialectical Behavioural Therapy (DBT) (see Chapter Nine, Sections 9.1.1, 9.1.2 and 9.2 respectively).

The use of such evidence-based interventions and therapeutic models within residential secure care has been shown to improve outcomes comparable to those in non-residential out of home care (De Swart et al., 2012).

There is tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of placing young people in residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started while a young person is in a secure residence unless the young person is transitioning back into the community where this intervention can continue with minimal disruption and they see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in secure residential care, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical-Behavioural Treatment). Alternatively, rehabilitative programmes could be implemented in a modular-based fashion, where one or several modules are delivered in residence, and the remaining modules post-transition.

Ethnicity and Culture

Māori are significantly over-represented in the care and protection population, and comprise 57% of those admitted to care and protection secure residential care in New Zealand. Therefore, there is a need for services to ensure that they are implementing culturally responsive evidence-based practices for Māori rangatahi, and that their staff and programmes are culturally informed and sensitive. Models, such as the Meihana Model (Pitama, Robertson, Cram, Gillies, Huria & Dallas-Katoa, 2007), provide a framework and practice model to guide health professionals in the assessment and intervention of Māori clients and their whānau. Additional kaupapa Māori frameworks and interventions that are recommended in the literature for use with young people include Te Pikinga ki Runga, Te Hui Whakatika, Huakina Mai, and He Awa Whiria, all of which are described within this review (see Chapter Ten). However, these models are currently lacking evidence as to their effectiveness.

Education

Despite young people in residential care often seen as being behind in their educational achievement compared with their peers in the community, there is limited research examining the effects of education programmes on academic outcomes among young people involved in the care and protection system. It is important that young people in care and protection secure residential care are provided with a comprehensive educational screening assessment, and high-quality educational services tailored to their identified needs to help them re-engage in education and catch-up to their peers. As outlined in Chapter Eleven, some promising education programmes have been developed, such as Positive Behaviour for Learning – School Wide (PB4L-SW). However, this is an area clearly in need of further research.

There appears to be no research or guidelines on the specific mix of professionals required in residential care education settings; however it seems likely that the presence of an educational psychologist, medical support for issues such as hearing loss, and the use of registered teachers would all be beneficial in terms of supporting young people in making the most of educational opportunities while in residence. In addition, given the over-representation of speech, language and communication difficulties present among the care and protection population, it is important to ensure speech-language therapy services are provided (Snow et al., 2015).

Vocational skills

There is a lack of research regarding the benefits of vocational and pre-employment training for young people in the care and protection system and secure residential care. However, the recognised benefits of young people being engaged in education could be generalised to include vocational and pre-employment training, where the acquisition of skills can increase the young person's chance of employment, consequently fostering positive outcomes in the long-term. Transitional staff could help a young person engage in such training programmes in the community post-discharge.

Crisis Management

Although restraint may be necessary as a last resort for the purposes of safety for the young person and staff, in general non-violent methods are both appropriate and necessary as an alternative. Two de-escalation and non-violent models of crisis intervention identified in the literature for use with young people in care and protection secure residences are: Non-Violent Crisis Intervention (NVCi) and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Sections 12.1 and 12.2 respectively). However, there has been limited published, peer-reviewed research conducted evaluating NVCi and TCI.

Physical Environment

A warm and home-like environment in residence is believed to help support the transition of the young person into residential care and to assist them to cope within the restrictive care environment (Bailey, 2002). Furthermore, providing kitchens, dining areas, lounges and individual bedrooms can ease the young person's transition into residential care and help them feel more "normal". Individual bedrooms offer the young person a private space where the young person can feel safe and contained, which can be therapeutic, particularly when living in a group situation (Bailey, 2002). Small facilities that enable 24/7 eyes-on supervision that have a home-like feel are used by Kibble Care (See Chapter Four, Section 4.3.1)

Family/whānau are seen as being an integral element of the rehabilitation of the young person. Therefore, to help increase the likelihood of family/whānau involvement in the treatment or intervention process, the young person should be placed in a secure residence that is as close to home as possible.

Addressing the needs of different client types

There are several distinct client types in the care and protection secure residential population: females, child offenders (< 13 years)⁵, young care and protection children (≤ 12 years), and those with significant trauma and neglect histories. An overview of how to best address the needs of these client types is provided in Chapter Thirteen.

5 This refers to children both with current and previous offences.

Currently, there is limited understanding or knowledge regarding the demographics and characteristics of these client types in care and protection secure residences in New Zealand. It is only with this information that a more thorough examination into how the needs of these different client types in care and protection secure residences can be met, in order to establish practice guidelines. However, it appears that due to the vulnerability and complexity of presentation among some female and younger care and protection children, considerations should be made concerning whether females should be separated from males, and children separated from adolescents.

Terms of Reference 4

Where secure residential care is required, the optimal service delivery model for care and protection residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes. We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.

Professionals in residential care

At the time of this review, the authors were unaware of any research or guidelines regarding the ideal mix of professionals for a secure residential care facility. However, the “best mix” of professionals within care and protection secure residences is likely to include qualified front-line staff with extensive training in how to work with young people with offending histories, and mental health and behavioural difficulties. There should be medical and mental health staff on-site, as well as education staff (preferably registered teachers), vocational staff, and at least one cultural advisor per site given the large proportion of Māori young people in care and protection secure residences. With regards to mental health, the presence of a registered psychologist, child psychiatrist, and psychiatric nurses are considered essential within a residential care environment, in order to adequately assess and manage the various mental health, emotional, and behavioural issues present among young people in secure residential care.

Staff attributes, capabilities, and qualifications

Interpersonal skills seen among effective staff who work with at-risk and high-needs young people include prosocial attitudes and behaviour, warmth, effective communication skills, and values aligning with those of the programme model (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000). Furthermore, the characteristics of staff working with young people, including professionalism and the ability to form prosocial relationships, have been found to mediate positive treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm, Boekee, Stams, & Vander Laan, 2011).

Internationally, there has been a shift toward increasing the level of professionalism of staff in residential care (Dekker et al., 2012; Fendrich et al., 2012; Lappi-Seppälä, 2011). For example, in Nordic countries at least 50% of residential care staff have tertiary qualifications (Lappi-Seppälä, 2011).

There appears to be no guidelines concerning the optimal staff-client ratio in secure residences. However, it is likely that having a high staff to young person ratio will help ensure staff are not overworked, consequently reducing staff burn-out and turnover, and an appropriate distribution of tasks across staff.

Training, support and supervision

It is important that staff are highly trained in the framework and model of care that is used within the residence, to ensure consistency in the implementation of the model. The Kibble Centre provides their staff with extensive training in how to effectively provide services to young people in residential care. In addition, it is essential that staff are provided with professional development training to develop and extend their skills relating to the effective management and care of young people in secure residences.

Staff that are well-supported, feel appreciated, and are provided with frequent supervision are less likely to experience burn-out, and more likely to stay motivated in delivering a high-level of service to the young people in secure residences. In addition, supervision is essential for intensive and demanding roles in order to assist staff to maintain and develop their rehabilitative work (Lyman & Barry, 2006; Mendel, 2000; Church, 2003).

Social workers

Social workers play a critical role in the care and management of the care and protection population. However, the current training for social workers in New Zealand does not include clinical skills training. Additional training in clinical skills provided to a targeted group of social workers (approximately 40) across New Zealand would be beneficial in order to deliver adequate care and management for the care and protection population.

Management/leadership

To ensure consistency of rehabilitative interventions and a united and motivated team of staff working in secure residences, it is essential that the residential organisation has strong and consistent leadership (Hollin, 2001). In addition, the use of clinical and community advisory groups can be an important support for the management and leadership of the organisation, and can provide informed outsider opinion to ensure that the organisation does not become insulated and “institutionalized” in the way that it operates.

Organisational culture

The best opportunity for effective rehabilitative and therapeutic interactions between staff and young people is within an organisation with a clear therapeutic philosophy, as well as a united vision which all staff are committed to. Organisations which are driven by qualified and committed leadership can improve outcomes for the young people admitted to care and protection secure residences. It is important that all staff are highly trained and committed to the model of care and the culture of the organisation, as inconsistent staff behaviour can become counterproductive and may undermine treatment integrity (Hollin, 2001).

Terms of Reference 5

Effective social work transitions into and from care and protection residences so that young people are well supported when leaving and returning to the community.

Transition and aftercare

Evidence suggests that the planning for transition from residence should commence shortly after admission to the residence, for two main reasons. Firstly, the length of stay for a young person is often unknown,

and therefore the transition plan should be in place in order to avoid gaps should the young person depart from residential care earlier than expected. Secondly, young people tend to have better outcomes when they have a transition plan in place (Lindqvist, 2011), as this likely reduces uncertainty in their future, allowing them to better focus on their current situation. This can also increase motivation to achieve goals in residence if they are beneficial for their post-residence plan. Furthermore, any positive outcomes gained from time spent in residential treatment may be lost if transition and post-residence support are not available to the young person (Guterman, Hodges, Blythe & Bronson, 1989).

For all young people transitioning from residence, it is essential that transition planning is inclusive of young people, their families/whānau (where possible) and significant others, and that planning processes are well-coordinated and tailored to the individual needs and circumstances of the young person to promote best possible outcomes. Given young people often find it difficult to maintain positive gains that they have made in residential care once they have transitioned post-residence, it is important that a young person’s transition is well-supported with a continuity of services in place before, during and after transition. Such post-residence support can include aftercare services.

Terms of Reference 6

Broaden the literature review to inform transitions (i.e., the use of assessment and the appropriateness of each assessment model in transitions).

Young people may transition from care and protection secure residences into out-of-home placements, including homes or residences implementing the Teaching Family Model (TFM) or Therapeutic Foster Care (MTFC) models (see Chapter Seven, Sections 7.2 and 7.3 respectively). In addition, Multisystemic Therapy (see Chapter Seven, Section 7.1) may be used for young people exhibiting emotional and behavioural difficulties while residing in their family home.

To the best of the reviewers’ knowledge, there appear to be no clear assessment models to guide the transition of a young person from secure residence into one of these evidence-based models, or to decide when a young person is considered “ready” to be transitioned back into the community. Instead, it appears that TFM, MTFC and MST each have admission/transition and discharge

guidelines (e.g., see Ministry of Social Development’s (2014) document concerning the TFM services in New Zealand). In addition, to help inform best possible placements for each young person based on their needs, decision-making models have been developed (see Chapter Four, Section 4.1.3, and Chapter Eight, Section 8.2).

Developing effective transitions and referral pathways between secure residences and alternative out-of-home placements in the community is essential to provide best possible outcomes for the care and protection population transitioning from secure residential care.

To help guide and inform the best possible placement for each young person, two main decision-making models have been developed internationally: The Multidisciplinary Team Model and the Decision Support Algorithm Model (see Chapter Eight, Section 8.2). Although these models are not assessment models for the transition process, they may be useful in guiding the best possible placement option for each young person based on their identified needs.

Terms of Reference 8

Commentary on residences as a “service”, as part of a continuum of services.

Residential-based services are typically situated within a wider continuum of care that comprises step-down homes (i.e., out-of-home care), multimodal family and community-based interventions, rehabilitative interventions, and interventions aimed at prevention (i.e., young people aged less than 12 years who present with conduct problems). It is important that each part of this continuum of care uses evidence-based models and interventions to help ensure that the needs of these young people and their families are met. Furthermore, having robust and effective resources throughout the continuum of care can help ensure that those who begin to exhibit problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of offending and/or being re-admitted into a secure residence.

To help address the maltreatment histories experienced by young people in care and protection secure residences, incorporating trauma-informed models of care and services within secure residences and

across the continuum of care should be considered. Implementing trauma-informed practices across agencies and the continuum of care can help smooth transitions from residence and close the divide between agencies that provide services to these young people (Zelechowski et al. 2013).

Internationally, the Kibble Education and Care Centre (see Chapter Four, Section 4.3.1) is a well-run and highly-regarded continuum of care for the care and protection population. Aspects of this model could be beneficial for implementation in the New Zealand context to strengthen the current care and protection continuum of care. This model is briefly described below.

The Kibble Education and Care Centre

The Kibble Education and Care Centre (Kibble) is a social enterprise in Scotland with the goal of providing a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences, and training to allow them to be successful in independent life. Kibble provides secure care, residential services, day services, intensive fostering, education and training, and transitional support all on-site.

Evaluations have been positive with findings that young people feel cared for and secure, and benefit from having their curriculum tailored to their individual needs (Education Scotland, n.d.). Staff have also been found to be highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.). It is important to note that there has been no external research conducted examining the effectiveness of Kibble.

Terms of Reference 9

A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry. This should include, for example, MoE specialist residential schools, forensic mental health facilities and examples of disability and other mental health residences/homes. This should include:

- a. The model of care used*
- b. The staffing arrangements*
- c. The kinds of clients and their needs*
- d. The intervention programme offered*
- e. Information on the physical restraint approaches used.*

Please refer to Chapter Three, Section 3.3 where an overview of the new Youth Forensic Mental Health Unit, Ministry of Education, Barnardos, Spectrum Care, Hohepa Trust, and Ministry of Health's Disability Support Services' contracted residences is provided.

PART A: The Care and Protection Population and Secure Residential Care in New Zealand

To set the context for this review, this section provides an overview of the care and protection population in secure residential care in New Zealand, the New Zealand care and protection system, and the New Zealand care and protection secure residences.

Chapter One provides a description of the characteristics and needs of the care and protection population in secure residential care, and how these differ across various care and protection client types. Chapter Two provides an overview of the care and protection system, including the governing legislative and regulatory framework in which Child, Youth, and Family care and protection secure residences exist. Chapter Three presents an overview of the care and protection secure residences in New Zealand, including admission criteria and the current services provided.

Chapter 1: The Current New Zealand Care and Protection Population in Secure Residential Care

To help determine what approach to care may best meet the needs of the care and protection population in secure residential care, it is important to first understand the demographics, characteristics and needs of this population. In this chapter, the characteristics and needs of the general care and protection population in secure residential care are described, followed by an overview of the care and protection client types, namely females, child offenders (<13 years), young care and protection children (\leq 12 years), and those with significant trauma and neglect histories.

1.1 An Overview of the General Care and Protection Population in Secure Residential Care

At any one time, CYF provides services for an estimated 400 to 450 children and young people who have high needs. From Fiscal Year (F)⁶ 2010 to 2014, there was an average of 113 distinct clients admitted to CYF's care and protection secure residences each year. The number of readmissions has increased over time, with 18 distinct clients readmitted in F2011 and 37 clients in F2014. On admission, the two most common statuses for these young people were s101 (custody order) and s78 (custody of child or young person pending determination of proceedings) orders. From F2010 to F2014, 73% of young people admitted to a secure care and protection residence had s101 orders. The average stay in a care and protection secure residence is 136 days, with a downward trend in duration over time (Hand & Tupai, 2015, unpublished).

Over the past five years, 55% of young people in care and protection secure residences have been male, with the majority (58%) aged 13 and 14 years, 24% aged 15 and 16 years, and 18% aged between 8 to 12 years. Just

over half of young people (57%) identified as Māori, and 37% as New Zealand European/Pākehā. In 2012/13, most young people had between three and six identified care and protection issues at admission to secure residence, with the main difficulties being: violence towards family/peers/public (83%), absconding (83%), alcohol and drug abuse (57%), harmful sexual behaviour (43%) and self-harming (35%). In addition, 30% were admitted due to offending behaviour and 17% for other behavioural and conduct problems (Hand & Tupai, 2015).

There is limited national level, aggregated information regarding the physical and mental health, behavioural, and educational needs, and child maltreatment histories of the care and protection population in secure residential care in New Zealand⁷. An overview is provided below of the information currently available regarding this population in New Zealand. Where possible, international research on the characteristics of the care and protection population (internationally referred to as the 'child welfare' population) is also presented.

1.1.1 Physical Health

Research indicates that young people in secure residences are among the most disadvantaged and vulnerable population of young people. In 2009, McKay and Bagshaw investigated the health needs of 94 young people residing in CYF secure residences (i.e., Te Au rere a te Tonga youth justice residence, Te Oranga care and protection residence, and Te Puna Wai o Tuhinapo youth justice residence). With regards to physical health, the main problems among young people in residence were asthma, skin problems, and sexual and dental health. Almost one-half (44%) of young people had poor access to dental health care, while 19% failed a hearing screening test, and 24% failed their vision screening test. Young people's sexual health was also concerning, with 92% disclosing that they have had sex and half (49%) reporting that they had used condoms always or most of the time (McKay & Bagshaw, 2009).

6 The New Zealand government's fiscal year runs from 1 July to 30 June of the following year.

7 CYF captures detailed information about an individual client's problems and needs, which is held on CYRAS and/or individual hardcopy case files at a local level. However, at the time of writing, there is no aggregated national or regional information about the needs of clients in CYF's care produced on a regular basis for operational or other reasons. This is due to the complexity of the client information and difficulty aggregating data; such information is not captured by CYRAS in a form that enables reporting (it is captured in free text or in attached documents, not in structured text); nor is there regular collation and reporting of such information by CYF or MSD. Despite this, CYF has a reasonable idea about the problems and needs of clients in residences through day-to-day operations information and a variety of internal reports.

1.1.2 Victimisation, Abuse, Mental Health and Behavioural Difficulties

A proportion of young people are placed in care and protection secure residences due to concerns regarding trauma, abuse, and neglect. Among the young people in care and protection secure residences as at 30 June 2012 (n = 76), 22% had been admitted due to risk of serious physical or mental abuse, 26% due to trauma, and 4% due to risk of serious sexual abuse (Hand & Tupai, 2015). In addition, McKay and Bagshaw (2009) found over one-half of boys (56%) and a quarter of girls (26%) in CYF secure residences reported being physically harmed on more than three occasions in the past year, while 39% had witnessed violence between adults at home on more than three occasions in the past year. High prevalence rates of historical maltreatment have also been found internationally among this population (e.g., Dale et al., 2007).

Internationally, the care and protection (i.e., child welfare) population in residential or out-of-home care have been shown to have a high prevalence of psychiatric disorders, substance abuse, behavioural difficulties, and suicidal ideation (Bath, 2009; Berridge, Biehal & Henry, 2012; Bronsard, Lancon, Loundou, Auquier, Rufo & Simeoni, 2011; Dale, Baker, Anastasio & Purcell, 2007; Department for Education, 2014; Duppong Hurley et al. 2014; Ford, Vostanis, Meltzer & Goodman, 2007). Similarly, in New Zealand, McKay and Bagshaw (2009) found 49% of those in secure CYF residences reported 'worrying a lot about things,' 37% had four or more somatic symptoms, 25% reported depressive symptoms, 49% reported feeling anger and irritability, 30% had self-harmed, and 20% had attempted to end their life. The majority (87%) of young people smoked cigarettes daily, 58% drank alcohol at least three days a week, and 49% used cannabis at least once a day (McKay & Bagshaw, 2009). Such difficulties may be the result of historical maltreatment, abuse and/or neglect, given its demonstrated association with a range of serious consequences (e.g., see Gilbert, Widom, Browne, Fergusson, Webb & Janson, 2009). This also extends to complex trauma which may disrupt normal development, including the attachment patterns (Cook et al., 2005).

1.1.3 Educational Needs, Intellectual Disability, and Language Impairment

Educational difficulties and intellectual disability are prevalent among young people in child welfare residences internationally (e.g., Bath, 2009; Berridge et al., 2012; Department for Education, 2014; Trout, Hagaman, Casey, Reid & Epstein, 2008), as well as speech, language and communication difficulties (Hagaman, Trout, DeSalvo, Gehringer, & Epstein, 2010; McCool & Stevens, 2011). There is limited information regarding the proportion of young people in care and protection secure residences in New Zealand who have educational difficulties, intellectual disability and language impairment. However, among a sample of young people identified by CYF as having high needs (N = 408), 23% had a physical or intellectual disability and developmental delay, and 7% had learning/education needs (Child, Youth and Family, 2013, as cited in Hand & Tupai, 2015). In addition, McKay and Bagshaw (2009) found 70% of young people had left school prior to their admission to residence, and the majority (84% of boys and 100% of girls) had been truant from school.

Further information regarding the educational services provided in CYF care and protection secure residences, as well as the education-related outcomes for this group of young people in New Zealand, is outlined in Chapter Three.

1.1.4 Risk and Protective Factors

An increased likelihood of child abuse, neglect, and involvement with child protection services is likely to arise from an interaction of numerous risk factors (Bromfield, Lamont, Parker & Horsfall, 2010). Factors found to be commonly associated with child maltreatment are domestic violence, parental substance misuse, and parental mental illness (Cleaver, Nicholson, Tarr & Cleaver, 2007; Scott, 2009). However, there is evidence to suggest that different risk factors may have a larger impact on certain types of abuse and neglect. Identified risk factors for child physical abuse include parents with a history of physical victimisation (Lamont, 2010; Pears & Capaldi, 2001), parent anger/hyper-reactivity, family conflict, and family cohesion (Stith, Liu, Davies, Boykin, Adler, Harris et al., 2009). Child neglect has been associated with parental mental illness (Cowling, 2004), the parent-child relationship, the parent viewing the child as a problem, the parent's

level of stress, parent anger/hyper-reactivity, and parent self-esteem (Stith et al., 2009). There is also evidence to suggest that the cumulative effects of exposure to multiple risks strongly influences negative child outcomes and maltreatment (Begle, Dumas, & Hanson, 2010; MacKenzie, Kotch, & Lee, 2011).

Understanding the causal factors and mechanisms that contribute to child maltreatment and subsequent involvement in care and protection services is highly complex, and beyond the scope of this report. As stated by Putnam-Horrnstein, Needell and Rhodes (2013), the research conducted in this area has highlighted that “child maltreatment is a dynamic and multifaceted event, subject to influences from a variety of sources operating via a number of pathways” (p. 117).

Research has also examined the protective factors for childhood abuse and neglect. Protective factors may include strengths that help to buffer and support families at risk. In 2012, the Administration on Children, Youth and Families (ACYF) contracted the Developmental Services Group Inc. to review protective factors among at-risk populations of children, young people and families (i.e., young people who are victims of child abuse and neglect, runaway and homeless youth, youth in or transitioning out of foster care, young people exposed to domestic violence, and pregnant and parenting teens). The ACYF identified ten protective factors that had the most empirical support across these populations: relational, self-regulation, and problem-solving skills, involvement in positive activities, parenting competencies, positive peers, caring adult(s), positive community environment, positive school environment, and economic opportunities (ACYF, 2013).

1.2 Needs of the Care and Protection Population in Secure Residential Care

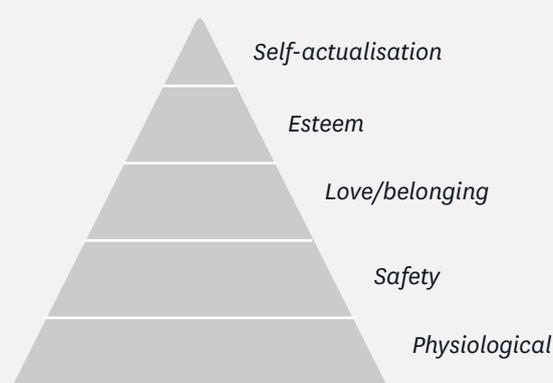
While the safety and protection of these young people are primary concerns, these young people present with multiple underlying difficulties and needs that should also be acknowledged given their association with the wellbeing of the young person and their family/whānau and long-term outcomes, including offending behaviour. The multiple needs of these young people span across individual, peer, family/whānau, education, and community-based domains. This has been highlighted by the aforementioned research where young people in secure residential care have been found to be functioning

at a significantly lower level than other children with respect to their language and literacy development, as well as indicators of health and wellbeing. Further needs among this population may include finding a high-quality and stable placement post-transition from residence, and wraparound services such as day programmes and education to help support the young person and their family/whānau post-residence (Hand & Tupai, 2015). In addition, often these young people in secure residential care have experienced multiple placements with whānau and non-whānau, likely resulting in limited access to, or being excluded from education (Hand & Tupai, 2015). CYF have become concerned that there appears to be an increasing severity and complexity of needs of young people admitted to care and protection secure residences.

It is important to note that although there is some information available regarding the difficulties and needs of the care and protection population in secure residential care in New Zealand, full understanding of these needs is restricted due to the limited national aggregated data concerning these young people (as noted in Hand and Tupai, 2015).

In addition to the difficulties and needs present among the care and protection population in secure residential care, these young people also have essential basic needs that all young people in the general population require. One model to help understand the basic needs of humans is Maslow’s Hierarchy of Needs (Maslow, 1970; see Figure 1).

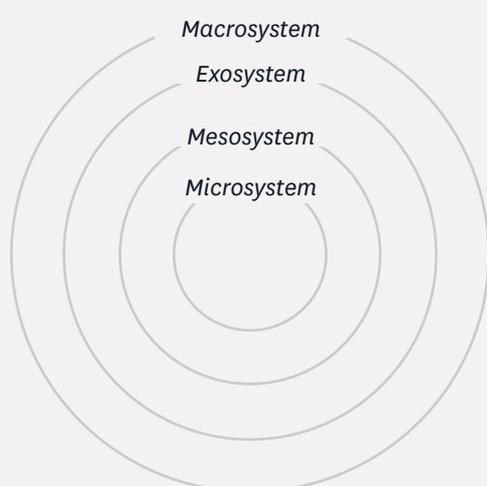
Figure 1. Maslow’s hierarchy of needs



Maslow suggested that the most basic needs must be met before higher-level concerns can be addressed. It is at the self-actualisation level, when all bottom four levels of basic need (i.e., physiological, safety, love/belonging, and esteem) have been met, where change can be made (Jones, 2004). Basic human needs can also affect a young person's engagement in treatment and their internal motivation for change (Ryan & Leversee, 2011). For example, when a young person's basic needs aren't being met, this can impair their ability to focus on anything except their own needs.

As conceptualised in Bronfenbrenner's (1979) ecological model, a young person and their family are seen as existing within a broader set of systems which they interact with, impact on, and are impacted by. As shown in Figure 2, according to Bronfenbrenner (1979) there are four nested systems that extend around the young person: the microsystem (the setting the individual has direct contact with; e.g., peers, school, family, church, health services), mesosystem (interactions between microsystems; e.g., interactions between family and teachers), exosystem (system or setting that does not directly involve the individual but still affects them; e.g., parent losing their job), and macrosystem (e.g., culture or subculture in which other systems are nested). When significant difficulties in one or more of these systems arise this can have considerable consequences on the development of the young person. Therefore, it is important to identify such difficulties and provide interventions to adequately address them.

Figure 2. Bronfenbrenner's ecological model



To effectively work with these young people, it is also important to recognise the nature of development that childhood and adolescence presents. For example, core developmental processes for adolescents include belonging and the formation of identity. Adolescents also inevitably face challenges during this life stage related to biological (e.g., puberty), cognitive (e.g., abstract thinking), psychological (e.g., emotional responses, identity), social (e.g., societal and parental expectations), and moral and spiritual domains.

1.3 Care and Protection Client Types

Although we can examine the characteristics and needs of the young people in care and protection secure residential care in general, it is apparent that within this population there are several client types with distinct needs that are important to recognise. These client types include females, child offenders (<13 years), young care and protection children (≤ 12 years), and those with significant trauma and neglect histories. We discuss the demographics, characteristics and needs of these client types below. In Chapters Fourteen and Sixteen we discuss research and the best practice literature regarding how to best meet the needs of these care and protection client types.

1.3.1 Females

From F2010 to F2014, 45% of young people in care and protection secure residences were female. There is limited information regarding the differing demographics, characteristics, and needs between males and females in care and protection secure residences in New Zealand and international jurisdictions. At the time of this review, the only information known to the reviewers regarding characteristics of the female population in New Zealand CYF residences was from a file review of 37 girls in youth justice and care and protection residences as at 1 July 2012 (Alliston, 2012). Data indicated 43% of these females in secure CYF residences had engaged in prostitution, 40% in sexual behaviour with multiple partners, 35% had previously or were currently displaying sexualised behaviour/language, and 11% had engaged in harmful sexual behaviour (Alliston, 2012).

Internationally, Handwerk et al. (2006) examined gender differences in a large-scale study among adolescents in residential care ($n = 2,067$). Handwerk et al. (2006) found that young females typically

exhibited more behavioural and emotional problems, had more psychiatric diagnoses at admission, and more in-programme problem behaviour than males. In addition, comparative to males, females exhibited more internalising problems, and at admission had higher rates of depression, suicide threats and attempts, self-injurious behaviour, histories of sexual abuse, and eating disorders (Handwerk et al., 2006).

1.3.2 Child Offenders: Crossover between the Care and Protection and Youth Justice Populations

‘Crossover youth’ can be defined generally as children who move between child welfare and youth justice systems. This move between systems is typically due to the effects of childhood abuse and/or neglect which not only give rise to a need for care and protection, but also increase the risk of offending behaviour (Widom, 1989; Thornberry, 2008). This is especially so when young people within care and protection services lack a stable home or school environment, supportive relationships and adequate healthcare (Bilchik & Nash, 2008). Understandably, this subgroup of the care and protection population have more complex needs and require more intensive interventions if they are to avoid long-term involvement within both systems.

In New Zealand, young people aged between 10 and 13 years who have offended and are deemed to require placement in residential care may be admitted into a care and protection secure residence or placed in alternative settings, such as group homes or with specialist caregivers. However, those aged between 10 and 13 years who commit indictable offences (i.e., murder, manslaughter, rape, or serious arson) are detained in youth justice secure residences⁸. To the best of the reviewers’ knowledge, it is unclear what proportion of young people in care and protection secure residences have been detained in residence due to offending behaviour under this process. However, with regards to the more general reasons for admission to care and protection secure residences at 30 June 2012, 83% were admitted due to issues related to violence towards family/peers/public, 83% absconding, 57% alcohol and drug abuse, 43% harmful sexual behaviour, 30% offending behaviour, and 17% for other behavioural

and conduct problems (Hand & Tupai, 2015).

There is limited information available to fully understand the differing characteristics and needs between young people in care and protection secure residences that have and have not engaged in offending behaviour. This information is essential to help identify and further understand the needs of these young people, beyond the needs associated with their offending behaviour.

1.3.3 Young Care and Protection Children

Of the young people admitted to one of New Zealand’s care and protection secure residences in F2014, 58% were aged 13 and 14 years, 24% were aged 15 and 16 years, and 18% were aged 8 to 12 years. There is limited information regarding the differing demographics, characteristics and needs between children (i.e., < 13 years) and adolescents (i.e., 13 years and older) placed in New Zealand care and protection secure residences. Therefore, although there are established developmental differences between children and adolescents that are important to acknowledge, any additional needs of these children is unknown. This information is essential to help identify and understand the needs of these young people and what factors may have contributed to their admission to a secure residence at a younger age.

One main concern regarding the needs of children and older adolescents is the mixing of these age groups in secure residences, resulting in a phenomenon referred to as the ‘peer contagion effect’. The peer contagion effect describes the process where delinquent adolescents influence one another, reinforcing each other’s behaviours (Dodge, Dishion & Lansford, 2006; Osgood & Briddle, 2006; Warr, 2002). In residence, younger children are exposed to adolescents who may be more aggressive and have more extensive offending histories.

1.3.4 Young People with Significant Childhood Maltreatment

As stated previously, a proportion of young people are placed in care and protection secure residences due to concerns regarding trauma, abuse and neglect. It is likely that a proportion of young people in these residences have significant trauma and maltreatment

⁸ Youth justice secure residences typically for young people aged between 14 and 16 years who have offended and are deemed to require detention in secure residential care.

histories. However, similar to the aforementioned client types in care and protection secure residences, there is limited information available to understand the unique characteristics and needs of young people in care and protection secure residences who have significant maltreatment histories. This information is essential to help identify and further understand the needs of these young people, and subsequently implement best practice guidelines regarding effective intervention and care and management.

Young people with trauma and victimisation histories, including those in residential treatment settings, are found to have complex presentations, including a high prevalence of psychiatric and behavioural issues, and complex trauma (see Zelechowski, Sharma, Beserra, Miguel, DeMarco and Spinazzola (2013) for an overview). Literature indicates that those with more extensive trauma histories have more complicated residential treatment needs (Boyer et al., 2009), such as psychiatric and behavioural difficulties. In addition, aspects of the residential environment may ‘trigger’ these young people, including being around other young people who also have maltreatment histories.

1.3.5 Disability

It is unknown what proportion of young people in care and protection secure residential care have some form of disability. However, those who are identified as having some form of disability, whether physical, cognitive, sensory, emotional, and/or developmental, have needs that should be identified so appropriate supports can be provided for these young people.

The reviewers of this report acknowledge the importance of meeting the needs of young people in care and protection secure residences who have disabilities. Providing services for young people with disabilities is a specialist area, and as such, the reviewers feel that it is beyond the scope of the report to adequately and comprehensively cover this area.

1.3.6 Ethnicity and Culture

Māori are significantly over-represented in the care and protection population, and comprise 57% of those admitted to care and protection secure residential care in New Zealand. The cultural needs of rangatahi Māori and how these needs can be addressed in residential care are outlined in Chapter Ten.

Summary

The care and protection population in secure residential care constitute some of the most disadvantaged and vulnerable young people in New Zealand, and present with a range of complex needs. Difficulties prevalent among this population span physical health, mental health and behaviour, substance abuse, extensive abuse histories, and education. There are also specific subgroups within this population who may be considered more vulnerable and at-risk for negative outcomes, including females, child offenders (<13 years), young care and protection children (≤ 12 years), and those with significant trauma and neglect histories. However, having full understanding of the needs of the general New Zealand care and protection population and protection population in secure residential care and these subgroups is limited due to the lack of aggregated data concerning the characteristics of these young people. It is essential that this information is gathered in order to understand the needs of these young people.

The differing levels of need present among these young people in secure residential care, as well as the wide range of risk and protective factors, must be taken into consideration for the care and management of these young people in order to provide them with the greatest chance of successful outcome.

Chapter 2: The New Zealand Care and Protection System

To understand the context in which care and protection secure residences exist, an understanding of the New Zealand care and protection system and governing legislative and regulatory framework for these residences is required. This chapter will provide an overview of the care and protection system in which care and protection secure residences operate.

Please note that the following is a brief overview of the main legislation in New Zealand concerning the care and protection population, and does not aim to provide an in-depth discussion of the intricacies and complexities that exist within the care and protection system.

2.1 Overview and Legislation

In New Zealand, the care and protection system is guided by several pieces of legislation, including the Adoption Act 1955, the Adult Adoption Information Act 1985, the Adoption (Inter-Country) Act 1985, the Care of Children Act 2004 (which replaced the Guardianship Act 1968 in 2005), and primarily the Children, Young Person's and their Families (CYPF) Act 1989.

The CYPF Act applies to children and young people from birth to their 17th birthday. The CYPF Act is legislation relating to children and young persons who are in need of care and protection, or who offend against the law. The Act is based on the philosophy that the safety and well-being of children and young people is paramount. In particular, the Act outlines procedures that aim to:

- a. Advance the wellbeing of children and young people as members of families, whānau, hapu, iwi, and family groups.
- b. Make provision for families to receive assistance in caring for their children and young people.
- c. Make provision for matters relating to children and young people's care and protection needs or to resolve issues of those who have offended wherever possible by their own whānau.

2.1.1 The Vulnerable Children Act 2014

The Vulnerable Children Act 2014 forms a significant part of a number of measures implemented in order to help protect vulnerable children, improve their well-being, and give them the best possible chance of thriving. The Act enables the responsible Minister, in consultation with children's Ministers, to set government priorities for improving the well-being of vulnerable children, and makes the heads of children's agencies (currently defined

as the NZ Police and the Ministries of Health, Education, Justice and Social Development) accountable for the Vulnerable Children's Plan to advance these priorities. It also states that child protection policies must be adopted as standard by District Health Boards, school Boards of Trustees, a range of government agencies, and other entities or individuals, including some non-government organisations, as prescribed by regulations.

The legislation also includes amendments to the CYPF Act 1989 (i.e., the Children, Young Persons and their Families (Vulnerable Children) Amendment Act 2014) and the KiwiSaver Act 2006. Changes to the legislation included:

- Parents who seriously abuse or kill children have to prove they are safe to parent if they go on to have another child.
- Courts can curtail and define guardianship rights of birth parents in extreme cases.
- Children removed from parents due to severe abuse and neglect can be placed with CYF home for life carers.
- Changes will also stop those who seek to destabilise new homes with Court proceedings which may disrupt care and threaten a child's wellbeing.

2.1.2 Roles, Functions and Responsibilities of Child, Youth and Family

Child, Youth and Family (CYF) is a service line of the Ministry of Social Development, a New Zealand government department and part of the New Zealand public service. CYF is primarily guided by the Children, Young Persons and their Families Act 1989. CYF's core functions are to:

- Protect children and young people who are at risk of, or have been, abused or neglected. This includes care placements and services for children and young people who can no longer live with their parents, and
- Work with young people to manage offending behaviour and reduce re-offending.

CYF has a central role in the management and provision of services for the care and protection population. For many children and young people in care, this means placement with extended family/whānau, or placement with non-family/whānau (i.e., non-kin care). For children and young people with very high needs, such services may include residential placement in one of four care and protection secure residences in New Zealand (see Chapter Three), CYF Group Homes (e.g., Family Homes, Supervised Group Homes, and the Teaching Family Model (TFM; see Chapter Seven, Section 7.2), and services under the Youth Services Strategies, which includes one-to-one specialist caregiver and therapeutic services (e.g., Multi-dimensional Treatment Foster Care, MTFC; see Chapter Seven, Section 7.3). CYF also contracts Barnardos New Zealand, a non-government provider, to operate the Te Poutama Ārahi Rangatahi (TPAR) residence for high-risk adolescents with harmful sexual behaviours (HSB). Further information about TPAR can be found at www.barnardos.org.nz/service/specialist-family-group-homes and Hand and Tupai (2015).

CYF's role involves working with wider justice and social services, as well as recognising the needs and aspirations of Māori with respect to the principles of the Treaty of Waitangi (i.e., protection, participation and partnership) and those of Pacific communities.

The responsibilities of CYF include:

- Receiving, assessing and investigating reports of child abuse and/or neglect.
- Taking emergency action when necessary to ensure the safety of children and young people.
- Receiving referrals from Police about children and young people who have committed offences.
- Coordinating Family Group Conferences (FGC) for both care and protection and youth justice clients as part of addressing issues and planning the prevention of re-occurrence of abuse, neglect or offending.
- Working to implement FGC plans and Court orders.
- Providing of services that children, young people and their families need to address their issues and improve wellbeing.

- Providing care services for children and young people in the custody of the Chief Executive, including residential services when required.
- Providing advice, research, evaluation and development of operational policies relating to services for children, young people, families, and communities.
- Assessing people who wish to adopt children and young people, and facilitating the exchange of identifying information for parties to past adoptions.
- Undertaking action as directed by the Courts, particularly the Family and Youth Courts.

Summary

The CYPF Act governs the New Zealand care and protection system, which emphasises the safety and well-being of children and young people being paramount. The Vulnerable Children Act 2014 outlines changes, including the accountability of five government departments in the protection and improvement of the lives of vulnerable children, to promote a better life for these young people. CYF are largely responsible for the management and provision of services for the care and protection population, including those residing in one of the four care and protection secure residences in New Zealand. These secure care and protection residences are discussed in further detail in Chapter Three.

Chapter 3: Care and Protection Secure Residential Care in New Zealand

The previous chapter provided an overview of the New Zealand care and protection system in which care and protection secure residences exist. In this chapter, an overview of the current care and protection secure residences in New Zealand is provided. Here, the residential care regulations, the agencies which provide services to young people in secure residential care and what these services and programmes involve is described. In addition, an overview of residential facilities in New Zealand for other high needs populations of young people in New Zealand is provided.

For the purpose of this review, these care and protection residences are referred to as “care and protection secure residences” to distinguish between these and other non-secure residences operating in the continuum of care for the care and protection population (e.g., specialist group homes).

3.1 Care and Protection Secure Residences in New Zealand

Care and protection secure residences sit within a larger continuum of care which provides specialist care services to young people in New Zealand who have a high level of needs and are not able to be maintained within their family/whānau. The objectives of practice for the care and protection population are to deliver high-quality services for the children and young people in the custody of the Chief Executive of CYF in a safe and humane environment, and in a culturally appropriate manner. The ultimate goal is to address their needs and make positive changes to the young people’s lives and relationships in order to assist with their reintegration to their family/whānau, hapu, iwi and other groups responsible for their ongoing wellbeing.

The care and protection continuum of care includes family/whānau care, non-whānau (or foster) care, and a range of more intensive care options. These more intensive options include the Youth Services Strategy (YSS), which comprises one-to-one specialist services (e.g., MTFC and TFM), foster care placements with wraparound programmes for those with intellectual disabilities, specialist group homes for conduct disorder and harmful sexual behaviours provided by non-governmental organisations (NGOs), programmes including Multisystemic Therapy (see Chapter Seven, Section 7.1) and Functional Family Therapy (see AGCP 2011, 2013), and Te Poutama Ārahi Rangatahi (TPAR). The care and protection continuum of care also includes four

CYF Family Home Plus pilot services, four Supervised Group Homes, and four care and protection secure residences. Admission to YSS services occur through the CYF national high needs service ‘hub’, admission to CYF Supervised Group Homes is determined by the local Residence Manager, and admission to the CYF Family Home Plus pilot services occur through CYF regional operations.

Secure care and protection residences are staffed facilities that provide 24-hour care and custody. The purpose of these residences, within the larger continuum of care, is to address acute care and protection needs when it is determined that other care alternatives within the community or family/whānau are inadequate or inappropriate. In New Zealand there are a total of four care and protection residences; two facilities in the North Island and two in the South Island. Of these, three are secure (i.e., secure doors and windows with perimeter fencing) and one is less secure (i.e., secure doors and windows but no perimeter fencing). These facilities include: Whakatakopokai, Auckland (20 beds), Epuni, Lower Hutt (10 beds), Te Oranga, Christchurch (10 beds) and Puketai, Dunedin (8 beds). In total, these residences provide 48 beds nationally. The annual operating budget for secure care and protection residences in New Zealand is around \$14 million.

Admission into care and protection secure residences occur through the CYF national high needs service ‘hub’, and all young people must be under the care, custody or guardianship of the Chief Executive of the Ministry of Social Development. The majority of admissions to care and protection residences are currently emergency admissions. The two most common legal statuses of young people admitted to care and protection secure residences in New Zealand are s101 (custody order) and s78 (custody of child or young person pending determination of proceedings). As noted previously, 73% of those admitted to a care and protection secure residence between F2010 and F2014 had s101 orders.

Children, Young Persons, and Their Families (Residential Care) Regulations (1996)

In addition to the legislation outlined in Chapter Two, the services provided by care and protection secure residences are guided by the Children, Young Persons, and Their Families (Residential Care) Regulations (1996). These regulations outline the rights of children and young people in residences, specifically relating to:

- The limitations on punishment and discipline.
- The management and inspection of residences.
- The boundaries of searches and inspections.
- Purposes and conditions of secure care (contact with others, meals, provided activities).
- What kinds of records that can be kept.

Information regarding the four care and protection secure residences in New Zealand, based on information outlined in each residence's visitor's pack, is displayed in Table 1.

Table 1. Characteristics of and Services Provided by Youth Justice Secure Residences

Residence	# of beds	# of units	Staffing	Assessment and case planning services	Health services	Education services	Residential programmes
Epuni Residence, Lower Hutt.	10 beds.	One unit. Mixed gender. One secure care unit. ⁹	49 FTE ¹⁰	Assessment of welfare, health and education needs. Risk screening including suicide ideation, alcohol and drug issues, psychological distress and mental health issues. Individual Care Plans for each client. May include behaviour management plans. Specialist assessments as required, eg, psychological assessment. Transition planning from residence to community. Multi-agency teams support assessment and planning processes (comprising CYF residence and local site staff, education and health services, and community-based mental health services).	Primary health care services ¹¹ provided on-site by a general practitioner and nurses. Currently provided by Vibe Health Service, Hutt Valley. Specialist mental health services provided by Infant, Children, Adolescent and Family Service (ICAFS), Hutt Valley District Health Board. Additional health services funded by CYF on a case-by-case basis. These may include medications, eye tests, glasses and orthodontic treatment.	Education services provided on-site by Central Regional Health School, a specialist state school funded by the Ministry of Education. Literacy and numeracy programmes cater for the varying learning levels of the young people. Programmes support more senior students to gain national qualifications. Some young people may attend local schools where this is part of their individual care plan.	A wide range of educational, therapeutic, cultural and recreational programmes are provided by residence staff and community organisations. Programmes include therapeutic services (eg, counselling), life skills, cultural programmes, physical health and activity, sports, arts and music, understanding one's rights.
Whakatakapokai Residence, Auckland.	20 beds	Two units. Mixed gender. One secure care unit.	55 FTE	As above.	As above. Primary health care services provided by Raukura Hauora o Tainui. Specialist mental health services provided by Taiohi Tu Taiohi Ora, Auckland District Health Board.	Education services provided on-site by Creative Learning Scheme, a contracted alternative education provider funded by the Ministry of Education. As above.	As above.

9 Each residence has a secure care unit, which is referred to as 'secure care' under Section 367 of the Children, Young Persons and their Families Act 1989. Secure care is used as a last resort when a young person is at high risk of harming themselves or others, or of absconding. A young person may only be held in secure care for 24 hours unless otherwise ordered by the court and then only for a maximum of 72 hours.

10 Staffing full-time equivalents as at 30 November 2015.

11 See Ministry of Health, Health Services for Children and Young People in Child Youth and Family (CYF) Care and Protection and Youth Justice Residences, Tier Level Two Service Specification, 22 September 2015, <http://nsf.health.govt.nz/service-specifications/current-service-specifications/child-health-service-specifications>.

Residence	# of beds	# of units	Staffing	Assessment and case planning services	Health services	Education services	Residential programmes
Te Oranga Residence, Christchurch	10 beds	One unit. Mixed gender. One secure care unit.	3.1 FTE		As above. Primary health care services provided by Pegasus Health. Specialist mental health services provided by Child, Adolescent and Family Mental Health Services (CAMHS), Canterbury District Health Board.	Education services provided on-site by Kingslea School, a specialist state school funded by the Ministry of Education.	As above.
Puketai Residence, Dunedin.	8 beds	One unit. Mixed gender. One secure care unit.	2.3 FTE		As above. Primary health care services provided by Musselburgh Medical Centre. Specialist mental health services provided by CAMHS Southland District Health Board. Occupational therapy services for five hours per week.	Education services provided on-site by Kingslea School.	As above.

3.1.1 Services Provided

An overview of the services provided by care and protection secure residences in New Zealand is provided below.

Assessment framework

Tuituia is the assessment framework used by CYF. The *Tuituia* framework reflects Māori perspectives of wellbeing, ensuring responsible practice for children and young people, many of whom are Māori. The aims of the framework are to ensure that young people are safe, feel as though they belong, and are healthy, achieving, and participating. *Tuituia* offers a holistic view of the child/young person, recording areas of need, strength and risk for the child/young person and their parents/caregivers that can then be shared throughout CYF care and protection, youth justice, residential and high needs services. The *Tuituia* assessment is used from intake to discharge, informing the intervention plan, placement decisions and ongoing work with the child/young person, their family/whānau, caregivers and other agencies.

The depth and breadth of a *Tuituia* assessment will vary for a child or young person depending on the nature of the concerns, purpose of engagement and the specific circumstances of each child/young person.

The *Tuituia* assessment covers three dimensions: *Mokopuna Ora*, *Kaitiaki Mokopuna* and *Te Ao Hurihuri*. *Mokopuna Ora* involves examining the holistic wellbeing of the child/young person, with specific regard to attachments and the degree to which these provide safety and security for the child/young person, health (both emotional and physical), identity and culture, behaviour, friendships and education.

Kaitiaki Mokopuna explores the capacity of the parents/caregivers of the child/young person to undertake the roles, responsibilities and obligations required to nurture and develop the wellbeing of their child/young person and looks specifically at factors impacting on safe parenting (e.g., their mental and physical wellbeing), safe and basic care for their child/young person, their relationship with the child/young person, skill and knowledge regarding how to parent/care for their child/young person, and guidance and supervision given to the child.

Te Ao Hurihuri examines the family/whānau, social, cultural and environmental influences surrounding the child or young person, with specific regard to the availability of networks of support and physical resources (e.g., housing and income), as well as family/whānau/hapu/iwi and wider connectedness of the child/young person and their family. Each dimension and sub-dimension within is scaled, with a high score indicating strengths and protective factors and a low score indicating greater need and highest concern. The scales are used to measure progress and show change over time for practitioners as well as the child/young person and their family/whānau.

While the overarching *Tuituia* framework is the same for all children/young people, assessment is tailored to the particular circumstances of each child/young person and what has brought them to the attention of CYF. Assessment involves asking why CYF are involved and what the current worries are related to the child/young person. Specific descriptors are available to assess those under the age of 5 years. Assessments completed by other professionals, for example health and education, Gateway, and psychological/psychiatric/cognitive assessments, are also used to inform the *Tuituia* final report.

The *Tuituia* final report is completed and kept as a formal record to be used as the assessment summary when completing a child and family assessment or investigation, a report to a family group conference or Court, or when a social work assessment is required.

More information regarding the *Tuituia* assessment framework can be found on the CYF website at: www.practicecentre.cyf.govt.nz/policy/assessment-and-decision-making/resources/the-tuituia-assessment-framework-guidelines.html.

Health

As shown in Table 1, primary health care services are provided on-site at residences by District Health Board (DHB) contracted providers. Mental health services are provided by Child, Adolescent and Family Mental Health Services (CAMHS) or Infant, Child, Adolescent and Family Services (ICAFS) of District Health Boards (DHBs). Additional health services are funded by CYF on a case-by-case basis, which may include medications, eye tests, glasses and orthodontic treatment.

Education

There are three education providers across New Zealand who deliver education services for young people in care and protection secure residences. Creative Learning Scheme provides services for the Whakatakapokai care and protection residence in Auckland, Central Regional Health School provides the education services for Epuni care and protection residence in Lower Hutt, and Kingslea School provides education services for Te Oranga and Puketai care and protection residences in Christchurch and Dunedin respectively.

In the 2013 Education Review Office (ERO, 2013) report on the education services provided within the care and protection secure residences, it was concluded the quality of education across most of the schools was “not of a consistently high standard”, and that “the quality of education at the residential schools needs to be improved” (ERO, 2013, p. 9). Of the nine residential schools (including youth justice secure residences and Te Poutama Ārahi Rangatahi¹²) two schools were considered by ERO to be effective, four were considered somewhat effective, and three considered as being of limited effectiveness.

Key features of the two residential schools deemed to be effective were: the strong relationships between staff and students, well-developed curriculum, and good levels of cooperation between teachers and CYF. However, most residential schools were found to require either “moderate or significant improvements in the delivery of the curriculum, the planning and programme design for individual students, and the processes to transition students to further education, training, or employment” (ERO, 2013, p. 1).

As identified in the 2015 interim report of the Expert Advisory Panel¹³, among those born in 1990/91, by the age of 22 years those who had some form of contact with CYF were more likely to have left school with few qualifications, and 80% of children and young people who were taken into CYF care left school with less than Level 2 NCEA qualifications (in contrast to 30% of young people who do not have contact with CYF for care and protection reasons).

Ethnicity and Culture

Given many young people in residences are Māori, it is necessary that culturally informed services are provided. Below, the bicultural framework used by CYF and Whānau Ora are briefly described.

Additional cultural models for the care and protection population are described in Chapter Ten.

CYF Indigenous and Bicultural Framework

The CYF Indigenous and Bicultural Framework establishes principled foundations for practice. The framework has eight guiding principles which are outlined briefly below. These are: *Te Reo Māori*, *Whakamanawa*, *Whakapapa*, *Kaitiakitanga*, *Manaakitanga*, *Tikanga*, *Rangatiratanga* and *Wairuatanga*.

Te Reo Māori is considered to be a life line to Māori culture and so the ability to use *Te Reo Māori* is central to engaging with Māori practice. *Te Reo* should be used throughout all dealings in a respectful and deliberate manner and practitioners need to at least have a working knowledge of commonly used Māori terms. Under the *Whakamanawa* principle, emancipation is based on potential that challenges and transforms oppression, and involves reinforcing the values and rights of Māori through participation and protection of cultural knowledge, practices and people.

The principle of *Whakapapa* involves displaying an active implementation of strong meaningful human connections, significant sites of engagement, and the value of relationships with the spiritual dimension. The principle of *Kaitiakitanga* is about roles, responsibilities and obligations to protect, support and sustain, and ensure that Māori participation is valued, advanced and promoted in a systematic, structured and sustainable way. The principle of *Manaakitanga* is about caring for, and giving service to enhance the mana of others, and involves identifying and enacting roles, responsibilities and obligations in advancing processes that recognise, care and strengthen mana in others. *Tikanga* is the diverse Māori processes that provide balance and stability, safety and integrity for all, and involves championing the voices and aspirations of whānau through modelling and leading the use of diverse Māori cultural practices.

¹² Te Poutama Ārahi Rangatahi is a specialist residential treatment facility for young men aged between 12-17 years who have engaged in harmful sexual behaviour located in Christchurch, and contracted to Barnardos by Child, Youth and Family and the Ministry of Education.

¹³ See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

The principle of *Rangatiratanga* is about the distinctive uniqueness of Māori leadership styles and involves using diverse Māori leadership to validate and legitimate inclusive cultural and communal responsiveness. The principle of *Wairuatanga* is about the implicit presence of Māori values, intuitive knowing and critical conceptual thinking, and involves grounding all activities that engage with Māori in Māori values, beliefs, theories, ideologies, paradigms, frameworks, perspectives and worldviews.

Whānau Ora

Māori-centred frameworks and initiatives have been developed in New Zealand to enhance the wellbeing and development of Māori. One such framework is Whānau Ora, a whānau-centred approach to Māori wellbeing that aims to empower families. Established in 2009, the Whānau Ora Taskforce developed a framework which requires Government agencies to work with families, rather than separate individual family members. More information regarding Whānau Ora can be found on the Ministry of Social Development's website at: www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whanau-ora.

Transition planning

Effective transition planning ensures positive and supportive reintegration back into the community, and provides young people with feelings of certainty and control over their future, increasing the likelihood of successful long-term outcomes. The aims of transition planning are to provide seamless transition from residential care to community care and to ultimately reduce the likelihood of readmission to a residence.

At the heart of successful transition planning is ongoing communication between the social worker and the residential case leader. The young person's family/whānau should also be included in the development of the plan, and should be provided with support and strategies to sustain change in behaviour. This may involve identifying and resolving issues in the home environment before the young person returns home. A transition plan will outline how transition phases will be prepared and managed for the young person, including where the young person will live (a stable placement option must be secured to ensure a positive transition and outcome), how the transition from residence to a home environment will be managed, any proposed familiarisation visits for the young person in preparation for transition, education, training or employment

(supporting what the young person has been doing in residence), and the continuation and/or initiation of rehabilitation/intervention services. In addition, the transition plan outlines the support required for the young person to complete the plan, support required by parents/caregivers, key contacts in the community, roles and responsibilities of any community providers post-residence, identification of a key support person (this may be the social worker), identification of who will set up initial appointments for the young person, details of agreed post-transition contact with residential staff, consideration of back-up options, and the objectives of the plan.

No later than two weeks prior to the transition date, the residential case leader, in consultation with the social worker, organises a pre-transition meeting. The purposes of the pre-transition meeting are to update on progress to date and to discuss and plan the young person's transition from residence to community. The pre-transition meeting finalises the arrangements for a key person from the community to build a working rapport with the young person during the residential phase. The social worker ensures the participation of key family/whānau members and significant others at the meeting and provides information about any service providers that will be involved with the young person after transition and, if required, ensures their participation at the meeting. The residential case leader ensures that all relevant information regarding the young person's time in residence is compiled and available for the meeting.

If the young person is to be placed in a supervised group home post-residence, the placement should ideally be near the young person's home and community, and a staff member from the group home should be invited to the pre-transition meeting.

Two weeks after the young person has been transitioned from residence, a post-transition meeting is held with the aim of checking that the plan is on track and risk factors are being managed. Those who should attend include the young person, family/whānau, the young person's key person, social worker, supervisor, residential staff member, and any additional key providers.

Further information regarding transition and aftercare is also outlined in Chapter Fourteen.

Restraint models

The care and protection secure residences in New Zealand use the Non-Violence Crisis Intervention (NVCi) model (see Chapter Twelve, Section 12.1 for an overview). NVCi is an international licenced de-escalation and physical intervention methodology which emphasises behaviour de-escalation and includes non-harmful physical restraints for use in extreme situations. CYF is currently strengthening the NVCi training for residential staff, and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Section 12.2 for an overview), an alternative to NVCi that is used in Australia, is to be looked into.

3.1.2 Outcomes and Evaluations

There appears to have been no evaluation reports conducted measuring the outcomes of young people post-discharge from care and protection secure residential care. However, monthly CYF governance reports, Office of the Chief Social Worker assessments, residence regulatory inspection reports, Office of Children's Commissioner (OCC) reports, and the Education Review Office (ERO) provide some indicators of performance regarding the care and protection and youth justice secure residences in New Zealand. An overview of ERO's 2013 report is outlined in Chapter Three, as well as education outcomes identified by the interim report of the Expert Advisory Panel. Here, a summary is provided of the OCC's *State of Care 2015* report, outcomes presented by the interim report of the Expert Advisory Panel, and the Office of the Chief Social Worker CYF residential care regulatory inspection reports.

Office of the Children's Commissioner's *State of Care 2015* report¹⁴

The Office of the Children's Commissioner's *State of Care 2015* report was a publicly published report on the findings from their independent monitoring of CYF in 2014-15. The report outlined a number of key findings. A brief summary of these findings is provided below.

Key Findings

Consistency

Although CYF was generally found to be good at keeping children safe from immediate risk of abuse and neglect and some sites and residences were found to meet or exceed expectations, overall CYF practice was not found to be consistent. Inconsistency with regard to "vision and direction, variable social work and care practice, and insufficient priority given to cultural capability" were found, with "a core issue with workforce capacity and capability" seen to be underpinning this (p.5).

Children at the Centre

It was also found that CYF does not put children at the centre of everything it does and while some children do report positive experiences with CYF, a number report negative and harmful experiences. The report observed that typically, "the longer a child spends in CYF care, the more likely they are to experience harmful negative consequences" (p. 5).

Outcomes of Children in the Care System

Due to a lack of reliable or easily accessible data on the outcomes of children in the care system, it is not clear whether children are better off as a result of state intervention; however what is available regarding "health, education and justice outcomes is concerning" (p. 5). The OCC noted that better collection and analysis of data is essential for CYF to improve its services and for the Government and the public to have confidence in CYF and other state agencies' ability to improve outcomes for vulnerable children.

Focus on Keeping Children Safe, not on Improving their Long-term Outcomes

The OCC report found that CYF focuses more on keeping children safe and less on improving their long term-outcomes. This observation was based on their monitoring findings, which found "strong intake and assessment practices in most of the CYF sites we monitored, but poor case management and oversight of young people in specialist care placements" (p. 6).

¹⁴ This report includes aggregate ratings for four youth justice residences and two care and protection residences. See: <http://www.occ.org.nz/our-work/state-of-care/>

Recurring Themes

Recurring themes in the OCC’s monitoring included that local planning is inconsistent, leading to a lack of clear purpose and direction in many sites and residences; cultural capability is not given sufficient priority; CYF’s partnerships and networks with external stakeholders need strengthening; and the quality of social work practice is inconsistent. Finally, the OCC report stated that the capacity for CYF to improve outcomes among children in care is constrained by the following: “limited resources, high caseloads, the organisation’s current KPIs which focus on timeliness of front-end work and not on-going support of care placements, and the need to invest in training across the organisation to develop a workforce with the appropriate skillset” (p. 33). In addition, issues consistently raised during visits concerned workforce capability, recruitment, training and retention.

The Voices and Experiences of Children

Across both care and protection and youth justice systems, children tended to state that they wanted:

- To be told what to expect and what they are entitled to;
- That the people taking care of them (including caregivers, care staff in residences, and CYF social workers) will be qualified for the job, keep them safe, and treat them with care and respect;
- To be supported to maintain positive relationships with their birth family/whānau;
- To have the number of movements between placements that they have to make kept to a minimum; and
- To have a say in decisions about their own care, and for their voice to be listened to.

Children also reported experiencing a high level of uncertainty about planning for transition out of residential care, and little say in decisions around this. Overall “the feedback from the children suggests a system that is not centred on their needs, and does not fully take into account the potential negative consequences of many actions on these children” (p. 38).

Recommendations

The OCC made a total of 53 recommendations for the improvement of services provided by CYF to help promote positive outcomes for these children. The recommendations were aligned with key themes, and were grouped into nine categories: Clarity of purpose, direction, and strategy (nine recommendations), ensuring child-centred practice (eleven recommendations), improving the quality of social work practice across all types of care placement (nine recommendations), building workforce capacity and capability (eight recommendations), building cultural capability (five recommendations), improving integration of services between CYF and other agencies (three recommendations) strengthening partnerships and networks (four recommendations), improving the physical environment in residences (two recommendations), and other recommendations relating to operational systems and processes (eleven recommendations).

The OCC also made seven aggregated, future-oriented recommendations to address current shortcomings and improve children’s outcomes:

1. Set clear expectations about CYF’s core purpose and the outcomes it needs to achieve;
2. Ensure CYF is fully child-centred in all its activities;
3. Invest more in on-going support for children in all types of care placements;
4. Address capacity and capability issues across the CYF workforce;
5. Improve cultural capability across the organisation;
6. Collect and analyse relevant data to drive improved outcomes for children; and
7. Set clear expectations for other state agencies responsible for improving the outcomes of children in care.

Interim Report of the Expert Advisory Panel

In 2015, the Expert Advisory Panel released an interim report¹⁵ outlining their initial assessment of the issues and future opportunities for Child, Youth and Family. A brief summary of their key findings is provided below.

15 See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

Hearing the Voices of Children and Young People

A small group of young people were interviewed about their experiences in the care and protection system. Main themes from this research were:

- We need more nurturing and love
- We want a say in what happens to us
- We have experienced trauma and need help to make sense of what has happened to us
- We crave belonging and being part of a family who bring out the best in us
- We want to strengthen our cultural identity and connection
- We do not stop needing help, support and nurturing just because we turn 17 years old.

Principles

The Panel agreed upon a set of principles¹⁶ to guide their assessment of the current system and consideration of options for the future system. These principles aim to:

1. Place the child or young person at the centre of what we do
2. Support families to care for their children
3. Use evidence-based approaches to get the best results
4. Support the connection of all children, including Māori children, to their family, cultures and communities
5. Have the same high level of aspiration for vulnerable children as we do for all other New Zealand children
6. Help all New Zealanders to make a difference for vulnerable people.

Performance of the Current Operating Model

The Panel outlined a number of issues with the current CYF system:

- “The current operating model places a high priority on completion of tasks with narrow responsibility and accountability within and between agencies. Decision-making tends to be focused on managing immediate risk and containing short term costs. This

focus has come at the expense of the prevention of re-victimisation, remediation of harm and supporting long term outcomes” (p.10)

- The system is fragmented and lacks common purpose and clear accountabilities
- The system does not place children at the centre
- The system does not reflect a high level of aspiration for vulnerable children
- New Zealanders are not actively engaged in making a difference for vulnerable children
- The system is not effective in supporting families and whānau to care for their children
- The system does not focus on providing earliest opportunities for a loving and stable family
- There is insufficient focus on the recruitment, support and retention of caregivers who are vital to provision of loving and stable families
- There is a lack of evidence-based approaches to achieve results
- The workforce lacks the capabilities and capacity to meet increasingly complex needs of the children and families
- There is more work to do on supporting the connection of children to their cultures and communities
- Vulnerable young people need and deserve far more support to make a successful transition to adulthood.

Life Outcomes

A number of poor life outcomes among children and young people who have contact with CYF were identified by the interim report. Among children born in 1990/91, by age 22 those who had some form of contact with CYF were more likely to have:

- Left school with few qualifications
- Been in receipt of a main benefit (nearly 9 out of 10 of those who had experienced State care were on a benefit by age 21)
- Been in receipt of a main benefit with a child

¹⁶ These principles were condensed from the 27 distinct principles outlined in sections 5, 6, 13 and 208 of the CYPF Act.

¹⁷ Insights MSD. (2014). Outcomes for Children in Care: Initial data-match between Child, Youth and Family, the Ministry of Education and the Ministry of Health (unpublished).

- Been referred to CYF for youth justice reasons
- Received a community or custodial sentence in the adult corrections system.

Using initial data-matching between Child, Youth and Family, the Ministry of Education and the Ministry of Health (2014)¹⁷, compared to the rest of the population children in care have lower levels of public health organisation enrolment and high rates of use of mental health services.

Additional findings regarding education outcomes are provided in Section 3.1.1 in this Chapter.

Changes

In response to the aforementioned issues, the Panel outlined a set of important changes to be made in the design and operation of the care and protection and youth justice systems:

- A child-centred system (shift from being primarily centred on the services, processes and administrative convenience of the agencies, to bringing the voice of children, young people and their families to the forefront)
- An investment approach (shift from an event-driven and response-based approach to one focused on evidence and long-term results across the social sector)
- A professional practice framework (shift from a rules, compliance and timeframe-driven practice to professional judgement)
- Engaging all New Zealanders.

Residential Care Regulations - Inspection Reports

CYF's care and protection and youth justice secure residences are assessed each calendar year by the Office of the Chief Social Worker to ensure each residence is compliant with the Children, Young Persons and Their Families (Residential Care) Regulations 1996, and with section 384 of the CYPF Act 1989.¹⁸ In addition, each residence is assessed to ensure that it is providing safe, appropriate care for children and young people.

At the time of writing this report, the inspection reports for Epuni and Puketāi care and protection residences were publically available for the calendar year 2015

(March), while 2014 (April) and 2013 (December) reports were available for Te Oranga and Whakatakapokai care and protection residences respectively¹⁹. Each residence's areas of strength and improvement identified by the inspection reports are summarised below.

Epuni (2015)

Areas of strength

Epuni's areas of strength included having child-focussed processes to ensure young people acclimatised and transitioned into the residence positively, good access to advocates in the grievance process, and positive relationships with the education and health providers.

Areas for improvement

Epuni's areas for improvement included the management of young people with specific needs, increased understanding of the CYPF Act 1989 and the regulations in respect of Searches and Seizures to ensure compliance in this, improved management of secure care processes, greater clarity about the behaviour management programme for both staff and young people, consistency of approach when applying sanctions and approaches taken to manage young people's challenging behaviour involve no more than the minimum amount of physical intervention necessary, improvements in recording practice, and that every effort is made to re-establish the community liaison committee.

Whakatakapokai (2013)

Areas of strength

Whakatakapokai's areas of strength included having an effective clinical practice framework, an individual care planning process, effective staff management, a well-managed grievance process, an excellent standard of nutrition, a well-maintained admissions register, and an engaged community liaison committee.

Areas for improvement

Whakatakapokai's areas for improvement included the need to increase the participation of young people in education and training, ensuring that approaches taken to managing children and young people's challenging behaviour involved no more than the minimum amount of physical intervention necessary, and that the full range of options for managing this behaviour were utilised,

¹⁸ See: www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/residential-care-inspection-report/

¹⁹ *ibid.*

the management of secure care processes (including ensuring grounds existed for the confinement of young people to their rooms in the unit), and the detail of recording in the daily log and secure care register. In addition, areas for improvement also included ensuring consents for medication examinations and treatment were obtained and clearly documented, enhancing the training available to support staff in the management of young people with mental health diagnoses and demonstrating challenging behaviour, and further strengthening the compliance monitoring process.

Puketai (2015)

Areas of strength

Puketai's areas of strength included the provision of comprehensive health and education services, the effective compliance monitoring system, a proactive community liaison committee, a senior management team that provided strong leadership and clear direction to staff, medication administration, a wide range of programmes (including offsite activities), a standard of nutrition, and a well-maintained admission register, security, and emergency management plans/

Areas for improvement

Puketai's area for improvement concerned individual care plans not containing all the relevant detail.

Te Oranga (2014)

Areas of strength

Te Oranga's areas of strength included well-developed plans for young people in secure care, good recording of daily reviews for the young people in secure care, good access to health support, a comprehensive grievance process in place with strong approaches from management to ensure the young people's voices were heard, and well-maintained medication records that were overseen.

Areas for improvement

Te Oranga's areas for improvement included ensuring that daily log recording is strengthened and meets all of the requirements of the regulations, ensuring young people always have access to regular social, recreational, sporting and cultural activities for at least two hours each day, and strengthening the recording of details in the admission and secure care registers, and ensuring that all records are kept confidential.

In addition, areas for improvement also included the management of secure care processes including ensuring all reviews are completed in a timely manner and that a range of planned, purposeful and varied activities are provided for young people, ensuring that daily log recording is strengthened and meets all of the requirements of the regulations, and strengthening of the compliance monitoring and reporting system to ensure that areas of non-compliance are addressed in a timely manner.

3.2 Additional programmes

Here, the Intensive Wraparound Service, an addition programme available for young people residing in CYF secure residences, is described.

3.2.1 Intensive Wraparound Service

The Intensive Wraparound Service (IWS) is run by the Ministry of Education and provides a range of intensive support services for young people from years 3 to 10 with highly complex and changing behaviour, and social or educational needs, including those with an intellectual impairment. A young person may be referred to IWS through special education staff or a Resource Teacher Learning and Behaviour (RTLB). The aim of IWS is to support children and young people to learn new skills and ways of behaving, stay at or return to their local school, behave in a positive and social way, and enjoy a successful home and school life.

Once referred, each young person is assessed by a psychologist. An individualised plan is then developed in conjunction with the young person, their family/whānau, school staff, and/or any other agencies also involved with the young person (e.g., CYF). This plan may include management strategies, resources for the classroom to provide support for the young person, professional development and training for the young person's teacher, and/or the young person being admitted to a residential special school. An overview of these residential schools is provided in Section 3.3.2.

More information about IWS can be found on the Ministry of Education's website at: <http://www.education.govt.nz/school/student-support/special-education/intensive-wraparound-service-iws/>. More information regarding educational programmes for young people with significant conduct problems is outlined in Chapter Eleven.

3.3 Other Residential Services for Young People in New Zealand

While reviewing CYF secure residences, it is important to consider how other secure and non-secure residences for young people in New Zealand currently operate.

Here, the features of some key residences for children and young people are briefly described, although this is not intended to be an exhaustive list. These residences are: the new youth forensic mental health unit; the Ministry of Education's residential special schools; Barnardos' specialist group homes and secure residence for young men with harmful sexual behaviours; Spectrum Care's residential homes and respite services for those with an intellectual disability and/or autism spectrum disorder; Hohepa Trust's residential services for children and youth adults with an intellectual disability; and the Ministry of Health's Disability Support Services' contracted residences for children and young people with disabilities.

3.3.1 Youth Forensic Mental Health Unit

A new 10 bed secure youth forensic unit is currently under construction, and will be opened at the end of April 2016. This unit will exist alongside the existing 8-bed national secure intellectual disability youth forensic unit and the 13 bed regional youth mental health unit. The aim is for the unit to have a strong link with youth justice secure residences and regional community-based youth forensic services.

This new youth forensic mental health unit is expected to cater for young people who are acutely unwell in residential services; however, the population of young people in secure residential care will still present with significantly complex needs.

Admission Criteria

Young people will be involved in the youth justice system, and require an in-patient admission for an acute episode of severe mental illness. Typically, these young people will be in a CYF youth justice secure residence on remand or on a Supervision with Residence order, hence the need for admission to a secure youth forensic unit rather than a generic youth mental health unit. They will meet criteria for and be detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992. On rare occasions they may be identified at the youth court by a youth court liaison clinician as requiring an immediate admission.

Further information regarding the access criteria can be found in the Nationwide Service Framework in the youth forensic service specifications at <http://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-services-specifications/youth>.

Length of stay

Due to the unit being under construction, there is no data on the average length of stay for the young people admitted to the unit. It is expected that the length of stay will be variable (ranging from a few days to a few months), with most staying for between two and six weeks.

Model of care

The unit will be a secure 10 bed hospital and be used for the assessment and treatment of acute episodes of mental illness. When the young people are deemed well enough, they will return to CYF care, with community youth forensic (i.e., RYFS, Hauora, Capital & Coast DHB, and Canterbury DHB) follow-up on site in the residence they transition to. A range of assessment and treatment services will be provided.

A detailed model of care document is in preparation by Capital & Coast DHB in consultation with regional youth forensic services around the country and the Ministry of Health.

Staffing

Staff will include a range of individuals across multiple disciplines, along with specialist Māori and Pasifika staff.

Type of clients and their needs

In addition to the information provided in 3.1.1, the youth forensic client cohort typically has complex needs that span the domains of social and youth justice services, education and health, including treatment for multiple co-existing mental health and Alcohol and other Drug (AoD) difficulties. The youth justice population typically have high levels of challenging behaviour and self-harm.

Tailored service provision requires high levels of interagency collaboration that extends beyond admission to include robust transitional arrangements, a secure and supportive place to live following their stay in the unit, and pro-social adults who provide trustworthy and on-going care and guidance to ensure pro-social development.

Intervention programme/s offered

The service will provide mental health and alcohol and drug treatment, and will involve families when possible and appropriate. Access to specialist assessment/programmes such as sexual offending will also be provided. The service will have a bi-cultural and therapeutic milieu and an on-site school and gymnasium.

The unit will not offer long-term therapeutic programmes. In many cases treatment may be commenced while the young person is in the unit, with follow-up post-discharge in residence by the specialist youth forensic team working on-site in the residence. It is expected that the involvement of youth forensic teams post-discharge will be more extensive than just monitoring, with involvement most weekdays. The community team will also arrange for the continuation of care by community CAMHS or other mental health teams when the young person leaves the residence.

Physical restraint

The unit will seek to reduce the use of physical restraint in accordance with mental health best practice guidelines on restraint minimisation, but details will be part of the CCDHB operating procedures.

Models of transition

Collaborative planning with CYF around stable post-residence placement during the transition stage will be essential so that a young person has a place to live that is stable, safe and prosocial.

3.3.2 Specialist Residential Schools

Within the education sector, three specialist residential schools exist: Salisbury School, Halswell Residential College, and Westbridge Residential School.

Salisbury School, Richmond

Salisbury School is a school for girls with challenging behaviours and intellectual disabilities. The school operates under its own Board of Trustees.

Halswell Residential College, Christchurch

Halswell is a school for boys with challenging behaviours and intellectual disabilities. The school is able to enrol up to five girls. It operates under a Combined Board of Trustees with Westbridge Residential School.

Westbridge Residential School, West Auckland

Westbridge is a co-educational school for students with challenging behaviours/conduct difficulties that are not related to an intellectual or other disability need. The school operates under a Combined Board of Trustees with Halswell Residential College. Westbridge caters to young people aged from approximately 8 to 14 years, with most young people aged between 9 and 11 years.

The actual enrolments at the schools over the last two years have been significantly below the notional rolls established for the schools. This discrepancy is due to the Intensive Wraparound Service (IWS) increasingly becoming the preferred service option and with prioritisation focussing on the most challenging young people.

Admission Criteria

Each residence provides services for students aged 10 to 14 years on entry.

Criteria for enrolment:

- The referral must demonstrate that all local service options and expertise have been assessed but the student's educational placement, community and family/whānau well-being is still at significant risk.
- Under section 9 of the Education Act, placement in a residential special school must occur through an agreement between the Secretary of Education (delegated to regional managers) and the student's family/whānau/guardians.
- A "home placement" must continue to be available for the student because students return home for school holidays. A residential special school is not an option when CYF or other agencies cannot find a home for a young person.

The referral process:

- Students are identified and prioritised within each of the four Ministry regions.
- The regional prioritisation panel (which is Ministry-led but involves principals and Resource Teachers: Learning and Behaviour cluster managers) ensure the student meets the criteria for IWS and then prioritises students on need and according to the number of spaces available in IWS.
- Students are referred through Resource Teachers: Learning and Behaviour or Ministry specialists.

- Referral is for the IWS, the practitioner making the referral must make a commitment to continued involvement with the students.
- Once accepted, the IWS psychologist develops a comprehensive plan for the student, and allocates funding to the student's school to implement the plan. The residential school will be considered as part of the three year intervention plan for the student or if the parent is requesting a residential school.

Length of stay

The average length of stay is twelve months (i.e., four school terms). This may be extended for one term if, for example, a student is due to leave in term four of the last year of primary school and intermediate. Therefore, transition may be deferred until the start of the following year.

Model of care

Residential special school placement is not a standalone intervention. Residential school placement is better regarded as an intervention option within the IWS service. It is expected that the residential school placement focuses on achieving specific goals outlined within the IWS plan. It is expected that the residential and school staff work together so that students experience consistency in approach and care.

Staffing

The schools have a teacher: student ratio of one teacher to five students, benchmarked against schools in CYF facilities, and based on the notional roll for the school. The principal has overall management and leadership. The manager of residential services and the day school senior teacher report to the principal. Halswell and Westbridge operate a combined ministerially appointed board. Salisbury has its own board. The IWS plan may fund some specific evidence-based interventions for a student or their family/whānau while the student is at the school.

Type of clients and their needs

Clients are girls and boys with challenging behaviours and intellectual disabilities, or young people with challenging behaviours/conduct difficulties that are not related to an intellectual or other disability need.

Intervention programme/s offered

All educational programmes are personalised through an Individual Education Plan. Personalised approaches and interventions occur as part of the IWS plan based on assessment and goals established through the assessment process. Positive participation programmes/experiences, and specific life skills teaching are also personalised through the education plan.

As noted above, the family/whānau/guardians may be offered interventions, such as parenting programmes, while the student is at the residential school. Holiday programmes are also planned to maintain the momentum of the programme beyond term-time.

Physical restraint

Time out/isolation is used in two schools and all staff are trained in Non-Violence Crisis Intervention (NVCi). At one school there is limited knowledge of their approach; however, the school adopts a restorative approach around incidents.

Models of transition

Transition is planned at the outset. The typical pathway if residential school placement occurs is:

- Referral to IWS
- Comprehensive assessment led by an IWS psychologist
- For some students, residential school is identified as part of the plan
- Residential school placement and transition to the school is based on the IWS plan. All parties agree on the key goals and programmes to be implemented while at the school
- IWS remains involved and monitors progress, and the residential school adapt plans as a response to progress made
- IWS leads transition back to home community/school and funds a plan for 12 months post-residential school placement
- The student transitions back to local community supports/services/school.

3.3.3 Barnardos

Barnardos operate a number of specialist group homes located in Auckland, Hamilton and Wellington, for boys aged 10 to 17 years who are in the care of CYF. Three of these group homes are specialist Harmful Sexual Behaviour (HSB) homes, where young males have engaged in any sexual behaviour that is of concern for the CYF social worker. There are a maximum of five boys in each home. Barnardos also operates Te Poutama Ārahi Rangatahi (TPAR), a secure 12-bed residence for male adolescents with high risk HSB.

Admission Criteria

Young males must meet the following admission criteria:

- Young males as defined in the CYPF Act aged 12 to 16 years. With approval of the CYF High and Complex Needs Team, Barnardos specialist group homes may accept young people aged 10 to 11 years old.
- Young males must be in the Custody of Child Youth and Family under an s101, s78, or s110 order. Other orders can be discussed with Barnardos.
- Young males must be attending therapy with SAFE, WELLSTOP or STOP and have a current assessment or report that includes a recommendation for the Barnardos Specialist Group Homes Programme.

Length of stay

The average length of stay at a Barnardos home for a young person is around 12-18 months. Length of stay can range from 6 months to 2.5 years. Length of stay depends on the client's progress at SAFE, and whether SAFE deem the young person to require long term or short term care.

Model of care

The model of care used in the home is Barnardos Journey model. The theoretical underpinning of the journey model combines social learning theory, trauma theory, and attachment theory with an emphasis on supporting therapy for HSB. The model has a cultural base derived from New Zealand's Te Whare Tapu Wha and Fono'fale models. Staff have ongoing training covering all of these areas to ensure informed and up-to-date practice.

The model and its practice is monitored and guided by our residential social workers. Each boy is matched with a journey coach in-house (youth worker). The journey coach works with the boys to set, achieve and review goals from a strengths based perspective. Goals range

from small house goals (e.g., making bed daily) to breaking down bigger goals set at their SAFE systems reviews (e.g., building trust with whānau).

A central component of therapy is the need for the boys to engage in 'normal' teenage activities. This enables them to demonstrate the new skills they are learning in a safe and monitored environment.

Staffing

Residential youth workers are well-established, with relatively low turnover over the last few years. Staff work a week-on and week-off system, working 80 hours in one week with seven sleepovers. Pay is commensurate with qualification, skill, experience and longevity. There are four full-time residential youth workers per residence, and a small pool of casuals who assist in covering any shifts. Sick leave is a rarity with this roster system.

Each residence has a qualified and experienced social worker who manages the day-to-day requirements and concerns of the clients. They liaise on a daily basis with clients, family/whānau, CYF, SAFE, schools and associated agencies, and are a critical component of the residence. They do not manage staff, but they direct staff on undertaking models of care and support them with key-working requirements. A team leader manages the residences and provides support and supervision to staff, and ensures the homes are visited and viewed several times a week.

Type of clients and their needs

The clients have all been referred by CYF through their local and/or national hub, and all have displayed some degree of HSB. Academically, a large percentage of clients are significantly behind their peers due to multiple placements, stand downs, exclusions and/or oppositional behaviours. Families are often fractured, unwilling, incapable or unable to cope with the boys' HSB and daily management. Many of the families have had CYF involvement for one or two generations.

Records indicate a higher proportion of Pākehā clients over the last 12 years. However, the ethnic breakdown of these young people needs to be considered in context with other factors, such as Māori and Pacific families preferring to have the young person undertake treatment from a safe extended family placement as an alternative to residence.

Education

Barnardos aims to build good relationships with local schools and alternative education programmes. Their residential social workers are pro-active in networking in this area, and maintain contact with a designated person within the education unit/ school to ensure all issues that arise are dealt with immediately and do not, where possible, escalate to unmanageable levels. This support is essential to ensure the boys are positively supported to help them stay in the education system.

Physical restraint

All staff are trained by Barnardos in Non-Violent Crisis Intervention (NVCi) and are required to hold a current certificate. Barnardos have an unwritten policy of 'no restraints' in their specialist family group homes which has been successfully applied over many years. This 'no restraint' policy supports the therapeutic ethos of the homes. Only in extreme circumstances would staff intervene for their or another client's safety. On rare occasions, Police have been called in for support.

Transition

Transition back to family post-residence is the preferred option, but is not always what occurs. For some young people, care to independence is more appropriate and others cannot be re-located back with whānau and have therefore ended up in unsuitable boarding homes in the community. Some young people have remained in boarding situations at schools. CYF hold responsibility to have an adequate transition plan in place, with Barnardos and SAFE assisting where possible. On some occasions, CTI services of Youth Horizons Trust and Dingwall are used for those located in Auckland. While it is acknowledged that CYF are faced with a lack of suitable placements post-residence, the transition planning for these young people could be improved.

3.3.4 Spectrum Care

Spectrum Care operates a number of adult residential homes and a Child, Youth and Respite (CYR) Service in Auckland for individuals with an intellectual disability and/or autism spectrum disorder. The CYR service includes respite and residential care for young people.

Each residential home has approximately four people. Several homes also have a separate flat, where individuals may reside in an independent living situation. These flats are monitored by staff. Some people live

independently in flats in the community and these people are monitored by staff.

Behaviour Support is provided by Explore Specialist Behaviour Advice NZ (Explore).

Admission Criteria

To receive services, a person must have an intellectual disability. All referrals to Spectrum Care are provided through Taikura Trust and/or CYF. Following a referral, Spectrum Care meets with Taikura Trust (or CYF) and the person's family, if appropriate. Current vacancies within Spectrum Care's services are discussed and whether they would be appropriate in meeting the individual's needs.

Length of stay

A person's stay in residential care may be for life. However, some individuals may transition to a supported living environment following an improvement in their skills and capabilities.

Model of Care

All residential services operate on a person-centred model. Spectrum Care also has an 'outcomes' philosophy, and uses Outcomes Brokers. The Outcomes process involves each person setting short- and long-term goals which staff are required to actively support and facilitate the achievement of.

Staffing

Residential services are staffed by Community Support Workers (CSWs), who work alongside people in the home. According to the needs of the people in each home, 24/7 care may be provided. CSWs complete training provided by Spectrum Care, and complete modules within the NZQA system.

CSWs are managed by a service co-ordinator, who is responsible for the operation of approximately three homes. The service co-ordinator oversees the operation of each home, and ensures that Outcome Plans and Behavioural Support Plans are up-to-date.

People and their needs

People who Spectrum Care support include young people and adults with an intellectual disability and/or those with autism spectrum disorder. Typically, adolescents aged 16 years and older are placed in residential services, and children are supported through respite services.

Intervention programme/s offered

Behavioural support is based on the Applied Behavioural Analysis and the Positive Support model. Services also operate on a holistic model of the individual.

Spectrum Care operates Aspiration Services, where people may participate in a day work service (e.g., lawn-mowing crew). Spectrum Care also operates Activity Centres, where people can engage in a range of activities.

Young people may be enrolled in schooling up to 21 years of age. The transition co-ordinator may meet with a young person and discusses their dreams, ambitions, and what they want to do after they complete school.

Physical Restraint

Spectrum Care staff are trained in Crisis Prevention Intervention (CPI). New staff employed by Spectrum Care are trained in CPI during their induction training. All staff must renew their CPI certification every two years. Spectrum Care adhere to the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.

Restraint may only be used as a last resort if a person is at risk of harm to themselves or others, after all other alternatives have been tried. Among 380 (approx.) people who live in Spectrum Care, approximately 36 have restraint included in their Behavioural Support Plans. Photos and scenarios regarding the restraint process for each individual are included in their plan. For those aged under 17 years, their restraint plan is reviewed every three months, and for those aged over 17 years restraint is reviewed every six months.

There is a list of 10 restraints that have been approved by the risk management group within Spectrum Care, which are individualised for each person. Staff are trained around these restraints, and they are practiced each month during team meetings. Typically, restraint may include escorting the client from one environment to another to help facilitate de-escalation of behaviour.

Restraint is monitored, and an incident form is completed each time restraint is used. Spectrum Care has a restraint monitoring group, comprising behavioural advisors and consultants. The restraint monitoring group meet each month, and review any new people that may require restraint to be included in their plan.

3.3.5 Hohepa Trust

Hohepa is a charitable organisation (trust) which provides services for children and adults with an intellectual disability. Hohepa provides residential and vocational/day services, and a private boarding school for children aged between 7 and 21 years.

The following information regarding Hohepa's residential homes was primarily provided by Hohepa Hawkes Bay.

Admission Criteria

Clients must have a diagnosis of intellectual disability (ID) and receive Ongoing Resourcing Scheme (ORS) funding. For those under the age of 17, clients must have s141 (CYPF Act) Family Group Conference approval/agreement. Children must be compatible with existing client groups at Hohepa, and require approval by the Ministry of Health (MoH) under the Memorandum of Understanding between MoH and CYF with regards to the s141 process. Before a placement at Hohepa is considered, all other options of support must have been explored.

Length of stay

At the initial Family Group Conference (FGC), it is determined that placement is for 12-months. At 12-months, the FGC is reconvened. Typically, the FGCs agree that placement at Hohepa will continue due to the complex needs of many children that receive Hohepa's services.

Model of care

The model of care can be best described as that of a 'residential boarding school', where the residential care is provided by an 'extended family'. This extended family consists of the house parents (i.e., house managers), a deputy (or assistant), and residential support workers. Hohepa, like many other Rudolf Steiner based organisations for people with disabilities, is often referred to as an 'intentional community'.

Staffing

Residential staff work split shifts, 8 hours per day. Each shift is led by either the house manager, assistant house manager, or a senior support worker. In addition, there is on-call 24/7 support for additional support and advice. There are also "awake" staff who work night shifts from 9pm to 7am. Due to the vulnerability and complexity of presentation of the children, the staff ratio is either 1:1 or 1:2. The role of the residential staff includes "parenting

tasks”, from personal care or training/teaching of household tasks (e.g., cooking, baking, cleaning, gardening). Staff also engage in recreational activities with the young people in their care. After further training, residential staff become key workers, which involves undertaking specific roles with individual children.

Staff who work within the school include teachers and teacher aids, therapists, and administration and kitchen staff. There is a close liaison between teachers and teacher aids and the residential support staff. Regular review meetings are held to consider the needs and subsequent progress of each child.

People and their needs

Over time, fewer children who have moderate intellectual disabilities have entered residential care; however, there has been a dramatic increase in the admissions of children who have Autism Spectrum Disorder (ASD). Currently, there are 37 residential pupils and one day pupil. Twenty-two children are subject to s141 orders, and one young person subject to a s101 (2) order. Thirty-four children have ID and ASD as primary and secondary diagnosis. The majority of children are severely or profoundly intellectually disabled.

Intervention programme/s offered

All young people have an Individual Education Plan (IEP) at the school and an Individual Developmental Plan (IDP) within the home. School staff and residential staff have input into both the IEP and IDP. The plans are then approved by the school principal and the Director of Services. The young person’s family/whānau also have input into the development of the IEP and IDP.

The school receives ORS funding and operates the New Zealand and Waldorf school curriculum. Behaviour support is provided by Explore. The school and residential homes work together on the individual’s development as well as the behaviour support programmes. These programmes are generally developed by specialist staff associated with Explore.

The young people’s health and mental health support is provided through DHB services, with regular reviews of progress and consultation with staff and families. Young people have access to various therapies, speech and language therapy (including augmentative communication), art-therapy, music therapy, occupational therapy, and nursing therapy.

Physical Restraint

Hohepa uses Non-violent intervention methods, namely Team-Teach (see www.team-teach.co.uk/introduction_Aims.html). Hohepa has one external trainer and a number of in-house staff who have been trained to conduct in-house courses for all staff. The training occurs soon after induction, and refresher courses are held generally every two years.

Hohepa is obliged by its contract with the Ministry of Health to ensure that an ongoing reduction in restraint occurs. Hohepa has a restraint minimisation committee, chaired by the Director of Services. The restraint minimisation committee meets regularly and reviews all restraints and also issues permission to use restraint for periods of up to three months, when this permission is then reviewed. All restraints are regarded as very serious incidents, and are reported in both hard copy and electronically.

Transition

Transition planning commences when the young person turns 18 years of age. However, entry into the adult residential community cannot be guaranteed by Hohepa.

3.3.6 Disability Support Services

The Ministry of Health’s Disability Support Services (DSS) contracts a number of community-based residential support services for children and young people with disabilities, including Autism Spectrum Disorder, or intellectual, physical or sensory disabilities. The young people who receive these services are aged between six and twenty years. Under certain guardianship conditions, as notified by the Ministry, the age range may extend to 20 years. However, young people aged 17 years will typically receive adult services.

All DSS funded residential placements for children and young people are approved under s141 of the CYPF Act, 1989. This section applies to any child or young person considered so severely mentally or physically disabled that suitable care for that child or young person can only be provided through the care of an organisation or body approved under s396.

Admission Criteria

Services are provided to children and young people with Autism Spectrum Disorder or an intellectual, physical or sensory disability who have needs that would be best met in a residential service as determined by a Family Group Conference (FGC).

DSS fund Needs Assessment and Service Coordination agencies (NASC) to work with children, young people, and their families to ensure appropriate supports are coordinated to support the child or young person to remain in the family environment. Such involvement may include a multi-agency approach. The NASC will identify whether residential care is the most appropriate option to support the disability needs of the child or young person. To guide the decision of whether an out-of-home placement is required, the NASC will take into consideration a range of factors, including the needs of the child or young person, the sustainability and suitability of the current supports, and access to community supports (both funded and unfunded).

Coordination of an appropriate placement

The NASC process will identify the level of support that is required to safely support the child or young person. This will include staffing levels (e.g., 1:1 or need for 'awake' staff), support required to complete Activities of Daily Living (ADL), and need to access specialist services, including behaviour support.

The NASC will work with the child or young person and their family to identify an appropriate placement with an s396 provider. This includes discussion with providers to ascertain whether a suitable placement is available to meet the individual needs of the young person. Placement allocation will also take into account factors including:

- Compatibility with other children and young people in the house, including consideration of health needs and behavioural difficulties
- Gender and age mixing (in line with the United Nations Convention on the Rights of the Child)
- Ability of the provider to meet the specific disability needs of the young person. The Ministry of Health has responsibility for issuing certificates for all children under s141 to ensure that the provider has the appropriate facilities and staff to meet the disability support needs of the individual (s141(4)).

No out-of-home placements can be agreed or coordinated until a Family Group Conference (FGC) under s145 of the CYPF Act is convened. Prior to the commencement of the FGC, the Ministry of Health approves the funding and placement of the young person.

Length of Stay

When a child or young person has been referred to an out-of-home placement under s141, this typically becomes a permanent arrangement resulting in a home for life into adulthood. The FGC expects that the voluntary out-of-home-placement must be reviewed annually, and a plan implemented for the young person's transition back to their family and region of origin.

Model of Care

There is no one particular model of care for children. Instead, the DSS supports the choice and flexibility of the young person and family to choose the most appropriate service provider for them. Guidelines for service provision are outlined in the DSS's service specification, s396 approval from CYF, and the best practice standards included in the Safer Organisations Safer Children guideline.

Staffing

The provider is responsible for employing competent staff for adequate hours for the needs of the children or young people to ensure 24-hour service provision. Staff should be experienced to provide a level of service relative to the child or young person's assessed needs. In addition, guidelines outline that providers must provide staff induction training and ongoing professional development, ensure 24-hour back-up and that adequate relief is available to staff, ensure that support and supervision is provided to staff, and monitor the quality of care provided by staff in accordance with the relevant standards and legislation.

Staff are provided training in abuse and neglect, fire safety, first-aid, and medication management (including PRN).

People and their needs

Those who receive DSS are children and young people with disabilities, including Autism Spectrum Disorder, or intellectual, physical or sensory disabilities. These children and young people have continuous support needs and require out-of-home residential services. Services are also provided to young people with disabilities and experiencing a mental illness if referred by a NASC.

Intervention programme/s offered

The NASC and residential provider have access to the following interventions, funded by the Ministry of Health:

- Specialist Behaviour Support Service
- Equipment and Modification Service
- District Health Board for medical requirements
- Mental Health services.

Once a young person enters residential services, they no longer have access to child development services. Staff have access to specialist clinical input, where necessary.

Physical Restraint

Staff are trained in restraint minimisation, risk and safety plans, challenging behaviours, and crisis intervention.

3.4 Effects of Secure Residential Care

This section provides a brief overview of the impacts secure residential care can have on children and young people in the care and protection system. This is not intended to be a thorough overview of the short, medium, and long term effects of secure residential care. Instead, the aim of this section is to highlight research that emphasises the CYPF Act 1989's stipulation that secure care should only be used if such a placement is necessary to prevent absconding or to prevent the child or young person from behaving in a manner likely to cause harm to themselves or another (section 368).

Young people in secure residential settings are seen to experience a range of negative outcomes, which are suggested to be the by-product of the residential setting itself (Ryan et al., 2008; Lee & McMillen, 2007). In secure residences, these young people are exposed to high risk peers, which can consequently lead to the development of deviant attitudes and behaviours (Ryan et al., 2008), such as substance abuse, academic problems, aggression, and delinquency (Lee, & McMillen, 2007). This seems to be further exacerbated when ties to family and prosocial peers in the community are severed (Ryan et al., 2008). Separating these young people from their families and communities makes adapting socially, personally, and academically in residence that much more challenging. This is a concern in New Zealand where, with only four care and protection residences in main centres, some young people in residence will be placed far from their family and community.

3.4.1 Residential Effects on Outcomes

Research has highlighted the importance of utilising the least restrictive or non-residential programmes when considering the placement and rehabilitation of a young person. For example, Ringle et al., (2012) found those who left residential care who had received the lowest level of restrictiveness had better outcomes in terms of reintegration into their family home and number of placements post-residence. These low-restriction residences involved the use of Teaching Family Homes (see Chapter Seven, Section 7.2 for an overview).

De Swart et al. (2012) conducted a meta-analysis of 27 studies to examine the effectiveness of institutional youth care. The authors compared institutional Evidence-Based Treatment (EBT) with non-institutional EBT, institutional care as usual (e.g. regular group care) with non-institutional care as usual (e.g. foster care), institutional care as usual with non-institutional EBT, and institutional EBT with institutional care as usual. Evidenced-based strategies appear to have common elements of being community-based, family-centred, and having wrap-around services involving collaboration between youth justice, mental health, academic and other services (Lambie & Randell, 2013). In addition, evidence-based strategies also appear to target real-world risk factors to help ensure that treatment results have the best possible chance of generalizing beyond residence (Henggeler, 2003).

Results from De Swart et al. (2012) found an overall mean effect size of $d=.129$, with individual study effect sizes ranging from $d=-.690$ to $d=1.806$. The results of the analysis showed that the only significant effect size was when institutional EBT was compared with institutional care as usual ($d = .34$), suggesting that institutional care can be as effective as non-institutional care, and more favourable outcomes are seen among youth in institutional care when EBT is implemented.

The research outlined above highlights that less restrictive or non-residential programmes should be the most utilised option, when possible. However, institutional programs that use well-grounded evidence-based approaches can produce good outcomes (e.g., De Swart et al. 2012). The latter is an especially important consideration for the populations of high-risk young people with complex needs for which non-residential treatment may not be appropriate.

Summary

There are four care and protection secure residences in New Zealand. These residences are used to address acute care and protection needs when it is determined that other alternative community-based or family/whānau care is inadequate or inappropriate. When determining the course of action for a young person who is in need of care and protection, it is important that such action aligns with the CYPF Act's philosophy of the safety and well-being of children and young people being paramount. Research highlights that less restrictive or non-residential programmes should be the preferred option wherever possible. However, optimal outcomes can be achieved with institutional programs using well-grounded evidence-based approaches.

Part A: Summary

The New Zealand care and protection population in secure residential care present with highly complex needs and a myriad of difficulties. The purpose of care and protection secure residences, within the larger continuum of care, is to address acute care and protection needs when it is determined that other care alternatives within the community or family/whānau are inadequate or inappropriate.

Young people in care and protection secure residences are some of the most vulnerable and at-risk young people in New Zealand. It is a group of young people we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of services in which they exist, to best address the needs and improve outcomes for this population. Part B provides an overview of the national and international research and best practice literature regarding services for the care and protection population.

Part B: Secure Residential Care - National and International Research and Best Practice

Understanding the national and international research and best practice literature regarding the care and management of the care and protection population is important to help guide service provision in New Zealand in order to provide the best level of care and enhance outcomes for this population of young people. Chapters Five to Fifteen describe international care and protection systems and continua of care, frameworks to guide care and protection services, models for secure care and step-down care, assessment, rehabilitative models, cultural frameworks, educational programmes, crisis management models, how the needs of different care and protection subpopulations can be met while in secure residential care, and transition and aftercare models.

Chapter 4: International Care and Protection Systems and Residential Care

Examining overseas models and systems for the care and management of the care and protection population can be beneficial to identify aspects that could be implemented for this population in the New Zealand context to enhance outcomes for these young people, their families and the community. This chapter provides an overview of international care and protection systems, comparisons between New Zealand and international care and protection jurisdictions, and international continua of care.

4.1 International Child Welfare/ Care and Protection Systems and Residential Care

Here, a brief overview of the care and protection systems of England and Wales, Scotland, the United States, Australia, and Nordic countries is provided. Where information was available, an overview of the role of secure residential care for this population in each jurisdiction is also described.

4.1.1 England and Wales

In England and Wales, the use of 'secure accommodation' is dealt with under section 25 of the Children Act 1989 and the Children (Secure Accommodation) Regulations 1991. Section 25 of the Children Act 1989 states:

A child being looked after by a local authority may not be placed, and if placed, may not be kept in a secure accommodation unless it appears:

- a. That he/she has a history of absconding and is likely to abscond from anything other than secure accommodation; and
- b. If he/she abscond he/she is likely to suffer significant harm (section 25(1)(a));

or

- c. If he/she is kept in anything other than secure accommodation he/she is likely to injure him/herself or other persons (section 25(1)(b)).

Secure Children's Estate²⁰

Within the Secure Children's Estate, there are Secure Children's Homes (SCH), Secure Training Centres (STC), and Young Offender Institutions (YOI). SCHs provide care in a secure setting for the most vulnerable looked after children and young offenders with challenging and complex needs. SCHs are children's homes which provide a locked environment and restrict a young person's liberty. They provide care and accommodation to children and young people who have been detained or sentenced by the Youth Justice Board (YJB) and those who have been remanded to secure local authority (LA) accommodation. They also accommodate and care for children and young people who have been placed there on welfare grounds by LAs and the courts. STCs and YOIs are used for young offenders. SCHs provide children and young people with support tailored to their individual needs; to achieve this they have a high ratio of staff to young people and are generally small facilities.

In England there are 16 SCHs; 15 are managed by local authorities and one by a charity (Nugent Care). There is one secure children's home in Wales which is managed by the local authority. Of the 16 English homes, 7 provide welfare places only and the remainder provide both welfare and youth justice places.

Placements for sentenced children are commissioned by the Youth Justice Board (YJB), whereas placements for children requiring detention on welfare grounds under Section 25 of the Children Act 1989 are commissioned by individual local authorities. There were a total of 229 children accommodated in SCHs in England and Wales at 31 March 2014, which represents an increase of 11% from 31 March 2013, and a decrease of 11% from 31 March 2010.

4.1.2 Scotland

The Children's Hearings Scotland (CHS) is responsible for dealing with children and young people under 16 years who commit offences, or who are in need of care and protection. Children under 18 years may be dealt with by CHS under circumstances where the young person is in the supervision of a hearing when he or she reaches 16 years and the supervision requirement is extended, or where their case is remitted to the hearings system for disposal following conviction by a court (The Scottish Parliament, 2011).

²⁰ Information was sourced from the Department for Education (2014), from the following website: www.gov.uk/government/statistics/children-accommodated-in-secure-childrens-homes-31-march-2014

In Scotland there are five secure care establishments which provide approximately 90 beds. Before any young person can be placed in secure accommodation, the children's panel must consider that the young person meets the legal criteria set out in The Children's Hearings (Scotland) Act 2011:

- a. The child has previously absconded and likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental, or moral welfare would be at risk;
- b. The child is likely to engage in self-harming conduct; or
- c. The child is likely to cause injury to another person.

4.1.3 United States of America

The primary responsibility for child welfare services rests with the States, and each State has its own legal and administrative structures and programmes that address the needs of children and families. However, States must comply with specific Federal requirements and guidelines in order to be eligible for Federal funding under certain programmes. For example, the Child Abuse Prevention and Treatment Act (CAPT Act) originally enacted in 1974 is the key Federal legislation addressing child abuse and neglect, which provides funding to States in support of prevention, assessment, investigation, prosecution and treatment activities. In addition, the CAPT Act identifies the Federal role in supporting research, evaluation, technical assistance and data collection activities, establishes the Office on Child Abuse and Neglect, and mandates the National Clearinghouse on Child Abuse and Neglect information. Furthermore, the CAPT Act sets a minimum definition of child abuse and neglect.

Between FY2005 and FY2011, there has been a reduction in the number of children entering care (311,000 to 252,320 young people), the annual number of children in care (i.e., prevalence from 513,000 to 400,540 young people), mean length of stay in child welfare (from 28.6 to 23.9 months), and the proportion of young people in out-of-family placements (from 8.5% to 5.9% in group homes, and 10% to 8.7% in residential treatment) (U.S Department of Health and Human Services, 2006, 2011, 2012). To help shorten the length of stay in care and achieve child welfare outcomes, key Federal legislation has emerged, including the Adoption Assistance and Child Welfare Act of 1980, the Adoptions and Safe

Families Act of 1997, and the Fostering Connections to Success and Increasing Adoptions Act of 2008.

Out-of-home placements in the United States range from independent living situations, foster homes, specialised foster homes or therapeutic foster homes, group homes, and residential treatment centres (Chor, 2013). In September 2013, 55,916 children were in congregate care. Congregate care comprises group homes, institutions, residential treatment facilities or maternity homes (US Department of Health and Human Services, 2015).

To reduce restrictive placements and increase placement stability, there has been more emphasis placed on the placement decision making process to improve children's experiences in out-of-home care (Blakey et al., 2012; Chor et al., 2012; James et al., 2004; Leathers, 2006; Rubin et al., 2007). As outlined by Chor, McClelland, Weiner, Jordan and Lyons (2015), there are two main models used for placement decision-making in child welfare: the multidisciplinary team model and the decision support algorithm.

Multidisciplinary Team Model

The Multidisciplinary Team Model involves interdisciplinary expertise and caregiver and client opinion in the decision making-process. Examples of the multidisciplinary team model include the Child and Family Teams (North Carolina; Snyder et al. 2012) and the Annie E. Casey Foundation, which has been implemented in more than 60 child welfare agencies in 17 states.

Decision Support Algorithm Model

The decision support algorithm model entails the matching of a young person's functioning needs and strengths to a placement based on clinical assessment and standardised criteria. Examples include the Child and Adolescent Level of Care Utilisation System (Fallon et al., 2006), the Child Severity of Psychiatric Illness (Lyons & Abraham, 2001), and the Child and Adolescent Needs and Strengths (CANS) Algorithm.

4.1.4 Australia

In Australia, statutory child protection is the responsibility of state and territory governments. Child protection policies and practices are under continual development on a jurisdiction-by-jurisdiction basis. There has been an increase in national focus on early intervention and family support services to help prevent families entering or re-entering the child protection system and to help minimise the need for

more intrusive interventions. Out-of-home care is a last resort for keeping children safe (Council of Australian Governments, 2009).

In 2013-14, there were 51,539 young people in out-of-home care in Australia. Out-of-home care can include independent living, home-based care, family group homes, and residential care. At 30 June 2014, there were 2,258 young people placed in residential care on care and protection orders. On an average day in 2013-14, there were 1,157 young people placed in residential care.²¹

At the time of writing this review, the authors were unaware of the number of residential facilities in Australia providing services and care for the care and protection population.

4.1.5 Nordic countries

The Nordic countries of Denmark, Sweden, Norway, and Finland use secure care only when young people have severe socio-emotional and behavioural problems, are unmanageable within a non-secure environment and/or are chronic absconders (Smeets, 2014). In addition, these countries have a philosophy of “best interests of the child” with regard to the use of residential care, and will only take this option if it is indeed in the young person’s best interests (Lappi-Seppälä, 2011). The residential care facilities themselves operate with a variety of programmes and models.

Young people may be placed in residential care if they pose a serious threat to their own or others’ safety, usually due to extreme behavioural issues and repeated crime, mental health issues, or drug and alcohol abuse (Storgaard, 2005). In most Nordic countries, young people in residential care for criminal behaviours are housed with those in residential care for child welfare reasons; although they may have different freedoms and processes in place within the residence (Storgaard, 2005). While these two populations of young people appear to have many differences, the underlying factors associated with their risk and problematic behaviours are considered to be similar: a history of abuse, neglect, exposure to violence, drug and alcohol abuse, and poverty (Lappi-Seppälä, 2011).

In Nordic countries, there does not appear to be any specific model implemented in residential care services that produces better outcomes among these young people comparative to other countries, and various types of models are implemented across residential facilities. Some residential facilities use various forms of milieu therapy, others operate a family type atmosphere, and some residential care facilities use the Teaching Family Model (Lindqvist, 2011). Programmes also include environmental therapy, Functional Family Therapy, cognitive behavioural therapy, and substance abuse treatment (Lappi-Seppälä, 2011).

²¹ Source: The Australian Institute of Health and Welfare (2015), from the following website: www.aihw.gov.au/publication-detail/?id=60129550762

Summary

Comparable to New Zealand, the reasons for a young person being either voluntarily or involuntarily admitted to a care and protection residential care facility in other jurisdictions appear to be due to the risk of safety to self or others, severe behavioural problems, criminal behaviour, history of absconding, and significant mental health concerns with additional care and protection issues (Smith, Duffee, Steinke, Huang & Larkin, 2008).

4.2 Comparisons between New Zealand and International Care and Protection Systems

Drawing comparisons between international jurisdictions in the use of residential care and detainment of young people involved in the care and protection system is difficult due to the differing calculation of rates of young people in care (i.e., number of young people in care per day versus per year), definition of what is considered residential care, and whether out-of-home care is considered a supportive service or coercive measure (Gilbert, 2012). Furthermore, international jurisdictions have different legislation, policy and practice for the care and management of the care and protection population. Given these difficulties in obtaining valid comparisons, the current review did not set out to provide a comprehensive examination of differences across jurisdictions. Here, we present available data across several jurisdictions regarding the estimated proportion of young people in residential care, and average length of stay (where data are available).

4.2.1 Age young people can remain in formal State care

As outlined in the Modernising Child, Youth and Family - Expert Panel: Interim Report (2015), the age young people exit care varies internationally. The maximum age young people can remain in formal State care for a number of countries, including New Zealand, is presented in Table 2 below.

Table 2. Age Young People can Remain in Formal State Care*

Age (years)	Country
17	New Zealand [£]
18	Australia, Ireland
18-19	Canada [¥] , Sweden [‡]
18-21	United States [§]
21	Scotland
21-24	England and Wales [†]

The exclusion of 17 year olds from the care and protection system in New Zealand is a well-noted difference between the New Zealand and international systems. As noted in the Interim Report, the definition of a young person under the CYPF Act has been criticised numerous times by the United Nations Committee on the Rights of the Child. Consequently, young care leavers fall into a ‘no-man’s land’ between care and full independence. More information regarding the implications of the age that young people remain in care in New Zealand is outlined in Chapter Fourteen.

4.2.2 Estimated Percentage and Rates of Young People in Residential Care

Table 3 displays the percentage and rates of young people in residential care across several jurisdictions identified by Ainsworth and Thoburn (2014, p. 17). Please note that these percentages and rates do not distinguish between those who have been detained in residence due to reasons concerning child welfare (i.e., care and protection) and youth justice.

Table 3. Estimated Percentage and Rates of Young People in Residential Care

Percentage of children in residential care	Country	Rates per 10,000 children in total population	Country
0-10	Australia, Ireland	<10	Australia, England, Ireland, USA
11-20	England, USA	10-29	Italy, Japan, Scotland, Spain
21-30	Hungary, Scotland, Spain, Sweden	30-39	Hungary, Israel
31-40	France, Romania	40-49	France, Germany
41-50	Denmark, Italy, Poland, Russian Federation	50-59	Denmark
51-60	Germany, Lithuania, Ukraine	60-69	Armenia, Romania
70-95+	Armenia, Czech Republic, Israel, Japan	70-99	Poland
		100+	Czech Republic, Lithuania, Russian Federation, Ukraine

To the best of the reviewers’ knowledge, there are no reported percentage and rates of young people placed in residential care in New Zealand. However, as at 31 March 2015, there were 4,119 children and young people in out-of-home care placements (CYF, 2015).

* Information Source: Expert Panel: Interim Report (2015, p. 96). In jurisdictions that provide formal care over the age of 18 years, young people may elect to exit formal care. This is primarily from 18 years; and from 16 years in Scotland.

£ There are a number of NZ young people who remain in formal care up to age 20 under a sole guardianship order.

¥ Remaining in care is available up to age 19 in several Canadian jurisdictions.

¥ In Sweden, the majority of young people do not finish school until age 19. While Court orders lapse at age 18, most out-of-home placements continue until schooling is finished.

‡ Remaining in care is available up to age 21 years in almost half of the States of the USA.

† In England and Wales, remaining in care between the age of 21 and 24 is conditional on attending tertiary education.

4.2.3 New Zealand and International Care and Protection Secure Facilities

The number of secure facilities (including secure residences), total number of beds, the number of young people placed in residence each year, legal orders resulting in placement, and average length of stay under the care and protection system across several jurisdictions are presented in Table 4.

Table 4. New Zealand and International Care and Protection Secure Facilities

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legislation and orders permitting placement in secure facility	Average length of stay
New Zealand ^a	Four secure residences (48 beds).	113 distinct client admissions each year.	s101 (custody order), s78 (custody pending determination of proceedings). 73% of those in care and protection secure residences in New Zealand have s101 orders.	The average length of stay for a young person in a care and protection secure residence is 136 days.
England and Wales	England: 15 secure children's homes managed by Local Authorities ^b (254 places) ^c , one secure children's home managed by a charity. Wales: one secure children's home. Of the 16 English homes, 7 provide welfare places only and the remainder provide both welfare and youth justice places.	At 31 March 2014, there were 211 children in Secure Children's Homes in England, and 18 in Wales. ^b At 31 March, 2014, there were 6,360 looked after children cared for in children's homes and hostels, or secure accommodation. ^d	Section 25 of the Children Act 1989 for the protection of himself and/or others. ^b	Time in days spent in custody for young people in secure children's homes at 31 March 2014: ^e 17% - less than 1 month 34% - 1 to 3 months 28% - 3 to 6 months 14% - 6 to 12 months.
Scotland ^f	5 secure care establishments (90 beds).	2013-14 average of 74 clients in secure care. Total of 232 admissions between 1 August 2013 and 31 July 2014.	Legal criteria set out in The Children's Hearings (Scotland) Act 2011.	In 2014, total population: 16% - less than one month 17% - 1 to 2 months 17% - 2 to 3 months 28% - 3 to 6 months 11% - 6 months to 1 year

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legislation and orders permitting placement in secure facility	Average length of stay
United States ^g	Unknown. *	On September 30 2013, there were 55,916 children in congregated care. **	<p>Current federal policy about the appropriate use of placement settings is limited. Federal law mandates that each child's case plan must include a discussion of how the child's case plan is designed to achieve a safe placement for the child in the least restrictive (most family-like) setting available and in close proximity to the home of the parent(s) when the case plan goal is reunification. Case plans must also address how the placement is consistent with the best interests and special needs of the child (section 475(5)(A) of the Social Security Act, CFR 1356.21(g)(3)). However, states have flexibility and discretion to make decisions for a child on a case-by-case basis to ensure that the best placement is made and the individual needs of the child are met.</p>	<p>Among young people in congregated care in 2008:</p> <ul style="list-style-type: none"> 36% - < 60 days 5% - 61 to 90 days 35% - 91 days to 1 year 24% - > 1 year. <p>Average = 9 months; however, 34% spent more than 9 months.</p> <p>Cumulative time spent in congregated care by age at entry into foster care for children in 2008 with 5-year follow-up:</p> <ul style="list-style-type: none"> Children ≤12 years: <ul style="list-style-type: none"> 20.7% - less than 1 week 11.9% - 8 to 30 days 9.6% - 31 to 60 days 5.1% - 61 to 90 days 11.0% - 91 to 180 days 14.2% - 181 to 365 days 24.1% - > 1 year Young people 13 years and older: <ul style="list-style-type: none"> 13% - < 1 week 10% - 8 to 30 days 7.2% - 31 to 60 days 5.2% - 61 to 90 days 14.7% - 91 to 180 days 23.1% - 181 to 365 days 23.5% - > 1 year.

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legislation and orders permitting placement in secure facility	Average length of stay
Australia ^h	Unknown [*]	At 30 June 2014, there were 2,258 young people placed in residential care on care and protection orders. On an average day in 2013-14, there were 1,157 young people placed in residential care.	There are differences in legislation, policy and practice in each State's care and protection system.	For all young people in out-of-home care, length of time continuously in care at 30 June 2014: ^{***} 2.1% - < 1 month 8.0% - 1 to 6 months 7.8% - 6 months to 1 year 12.6% - 1 year to 2 years 28.3% - 2 years to 5 years 41.1% - 5 years or more.
Norway	There are approximately 59 Child Welfare institutions. ⁱ In 2013, there were 1,745 beds in children's institutions. ^j	In 2013, there were 1,246 young people in children's institutions. ^j	The Child Welfare Act 1992, section 4.	Unknown.

* At the time of review, the authors were unable to comment on the number of residential treatment facilities for the care and protection population.

** Congregate care is defined as a placement setting of group home (a licensed or approved home providing 24-hour care in a small group setting of 7 to 12 children) or institution (a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience). These settings may include child care institutions, residential treatment facilities, or maternity homes.

*** At the time of review, the authors were unable to comment on the average time spent in residential care specifically.

a Hand & Tupai. (2015). Overview of Child, Youth and Family's Secure Care and Protection and Youth Justice Residences (unpublished).

b Department for Education. (2014). Children Accommodated in secure children's homes at 31 March 2014: England and Wales. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/317365/SFR14-2014_Text.pdf

c Department for Education. (2015). Children Accommodated in Secure Children's Homes at 31 March 2015. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/431660/SFR15-2015_Text.pdf

d Department for Education. (2014). Children looked after in England (including adoption and care leavers) year ending 31 March 2014. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/359277/SFR36_2014_Text.pdf

e Department for Education. (2014). Children accommodated in secure children's homes: 31 March 2014. Retrieved from: www.gov.uk/government/statistics/children-accommodated-in-secure-childrens-homes-31-march-2014

f The Scottish Government. (2015). Children's Social Work Statistics Scotland, 2013-14. Retrieved from: www.gov.scot/Resource/0047/00474429.pdf

g US Department of Health and Human Services. (2015). A national look at the use of congregate care in child welfare. Retrieved from: www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf

h Australian Institute of Health and Welfare. (2015). Child protection Australia 2013-14. Retrieved from: www.aihw.gov.au/publication-detail/?id=60129550762

i The Norwegian Child Welfare Services. Retrieved from: www.bufdir.no/en/English_start_page/The_Norwegian_Child_Welfare_Services/

j Statistics Norway (2014). Children's institutions, 2013. Retrieved from: www.ssb.no/en/soiale-forhold-og-kriminalitet/statistikker/barneverni

Summary

Drawing comparisons between New Zealand and international care and protection systems with regards to the use of secure residential care is difficult due to the differing standards and philosophies regarding the purpose of secure care, and the available alternatives to secure care. Nevertheless, it is useful to place New Zealand's care and protection system in an international context to see how it aligns with those of other jurisdictions.

4.3 Continuum of Care

A continuum of care is a system which guides clients through services over time, spanning all levels and intensity of care. It is important to take into consideration that secure residences comprise one part of the wider continuum of care that provides services to the care and protection population, and they do not operate in isolation. Here, Scotland's Kibble Education and Care Centre continuum of care is described. This continuum of care is a model which is seen as providing high quality service for young people in care. Aspects of this model could be beneficial for implementation in the New Zealand context to strengthen the current care and protection continuum of care.

4.3.1 Scotland: Kibble Education and Care Centre

Kibble Education and Care Centre (Kibble) is an independent, charitable service in Paisley, Scotland (Kibble, 2015). It is run as a social enterprise where any financial surplus made is reinvested back into the organisation. Kibble caters to young people aged between 5 and 25 years with significant social, emotional and behavioural needs.

Kibble's purpose is to provide a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences and training to allow them to be successful in independent life. Key values include safety, structure, stability and success. A strong emphasis throughout the various programmes and interventions provided by Kibble is that these young people are vulnerable and in need of care and protection.

Continuum of Care

Kibble provides secure care, residential services, day services, intensive fostering, education and training, and transitional support. All services aside from secure care are intended as preventative alternatives to secure accommodation.

Secure services

Where a secure placement is required, this is available at one of three secure residences located within the Kibble 'Safe Centre'. At any one time up to 18 young people may be in secure care. These secure services provide a safe and secure environment for young people aged between 12 and 18 who are at risk of harming themselves

or others, or who are considered as being at a point of crisis. Young people are referred to the secure service by either the Children's Panel or by a court order. Kibble has three units each of which house a maximum of six young people.

The secure services are integrated with all of Kibble's other services ensuring that those in secure care can still benefit from a care plan integrated with their education, access to specialist intervention services, a supported transition to their next stage and access to employment and training services.

Residential services

Kibble also provides residential services for looked after young people, both girls and boys, who have been referred by local authorities around Scotland. Residential care is available for up to 64 young people with a maximum of 8 beds per unit. Kibble has 10 units which cater to young people with a range of difficulties including severely traumatised young people, young people who exhibit extremely challenging behaviour and who need stability in their lives, those who display high risk behaviour requiring ongoing support and intervention, young people with a history of disruption, and those who generally need extra support. There are also smaller units with 2 or 4 beds for young people who have difficulty coping with larger groups and those who struggle with group living. One unit, Clyde, is specifically designed as a direct alternative or step down from secure care and is for young people who exhibit a range of harmful and inappropriate behaviours.

Three additional residences are also available to support young people leaving Kibble to return to the community. In these, young people are helped to prepare and adjust to life beyond school and residential campus living and are offered support when ultimately moving into independent living.

Day services

Kibble also provides day services with three day units. These are an alternative way for young people in their local community to access Kibble's education services. These young people often have a history of failed educational placements and disrupted learning, and some have learning difficulties such as dyslexia, as well as Autistic Spectrum Disorders and established patterns of offending behaviour.

Each young person who is enrolled in the day service has their own key worker who works closely with them and teaching staff to overcome barriers to learning. Young people work with their key worker to formulate plans and are updated regularly on their progress. In recognition of the trauma experiences of many of these young people, the day units are designed as spaces where young people can relax and have fun. This includes areas designed specifically as a calm space to be used during times of crisis. Holiday programmes are also available which involve activities and residential trips across the United Kingdom.

Intensive day services are also available as an alternative to residential care. This is intended to provide the young person with extra support outside of normal day service hours. This may include evening and weekend work (may involve hobbies/activities or extra time with key worker), family work (where the key worker spends time rebuilding relationships) and wrap around on call service for young people and their families.

Intensive Fostering

The Kibble fostering service provides homes for vulnerable young people (aged between 5 and 25 years) where foster care is considered the best alternative to living with their families. Two services are currently available and one will be opening in 2015. These are: Intensive Fostering Services (for those aged 12-18 years offering continuity of care), Adult Placement Services (allowing young people to continue living in their foster family home until they are 25), and Merton House Care Home (opening 2015: a care home for up to five children aged between 5 and 12 years with the aim of easing the transition to foster care).

Education and Youth Training

Kibble provides education services, both primary and secondary level, for young people who have difficulty staying engaged in learning. Each class has a maximum of five young people. The syllabus is flexible and includes practical activities, vocational training and qualifications, and academic qualifications. Additional opportunities are also available such as participating in the Duke of Edinburgh Awards or the Young Enterprise Scotland project. A peer mentoring system is also in place.

Kibble offers supported employment within KibbleWorks (a collection of small social enterprises) for young people aged between 16 and 25 years who face barriers to employment.

Framework and Programmes

All services are provided internally at Kibble with integrated care and education, in order to best enable young people to fulfil their potential. Within Kibble, young people are able to have their educational, mental health, physical health, and social needs all met on site.

Staff undergo a high level of training which includes training in areas related, but not limited, to trauma, emotional regulation, anxiety regulation, harmful sexual behaviour, social skills training and self-harm and suicide. There is an awareness of both the importance and prevalence of previous trauma experiences faced by many of the young people at Kibble.

Kibble's in-house Specialist Intervention Services (SIS) offer young people access to a team of forensic psychologists, social workers, family and programme workers. The Psychological Team delivers full forensic psychological assessments and therapies. The Programme Team delivers numerous evidence-based programmes and individually tailored interventions. The Family Service offers both group and individual family work.

There are two levels of psychological assessment available at Kibble. Within the first 72 hours at Kibble all young people are given the opportunity to undergo a psychological assessment. The aim of this is to screen for any acute mental health issues, substance abuse or suicidal/self-harm behaviour, as well as to identify any potential supports and the nature of any further specialist intervention services. The results of this first level psychological assessment are reviewed every 6 weeks. A second level psychological assessment is also available where necessary and is completed within 6-8 weeks. Such an assessment will only be completed if it is considered in the best interests of the young person and the public, and if it is proportional to the psychological needs of the young person.

A range of interventions are available at Kibble to support the needs of young people. Some of the programmes offered are outlined below.

Kibble implements The Ross Programme which is a cognitive skills development course addressing difficult and anti-social behaviour. The course aims to teach skills and values that promote social behaviour. The programme has been found to be successful at reducing the risk of re-offending and improving behavioural, and specifically conduct, difficulties (Curran & Bull,

2009). Kibble also implements the Substance Misuse programme which aims to reduce harmful substance abuse in young people.

The Offending is not the Only Choice programme addresses criminal behaviour with a focus on morality, victim awareness and consequential thinking. This programme has been found to reduce offending and seriousness of offending, and to be sustained over time (Glasgow Youth Justice Programmes Team, 2008). The Violence is not the Only Choice programme aims to reduce aggressive and violent behaviour by promoting calming techniques, conflict resolution and self-management. Kibble also implements the Keeping Cool, Thinking Smart: Managing Anger programme which aims to assist young people to control their anger with a focus on understanding the consequences of uncontrolled anger.

Short programmes on offer, typically used in a stand-alone or introductory setting, include motivational sessions, Eye Max (teaches young people to express their emotions to the maximum) and Anger Management Programme: Turn Down the Volume.

Tailored interventions provided by Kibble include Cognitive Behavioural Therapy, Eye Movement Desensitisation and Reprocessing (for use with individuals with severe trauma histories), Treating Problem Behaviours: A Trauma Informed Approach, Talking it over counselling service, Young Person's Family Work Programme and the Safer Lives Model.

Kibble also provides support to the families of young people. All families are offered general advice and support when their young person is placed within Kibble services. A group work programme named Handling Teenage Behaviour, carried out over 12 sessions, is available which allows families to share their experiences with other families. Interventions are also provided where necessary for the caregivers of young people with behavioural problems or the whole family.

Evaluation

In their "How good is our school?" evaluation of Kibble, Education Scotland reported that the young people were provided with a wide range of programmes and courses and that they benefited from having their curriculum tailored to their needs (Education Scotland, n.d.). Staff were reportedly highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.).

In their own evaluation of their interventions and programmes, the Kibble team reported that 100% of young people felt respected in sessions and 96% felt safe. In addition, 82% said that they had learned new skills (Kibble Education and Care Centre, 2015).

In a Care Service Inspectorate Report, the inspector reported that young people were actively involved in the making of decisions relevant to them and that they felt cared for, and that staff were working closely with young people to support their health and wellbeing (Care Inspectorate, 2013).

Limitations

Kibble has not been evaluated using strong methodology, such as randomised clinical trials (RCTs) or quasi-experimental studies. Furthermore, no comparisons have been made between Kibble and other jurisdictions with appropriate comparison groups. Further research is required, including a systematic evaluation to determine components of the model that are essential for positive outcomes.

Summary

Investigating what international models and systems of care and management are implemented for the care and protection population is useful for the consideration of what elements or aspects of these systems could be implemented in the New Zealand context to enhance current service provision. As outlined, there appears to be a trend internationally where secure care and protection residences are restricted to those young people who pose a risk of safety to self or others, have a high-risk of absconding, and/or exhibit severe behavioural problems. However, due to limited data, few comparisons can be drawn between New Zealand and international care and protection systems. Aspects of international continua of care, such as Kibble Care, could be considered for possible implementation in the New Zealand context.

Chapter 5: Frameworks to Guide Secure Residential Care and Protection Services

A framework is as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as principles to guide the assessment and treatment process. Using a unified vision and framework can provide a structure to help ensure all agencies operating within the residential facility are encompassing the same philosophy and values, and are working toward the same aims. This chapter provides an overview of the trauma, attachment and neurodevelopmental framework and the Neurosequential Model of Therapeutics (NMT) that could be implemented to guide services provided in secure residences for young people involved with the care and protection system.

When interpreting the evidence-base for each framework, it is important to note that Randomised Control Trials (RCTs)²² are considered the ‘gold standard’ of clinical trials, providing the most robust form of clinical evidence. RCTs provide strong foundations for drawing inferences about the effectiveness of frameworks for the care and protection population. Meta-analyses also provide useful estimates of the direction and magnitude of effects through statistically combining findings from independent studies. Therefore, for each framework, an outline of RCTs and/or meta-analyses conducted is provided. Where there is a lack of robust evidence, findings from studies using alternative study designs will then be discussed (e.g., pre-test/post-test, quasi-experimental designs); however, conclusions regarding the framework’s effectiveness from these studies can only be considered provisional.

5.1 Trauma, Attachment, and Neurodevelopment

Young people in care and protection services have been found to have levels of behavioural and emotional problems well above the general population, and in some cases, comparable to those in child and adolescent psychiatric institutions (Kjelsberg & Nygren, 2004). Both internalising (e.g., anxiety, depression) and externalising (e.g., aggression, delinquency) symptoms are common, along with related relational and interpersonal difficulties. Care and protection populations are also characterised by disproportionately high rates of trauma histories, predominantly in the form of neglect or abuse (Briggs et al., 2012; Hussey & Guo, 2002).

The combination of these two factors is not surprising considering the significant body of knowledge linking childhood trauma to a range of negative outcomes, including developmental delays, depressive and anxious symptoms, suicide attempts, antisocial and violent behaviour, and substance misuse (Colquhoun, 2009; Kaplow & Widom, 2007; Lansford et al., 2007; Mersky & Reynolds, 2007; Yampolskaya, Mowery & Dollard, 2014). Included within this are increased rates of post-traumatic-stress-disorder (PTSD: Cicchetti & Toth, 2005), although it has been suggested that PTSD does not sufficiently describe the effect of trauma on children and adolescents (Amendola & Oliver, 2013; Van der Kolk, 2005). In young people, trauma symptoms stretch far beyond those encapsulated in a PTSD diagnosis and can include conduct problems, symptoms of depression and anxiety, and impulsive, aggressive or sexualized behaviours.

Neurodevelopmental and attachment theories offer useful insight into long lasting, significant effects of trauma on children, and propose that adherence to the principles can help guide better practice in care and protection services (Kinniburgh, Blaustein, Spinazzola & Van der Kolk, 2005; Perry, 2006; Vela, 2014; Yampolskaya et al., 2014).

There is growing recognition that the link between childhood maltreatment and subsequent negative outcomes is mediated by biological consequences of trauma on the developing brain (Nemeroff & Binder, 2014). It has been suggested that the negative effect of trauma is so fundamental and serious, that it be considered acquired brain damage (Galton et al., 2008). This growing recognition has been influenced by advances in neuroimaging, and a more sophisticated understanding of neuro-development and brain plasticity. The development of the brain is complex and susceptible to influence from environmental factors, especially during sensitive periods such as infancy and early childhood (Perry, 2006). Extreme and chronic stress, such as that caused by abuse and neglect, has a durable, detrimental influence on development (De Bellis, 2005; Vela, 2014). As brain function develops sequentially (from most basic to most sophisticated), interruption at early stages of development can have a flow on effect, causing long lasting developmental delays and manifesting as attachment problems, difficulties

22 RCTs involve random allocation of participants to one of several interventions.

with self-regulation, maladaptive behaviours, negative emotional states and psychological difficulties.

Attachment theory also provides useful guidance when considering the issues prevalent among youth in care and protection services. It is based on the premise that forming attachment to a primary caregiver is a key developmental task, and that caregiver-child attachment significantly impacts identity, emotional regulation and interpersonal/relationship skills (Bowlby 1969, 1991). It is suggested that early attachment interactions form mental representations of the self, others and relationships that become templates for how the child perceives themselves and interacts with others throughout their lifetime. If a child has a caregiver who provides consistent nurturing in a safe environment, they will likely develop secure attachment. Children who are securely attached are typically easily comforted, have age appropriate interpersonal skills and positive long-term outcomes (Ainsworth, Blehar, Waters & Wall, 1978; Mennen & O’Keefe, 2005).

Young children who are neglected, abused or receive inconsistent nurturing from their primary caregivers, instead often develop anxious/avoidant, anxious ambivalent or disoriented/disorganised forms of insecure attachment (Ainsworth, et al., 1978; Main & Solomon, 1990). These young children use primitive coping strategies of avoidance, aggression or dissociation in order to survive their adverse environment. They are also likely deprived of the opportunity to develop more emotionally mature strategies, which are primarily learnt through positive caregiver-child interactions (Kinniburgh et al., 2005). As the child grows up, these behaviours may become increasingly inappropriate and dysfunctional, and increase the risk of other developmental and social problems (Mennen & O’Keefe, 2005).

There is overlap between neurodevelopmental and attachment perspectives. For example, the neural systems primarily responsible for threat perception and arousal are primarily located in the lower brain and the limbic system (Gralton, Muchatuta, Morey-Canellas & Lopez, 2008). These are basic areas of the brain that develop rapidly in infancy and early childhood. Infants are dependent on their primary caregivers to provide a safe, secure environment to regulate their affect because their undeveloped limbic systems are not yet able to do this (Jonsson & Jonsson, 2009). The amygdala, part of the limbic system, plays a crucial role in modulating

vigilance levels and generating negative emotional states. Secure infant-caregiver attachment relationships encourage the limbic system to develop affect regulation as part of normal development. However, trauma in early life can cause deregulation of the amygdala, therefore playing an important role in the subsequent development of arousal problems and hyper vigilance (Donegan et al., 2003).

It has been suggested that child welfare services would do a better job of protecting children from both immediate threat and longer-term negative outcomes if guided by principles of attachment theory (Mennen & O’Keefe, 2005). Care-givers, whether parents, staff, or foster parents, should be informed by an understanding of attachment theory in general, and the specific attachment patterns of the child in question.

Attachment focused trauma interventions such as the Attachment, Self-Regulation and Competency framework (ARC), propose that parents, caregivers and staff be trained to deal with intense affect, and to respond to affect instead of its behavioural manifestations (Kinniburgh et al., 2005). The importance of facilitating a structured, predictable environment and the promotion of positive attachment relationships in the young person’s life is also emphasised, as feelings of safety and security are considered the foundation for subsequent work on self-regulation and developmental competencies. Neuro developmental approaches to trauma intervention also propose that developmental interruptions or delays must be addressed to effectively intervene with young people with trauma histories. The level of a child’s development in multiple domains (e.g. emotional, communication) should guide the nature and timing of therapeutic activities to ensure it is appropriate and to increase effectiveness (Perry, 2006). Both attachment and neurodevelopmental approaches emphasise the importance of repetition to create positive attachment relationships and to ‘rewire’ brain systems, respectively.

5.1.1 Neurosequential Model of Therapeutics

Aligned with the aforementioned trauma, attachment and neurodevelopmental framework, the Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive and neurobiologically informed approach to clinical work. Core principles of neurodevelopment and traumatology are integrated into

a comprehensive approach to the young person, family, and their broader community. NMT is not a specific therapeutic technique or intervention; it is a framework which helps organise the young person's history and current functioning to optimally inform the therapeutic process.

More information regarding NMT can be found in Perry (2006, 2009) and Perry and Hambrick (2008), and on the Child Trauma Academy website at: childtrauma.org/nmt-model. There are reportedly over 50 organisations using the NMT as part of standard clinical practice (Perry & Dobson, 2013).

Programme Model

NMT has three key components: training/capacity building, an assessment of insults, stressors and challenges, and a set of recommendations for intervention and enrichment (Perry, 2006; 2009). Two assumptions underlie the NMT. The first is that therapeutic and educational efforts are most effective when they are provided in a sequential manner that replicates neural organisation and development. The second is that therapeutic interventions must provide adequate patterns and frequency of experiences that will activate and influence the areas of the brain mediating the dysfunction. The NMT process involves identification of the young person's strengths and vulnerabilities across key domains of functioning (sensory integration, self-regulation, relational and cognitive) and areas in the brain, which have been impacted by adverse developmental experiences. Based on this information, a selection and sequence of interventions and activities are identified and implemented.

NMT Assessment: Where the child has been

NMT assessment begins with a review of the key insults, stressors, and challenges, present during the young person's development. Assessment reviews the timing, nature and severity of developmental challenges and scores these to determine a developmental "load". This is then used to estimate which networks and functions have been impacted by developmental insults or trauma. The developmental history also includes a review of the relational history of the young person during development (Perry, 2009).

NMT Functional Review: Where the child is

The second component of the NMT process is a review of current functioning. This allows for estimates to be made concerning which neural systems and areas of the

brain are involved in the individual's neuropsychiatric symptoms, as well as their key strengths. A visual map is developed during this stage that shows developmental status across various domains of functioning. This allows for discussion around trauma, brain development and the rationale for recommendations as it allows progress to be tracked. Interdisciplinary staffing is required for the success of this component, in addition to a working knowledge of neural organisation and functioning.

NMT Recommendations: Where the child should go

The third component of NMT involves providing specific recommendations for therapeutic, enrichment and educational activities. Recommendations and subsequent interventions and enrichments are not constrained by conventional limits of mental health symptoms. The NMT mapping process enables the development of a unique sequence of developmentally appropriate interventions and enrichments that aim to help the young person re-approximate a more normal developmental trajectory. Interventions should start with the lowest underdeveloped/abnormally functioning set of problems in the brain and move sequentially up the brain as improvements are seen. Problems with self-regulation will need to be addressed before therapeutic work can address relational problems, and relational problems will need to be addressed before therapeutic work can move to verbal and insight oriented interventions.

Recommendations for co-therapeutic activities where parents and children can engage and receive mutually beneficial services are also common.

Evidence

Evidence supporting the use of the NMT can be found for very young children with emotional and behaviour problems. Barfield, Gaskill, Dobson and Perry (2012) conducted two studies to examine the use of the NMT on social-emotional development and behaviour among 28 children. The first study was a pre-test/post-test design with multiple time series measures, and the second study included a quasi-experimental, multiple time series design, with pre-test/post-test measures to examine changes in behaviour. Findings showed that inclusion of the NMT assessment and recommended interventions into therapeutic preschool programmes facilitated social and emotional development among high risk and traumatised children, as well as significant growth in nearly every area of socio-emotional

development. In addition, gains made from participation in the programme were maintained at both 6- and 12-month follow-ups (Barfield et al., 2012).

Individual case study data suggests NMT may be successful among older children (Perry & Dobson, 2013); however there appears to be no current empirical evaluations available examining the NMT.

Limitations

Research using sound methodology (i.e., RCTs) is needed to draw strong conclusions regarding the efficacy of the NMT among the care and protection population in secure residential care.

Implementation of the NMT requires highly skilled senior clinicians to lead the process with a unique combination of clinical and preclinical skills and knowledge of child development, clinical traumatology and developmental neuroscience, and requires considerable training for staff (Perry, 2009; Perry & Dobson, 2013). A lack of resources to follow through with the NMT recommendations has also been reported (Perry & Dobson, 2013). Furthermore, NMT intervention outcomes may be poor where the young person's relational environment is chaotic/impoverished or impermanent (e.g., in foster care) (Perry, 2009).

New Zealand Context

NMT was integrated into the services in Puketai care and protection secure residence under the previous Team Leader of Clinical Practice, Sean Twomey. In New Zealand, other practitioners trained in the NMT model include Brendan Ward (CYF, Rotorua) and Kathryn Berkett (Brainwave Trust; www.kbkonsulting.co.nz).

Summary

Implementing a framework in residential facilities can help ensure those providing services within a residence are working toward the same philosophy and aims. As outlined, the Neurosequential Model of Therapeutics (NMT), a trauma, attachment and neurodevelopmental framework, could be implemented to guide services provided in care and protection secure residences. At this time, this framework appears to have limited empirical evidence for its efficacy among the care and protection population in secure residential care. However, this framework provides a useful insight into the effects of trauma, and principles to guide practice in care and protection services.

Chapter 6: Models for Secure Care and Protection Residential Care

A model of care is a therapeutic or rehabilitative model that can be implemented in residential services, and sits underneath the overarching framework (see Chapter Five). Similar to implementing a framework in care and protection secure residences, a unified model of care can provide a structure to help ensure all agencies are working toward the same philosophy and aims, consequently leading to a greater level of consistency in approach. Secure residential care models discussed in this chapter were identified through the California Evidence-based Clearinghouse for Child Welfare, reviews of treatment models for group homes and residential care (e.g., James, 2011), and searches via internet search engines and electronic databases (e.g., PsycINFO). The final secure care models were selected due to their promising evidence-base for use in care and protection secure residential care and/or their current use in secure residences in New Zealand or internationally.

It is important to note that when interpreting the evidence for each model of care presented in this chapter, studies that do not use RCTs provide a weaker foundation for drawing inferences about the effectiveness of the model. In such cases, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as “significant” are those that are statistically significant at the $p < .05$ level.

6.1 The Sanctuary Model

The Sanctuary Model is a trauma-informed evidence-based systems approach, which can be used in care and protection secure residences to assist clients to heal from damaging and traumatic experiences (Bloom & Sreedhar, 2008; Esaki et al., 2013; Esaki, Hopson & Middleton, 2014). The Sanctuary Model recognises trauma as having a huge impact on an individual, causing a person to become trapped in a “loop of destructive repetition”, which includes disruption to attachment relationships (Clarke, 2012). The Sanctuary Model is an enhanced therapeutic community model, in which both staff and clients directly participate in order to create a healing community (Esaki et al., 2013). The model also has a focus on teaching young people and their families how to create and sustain non-violent lives (Clarke, 2012). The Sanctuary Model is designed to assist in the development of structures, processes, and behaviours on the part of staff, clients, and the community as a whole that can counteract the biological, affective,

cognitive, social, and existential wounds suffered by the victims of traumatic experience and extended exposure to adversity.

The Sanctuary Model acknowledges that staff are the key to facilitating change for clients, and works within a trauma framework to change the organisational culture, in order to ensure that clients and staff are able to work together appropriately to achieve positive therapeutic outcomes (Esaki et al., 2014). A positive organisational culture is also more conducive to positive staff attitudes regarding the implementation of changes in practice, which then lead to a better therapeutic environment for clients (Esaki et al., 2014). This is done by assisting the organisation to develop structures improving organisational morale, through the support of frontline staff, by ensuring they have adequate supervision and allowing them to play a more significant role in the organisation (Clarke, 2012).

The Sanctuary Model moves away from a medical model, flattens traditional hierarchies within organisations, and also encourages clinical staff to have a more proactive role within the community (Rivard et al., 2004).

The Sanctuary Model is not manualised, and instead offers an intensive training programme facilitated by staff from the Sanctuary Institute (James, 2011). The Sanctuary Model has been adopted by more than 200 agencies worldwide.

Programme Model

There are four core components within The Sanctuary Model: Trauma Theory foundation, Sanctuary Commitments and Norms, SELF, and the Sanctuary Toolkit (Esaki et al., 2013; Esaki et al., 2014). In addition, within the theoretical foundation framework, there are four additional trauma concepts that the model relies upon: trauma theory, social learning theory, non-violent practice, and complexity theory.

Trauma Theory Foundation

There are four concepts within trauma theory that The Sanctuary Model asks to focus on: Parallel Process, Collective Disturbance, Vicarious Trauma, and Re-enactment (Clarke, 2012). Parallel Process is the recognition of the impact that trauma and adversity can have on an organisation, through the interactions between under-resourced agencies, highly stressed and sometimes inexperienced staff, and clients who are expressing extreme behaviours (Clarke, 2012). Collective Disturbance refers to the occurrence where a strong

emotion among a group of people becomes linked to an unrelated situation. This can result in a high level of emotion remaining present within the community, but the community may struggle to find the source (Clarke, 2012). Vicarious Trauma is a term used to describe the negative traumatic impact on carers and staff due to listening to a person talk about trauma, or being exposed to their trauma related behaviours. Finally, Traumatic Re-enactment refers to the phenomenon whereby a person who has experienced trauma in the past, re-enacts their original trauma response, but in a different setting or situation (Clarke, 2012).

The use of a trauma recovery framework assists clients to develop effective and appropriate coping skills, with the purpose of replacing negative cognitive, social, and behavioural coping strategies (Clarke, 2012).

Sanctuary Commitments and Norms

There are seven commitments which The Sanctuary model requires adherence to. These are Non-Violence, Emotional Intelligence, Inquiry and Social Learning, Democracy, Open Communication, Social Responsibility, and Growth and Change. Further information regarding these norms can be found in Clarke (2012).

SELF Framework

Within the trauma theory utilised by The Sanctuary Model, the SELF framework offers a simple way for all involved with the Model, including clients and families, to understand and respond to trauma-based issues that they may have (James, 2011). SELF is an acronym for Safe, Emotional Management, Loss, and Future. Safety refers to “attaining safety in self, relationships and environment”. Emotional Management refers to “identifying levels of affect and modulating behaviour in response to memories, persons and events”. Loss refers to “feeling grief and dealing with personal loss”, and Future refers to “trying out new roles, ways of relating and behaving as a ‘survivor’ to ensure personal safety and help others” (Clarke, 2012, p. 57).

Sanctuary Toolkit

Finally, Sanctuary Tools are the practical activities used in order to implement the commitments and theories outlined above. These include activities such as community meetings, care planning, case reviews,

psychoeducation groups, and safety/self-care plans (for both clients and staff) (Clarke, 2012; James, 2011).

Training and Implementation

Key staff from all relevant levels of the organisation attend a five day training session facilitated by Sanctuary Institute trainers. Staff then return to their organisation and form a Core Team who preside over the implementation of the Model within the organisation (Clarke, 2012).

Evidence

The Sanctuary Model has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having “promising research evidence” for young children placed in higher level placements²³.

In one quasi-experimental study, Rivard, Bloom, McCorkle and Abramowitz (2005) examined The Sanctuary Model among young people with histories of maltreatment who had been placed in residential care. Using standardised measures, Rivard et al. (2005) found The Sanctuary Model demonstrated significant improvements in coping skills, sense of personal control and verbal aggression. In addition, improvements in safety and positive behaviours from clients and staff were found (Rivard et al., 2005). However, these findings were presented as being preliminary.

Limitations

To the best of the reviewers’ knowledge, The Sanctuary Model has not been evaluated using RCTs among young people involved in the care and protection system and/or in secure residential care. Research using RCTs is needed to draw strong conclusions regarding the efficacy of The Sanctuary Model for this population.

The Sanctuary Model requires full commitment from the organisation in order to ensure successful implementation and positive outcomes (Clarke, 2012; Esaki et al., 2013; Esaki et al., 2014; Rivard et al., 2004). However, the main limitation discussed in the literature with regards to implementation is the challenges inherent in making widespread cultural changes to an organisation, particularly when the organisation has existed for a long time, and where there is resistance from staff to make the necessary changes (Esaki et al.,

²³ The Clearinghouse defines ‘higher levels of placement’ as group, residential, and community treatment facilities. More information on the different levels can be found at the following website: www.childsworld.ca.gov/res/pdf/OverviewClassificationLvls.pdf

2013; Rivard et al., 2004). In addition, difficulties in staff relationships, trust, and communication may come to light when the organisational structure and culture changes (Rivard et al., 2004).

6.2 Behaviour Modification

Behaviour modification is a treatment approach based on learning theory and operant conditioning, which posits that behaviour can be altered or maintained by the consequence of one's actions. Behaviour modification uses reinforcement (either positive or negative) to increase desired behaviours, and punishment (either positive or negative) to decrease undesired behaviours. Token economy and point level systems are behaviour modification strategies that are frequently implemented in residential settings for young people. Token economy and point level systems are often combined and employed together.

Token Economy

The token economy is described as a reinforcement system, where desired behaviour (or absence of problematic behaviour) is reinforced through tokens, such as coins, that are exchanged for back-up reinforcers (Rodriguez, Montesinos & Preciado, 2005). Back-up reinforcers are objects, privileges or activities that are appealing to the young person to motivate them to engage in desired behaviours to earn tokens toward earning the reinforcer. Elements of a token economy include: identifying the target behaviour, identifying what back-up reinforcers to use and the token value of each reinforcer, determining how tokens will be earned and spent to access the back-up reinforcers, gathering baseline information on the current behaviour of the young person, and consistent implementation by staff. The development of the token economy has been credited to Montrose Wolf (Risley, 1997), and was introduced for use in a therapeutic setting by Ayllon and Azrin (1968).

Point Level Systems

Point Level Systems involve young people either advancing or dropping "levels" based on set contingencies (Hagopian, Rush, Richman, Kurtz, Contrucci & Crossland, 2002). These contingencies may include young people not engaging in inappropriate behaviours (e.g., swearing). Young people often start in the most restrictive level, and after displaying desired behaviour for a set amount of time, advance to higher

levels. As young people advance to the next level they often have more access to privileges coupled with less restrictions (Hagopian et al., 2002).

More information on the components of token economy and point level systems can be found in Ayllon and Azrin (1968), Doll, McLaughlin and Barretto (2013), Hagopian et al. (2002), and Kazdin (1977).

Evidence

Early implementation of token economies produced positive results across a range of settings. However, no recent research has been conducted examining token economies or point-level systems using sound methodology (i.e., RCTs) among child welfare/care and protection populations. An overview of research examining token economies or point-level systems is provided below.

In a reversal experimental design, Phillips, Phillips, Fixsen and Wolf (1971) found token reinforcement positively modified pre-delinquent behaviours among six boys, including promptness at the evening meal, room-cleaning behaviour, saving money and accuracy of answers on a news quiz. Milan and McKee (1976) implemented the token economy in an adult male prison system also using reversal design experiments and found improvement in observed behaviours (e.g., arising at a determined time, making the bed, cleaning, maintaining a well-groomed personal appearance). Similarly, point level systems was found to be effective in managing the shaping of appropriate behaviours and decreasing behavioural excesses in a children's psychiatric unit using a non-experimental study design (Jones, Downing, Latkowski & Ferre, 1992). Furthermore, level systems demonstrated improvement in disruptive behaviours (e.g., decrease in disruptive and off-task behaviours, increase in task completion) in a classroom setting in a reversal design study (Mastropieri, Jenne & Scruggs, 1988).

Behaviour modification approaches are also incorporated in the empirically-validated Teaching Family Model (see Chapter Seven, Section 7.2) and Multi-dimensional Treatment Foster Care models (see Chapter Seven, Section 7.3) for conduct problem behaviour.

Limitations

The token economy and point and level systems strategies have been strongly critiqued in the literature (see Mohr, Martin, Olson, Pumariega & Branca, 2009;

Mohr & Pumariega, 2004; Tompkins-Rosenblatt & VanderVen, 2005; VandderVen, 1995, 2000). These behaviour modification strategies have not been evaluated by recent research implementing RCTs, the assumptions upon which these programmes are based do not stand up to empirical scrutiny or theoretical validity and these behaviour modification strategies are yet to be evaluated by recent research implementing sound methodology (Mohr et al., 2009). Point and level systems strategies have been critiqued as being counterproductive and non-client centred as they neglect individual differences among children (Mohr et al., 2009). Furthermore, such approaches are punitive and require children to earn things that could be argued are the essence of treatment (e.g., activities) (Mohr et al., 2009). The American Association of Children’s Residential Centres (2014) recommended the removal of point and level systems, particularly for children and young people with severe trauma.

Mohr and colleagues (2009) suggest these behavioural modification strategies should be replaced with client-centred approaches.

New Zealand Context

Token economy and level systems are currently used in care and protection secure residential facilities in New Zealand. Other residential facilities in New Zealand, including Odyssey House’s youth services residential programme, also implement these behaviour modification strategies. However, there appears to have been no evaluation conducted on the current behaviour modification programmes being implemented in New Zealand secure residential facilities for young people.

6.3 Positive Peer Culture

Positive Peer Culture (PPC) is a peer-helping group-based treatment model for use in residential care among children and young people aged 12 to 17 years who present with similar difficulties. PPC was developed by Vorrath and Brendtro (1985), to help effectively counteract the “peer contagion effect” that is often seen among groups of troubled youth in treatment interventions. The peer contagion effect refers to the consolidation of antisocial behaviour when delinquent young people are grouped together (Dodge, Dishion & Lansford, 2006; Warr, 2002). The PPC model aims to replace this negative social environment with a positive peer culture, developing prosocial behaviours and attitudes through the teaching and modelling of

prosocial values, such as altruism, responsibility, self-worth, autonomy, and acceptance (Vorrath & Brendtro, 1985).

Underlying PPC is the belief “that young people can develop self-worth, significance, dignity and responsibility only as they become committed to the positive values of helping and caring for others” (Vorrath & Brendtro, 1985, p. xi). The overall goals of PPC are:

1. To meet the universal growth needs of youth for affiliation, achievement, autonomy and altruism.
2. Improve social competence.
3. Cultivate strengths in troubled and troubling youth.
4. Convert negative peer influence into care and concern for others.
5. Develop social interest through leadership and guidance from trained adults.

Further information regarding PPC can be found in Vorrath and Brendtro (1985), on the California Evidence-based Clearinghouse for Child Welfare website at www.cebc4cw.org/program/positive-peer-culture/detailed, and in James (2011).

Programme Model

PPC treatment is value-based and process-oriented. Adult authority is largely de-emphasised under the model, making young people responsible for the majority of their treatment, but under the supervision of adult staff (Vorrath & Brendtro, 1985).

The four treatment components are: (i) building group responsibility, (ii) group meeting, (iii) service learning and (iv) teamwork primacy. In the first component of building group responsibility, the members learn to keep each other out of trouble. The second component highlights the importance of the group meeting as a medium through which problem-solving and helping other group members is facilitated. The group meetings are structured, and include problem reporting, problem solving, and group leader’s summary. The third component of service learning is where the young people participate in community projects to help reinforce the PPC value of caring for and helping others. The last component is teamwork primacy, which is a programme management model that prioritises teamwork.

The recommended PPC group size is between 8 and 12 young people, with treatment implemented over 6 to 9 months. It is recommended that group meetings are run

for 90 minutes, 5 days per week. PPC has a programme manual, and training is available through The Academy for Positive Peer Culture. Adequate training is essential to guide the group process.

Evidence

The PPC model has been used in various sites in Canada and the Netherlands. PPC has been recognised by the California Evidence-based Clearinghouse for Child Welfare as being “supported by research evidence” for young children placed in higher level placements.

Studies evaluating PPC include an experimental design (McVicar, 1991), a quasi-experimental study (Sherer, 1985), and two one-group pre-test/post-test design studies (Ryan, 2006; Steinebach & Steinebach, 2009). Findings from these studies are outlined below.

McVicar (1991) found significant positive treatment effects of the PPC model in an experimental design study, including advanced moral reasoning, reduced antisocial and disruptive behaviour, and healthier institutional climate. Similarly, among street-corner gangs using a quasi-experimental design study, Sherer (1985) found significantly improved moral development and increased resistance to temptation.

Ryan (2006) examined PPC in a one group pre-test/post-test design among young people released from a residential programme that employed the PPC model. Findings showed 41% of young people were arrested post-release from residential care, which Ryan (2006) reported were comparable to those found in the delinquency literature. However, victims of physical abuse and neglect were found to be at higher risk for arrest following PPC intervention (50% versus 37%). Ryan (2006) concluded that PPC programmes may not be the most effective strategy for youth in the youth justice system with histories of maltreatment. We could infer that these findings are transferable to the care and protection population, given the high prevalence of maltreatment among this population.

Steinebach and Steinebach (2009) conducted a one group pre-test/post-test design to evaluate PPC among adolescent males in a residential treatment facility who exhibited behavioural problems and delinquency. Over the three-year period, a reduction in violence and increase in prosocial behaviour and self-esteem were found; however, actual rates were not reported. Limitations of this study included no randomisation of participants, and a lack of control or comparison group.

Further studies examining PPC among youth in residential treatment have evaluated an adapted PPC programme – EQUIP. Findings from these studies are outlined below.

EQUIP

EQUIP (Gibbs, Potter, & Goldstein, 1995) is an adaptation of PPC (see Chapter Six, Section 6.3) which also incorporates components from Aggression Replacement Training (ART; see Chapter Nine, Section 9.1.1). In the Netherlands, five studies have evaluated EQUIP, among young offenders – one RCT (Leeman, Gibbs and Fuller 1993), two quasi-experimental pre-test/post-test design studies (Brugman & Bink, 2011; Nas, Brugman & Koops, 2005), and two quasi-experimental designed studies which included measures of programme integrity (Helmond, Overbeek & Brugman, 2012, 2015). Overall, research evaluating EQUIP has found mixed results for young offenders. An overview of this research is provided below.

Leeman et al. (1993) conducted a RCT and found EQUIP to be effective in increasing social skills and reducing recidivism 12-months post-release for male youth at a medium-security correctional facility (15% recidivism rate among EQUIP group, 40.5% among control group), but no significant differences in moral judgement were found between groups.

Nas et al. (2005) evaluated EQUIP among male young offenders in a high-security correctional facility using a quasi-experimental pre-test/post-test study. The matched control group of young people were from two facilities that offered care as usual. Those who completed EQUIP had significantly greater reductions in cognitive distortions compared to the control group (total effect size, $d = .27$). However, no differences were found on moral judgement, social skills and social information processing.

Brugman and Bink (2011) used a quasi-experimental pre-test/post-test design with a control group to examine EQUIP among youth offenders in high-security youth correctional facilities. A significant reduction in cognitive distortions among the EQUIP group was found, but no differences were found in speed or seriousness of offending post-release (Brugman & Bink, 2011).

Helmond et al. (2012) investigated programme integrity and effectiveness of EQUIP in six youth correctional facilities in the Netherlands and Flanders using a quasi-experimental study. Those who received EQUIP had

stable social skills and moral value evaluation scores from pre- to post-intervention, while those in the control group exhibited a decrease in these scores. EQUIP was not found to improve moral judgement or reduce cognitive distortions. The treatment integrity was found to be 'low to moderate' across the facilities; however, program integrity was not found to moderate the effectiveness of EQUIP.

Helmond et al. (2015) used a quasi-experimental study design to examine program integrity and effectiveness of EQUIP on recidivism among a sample of 133 incarcerated youth in the Netherlands. Overall the EQUIP programme was implemented with low-to-moderate levels of programme integrity. No differences between the experimental and control groups were found in the prevalence, frequency and severity of recidivism, and high levels of programme integrity in the low-to-moderate-range did not improve effectiveness of EQUIP on recidivism for the experimental group.

Limitations

The PPC has been primarily investigated among young offenders, with mixed outcomes. Further research using sound methodology (i.e., RCTs) is needed in order to draw strong conclusions regarding the efficacy of PPC among the care and protection population in secure residential care.

Some limitations of the PPC model have been identified in the literature. Brugman and Bink (2011) found no differences between the EQUIP treatment group and the control group on speed or seriousness of reoffending, while Ryan (2006) noted that PPC may be limited for young people in the youth justice system who have experienced maltreatment. In addition, a qualitative study of young people who had completed a PPC programme found the young people were critical of the group process (Kapp, 2000). Furthermore, studies have shown EQUIP is typically implemented with low-to-moderate integrity (Helmond et al. 2012, 2015), suggesting that the programme may pose a high bar of implementation requirements. As noted by Quigley (2004), the PPC has been "misunderstood, misused and improperly implemented" (p. 136).

6.4 Stop Gap

Stop-Gap is a secure residential model, developed by the Devereux Centre for Effective Schools in Pennsylvania, for children with emotional and behavioural disorders (McCurdy & McIntyre, 2004). The Stop-Gap model

emphasises short-term confinement in residential care providing "a stop-gap for children and youth caught in a downward spiral of increasingly disruptive and antisocial behaviour" (McCurdy & McIntyre, 2004, p. 141). The aim is to stabilise the young person with emotional and behavioural disorders. The duration of time spent in residence is dependent on the young person's needs, however will ideally be for less than 150 days (Zakriski, Wright & Parad, 2006). While the young person is in residence, Stop Gap also prepares the young person and their family for positive outcomes in community-based care (McCurdy & McIntyre, 2004).

Further information regarding the Stop-Gap model can be found in McCurdy and McIntyre (2004) and James (2011).

Programme Model

The programme model has three tiers of intervention: (i) Environment-based, (ii) Intensive, and (iii) Discharge-related intervention. McCurdy and McIntyre (2004) state that any residential facility implementing the Stop-Gap model should provide services across these three tiers of care. Each tier is described briefly below.

Environment-based intervention

Under this first tier, the aim is to provide an environment which produces a decrease in behaviour to a level that enables the young person to be discharged to community-based care and intervention. Services and programmes provided to young people at this level include token economy, social skill intervention, academic intervention, anger management skills training, and problem solving skills training. McCurdy and McIntyre (2004) argue that acquisition of these skills and adaptive behaviours will help facilitate sustained behavioural change.

Intensive intervention

It is proposed that the first tier of Stop-Gap, the environment-based intervention, should be sufficient for most young people entering residential treatment in reducing their problematic behaviour to a level where they can begin to re-integrate into the community. However, a young person with serious problematic behaviour which either does not improve or intensifies will be provided with more intensive services under the second tier of the Stop-Gap model (McCurdy & McIntyre, 2004). Intensive services include a functional behavioural assessment (FBA) and behaviour support plans.

The Naturalistic Functional Assessment (NFA; Repp, 1999; Repp & Karsh, 1994) is the FBA recommended by Stop-Gap to identify behavioural function and conditional probabilities in a residential setting. Information from the NFA and interviews with team leaders is used to develop behavioural support and individualised crisis management plans.

Discharge-related intervention

The third tier concerns the preparation of the young person and their family for discharge back into the community. The aim of discharge intervention is to maintain and generalise the skills obtained while the young person is in residence (McCurdy & McIntyre, 2004). Discharge-related interventions begin as soon as the young person is admitted to the residence, and extends through to discharge and follow-up. Stop-Gap incorporates intensive case management, parent management training, and community reintegration in order to help overcome typical difficulties associated with residential facilities, such as minimal family involvement, decision-making in treatment process, and lack of community involvement and access for the young people residing in residences (see McCurdy and McIntyre (2004) for an overview of these services). If the young person is unable to return to the care of their immediate family, then a family relative, foster care or treatment foster care placement is organised (McCurdy & McIntyre, 2004).

Evidence

Stop-Gap model was recognised by the California Evidence-based Clearinghouse for Child Welfare as having “promising research evidence” for young children placed in higher level placements. The Stop-Gap model is believed to be advantageous in several ways. Stop-Gap is considered to be in-line with the stance of placing children and youth in the least restrictive and community-based forms of treatment; however, Stop-Gap still recognises the need for secure facilities to be available for the most at-risk young people (McCurdy & McIntyre, 2004; Zakriski, Wright & Parad, 2006). In addition, the treatment components recommended (e.g., parent management training) are typically manualised and have strong empirical-evidence among young people with complex needs.

One non-randomised control study by McCurdy and McIntyre (2004) evaluated the effectiveness of Stop-Gap on reducing the use of therapeutic holds (i.e.,

therapeutic restraint). Two residential treatment centres were compared; one treatment centre which had implemented the environment-based intervention of the Stop-Gap model, while the comparison group provided traditional residential treatment centre services. Both groups were matched on population number, gender, and disability. After 12 months, the environment-based intervention had a decline in use of therapeutic holds, while the comparison group had an increase in use (McCurdy & McIntyre, 2004). No other studies have evaluated the Stop-Gap model.

Limitations

Although Stop-Gap has demonstrated promise, there is a lack of empirical evidence on programmes implementing the full model. Research using sound methodology (i.e., RCTs) is needed in order to draw strong conclusions regarding the efficacy of Stop-Gap among the care and protection population in secure residential care.

Summary

Implementing an overarching model of care in care and protection secure residences can help create structure, and ensure a consistent vision and philosophy of care is held by the agencies working in these facilities. Here, the Sanctuary Model, token economy and point level systems, Positive Peer Culture (PPC), and Stop-Gap were described. At this stage, the Sanctuary Model shows promising results; however, further research using sound methodology is required to establish its efficacy. Token economy and point and level systems have been strongly critiqued as being non-client centred, and have not been examined by recent research using sound methodology. PPC has had mixed results, and RCTs examining the model among the care and protection population in residential care are needed. Finally, although Stop-Gap has a lack of empirical evidence, this model is in line with the philosophy of placing children and youth in residence for the shortest amount of time, recommends the use of evidence-based programmes, and emphasises the need for more community-based forms of treatment.

Chapter 7: ‘Step-down’ Care Models

The treatment models outlined in the previous chapter are evidence-based and/or highly regarded internationally for providing residential-based services for the care and protection population. The following is an overview of evidence-based models that can be implemented as an alternative to residential or institutional services, either while the young person resides with family or in out-of-home care, such as foster care and group homes. This aligns with the philosophy of providing services for these young people via the least restrictive medium, ideally within the community and with family involvement in the treatment and reintegration process.

Here, models that can be implemented for the care and protection population are described, including their programme model and evidence-base. These secure residential care models were identified through the California Evidence-based Clearinghouse for Child Welfare, reviews of treatment models for group homes and residential care (e.g., James, 2011), and searches via internet search engines and electronic databases (e.g., PsycINFO).

It is important to note that RCTs provide strong foundations for drawing inferences about the effectiveness of ‘step-down’ care models. In addition, meta-analyses provide useful estimates of the combined size and direction of effects across independent studies. Here, an outline of RCTs and/or meta-analyses for each ‘step-down’ care model is provided. Where there is a lack of robust evidence, findings from studies using alternative study designs (e.g., pre-test/post-test) will then be discussed; however, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as “significant” are those that are statistically significant at the $p < .05$ level.

7.1 Multisystemic Therapy

Multisystemic Therapy (MST), developed by Henggeler and colleagues, is a multimodal family and community-based treatment for addressing serious conduct problems, offending behaviour, and social, emotional and behavioural problems in children and adolescents.

MST is based on Bronfenbrenner’s (1979) social-ecological theory, where an individual’s development and behaviour is influenced by their social ecology. MST promotes behavioural change by targeting the

systems that are believed to maintain conduct problem behaviours among young people, namely their family, peers, school and community. In particular, MST views the family and/or caregivers as the primary source of change and aims to empower them to facilitate change in the young person’s social ecology (Henggeler & Sheidow, 2012). MST is implemented for youth aged 12 to 17 years for a typical duration of three to five months.

MST is an individualised intervention, with nine treatment principles that provide a framework for intervention:

1. The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context.
2. Therapeutic contacts emphasize the positives and use systemic strengths as levers for change.
3. Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behaviour within and between multiple systems that maintain the identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members’ needs across multiple systemic contexts.

(Henggeler, 2012, p. 184)

Further information regarding MST can be found in several clinical volumes (Henggeler, Schoenwald, Rowland & Cunningham, 2002; Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 2009), in a review of treatment models for conduct problem behaviour

and delinquency (Henggeler & Sheidow, 2012), on the blueprints website at www.blueprintsprograms.com, and on the MST website at www.mstservices.com.

Programme Model

Guided by the nine treatment principles, MST is implemented in the family home and other locations in the community. An individualised treatment plan for each young person is developed integrating evidence-based interventions.

Interventions at the family level include structural family therapy, strategic family therapy, and behavioural parent training (Henggeler et al., 2009). Interventions at the peer level aim to decrease associations with antisocial peers, while interventions in the school domain aim to increase positive communication between caregivers and teachers, and restructure the young person's activities after school to facilitate school performance. At the community level, the young person is encouraged to engage in prosocial recreational and social activities. Individual-based interventions are also implemented for the young person, including cognitive behavioural therapy (Henggeler et al., 2009). If an intervention is deemed successful, then a plan is employed to facilitate continued outcomes. If an intervention is not successful then the MST team identifies the cause of failure and subsequently implements new interventions (Henggeler & Sheidow, 2012).

Interventions in each domain are integrated into the broader MST model and quality assurance and improvement system (Henggeler, 2012). The quality assurance and improvement system includes three components: training, organisational support and implementation and reporting to help maintain the reliability and sustainability of the MST programme.

The MST team consists of 2 to 4 full time masters-level therapists and a half-time doctoral or advanced masters-level supervisor (Henggeler & Sheidow, 2012). Each therapist has a caseload of 4 to 6 families. Therapists rotate on an on-call schedule so one therapist is available for families 24 hours a day, 7 days a week.

Implementation

MST has been disseminated in fourteen countries (MST Services Inc., 2010), including Norway, Australia, Canada, Denmark, Ireland, England, Sweden, Switzerland, the Netherlands, New Zealand, and in over 30 states in the U.S.

Evidence

MST is one of the most extensively validated and highly regarded treatment models for children and adolescents exhibiting offending and problematic behaviours. MST is considered to be “well-supported” by research by The California Evidence-Based Clearinghouse for Child Welfare.

In relation to the child welfare population, Ogden and Hagen (2006) investigated the effectiveness of MST compared to regular child welfare services utilising a RCT in Norway. The sample consisted of 75 adolescents who were referred to child welfare services. Compared to young people receiving regular interventions from child welfare services, those who received MST had significantly lower behavioural problems and delinquency, and were less likely to be placed in out-of-home care at two-years follow-up (52% and 72% living at home or under caregiver supervision at follow-up, respectively). Effect sizes were calculated between groups at follow-up for self-reported delinquency ($d = .26$), parents' Child Behaviour Checklist (CBCL) ratings ($d = .50$), and Teacher's Report Form (CBCL) ratings ($d = .68$) (Ogden & Hagen, 2006).

Van der Stouwe, Asscher, Stams, Dekovic, and van der Laan (2014) identified fifty-one studies (22 independent samples) examining the effectiveness of MST among antisocial, conduct disordered and/or delinquent youth. These studies had been conducted across the Netherlands, United States, United Kingdom, Canada, Sweden and Norway, using RCTs and quasi-experimental designs. In their meta-analysis, van der Stouwe et al. (2014) found small significant effects of MST on delinquency ($d = .201$), psychopathology ($d = .268$), substance use ($d = .291$), family factors (i.e., family functioning, parenting skills, mental health; $d = .143$), out-of-home placement ($d = .267$) and peer factors ($d = .213$).

Van der Stouwe et al. (2014) found moderators of the effectiveness of MST to include the study (e.g., country, research design etc.), treatment (e.g., duration), sample (e.g., offenders, sex offenders), and outcome characteristics (i.e., delinquency type). Specifically, van der Stouwe et al. (2014) found that MST was most effective when implemented with young people aged less than 15 years, (delinquency: $d = .421$; psychopathology: $d = .4$; family factors: $d = .253$), and in studies including a larger proportion of Caucasian youth offenders (delinquency: $d = .291$). In addition, positive treatment

effects were found to be more prominent among those aged over 15 years when treatment targeted peer relationships and risk and protective factors at the school-level (van der Stouwe et al., 2014).

An adapted MST model for Child Abuse and Neglect; (MST-CAN) is also considered to be “supported by research evidence” by The California Evidence-Based Clearinghouse for Child Welfare. One RCT has been conducted evaluating MST-CAN (Swensen, Schaeffer, Henggeler, Faldowski & Mayhew, 2010). An overview of this study is provided below.

MST-CAN was examined using an RCT among 86 physically abused young people and their families (Swenson et al. 2010). Swenson et al. (2010) found that comparative with those assigned to the Enhanced Outpatient Treatment (EOT) condition, MST-CAN demonstrated significant reductions in mental health symptoms (internalising symptoms – $d = .71$; Child Behaviour Checklist total symptoms – $d = .85$; PTSD – $d = .55$; Trauma Symptom Checklist Children (TSCC) – dissociation – $d = .73$; TSCC – PTSD – $d = .68$), parent emotional distress (Global Psychiatric Distress – $d = .63$), parenting behaviours associated with maltreatment (Conflict Tactics Scale, subscales: neglect – $d = .89$ (youth report), $d = .28$ (parent report); psychological aggression – $d = .21$ (youth report); minor assault – $d = .14$ (youth report); severe assault – $d = .54$ (youth report), $d = .57$ (parent report), and non-violent discipline – $d = .20$ (youth report), $d = .57$ (parent report)), out-of-home placements ($n = 13$ versus 6 people placed, respectively), and changes in placement ($M = 0.76$ versus 0.25, respectively) 16-months post-baseline. In addition, parents in the MST-CAN group demonstrated significant increases in total social support ($d = .46$), appraisal support ($d = .67$), and belonging support ($d = .57$). Compared to the EOT group, MST-CAN was not significantly more effective at reducing incidents of re-abuse (11.9% versus 4.5%, $p < .05$) (Swenson et al., 2010).

Swenson et al. (2010) also examined the clinical significance of outcomes following MST-CAN intervention. MST-CAN demonstrated a reduction in the proportion of young people scoring in the clinical range for PTSD symptoms (baseline = 17.8%, 16-months post-baseline = 8.9%), and parents exceeding clinical thresholds for psychiatric distress (baseline = 20.5%, 16-months post-baseline = 5.3%). Comparative to the EOT group, MST-CAN young people reported fewer incidents of severe assault by their parent (9.8% versus 4.7%, respectively) (Swenson et al. 2010).

Dopp, Borduin, Wagner and Sawyer (2014) calculated that for every one dollar spent on MST treatment, MST returned \$5.04 in savings to taxpayers and crime victims 25 years post-treatment.

Limitations

The research examining MST has been primarily conducted among the youth justice population. Further research utilising RCTs and follow-up periods are needed before strong conclusions can be made regarding the efficacy of MST for the care and protection population. Thus, conclusions which can be drawn from the available research for the care and protection population are provisional.

Implementation of MST is intensive, requiring a high workload and demand for MST therapists and supervisors. In addition, the replication of MST in Sweden did not reproduce findings similar to those found by the developers of MST (Sundell, Hansson, Lofholm, Olsson, Gustle & Kadesio, 2008). However, this was attributed to low treatment fidelity by MST therapists, and the strength of intervention provided to the Sweden comparison group relative to that provided to comparison groups in the U.S.

New Zealand Context

Currently there are six teams in New Zealand across Auckland, Wellington, Christchurch and Hawkes Bay who are trained in and deliver MST.

Curtis, Heiblum, Ronan, and Crellin (2009) examined the effectiveness of MST for the treatment of adolescent offenders in New Zealand using a pre-test/post-test design with 6- and 12-month follow-up periods. The authors found a significant decrease in offending behaviours (pre-treatment: 51%; post-treatment: 41%; 6-month follow-up: 35%; 12-month follow-up: 27%), and an increase in youth compliance and family relations. Reductions in the frequency ($d = .23$) and severity ($d = .16$) of offending were also found between pre- and post-treatment, and were maintained at 6- and 12-month follow-up. The effect sizes found post-treatment were comparable to those of international MST studies, with effect sizes significantly greater than those of the control groups. However, gains in school attendance and out-of-home placements reduced across the follow-up periods. In addition, Curtis et al. (2009) found the therapist and supervisor attrition rate was 42%, which may reflect the intensive workload and demand of implementing MST.

7.2 Teaching Family Model

The Teaching Family Model (TFM) is a model used with young people who are at risk of escalating criminal behaviour, self-injurious behaviour, or emotional disturbance, and with families who are known by social welfare authorities and are at risk of having their children removed from their care (James, 2011). This model may be used either as an adjunct, to help avoid the need for secure residential care for the child (step-down), or as a transitional option for young people coming out of residential care before they return to their biological family or transition to independence.

The goals of TFM include that it is humane, effective, individualized, satisfactory to stakeholders, cost efficient, replicable, and integrated. Further discussion of these goals can be found in Fixsen et al. (2007).

TFM is a group home scenario, where up to eight young people, up to the age of 17 years, are housed together in a home (as opposed to a residential facility) where they are cared for by Teaching Parents, who are often a married couple (Fixsen, Blasé, Timbers & Wolf, 2007; James, 2011; McLean, Price-Robertson & Robinson, 2011). The Teaching Parents are carefully selected and highly trained in the use of appropriate interactions, positive support and skill acquisition (James, 2011; McLean et al., 2011). They are also supported through on-call professional consultation, and are thoroughly evaluated on a regular basis (James, 2011).

Important aspects of the model include the teaching parents' proactive efforts in assisting the young people to learn interpersonal relationship skills and life skills, and the use of a therapeutic community style peer leadership format (Fixsen et al., 2007; James, 2011). The use of a token economy and high levels of positive reinforcement are further essential components of the TFM (Lee & Thompson, 2008). The environment is based on family style living, which is considered essential in terms of allowing the young people to learn in a caring, consistent and normalized environment, which assists them to transition back to living with their biological family (Fixsen et al., 2007; James, 2011).

TFM is typically used in group home settings but can also be applied to foster care and treatment foster care settings, as well as schools and psychiatric care settings (Fixsen et al., 2007; James, 2011). TFM is manualised and professional training is available (James, 2011).

Evidence

TFM has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having “promising research evidence” for young children placed in higher level placements.

Several studies have been conducted evaluating the effectiveness of TFM among young people with conduct problem behaviour, and offending behaviour. TFM has been evaluated using one RCT (Lewis, 2005), one quasi-experimental study with a matched comparison group (Thompson, Smith, Osgood, Dowd, Friman & Daly, 1996), four quasiexperimental studies with non-matched comparison groups (Bedlington, Braukmann, Ramp & Wolf, 1988; Kirigin, Braukman, Atwater & Wolf, 1982; Slot, Jagers & Dangel, 1992), three pre-test/post-test studies (Jones & Timbers, 2003; Larzelere, Daly, Davis, Chmelka & Handwerk, 2004; Slot et al. 1992), and one retrospective study using propensity matching (Lee & Thompson, 2008). An overview of these studies is provided below.

Using a RCT, Lewis (2005) examined an adapted version of TFM for use in the family home (called the Families First Intervention), for young people referred by the school or youth court due to serious problems in functioning. Those in the Families First intervention showed significant improvement on family functioning, child behaviour problems, physical care and resources, and parental effectiveness from pre- to post-test. The only non-significant difference between the treatment and control groups was for parent effectiveness/parent-child relationships from pre-test to follow-up. The author reported that the latter finding may have been due to the control group's improved score over time (Lewis, 2005).

Thompson et al. (1996) examined Boys Town, an updated adaptation of the TFM (see Daly and Dowd, 1992) among young people admitted to the residential programme by referral from social services. The follow-up period for this quasi-experimental study was approximately four years post-discharge. Those placed in Boy's Town had significantly higher grade point averages, completed more years of school, and had a higher rate of high school graduation than those in the control group (83% completed high school/GED versus 69% of controls) (Thompson et al. 1996).

Among court adjudicated youth using a non-equivalent comparison group design study, Bedlington et al. (1988) found that compared to those in non-TFM homes, those

in a TFM home scored significantly higher on staff-youth relationships and interactions, pleasantness, prosocial behaviour, staff teaching activities, and disapproval of deviance.

Kirigin et al. (1982) compared court assigned youth in TFM homes and non-TFM on offence and institutionalised rates at one year post-discharge in a non-matched comparison group design study. Compared to the comparison group, fewer young people in the TFM group had engaged in offending and were institutionalised one year post-discharge. However, differences between groups were not statistically significant.

Slot et al. (1992) conducted three studies to determine the effectiveness of cross-cultural replication of TFM in the Netherlands. The first study was a pre-test/post-test design, and the second and third studies were quasi-experimental designs with non-matched comparison groups. Most youth in the TFM sample had been detained in care by a youth court judge. In study one, pre- and post-treatment scores indicated significant improvement was found in overall adjustment, family adjustment, relationship with parents, social competence, offence rates, problems at home, and ability for relationships outside family. However, no significant improvement in academic and vocational aspirations was found. In study two, the offending patterns of the Dutch youth who completed treatment in the TFM were compared to those of a non-treatment group from Canada. At six months post-treatment, analyses found a reduction in the number of Dutch youth considered frequent offenders (a 68% decrease) and an increase in the number of youth considered non-offenders (94.1% increase). When compared to the non-treatment group from Canada, the Dutch sample showed a considerable trend toward less serious offending (73% versus 20%), while the Canadian youth showed a trend toward more serious offending (24% versus 3%; Slot et al. 1992). Finally, in study three, the effects and costs of placement in a TFM were compared to those of placement in a Dutch State Correctional Institute. No differences were found between groups on measures of problems (e.g., overall adjustment, adjustment within family, relation with parents, offences etc.), abilities for relationships outside family, and community participation. Costs of TFM were one-fourth that of placement in a state institution (Slot et al. 1992).

Jones and Timbers (2003) examined TFM's effectiveness in reducing physical restraint, seclusion and negative incidence reports in a pre-test/post-test design of two facilities in the United States that employed the TFM (Barium Springs and Bridgehouse). Barium Springs demonstrated a 40% reduction in restraints and 80% reduction in negative incident reports. Bridgehouse had a 75% reduction in restraints and seclusion. All findings, except for Barium Springs' restraint level, reached statistical significance (Jones & Timbers, 2003).

Larzelere et al. (2004) evaluated the Boys Town family programme in a pre-test/post-test study design with a three month follow-up. Young people discharged from TFM had been referred by youth justice (34%), social services (21%), mental health (17%), family/self (17%), or other (11%). Both boys and girls showed significant improvement on all outcome scores (Child Behaviour Checklist (CBCL), Diagnostic Interview Schedule for Children (DISC), and Restrictiveness of Living Environment scale), except for scores among boys on the CBCL 'social problems' narrow-band scale. The percentage of young people with diagnosable psychiatric disorders decreased from 60% to 25% from admission to 12-months later. Between discharge and follow-up 9.8% of girls and 9.4% of boys were arrested, whereas prior to admission, 59% of girls and 67.9% of boys had been arrested. At three months post-discharge, the young people were functioning at comparable rates to national norms for being in school or having graduated (93% versus 90%), being neither in school nor working (8.1% versus 8%), and being employed (52.9% versus 58.4%) (Larzelere et al., 2004).

Finally, Lee and Thompson (2008) compared outcomes between young people in TFM and MTFC (see Chapter Seven, Section 7.3) in a retrospective study using propensity matching. Those in TFM were more likely to be favourably discharged, more likely to return home, and less likely to experience a subsequent formal placement than those in MTFC. No differences were found between groups for legal involvement or the likelihood of living in a homelike setting six months post-discharge. These findings suggest that placement in a group home, such as TFM, can be more or just as effective as MTFC for some youth (Lee & Thompson, 2008).

Limitations

Of the research that is currently available, findings regarding TFM are promising. However, more research utilising RCTs and follow-up periods are needed before strong conclusions can be made regarding the efficacy of TFM for the care and protection population. Therefore, conclusions that can be drawn from the available research are provisional.

New Zealand Context

Youth Horizons runs four residential therapeutic homes for adolescents with significant emotional and behavioural difficulties and/or involvement with youth justice, three of which are in Auckland, and one in Hamilton. Hamilton House is the residential therapeutic home run by Youth Horizons based in Waikato and functioning as a TFM. Two treatment foster care programmes run by Youth Horizons also implement the TFM model.

7.3 Therapeutic Foster Care (Multidimensional Treatment Foster Care)

Therapeutic Foster Care (Multidimensional Treatment Foster Care; MTFC) was developed by Chamberlain (2003) and is a foster care intervention model for young people exhibiting severe behavioural and emotional difficulties who are in need of an out-of-home intervention. MTFC is seen as an alternative model to secure residential care. MTFC is also referred to as the Oregon Treatment Foster Care and Treatment Foster Care.

MTFC is based on social learning theory, and utilises behavioural therapy and cognitive-behavioural therapy approaches. The philosophy of MTFC is to provide the young person with reinforcement and encouragement from prosocial adults in a naturalistic setting. Under the model, the role of the foster parent is to provide supervision, monitoring, and the promotion of prosocial behaviours. MTFC aims to ultimately reunite the young person and their family, and to promote long-term successful outcomes (Chamberlain, 2003). MTFC is implemented for youth aged 12 to 18 years; however, a preschool version (MTFC-P) is also available for young children aged 3 to 6 years (e.g., Fisher, Gunnar,

Chamberlain & Reid, 2000). Implementation of MTFC is recommended over a minimum of six months before the young person is transitioned back to their family environment.

Further information regarding MTFC can be found in Chamberlain (2003), Henggeler and Sheidow (2012), on the multidimensional therapeutic foster care website at www.mtfc.com, and on the blueprints website at www.blueprintsprograms.com.

Programme Model

MTFC treatment is individualised, with the young person placed in a one-on-one foster care environment, with foster parents who are part of a treatment team. The treatment team includes a range of specialists, including a therapist, behaviour support specialist, family therapist, psychiatrist, and team supervisors.

A highly structured behavioural management plan is implemented, which aims to surround the young person with positive, encouraging adults who provide a highly structured and supervised context. The aim is to reduce or eliminate associations with antisocial peers, and to increase engagement with prosocial peers and activities. Clear rules and contingencies are established, and the young person's behaviour is closely monitored.

Individual therapy is provided to the young person, a skills trainer offers real-world opportunities to the young person, and a family therapist works with the young person's family. Services are provided both in the foster home, in the family home, and in the community.

Evidence

Multi-dimensional Treatment Foster Care (MTFC) is the only established evidence-based foster care intervention. MTFC is considered to be "well-supported" by research by The California Evidence-Based Clearinghouse for Child Welfare (referred to as 'Treatment Foster Care Oregon – Adolescents'). MTFC sites have been implemented in the United States and across Europe, including Norway, Denmark, the UK, Ireland, and the Netherlands.

Multiple RCTs have been conducted examining MTFC (e.g., Chamberlain & Reid, 1991, 1998; Eddy & Chamberlain, 2000; Eddy, Whaley & Chamberlain, 2004; Leve, Chamberlain & Reid, 2005; Leve & Chamberlain, 2007; Chamberlain, Leve, & DeGarmo, 2007). RCTs have evaluated MTFC across a range of adolescent populations, including those involved in the youth justice system (e.g., see Fisher & Chamberlain (2000)

for an overview), referred from a state mental hospital (Chamberlain & Reid, 1991), young people in social services (e.g., Hansson & Olsson, 2012; Westermark, Hansson & Olsson, 2010), and youth justice and/or high-risk girls (e.g., Chamberlain et al., 2007; Leve et al. 2005; Leve & Chamberlain, 2007; Smith, Chamberlain & Eddy, 2010).

Among a sample of people involved in social services, Westermark et al. (2010) conducted an RCT and found MTFC significantly reduced externalising and internalising problems on the Youth Self Report (YSR) and Child Behaviour Checklist (CBCL) measures, as well as scores on the depression and anxiety subscales and global severity index (GSI) on the symptom checklist-90 (SCL-90) from baseline to 24-month follow-up. Compared to treatment as usual, MTFC was found to significantly reduce YSR externalising difficulties ($d = -.33$), depression scores (as measured by the SCL-90; $d = -.57$) and GSI scores ($d = -.56$). MTFC also demonstrated a reduction in internalising and externalising symptoms and total difficulties (as measured by the CBCL; $d = -.51$, $-.19$ and $-.57$, respectively), and anxiety symptoms (as measured by the SCL-90; $d = -.67$) compared to the treatment as usual group; however, these findings were approaching significance ($ps < .10$; Westermark et al. 2010).

In a quasi-experimental pre-test/post-test design study using a sample of English girls in need of a new foster care placement and who were exhibiting complex difficulties (i.e., behavioural and emotional) and/or had histories of offending, Rhoades et al. (2013) found MTFC demonstrated improvements in rates of offending ($d = .76$), violence ($d = .26$), risky sexual behaviour ($d = .28$), self-harm ($d = .42$) and school activities ($d = .37$).

RCTs have found MTFC to be associated with a decrease in the number of violent offences post-treatment (Eddy et al. 2004), decrease in the number of criminal referrals, number of days in locked settings, and self-reported delinquency (Chamberlain et al. 2007), reduced self-reported tobacco, marijuana and other drug use (Smith et al., 2010), a reduction in the number of days spent in locked settings, and increased school attendance and homework completion (Leve et al., 2005; Leve & Chamberlain, 2007).

Aos, Phipps, Barnoski and Lieb (2001) found MTFC to be very cost effective, with every dollar spent on treatment MTFC returning \$43.70 in benefits.

Limitations

The research examining MTFC has been primarily conducted among young people who have engaged in offending behaviour. Although research has examined MTFC among the care and protection/child welfare population, including an RCT (i.e., Westermark et al. 2010), further research utilising RCTs is required before strong conclusions can be made regarding the efficacy of MTFC among this population.

Training in MTFC is complex, and the set-up and implementation of MTFC can be time consuming. In a study of implementation of MTFC across 51 countries, Chamberlain, Brown and Saldana (2011) found that several sites failed in the pre-implementation phase.

New Zealand Context

MTFC is provided by Youth Horizons Trust in Auckland. Youth Horizons provides MTFC for young people aged 12 to 16 years old who exhibit significant behavioural problems. More information can be found at www.youthhorizons.org.nz.

7.4 CARE (Children and Residential Experiences)

The CARE model was developed by the Residential Child Care project at Cornell University. The model is based on theories of how children change, grow and develop and the premise that residential care can improve child well-being if practices are implemented to serve the best interests of the child.

Anglicare is a funded non-governmental organisation and is the organisation implementing CARE in Australia. Anglicare does not support secure care based models of out-of-home care viewing such an approach as unnecessarily punitive for young people whose problem behaviour is often pain based (Crouch, Sterling & Ingram, 2013).

Further information regarding CARE can be found on the Cornell University's website at: rccp.cornell.edu/caremainpage.html.

Programme Model

The CARE programme is based on six principles, established from the results of literature reviews, surveys of experienced childcare workers and supervisors, and standards reviews. The principles are that residential

care should be developmentally focussed, family involved, relationship based, competency centred, trauma informed and ecologically oriented (Holden, Izzo, Nunno, Smith, Endres & Holden, 2010).

Developmentally Focussed

The CARE model aims to enhance children's chances for normal development, recognising that children in residential care may need additional support in order to do this (Holden et al., 2010). All activities offered under the model are appropriate to their developmental level, promote self-efficacy and improve self-concept.

Family Involved

Family involvement and positive contact with families is considered key to the model as children are seen to benefit when their families work in partnership with the care organisation. Maintaining connections between children and their family and community fosters resiliency and improves self-concept, benefitting the child's ethnic, racial and cultural identity.

Relationship Based

A focus of residential care under this model is the need for children to develop healthy attachments and trusting relationships with the adults who care for them.

Competency Centred

Activities within the CARE model are designed to build competencies and life skills such as managing their environment, mastering new skills and coping with challenges. This is seen as a primary responsibility of staff in the organisation.

Trauma Informed

The importance and prevalence of trauma in the lives of young people in residential care are recognised and are a key element of the CARE model. Staff in the organisation are responsible for ensuring the environment is safe and nonviolent and interactions involve sensitivity and an understanding that many behaviours are rooted in trauma and pain.

Ecologically Oriented

The CARE environment is engaging and supportive and environmental supports are matched to individual children's needs. There is an understanding that all activities and interactions in residential care impact on the developmental trajectories of children.

Evidence/Limitations

To the best of the reviewers' knowledge, no peer-reviewed research examining the CARE model among the care and protection population has been published.

The CARE model was developed in the United States and does not appear to have been modified to account for the needs of indigenous young people. This presents as problematic for the New Zealand context, where rangatahi Māori are over-represented in the care and protection population.

7.5 Spiral to Recovery

Spiral to Recovery is a non-secure residential care model developed in Northern Queensland, Australia. It is a model of Therapeutic Residential Care catering for young people with complex and significant needs. The model can also be adapted for younger children or those with less complex difficulties.

The Spiral to Recovery model demonstrates a move away from a purely trauma-focused approach. The model was developed to meet the needs of indigenous and non-indigenous children and young people in Australia, and is based on the assumption that recovery requires actual and felt safety.

Programme Model

The programme model has four stages of recovery for the young person to travel through: Safety, Emotional Intelligence, Exploration, and Connection and Empowerment. The stages in the model have been developed in an Australian context and each are guided by a lens of culture, with cultural safety a key component to the model.

Safety

It is recognised that a young person will often be in a fear based state when entering a new placement. A preliminary assessment will be conducted at this stage to allow staff to address immediate needs and concerns related to health, family contact or cultural safety. Any assessment has been designed to be culturally appropriate.

Emotional Intelligence

The purpose of the Emotional Intelligence stage is to increase the young person's emotional awareness and skills, as well as moral development. Cultural safety is emphasised in the Emotional Intelligence stage through an emphasis on identity.

Exploration

The exploration stage involves story telling which reflects the contribution of Aboriginal and Torres Strait Islander storytelling traditions as a framework for regulation and healing.

Connection and Empowerment

Under the Spiral to Recovery model there is a focus on ultimate return to family and community.

Evidence/Limitations

To the best of the reviewers' knowledge, there appears to have been no evaluations or research conducted on the Spiral to Recovery model.

Summary

Given the detrimental effects of secure residential care for young people in the care and protection population, where possible, services should ideally be provided to these young people via the least restrictive medium, with emphasis on community-based services. This chapter provided an overview of five such community-based models that can be implemented for the care and protection population: Multisystemic Therapy (MST), Teaching Family Model (TFM), Multi-dimensional Treatment Foster Care (MTFC), the CARE model, and Spiral to Recovery. At this stage, MST, TFM and MTFC models have demonstrated beneficial outcomes among the young people in the care and protection population. As such, these models could be utilised in New Zealand as alternatives to residential services for this population, either while the young person resides with their family or where the young person is in an out-of-home care placement.

Chapter 8: Assessment

The assessment process of a young person can help identify which interventions may be most appropriate to target their identified needs, and what considerations should be made regarding the intensity and/or frequency of treatment and level of intervention (e.g., out-of-home care). CYF's assessment framework, Tuituia, is briefly described in Chapter Three, Section 3.1.1.

In this chapter, a brief overview is provided of what the assessment of young people in care and protection secure residences should entail, including evidence-based assessment tools for this population. Please note that this chapter does not aim to provide a comprehensive overview or guideline of how assessment should be conducted for the care and protection population in secure residential care.

8.1 Assessment of the Care and Protection Population in Secure Residential Care

Effective assessment allows for tailored and appropriate intervention, and helps agencies to assign young people to appropriate levels of treatment and intervention with necessary levels of intensity and security (Vincent, 2012). In addition, assessment helps to ensure scarce resources are allocated in the most appropriate way to benefit the young person (Vincent, 2012). Assessment should begin when a young person first has contact with CYF services to identify any immediate needs, with reassessment conducted periodically right through to the young person's exit from CYF services. Reassessment is important given a young person's needs and circumstances may change over time, including their developmental and psychosocial needs.

When a young person is first admitted into a secure care and protection residence, an initial assessment should be conducted to identify the immediate acute needs of the young person to help ensure these needs are addressed. This initial assessment may also help to identify factors that need to be taken into account in order to provide adequate care and management of the young person while in residence. The assessment may include screening for physical and mental health needs, substance use, and any imminent risk to self, to others and from others, including self-harm or suicidal ideation. Assessment should be conducted in a space where the child/young person can feel comfortable, private and secure (Substance Abuse and Mental Health Services Administration, 2012).

A further comprehensive assessment of each young person should be conducted to help inform the young person's individualised rehabilitation plan. This assessment should cover physical and mental health problems, education needs or issues, cognitive difficulties, substance use, and risks to self, to others and from others. The young person's strengths (i.e., protective factors) should also be identified. Such a comprehensive assessment is implemented by the Kibble Education and Care Centre. The assessment should also involve identification of a wide range of risk and protective factors of the young person's family and other supports. This systemic and holistic approach to assessment is in line with the understanding that behavioural and mental health issues are often caused or contributed to by the young person's childhood, and environment, including their family, peers and community. Assessment should be informed by a range of sources, including self-reported information from the child/young person, the views of parents/caregivers and relevant information from other agencies involved with the child/young person (e.g., health, education).

Having a standardised assessment process and measures can facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. A brief overview of some assessment tools that can be used for this population is provided below.

8.1.1 Assessment Tools for the Care and Protection Population

There is a considerable range of assessment tools that could be used for the care and protection population in secure residential care. It is beyond the scope of this review to provide an overview of the range of assessment measures, and their validity and reliability for this population. Here, a description is provided of six assessment tools that can be used to assess risk, protective factors, and the range of needs and presenting difficulties among the care and protection population. In addition, an overview of four assessment tools that can be utilised for those exhibiting offending-related behaviours is also provided.

The Massachusetts Youth Screening Instrument – Second Edition

The Massachusetts Youth Screening Instrument second edition (MAYSI-2) was developed by Grisso et al. (2001) to identify individuals who are at risk for serious mental,

emotional and behavioural difficulties. The MAYSI-2 is a 52-item screening tool, comprising seven scales: alcohol/drug use, anger/irritability, depression/anxiety, somatic complaints, suicide ideation, thought disturbance, and traumatic experiences. Administration takes between 10 and 15 minutes. The MAYSI-2 has good internal consistency (e.g., see Ford, Chapman, Pearson, Borum, & Wolpaw, 2008) and test-retest reliability (e.g., see Grisso & Barnum, 2006).

The Child Behaviour Checklist

The Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2001) is a parent-rating scale for emotional and behavioural problems in children and young people aged 4 to 18 years. Additional versions are available for teachers (i.e., the Teacher's Report Form) and the young person (Youth Self Report). The CBCL assesses problems across eight categories: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, and aggressive behaviour. The CBCL also has a scale set to show scores associated with disorders from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association 2000): anxiety, oppositional defiant disorder, conduct problems, somatic problems, affective problems, and attention deficit disorder. The CBCL has demonstrated good reliability and validity (e.g., Achenbach & Rescorla, 2001; Nakamura, Ebesutani, Bernstein & Chorpita, 2009).

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1994) is a brief screening scale for emotional and behavioural problems among young people. The SDQ is used extensively worldwide in child and adolescent mental health. The SDQ has 25 items, comprising five scales: emotional symptoms, conduct problems, peer relationship problems, hyperactivity/inattention difficulties, and prosocial behaviours. The SDQ has demonstrated good reliability (Hawes & Dadds, 2004), and external validity (Goodman, 2001; Hawes & Dadds, 2004).

Substances and Choices Scale

The Substances and Choices Scale (SACS) is a self-reporting measure for assessing and monitoring substance use among young people. The SACS is a one-page form comprising three sections: frequency of occasions of use (past month for a range of substances); alcohol and drug taking behaviour, symptoms and

impacts/consequences (past month); and frequency of tobacco use (past month). The SACS has demonstrated sound reliability, congruent validity, and predictive ability in New Zealand (e.g., Christie et al. 2007).

CAGE Questionnaire - Substance Abuse Screening Tool

The CAGE is a self-report measure for assessing problem drinking and potential alcohol problems. The CAGE is a widely used tool to assess alcohol use among individuals in primary care settings and general population surveys. The CAGE is a short screening tool, comprising only four questions. The CAGE has demonstrated sound test-retest reliability (0.80-0.95) and adequate correlations with other screening instruments (0.48-0.70) (Dhalla & Kopec, 2007). The CAGE is a valid tool for detecting alcohol abuse and dependence, particularly in medical and surgical inpatients, ambulatory medical patients and psychiatric inpatients (average sensitivity and specificity: 0.71 and 0.90, respectively) (Dhalla & Kopec, 2007).

Kessler Scales: Non-specific Psychological Distress

The Kessler screening tools are self-report measures of non-specific psychological distress (i.e., risk of an anxiety or depressive disorder). The Kessler scales consist of 6-item (Kessler-6; K6) and 10-item (Kessler-10; K10) scales, which have been extensively used in a range of population and community surveys in New Zealand (New Zealand Health Survey, New Zealand Mental Health Survey) and internationally. The K6 has demonstrated good measurement precision in the New Zealand context (Krynen, Osborne, Duck, Houkamau & Sibley, 2013), and is seen to perform as well as the K10 (Kessler et al. 2010).

For young people in care and protection secure residences who present with offending-related behaviours, the Youth Level of Service/Case Management Inventory (YLS/CMI), Structured Assessment of Violence Risk in Youth (SAVRY), Novaco Anger Scale and Provocation Inventory (NAS-PI), and The Structured Assessment of Protective Factors for violence risk – Youth Version (SAPROF-YV) could be used. An overview of these assessment tools is provided below.

The Youth Level of Service/Case Management Inventory

The Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), is widely used as a risk assessment and case management tool, which provides assistance in the planning of intervention and risk management. The YLS/CMI has strong predictive validity among male and female young offenders (Olver et al., 2009; Luong & Wormith, 2011; Vitopoulos et al., 2012), including among New Zealand young offenders (Mooney, 2010).

Structured Assessment of Violence Risk in Youth

The Structured Assessment of Violence Risk in Youth (SAVRY; Bartel, Borum & Forth, 2000; Borum, Bartel & Forth, 2002) comprising 24-items in three risk domains: historical risk factors, social/contextual risk factors, and individual/clinical factors. Protective factors are also identified. The SAVRY has shown good predictive validity for re-offending among young people in North America (e.g., Schmidt, Campbell, & Houlding, 2011), Europe (Singh, Grann, & Fazel, 2011), and Australia (Shepherd, Leubbers, Ogloff, Fullam & Dolan, 2014).

For young people who have committed a violent offence, use of the SAVRY could be considered to identify their risk and needs. Administrators of the SAVRY should have experience in individual assessment and knowledge of child and adolescent development.

Novaco Anger Scale and Provocation Inventory

Novaco Anger Scale and Provocation Inventory (NAS-PI) is a 60-item self-report measure that assesses cognitive, arousal and behavioural domains of anger. Although the NAS-PI has not been validated in New Zealand, the measure has demonstrated good predictive validity of violence (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey & Banks, 2001) and discriminating between aggressive patients and non-clinical controls (Jones, Thomas-Peter & Trout, 1999).

Structured Assessment of Protective Factors for Violence Risk – Youth Version

The Structured Assessment of Protective Factors for Violence Risk – Youth Version (SAPROF-YV) is an assessment tool designed for the assessment of protective factors for violence risk among young people. The adult version, SAPROF, has been successfully implemented in a range of settings and in multiple countries. The SAPROF-YV assesses 16 dynamic

protective factors. Validation studies are currently being conducted in The Netherlands, Spain, UK, US, Canada and Singapore.

More information regarding the SAPROF-YV can be found at the following website: www.saprof.com/saprof-youth-version.

8.2 Models to inform placement-type decisions

As mentioned in Chapter Four (Section 4.1.3), to help reduce restrictive placements and increase placement stability, there has been more emphasis placed on the placement decision making process to improve children's experiences in out-of-home care (Blakey et al., 2012; Chor et al., 2012; James et al., 2004; Leathers, 2006; Rubin et al., 2007). Chor et al. (2015) outlined two main decision models for the placement decision-making in child welfare: The Multidisciplinary Team Model and the Decision Support Algorithm.

The Multidisciplinary Team Model involves interdisciplinary expertise and caregiver and client opinion in the decision making-process. The Child and Family Teams (North Carolina; Snyder et al., 2012) and the Annie E. Casey Foundation multidisciplinary team decision-making model are examples of this decision-making model. The Decision Support Algorithm Model entails the matching of a young person's functioning needs and strengths to a placement based on clinical assessment and standardised criteria. The Child and Adolescent Level of Care Utilisation System (Fallon et al., 2006), the Child Severity of Psychiatric Illness (Lyons & Abraham, 2001), and the Child and Adolescent Needs and Strengths (CANS) Algorithm are examples of Decision Support Algorithms.

As outlined in Chor et al. (2015), there is limited research examining these decision-making models in child welfare. This may be due to a variety of reasons including inconsistent placement criteria across child welfare. However, this is an important area of research that requires attention to match young people to appropriate placement options, and to improve long-term outcomes for these young people.

Summary

A comprehensive assessment is essential in order to guide the most effective intervention approach that best meets the young person's identified needs and risk. As outlined, a comprehensive assessment should include the identification of the young person's strengths, and any difficulties or issues related to their physical and mental health, educational needs, cognitive abilities, and substance use, in addition to any risk to self, to others and from others. The assessment should also identify risk and protective factors of the young person's wider environment, including their family/whānau and other supports. The assessment of each young person in CYF care should be standardised and incorporate assessment tools to facilitate objectivity and ensure consistency between practitioners. Utilising a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

To better match a young person's needs with placement-type and reduce restrictive placements, the utility of placement decision-making models, such as the multidisciplinary team model and decision support algorithm model, could be investigated for the New Zealand context.

Chapter 9: Rehabilitative Programmes

Young people in care and protection secure residences present with a variety of complex needs, including mental health and behavioural difficulties. It is important, therefore, that a range of evidence-based interventions are available for these young people to help address these needs. In this chapter, an overview of cognitive-behavioural treatment approaches, dialectical behavioural therapy (DBT), alcohol and other drug programmes, and Sensory Modulation is provided.

It is important to note that when interpreting the evidence for each rehabilitative programme presented in this chapter, studies that do not utilise RCTs provide a weaker foundation for drawing inferences about the effectiveness of the programme. In such cases, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as “significant” are those that are statistically significant at the $p < .05$ level.

9.1 Cognitive Behavioural Therapy Approaches

Young people in residential care often share a commonality in their propensity to experience negative core beliefs, schemas, and cognitive distortions (Lipsey, Chapman and Landenberger, 2001). Cognitive behavioural therapy (CBT) is the most common treatment or intervention used to assist people with these kinds of difficulties. CBT is used to identify and then correct negative core beliefs, schemas, assumptions and cognitive distortions, through the use of both cognitive and behavioural techniques (Raftery, Steinke & Nickerson, 2010). When used with young people in residential care, CBT may focus on trauma related sequelae if used in a care and protection setting. Currie, Wood, Williams and Bates (2012) assert that CBT should be included in any programme for young people aiming to change aggressive and antisocial behaviour, in order to address both the cognitive and behavioural aspects of these behaviours. Such programmes are thought to be the most effective in reducing these behaviours.

The two forms of CBT described below are: Aggression Replacement Training (ART) and Trauma-Focused CBT (TF-CBT).

9.1.1 Aggression Replacement Training

Aggression Replacement Training (ART) is a CBT-based intervention for young people who experience difficulty with anger and violence. ART helps young people to develop awareness of what to do in triggering situations, how to control their anger, and how to develop an ability to see situations from other people’s perspective (Currie, Wood, Williams & Bates 2012). Further information regarding ART can be found in Amendola and Oliver (2013).

ART is delivered over 10 weeks to groups of six to eight young people, with three classes each week in the three components that make-up the programme: Structured Learning Training/Skillstreaming²⁴, Moral Reasoning Training, and Anger Control Training (Gunderson & Svartdal, 2006). The young people are generally grouped together based on age and similarity of problems (Gunderson & Svartdal, 2006). Participation in the programme is preferably voluntary, and can be utilised by young people up to the age of 17 (Gunderson & Svartdal, 2006).

Within the Structured Learning Training/Skillstreaming component, young people learn social skills through the use of modelling, role playing, feedback, and homework (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001). During the Anger Control Training component, the young people learn about triggers and cues for their anger reactions, and anger reducers, self-talk, self-evaluation and consequential thinking (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001). Finally, the Moral Reasoning Training component involves learning how to view the world differently, and in particular the ability to see a situation from the other person’s standpoint and make appropriate and socially acceptable decisions based on this reasoning (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001).

Evidence

ART has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having “promising research evidence” for young children placed in higher level placements. Furthermore, in their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found

²⁴ Skillstreaming is an intervention which teaches a range of prosocial behaviours and skills to children and adolescents.

ART to be the third most commonly implemented programme, with 13 of the 75 agencies using ART.

No RCTs have been conducted examining ART among children and adolescents. However, ART has been evaluated among young people exhibiting aggressive and offending behaviour by multiple studies utilising various alternative methodological designs. An overview of these studies and their findings is provided below. Nugent, Bruley, and Allen (1999) used an interrupted time series design study to evaluate an adapted version of ART among 522 boys and girls in a runaway shelter over a 21-day period. The results indicated that ART led to a significant decrease in antisocial behaviour among males and females (14% and 29.4% decrease, respectively). Limitations of this study included a lack of control or comparison group, and concerns regarding how agency staff recorded male antisocial behaviour incidents in case files.

Perseus House, a residential program for male and females in Pennsylvania, conducted a quasi-experimental evaluation for both community-based and residential programming (Neal, 2012). Findings demonstrated significant increases in Skillstreaming skills scores, achievement, and staff ratings of youth's overall psychological and social functioning, and significant decreases in aggression scores and thinking errors. Among 1127 young people in the Collaborative Intensive Community Treatment Program, the recidivism rate one-year post-discharge was 10.5%. Among 853 young people in the Residential Program, the recidivism rate one-year post-discharge was 7%. Limitations of this research include a lack of control or comparison group. To the best of the reviewers' knowledge, this study has not been published in a peer-reviewed journal. Gunderson and Svartdal (2006) conducted a non-equivalent control group design to examine the effectiveness of ART among 65 children and young people with varying degrees of behavioural problems. ART intervention resulted in improvements in both social skills and behavioural problems from pre- to post-intervention, compared to the control group.

In a non-randomised design study, Holmqvist, Hill and Lang (2009) evaluated ART and token economy within two treatment units, and compared these findings with two units that used a treatment programme based on an object-relational and developmental treatment model. There were multiple limitations to this study, including a limited number of young people participating from

two of the residential units (i.e., 6 and 7 young people), and lack of programme integrity. Findings showed no differences between the treatment models on sentences and police suspicion reports post-discharge.

ART has also been evaluated among youth offenders. An overview of these studies is provided below.

The Washington State Institute for Public Policy (WSIPP) conducted an outcome evaluation to examine the effectiveness of the ART program among a group of 704 medium- and high-risk youth offenders. Findings were compared with a control group of 525 youth offenders, who received Youth Justice Court services (treatment as usual). ART was associated with a 24% reduction in 18-month felony recidivism comparative to the control group (Barnoski, 2004). To the best of the reviewers' knowledge, this study has not been published in a peer-reviewed journal.

Hornsveld, Kraaimaat, Muris, Zwets and Kanters (2014) examined ART using a pre-test/post-test design among young people convicted by the court for a violent offence who were referred to a forensic psychiatric outpatient setting. Comparing pre- and post-intervention measures, ART was associated with a significant reduction in self-reported physical aggression ($d = .28$) and social anxiety ($d = .31$). A trend of reduction in hostility ($p = .056$; $d = .25$), aggression ($p = 0.50$; $d = .21$) and anger ($p = .058$; $p = .21$) were also found. Overall, these results provide some support for ART among young violent males receiving treatment in forensic psychiatric outpatient settings.

Currie et al. (2012) examined ART among twenty aggressive youth offenders in Australia using a pre-test/post-test design, with 6- and 24-month follow-up. Participants reported significant reductions in aggressive behaviours and thoughts, cognitive distortions, and impulsivity and some improvement in social problem-solving skills at treatment-end. These treatment effects were maintained at the 24-month follow-up.

A review of ART by Reddy and Goldstein (2001) reported that the programme can be easily replicated and evaluated in residential care (Reddy & Goldstein, 2001). In addition, Amendola and Oliver (2013) suggest that the use of ART should be paired with Trauma Focused Cognitive Behavioural Therapy (TF-CBT) in order to increase the effectiveness of both interventions.

EQUIP

EQUIP (Gibbs, Potter, & Goldstein, 1995) is an adaptation of PCC (see Chapter Six, Section 6.3) and components from ART. Research evaluating EQUIP has found mixed results for young offenders. An overview of this research is provided in Chapter Six, Section 6.3.

Limitations

Despite some research demonstrating the benefits of ART among young people in residential care, findings are mixed. In addition, no RCT examining the ART programme has been conducted; however, Leeman et al. (1993) examined EQUIP using a RCT (see Chapter Six, Section 6.3). Further research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of ART for the care and protection population.

9.1.2 Trauma Focused Cognitive Behavioural Therapy

Trauma Focused Cognitive Behavioural Therapy (TF-CBT) is a form of CBT often used in secure care and protection residences to assist young people to deal with the traumatic experiences that are often underlying the behavioural and mental health issues causing them to end up in secure care (Holstead & Dalton, 2013). TF-CBT addresses symptoms of post-traumatic stress disorder (PTSD), and incorporates attachment, humanistic, and family therapy models in order to do this (Holstead & Dalton, 2013).

Within care and protection secure residences, a high proportion of young people have experienced significant trauma. These trauma experiences contribute to the issues that these children present with, including mental health diagnoses such as PTSD, as well as aggression, trust and attachment issues, and developmental delays (Brown, McCauley, Navalta, & Saxe, 2013; Holstead & Dalton, 2013). These young people also often have neurobiological changes which result in sleeping difficulties, and issues with concentration, physical symptoms, and difficulty regulating emotion (Cohen, Mannarino & Murray, 2011).

TF-CBT uses cognitive and behavioural strategies to assist young people in care with coping skills, relaxation and in-vivo strategies²⁵, affective modulation²⁶, and cognitive processing of trauma experiences (Cohen et al., 2011; Holstead & Dalton, 2013). The young person also develops a trauma narrative to assist with the processing of the traumatic experiences. Parent or caregiver involvement is essential to the treatment process (Cohen et al., 2011; Holstead & Dalton, 2013).

The experience of placement in residence can itself be traumatic as it involves a change in environment, confinement and being placed with other young people who may exhibit disturbing behaviours. TF-CBT works to assist the young person to differentiate between genuine current dangers versus a reminder of historical trauma (Cohen et al., 2011).

Evidence

TF-CBT has been recognised by the California Evidence-based Clearinghouse for Child Welfare as being “well-supported by research evidence” for young children placed in higher level placements. In their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found TF-CBT to be the second most commonly implemented programme, with 26 of the 75 agencies using TF-CBT.

Numerous RCTs have been conducted on TF-CBT for young people or children with trauma and/or PTSD (e.g., Black, Woodworth, Tremblay & Carpenter, 2012; Cohen & Mannarino, 1996; Cohen, Mannarino, & Iyengar, 2011; Deblinger, Lippmann & Steer, 1996; Deblinger, Mannarino, Cohen, Runyon, & Steer 2011; Deblinger, Steer & Lippmann, 1999; King, Tonge, Mullen, Myserson, Heyene, Rollings et al. 2000) with findings demonstrating significantly reduced PTSD symptoms and behavioural problems post-treatment.

Holstead and Dalton (2013) assert that there is strong evidence for the use of TF-CBT in treating young people who are experiencing PTSD symptoms. In addition, in their review of TF-CBT research, Ramirez de Arellano, Lyman, Jobe-Shields, George, Dougherty, Daniels et al. (2014) found TF-CBT demonstrated significant decreases in PTSD symptoms, with medium-range effect sizes.

25 This refers to the graded exposure to trauma reminders in the young person’s environment (i.e., triggers) so they learn to manage their emotional responses, and reduce avoidance behaviours.

26 This refers to the identification and modulation of affective states, including problem solving and anger management.

However, there were inconsistent findings for TF-CBT in reducing depressive symptoms and behaviour problems (e.g., sexual behaviour, aggression) (Ramirez de Arellano et al. 2014). Furthermore, in their systematic review of evidence-based treatments for children exposed to childhood maltreatment, Leenarts, Diehle, Doreleijers, Jansma and Lindauer (2013) found TF-CBT to be the best-supported treatment. Of the five studies evaluating TF-CBT included in Leenarts et al.'s (2013) systematic review, the between group effect sizes ranged from 0.22 to 0.70.

From 2011 to June 2014, Cohen and Mannarino began conducting a RCT of two delivery strategies for TF-CBT among adjudicated young people in 10 residential treatment facilities in New England. The reviewers are unaware of any published results from this study. It is strongly recommended that CYF follow-up on the findings of this project to determine the efficacy of TF-CBT among young people in secure residential care.

Limitations

Although there is strong empirical evidence for TF-CBT for young people exposed to childhood maltreatment, at this stage the reviewers are unaware of any empirical evidence evaluating TF-CBT among young people in residential care. However, given the prevalence of maltreatment experienced among the care and protection population in secure residences, it is likely that utilising TF-CBT would provide some benefit. As stated above, it is recommended that CYF follow-up the findings of Cohen and Mannarino's research regarding TF-CBT among the young people in residential facilities.

9.2 Dialectical Behavioural Therapy

Dialectical Behavioural Therapy (DBT) was developed by Marsha Linehan (1993) for the treatment of Borderline Personality Disorder, chronic suicidal behaviour, and emotional problems. DBT helps individuals to obtain skills in distress tolerance, emotional regulation, interpersonal conflict, and mindfulness. DBT has been found to be effective with young people in residential care who often present with self-harming behaviour, suicidal ideation, emotional problems, and anger.

DBT combines cognitive-behavioural, skills-building techniques, mindfulness, and acceptance and change techniques based on Buddhist principles (Shelton, Kesten, Zhang & Trestman, 2011). DBT aims to replace ineffective, maladaptive emotional and behavioural

responses with more effective, skilful responses. Treatment targets include life-threatening behaviours, therapy-interfering behaviours, quality of life, and skills acquisition.

DBT has four modules: interpersonal effectiveness, emotional regulation, distress tolerance, and mindfulness (Linehan, 1993). Within these four modules, adolescents are taught skills, such as being intentional in the moment (i.e., mindfulness), how to distract themselves from unpleasant emotions (i.e., distress tolerance), and coping with interpersonal conflict (i.e., interpersonal effectiveness).

DBT has been adapted for adolescents (DBT-A; Rathus & Miller, 2002) and children (Perepletchikova, Axelrod, Kaufman, Rounsaville, Douglas-Palumberi & Miller, 2011), and a manual is currently being developed to apply DBT to school settings (Mazza, Dexter-Mazza, Murphy, Miller & Rathus, in press).

Further information regarding DBT can be found in Linehan (1993), Linehan and Dimeff (2001), the 2011 report by the California Department of Corrections and Rehabilitation (Office of Research, Juvenile Justice Research Branch, Carr, Fitzgerald & Skonovd, 2011), and on the DBT New Zealand website at www.dbtnz.co.nz.

Evidence

In their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found DBT to be the most commonly implemented programme, with 29 of the 75 agencies using DBT.

No RCTs have been conducted examining the effectiveness of DBT among the care and protection/child welfare population. However, research investigating outcomes of DBT treatment among adolescents is beginning to accumulate. Adaptations of DBT for the adolescent population have indicated positive results among an inpatient hospital setting sample, including reduced behavioural incidents during admission, parasuicidal behaviour, depressive symptoms, and suicidal ideation (Katz, Cox, Gunasekara & Miller, 2004). In a recent RCT conducted among adolescents at an outpatient adolescent psychiatric clinic, the DBT-Adolescent (DBT-A) treatment group had reduced self-harm, suicidal ideation and depressive symptoms in comparison with the enhanced usual care control group (Mehlum, Tormoen, Ramberg, Haga, Diep, Laberg, et al., 2014). See Groves, Backer, van den Bosch and Miller (2012) for a review on adaptations of DBT among adolescents.

James, Winmill, Anderson and Alfoadari (2011) piloted the DBT programme among adolescents in the looked-after care system. The intention-to-treat analysis found a significant reduction in depression scores, hopelessness scores and frequency of self-harm among those who completed treatment. In addition, a significant increase in global functioning was found. Furthermore, there was an improvement in overall social functioning, with young people moving from secure accommodation, returning home, and entering independent living from homelessness. However, 35% of adolescents failed to engage in therapy (James et al., 2011).

DBT has been adapted for children, with one one-group pre-test/post-test design study showing DBT was associated with significant reductions in depressive symptoms and suicidal ideation (Perepletchikova et al., 2011). Implementing DBT skills groups in school settings was also found to produce positive outcomes, including reduced externalising and internalising symptoms, as well as increasing positive behaviours, in one pre-test/post-test design study among non-suicidal oppositional defiant adolescents (Nelson-Gray, Keane, Hurst, Mitchell, Warburton, Chok & Cobb, 2006).

DBT has been evaluated among youth offenders in correctional facilities in two pre-test/post-test studies (Trupin, Stewart, Beach & Boesky, 2002; Shelton et al., 2011), and one pilot study has evaluated DBT among youth offenders with mental health difficulties residing in state institutions (Drake & Barnoski, 2006). An overview of this research is provided below.

In a pre-test/post-test intervention study with a comparison group, Trupin et al. (2002) found significant reductions in serious behaviour problems during the 10-month period of treatment. In addition, although not statistically significant, reductions in suicidal acts, aggressive behaviours and class disruption among incarcerated female youth offenders post-DBT were found (Trupin et al., 2002). Similarly, Shelton et al. (2011) conducted a one-group pre-test/post-test design study evaluating a 16-week DBT course among male incarcerated adolescents, and found a significant reduction in aggression, the number of disciplinary tickets, and using distancing as a coping strategy. Shelton et al. (2011) also found improved scores for negative affect and self-control, however these were not significant.

The Washington State Institute for Public Policy piloted DBT to examine its effect on recidivism. Using a post-test design study with a comparison group, findings indicated that 40% of the DBT group and 46% of the comparison group was reconvicted with a new felony within 36 months post-release, which represented a 15% reduction (Drake & Barnoski, 2006). In addition, 19% of the DBT group had been reconvicted with a violent offence, while 21% of the comparison group had been reconvicted, representing a 9% reduction (Drake & Barnoski, 2006).

Limitations

Research is still in emerging phases regarding efficacy of DBT among young people in secure residential care. To date there has been no RCT conducted examining DBT for this population. Further research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of DBT for the care and protection population. Nonetheless, implementing DBT among young people could offer a new direction of treatment for the care and protection population in New Zealand.

New Zealand Context

The feasibility of researching DBT among adolescents with self-injuring behaviour was assessed in New Zealand in 2010 (Cooney, Davis, Thompson, Wharewera-Mika & Stewart, 2010). The study utilised a RCT, and included 29 adolescents who had engaged in self-injurious and suicidal behaviour. Fourteen adolescents received 6 months of DBT, and 15 received treatment as usual. Results found that DBT was 'acceptable' to the young people, their families, and clinicians, with a 93% completion and attendance rate.

In 2009, Te Pou assessed the feasibility of future service development utilising DBT in mental health services in New Zealand. The report identified that DBT has strong evidence in treating complex and high-risk problems, is strongly supported among district health boards, consumer advisors, and DBT leaders and clinicians, and that there is a small group of specialist DBT trainers in New Zealand (i.e., DBTNZ). However, noted barriers to extending DBT services in New Zealand included the cost, access to training, and the expertise of knowledge required to do so. This report can be located on the Te Pou website at www.tepou.co.nz.

9.3 Alcohol and Other Drugs

Research indicates that a high percentage of young people in secure residential care facilities misuse alcohol and drugs (Wells, Chuang, Haynes, Lee, & Bai, 2011). This is thought to be due to a variety of factors including increased incidence of mental health issues, trauma experiences, family of origin modelling, and an increased incidence of risk behaviours (Kepper, Monshouwer, van Dorselaer & Volleburgh, 2011). Young people in residence with co-occurring mental health and substance use disorders are particularly challenging to treat, and are known to experience poor outcomes (Hawkins, 2009).

There are two main avenues of treatment for substance use disorders in dual diagnosis adolescents. The first is serial treatment, which entails treatment for one disorder (usually substance use treatment first), followed by treatment for any other mental health issues present. The second is parallel treatment, where treatment for both disorders occurs concurrently. The latter is the treatment avenue most likely to suit secure care and protection residences, as a substance use treatment modality could be incorporated into the wider therapeutic model and suite of interventions.

Very limited research is available that directly examines treatment models for young people in care and protection secure residences; however two promising outpatient treatments could likely be modified for use within the residential setting: Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5 and Seeking Safety. These two programmes are described below. The following also outlines the Therapeutic Community model, which is the most common intensive residential treatment for drug and alcohol misuse.

9.3.1 Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5

Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5 (MET/CBT5) is a five session motivational enhancement and CBT therapy programme consisting of two individual MET sessions, followed by three sessions of group CBT (Hawkins, 2009). The first two MET sessions are intended to progress the young person through the stages of change (Hawkins, 2009), as a lack of motivation to change behaviours can be a

huge barrier to treatment for substance use disorders. The CBT sessions are intended to assist the young person to learn and practice coping skills to avoid relapse upon encountering high risk situations (Hawkins, 2009).

Evidence

MET/CBT5 has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having “promising research evidence” for young children placed in higher level placements.

Among adolescents, MET/CBT5 has been evaluated by two RCTs (Dennis, Godley, Diamond, Tims, Babor, Donaldson & Funk, 2004; Godley, Garner, Passetti, Funk, Dennis & Godley, 2010), one non-randomised comparison study (Mason & Posner, 2009), and one quasi-experimental study (Ramchand, Griffin, Suttorp, Harris & Morral, 2011). An overview of this research is provided below.

Dennis et al. (2004) conducted a RCT to evaluate MET/CBT5 among outpatient adolescents with cannabis use disorders. MET/CBT5 was compared with a 12-session regimen of MET and CBT (MET/CBT12), another that included family education and therapy components (Family Support Network (FSN), the Adolescent Community Reinforcement Approach (A-CRA) and Multidimensional Family Therapy (MDFT). All interventions produced significant improvements for days of abstinence and the proportion of adolescents in recovery at the end of the study. When controlling for initial severity, MET/CBT5, MET/CBT12 and ACRA were the most cost-effective interventions (Dennis et al., 2004).

The sample included in Dennis et al.’s (2004) study comprised adolescents with co-occurring disorders with 53% having conduct disorder, 38% ADHD, 23% generalized anxiety, 18% depression, and 14% traumatic stress disorders. This cohort also had 83% of young people with some form of justice system involvement. Mason and Posner (2009) conducted a non-randomised comparison study examining MET/CBT5 among adolescents in an urban community setting enrolled in a substance abuse treatment program. Findings indicated that MET/CBT5 had significantly reduced adolescent alcohol use, in comparison with the control group. Godley et al. (2010) used an RCT to evaluate a seven-session version, MET/CBT7, among adolescents with substance use disorders. The study used a cross-treatment design and compared MET/CBT7 to a control condition, with and without Assertive Continuing Care

(ACC), a home-based continuing care approach for adolescents discharged from residential treatment. Most of the sample been involved in the youth justice system (73%). Adolescents who received MET/CBT7 had somewhat lower increases in the percentage of days abstinent over the 12-month follow-up, although the effect sizes were small. However, a cost effectiveness analysis showed that MET/CBT7 without ACC was most cost-effective intervention (Godley et al., 2010).

Ramchand et al. (2011) compared MET/CBT5 with three outpatient treatment programmes for substance abuse among adolescents in a quasiexperimental design. Findings suggested that the MET/CBT5 group had significantly reduced substance use frequency and problems, and illegal behaviours (as measured by the Illegal Activities Scale; Dennis et al. 2010) 12-months post-treatment. No significant differences were found between groups concerning emotional problems, institutionalisation rates, or achieving 'recovery' status at 12 months (Ramchand, et al. 2011).

Limitations

To the best of the reviewers' knowledge, MET/CBT5 has not been evaluated using RCTs among young people involved in the care and protection system and in secure residential care.

9.3.2 Seeking Safety Programme

The Seeking Safety programme (Najavits, 2007) was developed in the 1990s for use with people who have a dual diagnosis of a substance use disorder and PTSD. Seeking Safety is essentially a CBT intervention, but also includes aspects of interpersonal case management (Hawkins, 2009). Five principles underlie the intervention:

- Safety as a priority
- Integrated treatment of both disorders
- A focus on ideals, which is intended to counteract the loss of ideals experienced in both PTSD and substance use disorders
- Contents areas include cognitive, behavioural, interpersonal, and case management
- A focus on therapist processes.

Flexibility is a key feature of the Seeking Safety programme with 25 topics that can be presented separately from each other, either individually or in

groups, and in a customizable form which can be modified to suit the population it is being used with (Hawkins, 2009).

Evidence

Seeking Safety has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements.

One RCT has been conducted evaluating the Seeking Safety programme among adolescent females who met criteria for PTSD and substance use disorder (Najavits, Gallop, & Weiss 2006). Compared to the treatment as usual group, the Seeking Safety programme demonstrated a reduction in substance use, trauma related problems, and cognitions related to both PTSD and substance use (Najavits et al., 2006).

The Seeking Safety programme has been evaluated among adults in a variety of settings and has produced positive results, including a reduction in substance use, reduction in PTSD and other mental health symptoms, and improvements in social adjustment (e.g., Hien et al., 2004; Najavits et al., 1998; Zlotnick et al., 2003).

Limitations

To the best of the reviewers' knowledge, the Seeking Safety programme has not been evaluated among young people in a residential environment, those in the care and protection population, or among those exhibiting problematic behaviour (e.g., conduct problems). Research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of Seeking Safety for the care and protection population.

9.3.3 Therapeutic Communities

Therapeutic community (TC) is a milieu therapy model most often used to treat drug and alcohol users, through the use of both self-help and mutual support (Magor-Blatch, Bhullar, Thomson & Thorsteinsson, 2014). The essential elements of a TC include the requirement that the participants live together as a community, preferably isolated from most external influences. This is important in order to ensure that the community develops a sense of social togetherness and a sense of community and prosocial values (Abdel-Salam & Gunter, 2013; Fortune, Ward & Polaschek, 2014). Other aspects of TC include a confrontational approach in which participants are made aware by staff and peers of aspects of themselves or their behaviour that are detrimental to their recovery and

to the community, democratisation, in which decision making is shared by the community, and tolerance of behaviour of others (Abdel-Salam & Gunter, 2013; Fortune et al., 2014).

When used with adult clients, a TC will normally have a progressive system of 'levels' which the participants can attain through achieving certain social and personal goals (Molloy, Sarver & Butters, 2012). As the participants move through these levels they are given more responsibility within the programme, and are ultimately responsible for aspects of the day to day running of the programme, as well as assisting newer participants with issues, allowing staff to focus on therapeutic aspects. When implementing TC with adolescents, it may not be as easy or practical to afford them the same responsibilities as adults in TCs, particularly in situations where the adolescent is quite young and emotionally immature. For this reason, adolescent TCs are normally referred to as "modified TC". Modified TC for adolescents may involve more staff involvement rather than utilising senior participants, and more restrictions on the movements and decision making capabilities of the participants.

TCs are considered to be an intensive form of treatment and duration is typically between 6 and 12 months (Molloy et al., 2012).

Evidence

TC has been evaluated using various methodological designs. However, no RCTs have been conducted among young people in residential care. An overview of the current research on TC among adolescents is provided below.

Hawke, Jainchill and De Leon (2000) examined drug use, criminal and HIV risk behaviour in a one-year post-treatment outcome study among adolescent amphetamine users and nonusers in the United States and Canada one-year post-treatment in a TC. Findings showed significant reduction for regular drug use, criminal involvement, drug offences, property offences, violent offences, and having sex while high. Amphetamine use was not associated with treatment outcome (Hawke et al., 2000).

In a 5-year post-treatment outcome study, Jainchill, Hawke, and Messina (2005) examined The Recovery House (RH) programme, a therapeutic approach that integrates TC for drug and alcohol use, among adolescents admitted to a residential therapeutic

community in the United States. The RH programme focuses on the antisocial behaviours of these young people, as well as the substance use. With the exception of alcohol use, no significant differences were found in the number of young people reporting substance use pre- to post-treatment, including marijuana, cocaine and opiate use. However, the use of drugs, other than marijuana and alcohol, was infrequent. With regards to criminal activity post-treatment, drug possession, drug sales, violent crimes and property damage, there were significant decreases in involvement. An increase in the number of young people involved in "hustles" (e.g., prostitution, forgery) was found, and the number of weapon offences did not change post-treatment (Jainchill et al. 2005).

Similar to the aforementioned studies, Morral, McCaffrey, and Ridgeway (2004) found significantly lower substance use rates and improved psychological functioning among a group of adolescent probationers who underwent TC treatment in a 12-month outcome study using a case-mix adjustment approach. Compared to a matched control group (alternative probation disposition), the TC group demonstrated a significant reduction in past month substance problem ($d = -.27$), substance use density ($d = -.25$), substance involvement (past 90 days; $d = -.24$), somatic symptoms ($d = -.32$), and anxiety symptoms ($d = -.29$). No differences were found between groups on crime outcomes (i.e., arrests, property offences, violent offences, drug offences etc. in the previous 90 days) (Morral et al., 2004).

In an exploratory study using quantitative and qualitative data, Perry and Duroy (2004) compared young heroin users with non-heroin users admitted to a TC at 12-month follow-up on substance use, psychosocial and criminal justice measures. Findings indicated that both heroin and non-heroin young adults in TC achieved positive outcomes following TC treatment, including reduced substance use (e.g., days used any drugs (past 90 days)), behavioural complexity, general mental distress and improved general social support. Property crime, interpersonal crime and drug crime also reduced for both groups post-treatment.

Gordon et al. (2000) used a non-randomised design with matched control group to examine TC among adolescents who had been convicted of a Felony 1 or 2 offence. The comparison group comprised young people from a youth justice detention centre in Ohio. The authors found that adolescents in the TC group were

less likely to receive a reconviction or be recommitted post-treatment than the comparison group (for both reconvictions and commitments: TC group: 26% (Caucasian) 39% (ethnic minority); Comparison group: 37% (Caucasian) 52% (ethnic minority)) (Gordon et al., 2000).

There is also benefit in using TC with clients who have experienced trauma and attachment issues, due to the use of a pro-social community model, and the inclusion of staff as part of the community. This can assist these attachment disordered clients to form secure attachments, and can allow staff time to engage in appropriate therapeutic work (Haigh, 2013).

Limitations

Research suggests that there is promising evidence for the use of TC among adolescents. However, further research using sound methodology, including RCTs, is needed to draw strong conclusions regarding the efficacy of TC for the care and protection population.

The main limitation of the TC model is that it is designed specifically and is most effective for treatment of drug and alcohol addiction (Fortune et al., 2014). The use of TC models for care and protection populations may be limited due to the time young people typically spend in secure residential care compared to the six to nine months required for TC treatment, and the range of presenting problems among these populations, some of which may not be compatible with the use of a TC model. However, the RH programme examined by Jainchill et al. (2005) could be a suitable alternative for the care and protection population.

Finally, the operation of a TC requires an organisation that runs effectively and is staffed by caring, knowledgeable and experienced staff, as negative experiences can re-traumatise clients who are already suffering from the after effects of childhood trauma (Cross, 2012). TC staff need to ensure consistency, and have the ability to regulate emotions under stress, and to avoid transference and counter-transference as much as possible while still maintaining the therapeutic alliance (Cross, 2012). It would be wise if implementing a TC to first analyse the organisational culture and staff mix and qualifications in order to determine whether a TC could be operated effectively.

9.4 Sensory Modulation Model

Many adolescents in residential care exhibit difficulties with emotion regulation and reactive behaviour, and may appear disorganised and without controls or inhibitions. The Sensory Modulation (SM) model is a trauma-specific treatment model used to address arousal regulation that is seen to underlie dysregulation. The underlying assumption of the SM model is that in order for language, imagination and symbolic expressive function to emerge (which are required for psychotherapeutic and language-based interventions), the young person must first be sufficiently regulated, organised, grounded, and present. Goals of the SM approach include facilitating self-awareness, self-shaping, planning and practicing, self-regulation, and positive change and repertoire expansion (Champagne, 2008).

More information regarding the use of SM in the treatment of young people in residential care can be found in Warner, Koomar, Lary and Cook (2013).

Programme Model

The SM model is not intended to be used to the exclusion of other assessments or therapeutic interventions, but rather it is to be used to support the ability of a young person to participate more actively in the varied assessment and therapeutic processes implemented to address their needs. SM approaches are collaborative, meaningful, trauma-informed, recovery focused, and sensory supportive.

SM intervention involves the deliberate use of activities, behavioural strategies, specific equipment, and modification of the physical and social environment to assist the regulation of an individual's sensory experience in order to enable them to manage their arousal. SM interventions can be utilised with those demonstrating hyper-arousal or hypo-arousal.

SM interventions include sensory screening and assessment, exploration of sensory tendencies and preferences, development of sensory-based activity schedules (often referred to as diets), use of specific sensorimotor activities and modalities, modification of the physical environment, and education of family and caregivers (Champagne, 2008; Champagne & Stromberg, 2004; LeBel, Champagne, Stromberg & Coyle, 2010).

Evidence/Limitations

The SM approach has been used in a range of existing practices and organisational processes such as initial assessment, treatment planning and implementation, crisis prevention and de-escalation, policy and procedure development and environmental enhancements (LeBel et al., 2010). However, research specifically supporting the use of SM among young people is limited. Few studies have evaluated SM, and no RCT has been conducted. The reviewers are unaware of any empirical evidence examining SM among the care and protection/child welfare population or those exhibiting problematic behaviour (e.g., conduct).

New Zealand Context

A pilot study has explored the use of SM in acute mental health services in New Zealand as part of a larger initiative to reduce the use of seclusion and restraint (Sutton & Nicholson, 2011). The research involved collaboration between Te Pou, the Occupational Science and Therapy Department at Auckland University of Technology, and the adult mental health inpatient units of four district health boards. SM was perceived as an effective tool for inducing a calm state among the majority of people who used it, SM supported the rapid building of trust and rapport for both service users and staff members, and SM facilitated the development of service users' self-management, increasing their awareness and ability to regulate their own emotional levels. These findings provide preliminary support for the use of SM in the New Zealand context. However, it was noted that SM must be considered as only one component of greater organisational change required to reduce seclusion and restraint rates.

Summary

Given the care and protection population in secure residential care present with a range of complex needs, a suite of evidence-based interventions should be available in order to help address these needs. Here, Aggression Replacement Training (ART), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)²⁷, Dialectical Behavioural Therapy (DBT), and a range of programmes to address alcohol and other drug difficulties were outlined. At this time, ART, TF-CBT, DBT, MET/CBT5 and Therapeutic Communities have demonstrated promising research findings that suggest implementation among the care and protection population in New Zealand could provide positive outcomes. For secure care and protection residences in New Zealand, any interventions implemented should be complementary to the therapeutic environment the residences are seeking to create.

It is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started in secure residence unless a young person is transitioning back into the community where this intervention can continue with minimal disruption and they continue to see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in residence, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical Behavioural Therapy). Alternatively, rehabilitative programmes could be implemented in a modular-based manner, where one or several modules are delivered in residence, and the remaining modules post- transition.

²⁷ Trauma-Focused CBT presents as a particularly promising programme for the care and protection population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

Chapter 10: Ethnicity and Culture

As noted earlier, Māori are over-represented in the care and protection population, including those residing in residential care. Scholars, including Mason Durie, highlight the importance of creating contexts that enable Māori to develop a secure and more positive cultural identity in order to address issues that create a cycle of poverty, truancy, and offending (Durie, 2005; Jackson, 1988). Longitudinal research has also demonstrated that having a strong cultural identity and a connection with culture are protective factors against engaging in offending for Māori (Marie, Fergusson & Boden, 2009). Therefore, it appears vital to not only implement interventions that are responsive to challenging behaviours presented by rangatahi Māori, but also to invest in culturally responsive evidence-based practices that help strengthen cultural identity, address cultural needs, and consequently promote positive cultural, educational, and socio-economic outcomes.

Cultural safety and cultural competency are performance requirements of health practitioners in all professional health regulatory bodies, as outlined in The Health Practitioners Competency Assurance Act (2003).

As outlined in Chapter Three, CYF residences use the indigenous and bicultural framework for working with Māori. In addition, Māori-centred frameworks and initiatives have been developed in New Zealand, including Whānau Ora – a whānau-centred approach to Māori wellbeing that aims to empower families.

A comprehensive overview of a te ao Māori perspective on conduct problems among adolescents, core elements of kaupapa Māori programmes, and the range of kaupapa Māori programmes that are currently available to address conduct problem behaviours are outlined in the 2011 and 2013 AGCP reports. Three kaupapa Māori programmes were deemed to be the most intensive in the AGCP (2013) report, and therefore the most appropriate to implement among rangatahi Māori residing in residential care. These programmes are: The Meihana Model, Te Pikinga ki Runga, and Te Hui Whakatika. In addition, a promising kaupapa Māori school-wide approach, Huakina Mai, has been identified. These programmes are described briefly below.

10.1 Kaupapa Māori Programmes

10.1.1 The Meihana Model

The Meihana Model (Pitama, Robertson, Cram, Gillies, Huria & Dallas-Katoa, 2007) provides a framework and practice model for health professionals in the assessment and intervention of Māori clients and their whānau. The model is an extension of the Te Whare Tapa Whā model (Durie, 1985), and includes six components – whānau (family), wairua (beliefs, connectedness and spirituality), tinana (physical health), hinengaro (psychological and emotional wellbeing), taiao (physical environment) and iwi katoa (support services and systems in the health environment) – which are overlaid with the core concept of ‘Māori Beliefs, Values and Experiences’ (Pitama et al., 2007). The six components interconnect to form a multi-dimensional assessment tool, which enables a comprehensive picture to be formed of the context in which the client’s difficulties are occurring (Pitama et al., 2007). The individual is viewed as existing within a collective, which should be engaged with and utilised in the assessment and intervention process. This framework allows for a more thorough assessment and intervention programme to be developed. It is believed that such a framework validates the beliefs, values and experiences of Māori in a clinical setting (Pitama et al., 2007).

The Meihana Model is used within the Indigenous Health Framework utilised in the training of medical students at the University of Otago, based in Christchurch (Pitama, Huria & Lacey, 2014). This framework also comprises the Hui Process (Lacey, Huria, Beckert, Gillies & Pitama, 2011), which helps to facilitate an enhanced relationship between the doctor and Māori client from the initial meeting to the end of the session (see Pitama et al. (2014) for an overview).

The Meihana Model is considered to be a ‘sustained’ kaupapa Māori programme (AGCP, 2013). Increased quality interactions between health practitioners and Māori clients and whānau have been found when using the Meihana Model (Lacey et al., 2011; Pitama et al., 2007; Pitama, 2012). More information on the Meihana Model can be found in Pitama et al. (2007) and Pitama et al. (2014).

10.1.2 Te Pikinga ki Runga

Te Pikinga ki Runga: Raising Possibilities (Macfarlane, 2009) is a framework for the assessment and programme planning of Māori exhibiting problematic behaviours in educational settings. The framework is based on the three Treaty of Waitangi human-rights principles – partnership, protection and participation (Macfarlane, 2009). Under the principle of partnership, engaging with and building effective partnerships with whānau are essential. Under the principle of protection, meeting the needs (i.e., wellbeing, identity and self-concept) of the young person in a strengths-based and holistic manner is vital. Such a holistic approach is based on four domains: hononga (relational), hinengaro (psychological), tinana (physical), and mana motuhake (self-concept), each of which comprises three subdimensions. The 12 subdimensions are presented in a grid, along with reflective questions, to assist the practitioner in implementing the framework. Finally, under the principle of participation, it is important that the presence, participation and learning of the young person is supported and enhanced within the learning context (Macfarlane, 2009).

Te Pikinga ki Runga is considered a ‘sustained’ kaupapa Māori programme (AGCP, 2013). More information on the Te Pikinga ki Runga can be found in Macfarlane (2009).

10.1.3 Te Hui Whakatika

Te Hui Whakatika (Hooper, Winslade, Drewery, Monk & Macfarlane, 1999) is based on the traditional hui (assembly, gathering), where a culturally-grounded space is created to provide support and to seek and achieve resolution, consequently restoring harmony. In essence, Te Hui Whakatika promotes concepts that now underpin restorative justice. The Hui Whakatika process has four phases: preparing the groundwork, the hui proper (the hui phase), forming/consolidating the plan, and follow-up and review. Te Hui Whakatika has been implemented in several primary and secondary schools across the Waikato, Bay of Plenty and Canterbury regions.

Te Hui Whakatika is considered an ‘emerging’ programme (AGCP, 2013). More information on the Te Hui Whakatika model can be found in Hooper et al. (1999), Bateman and Berryman (2008), and Berryman and Macfarlane (2011).

10.2 Kaupapa Māori school-wide approach: Huakina Mai

Huakina Mai (“opening doors”) was developed by the Ministry of Education, University of Canterbury and Te Runanga o Ngāi Tahu. Huakina Mai aims to facilitate positive outcomes for Māori students and their whānau by promoting a positive school culture that is developed through collaboration between whānau, schools and iwi. Huakina Mai is based on five principles: whanaungatanga (relationships), kotahitanga (unity), rangatiratanga (leadership), manaakitanga (ethic of caring), and pūmanawatanga (centrality of te ao Māori) (Savage, Macfarlane, Macfarlane, Fickel & Te Hēmi, 2014). Huakina Mai is currently being trialled in two Canterbury schools in 2014-2015.

More information on Huakina Mai can be found on the Te Kete Ipurangi website at <http://pb4l.tki.org.nz/Kaupapa-Māori/Huakina-Mai>, and in Savage et al. (2014).

10.3 He Awa Whiria: “Braided Rivers”

Although evidence on kaupapa Māori programmes appears to be accumulating, limited information is available regarding ways to effectively and appropriately combine Western science and kaupapa Māori perspectives concerning programme effectiveness. In an attempt to integrate these two perspectives, Macfarlane proposed the concept of a braided river (he Awa whiria) (AGCP, 2011). The model firstly recognises that these two knowledge perspectives (i.e., two main streams) are distinct; however, the two streams interconnect with knowledge from one perspective helping to inform the development of programmes of the other perspective, and vice versa. In addition, the methodologies used to evaluate programmes from the Western science stream can be utilised by kaupapa Māori research, and vice versa. Thus, the streams connect through minor tributaries. The two streams finally converge, with the perspective that a programme is considered effective when it is accepted as having evidence from both streams.

10.4 Cultural Needs of the Care and Protection Population in International Jurisdictions

Here, the cultural needs of young people in the care and protection population in Australia and the United States are discussed, including how these cultural needs are met and addressed.

10.4.1 Australia

Aboriginal and Torres Strait Islander children and young people are over-represented in the out-of-home care population throughout Australia. Established in 1984, The Aboriginal and Torres Strait Islander Child Placement Principle has been codified in legislation in Victoria, New South Wales, South Australia and the Northern Territory, and recognises that Aboriginal and Torres Strait Islander people have the knowledge and experience to make the best decisions concerning their children, and acknowledges the importance of children and young people staying connected to their family, community, culture and country (Child Family Community Australia, 2014). It also promotes a partnership between the government and Aboriginal and Torres Strait Islander communities with regards to any decision making concerning the welfare of indigenous children; however, this often does not occur until late in the process.

One non-secure residential care model developed to meet the needs of indigenous and non-indigenous children and young people in Australia is the Northern Queensland model, Spiral to Recovery (see Chapter Seven, Section 7.5). The model has four stages of recovery for the young person to travel through (Safety, Emotional Intelligence, Exploration, and Connection and Empowerment), each of which are guided by cultural safety as a key component.

There are also Aboriginal and Torres Strait Islander run out-of-home care providers. Guardian Youth Care is a non-profit residential out-of-home care provider in New South Wales, providing varying residential support options for Aboriginal and Torres Strait Islander and non-Aboriginal children and young people aged between 12 and 18 years (Guardian Youth Care, 2013). Guardian Youth Care believes that every child deserves the right to be raised in an environment that connects them with their culture and spiritual heritage. Aboriginal Family Support Services Inc. provides culturally appropriate short-term emergency residential care for children and young

people aged between 0 and 17 years, who are unable to live with their parents and are under the guardianship or custody of the Minister (Aboriginal Family Support Services Inc, 2015). Priority is given to Aboriginal children and young people.

10.4.2 United States

American Indian and Alaska Native young people are disproportionately represented in the care and protection (i.e., child welfare) system (Caringi & Lawson, 2014). There is very limited information available on treatment and interventions that are culturally tailored to meet the needs of Native American Indian and Alaska Native young people in residences. At best, cultural needs are incorporated into mainstream practice as one of a long list of considerations. Care and protection and youth justice matters are often dealt with within tribal and community systems which is considered by some to be the preferred approach (Caringi & Lawson, 2014), with some tribes having their own secure youth justice residences (Arya & Rolnick, 2005).

Summary

Any programmes implemented for rangatahi Māori should use well-recognised and culturally grounded frameworks, such as those outlined in this chapter, to ensure that an ecological perspective that is culturally informed is provided. Further research should be conducted to attempt to understand both what leads rangatahi Māori to require CYF involvement, and what approaches need to be implemented to facilitate the best outcomes for rangatahi Māori in the care and protection system. Conversely, strengths-based approaches that report on the key (cultural) indicators for rangatahi Māori who have succeeded at school and beyond must be considered.

Chapter 11: Education

Young people in residential care often perform at a lower level academically than their peers, have fewer qualifications than other young people their age, and progress through the education system at a slower rate (Gharabaghi, 2011; Zeller & Köngeter, 2012). Poor educational achievement can affect the young person later in life, leading to unemployment and sometimes homelessness (Gharabaghi, 2011). Therefore, it is essential that intensive educational services by skilled professionals are offered to help these young people catch up to their peers. As outlined in Chapter Three, three education providers in New Zealand deliver education services for secure care and protection residences.

The following provides an overview of three educational approaches that can be implemented among young people with significant conduct problems: Positive Behaviour for Learning (PB4L), Alternative Education, and Prevent-Teach-Reinforce.

11.1 Positive Behaviour for Learning

Positive Behaviour for Learning (PB4L) is an initiative developed from the 2009 Taumata Whanonga in response to concerns about the effects of problematic behaviours on the educational achievement and overall wellbeing of young people. PB4L is led by the Ministry of Education in a joint initiative between several education sector organisations. The PB4L initiative aims to plan and support programmes that are able to intervene early in the young person's life, are evidence-based, can be delivered with fidelity, be consistent in quality across New Zealand, and can be sustained over the long-term.

PB4L comprises ten evidence-based programmes aimed at enabling parents, teachers and schools to address problematic behaviour and to promote positive outcomes for these young people. Programmes to support schools include the School-Wide framework, Wellbeing@school, Behaviour Crisis Response Service and Intensive Wraparound Service. A programme to support teachers includes the Incredible Years: Teacher programme, and for parents the Incredible Years: Parent programme. In addition, Kaupapa Māori programmes, such as Huakina Mai (see Chapter Ten, Section 10.2), are being trialled.

Further information regarding PB4L can be found on the Ministry of Education website at: <http://www.education.govt.nz/ministry-of-education/specific-initiatives/pb4l/>

The Positive Behaviour for Learning – School Wide (PB4L-SW) is a whole-school approach to addressing problematic behaviours being introduced in New Zealand. This programme is described briefly below.

11.1.1 Positive Behaviour for Learning - School Wide

Positive Behaviour for Learning - School Wide (PB4L-SW), also known as Positive Behaviour Support (PBS), School Wide Positive Behaviour for Learning (SWPB4L), or Positive Behavioural Interventions and Supports (PBIS), is one of the cornerstone programmes for the PB4L initiative. PB4L-SW is a whole of school approach that emphasises the readjustment of environments, teaching of replacement behaviours, and a continuum of consequences to reduce or eliminate problematic behaviour (Horner et al., 2005; Spaulding et al., 2010).

The PB4L-SW framework models the School-Wide Positive Behaviour Support (SWPBS) programme developed by the Office of Special Education Programs – Centre on Positive Behaviour Interventions and Supports (see www.pbis.com) in the United States. PB4L-SW originates from Applied Behaviour Analysis, and expands on behavioural principles to include the familial and interpersonal contexts of the young person with problematic behaviours. PB4L-SW is a three tier programme to manage challenging behaviour. The goal of PB4L-SW is to increase positive behaviour and academic achievement through the promotion of a prosocial and positive climate (Horner & Sugai, 2000).

Further information regarding PB4L – School Wide can be found in Savage, Lewis and Colless (2011), on the Te Kete Ipurangi website at <http://pb4l.tki.org.nz/PB4L-School-Wide>, Ministry of Education website at www.education.govt.nz, and in the 2014 evaluation report to the Ministry of Education (Boyd, Dingle, Herdina and the New Zealand Council for Educational Research, 2014).

Programme Model

PB4L-SW has three levels of prevention and intervention (Flannery, Sugai, & Anderson, 2009; Sugai & Horner, 1999, 2006). The primary level interventions are designed for all students in the school and include teaching of behavioural expectations and reinforcement. Secondary level interventions are designed for up to

approximately 15% of students who have more intensive behaviour and learning support needs. Secondary level interventions involve small group social skills training, behavioural expectations, and reinforcement. Tertiary level interventions are for those who exhibit severe and challenging behaviour, and include individualised specialised behaviour interventions (Flannery et al., 2009; Sugai & Horner, 1999, 2006).

Evidence

The PB4L-SW programme itself has not been subject to empirical testing; however, the US programme on which it is based (SWPBS) has been examined in several studies, including RCTs (e.g., Bradshaw, Mitchell & Leaf, 2010; Horner, Sugai, Smolkowski, Eher, Nakasato, Todd & Esperanza, 2009). An overview of these findings is provided below.

In a five-year longitudinal RCT, Bradshaw et al. (2010) examined the effectiveness of PB4L-SW implemented in 21 elementary schools in the United States. Over the course of the study, schools that had implemented PB4L-SW showed a significant reduction in the percentage of children with a major or minor office discipline referral (from 18.8% to 18.1%, $d = .08$), and the number of major and minor discipline referrals per student ($d = .12$). In addition, Bradshaw et al. (2010) found a significant reduction in the number of suspensions over time ($d = .27$). Although non-significant, PB4L-SW schools also showed greater gains in fifth-grade math scores compared to comparison schools ($d = .54$).

Horner et al. (2009) conducted a randomised, wait-list controlled effectiveness trial of PB4L-SW in elementary schools in the United States. Findings showed that schools that implemented PB4L-SW were significantly more likely to be perceived as a safer environment, and associated with significant increases in third-grade reading performance. The study also found low rates of office discipline referrals among the PB4L-SW schools compared to those reported by a national database; however, due to no pre-PB4L-SW data being available, this finding could not be attributed to PB4L-SW.

Several studies using a range of alternative methodological designs to that of RCTs have also examined the effects of implementing PB4L-SW on a range of outcomes (e.g., Lane, Wehby, Robertson, & Rogers, 2007; Lassen, Steele & Sailor, 2006; McIntosh, Bennett, & Price, 2011). These studies are briefly described below.

Lane et al. (2007) used a repeated-measures design study to compare the effects of PB4L-SW across different groups of high school students, namely those with externalising behaviours, internalising behaviours, co-morbid behaviours (i.e., both internalising and externalising characteristics), those with typical behaviours (i.e., no externalising or internalising behaviours), and high-incidence disabilities (i.e., students who had specific learning disabilities, other health impaired, or speech/language impairments). Results from this study indicated that these five groups of students responded differently to PB4L-SW. Over time, the internalising group showed the greatest improvements in GPA ($d = 0.39$) in comparison with the externalising ($d = .22$), co-morbid ($d = -.12$), high-incidence ($d = -.06$) and typical ($d = .03$) groups. All groups, except for the co-morbid group, showed decreases in unexcused lateness to class (internalising: $d = -.60$; typical: $d = -.72$; co-morbid: $d = .36$; high-incidence: $d = -.46$; externalising: $d = -.17$). With regards to suspensions, all groups had some decrease in the rates of suspension (internalising: $d = -.27$; typical: $d = -.21$; co-morbid: $d = -.05$; high-incidence: $d = -.16$; externalising: $d = -.04$). However, the externalising and co-morbid groups were least responsive. The typical group were the only group to show a decrease in disciplinary contracts ($d = -.25$). Overall, the findings suggest that the internalising group were most responsive to PB4L-SW, while co-morbid students were the least responsive (Lane et al., 2007).

Lassen et al. (2006) examined the effect of PB4L-SW in an urban, inner-city middle school in a 3-year longitudinal study. Over time, PB4L-SW was associated with significant reductions in the average number of office disciplinary referrals per student, average number of long-term suspensions per student, and an increase in standardised math and reading scores. In addition, analyses found that treatment adherence was significantly correlated with a reduction in problem behaviours (Lassen et al. 2006).

An outcome and fidelity of implementation study was conducted by McIntosh, et al. (2011) examining PB4L-SW across eleven elementary schools and one secondary school in Canada. Findings showed that in comparison with PB4L-SW low implementing schools and other districts and provincial schools, moderate to high fidelity PB4L-SW schools had decreases in office disciplinary referrals, number of students at risk for significant behaviour challenges, increased academic achievement

(as measured by the percentage of students meeting or exceeding standards on an achievement test), and student perceptions of school safety (McIntosh et al., 2011).

A pre-test/post-test comparison group design by Nelson, Martella and Marchand-Martella (2002) and an outcome study by Muscott, Mann and LeBrun (2008) found comparable findings to those outlined above, including reduced disciplinary actions and improved academic performance among schools implementing PB4L-SW.

Implementation

PB4L-SW has been implemented in over 10,000 schools in the United States. Several reports have documented the process for successful implementation of PB4L-SW (e.g., Bohannon, Fenning, Borgmeier, Flannery & Malloy, 2009; Chitiyo & Wheeler, 2009; Flannery, et al., 2009). A New Zealand study found the key elements of successful implementation to be schools' readiness, student empowerment, community input, professional learning and evidence-based decision making (Savage et al., 2011). Lassen et al. (2006) found an inverse relationship between PB4L-SW implementation and disruptive behaviour, highlighting the importance of adherence to the PB4L-SW features to achieve outcomes.

New Zealand Context

PB4L-SW is currently implemented in over 500 schools in New Zealand, and is on track to meet the target of 828 schools using the programme by 2017. In 2013, the New Zealand Council of Education Research (NZCER) began evaluations of PB4L-School Wide service. Analysing data from 87 PB4L-SW schools in New Zealand between 2009 and 2011, the 2013 School-Wide Indicator Report found that stand-down rates had reduced when compared with non-PB4L-SW schools, as had the gap between student retention rates in PB4L-SW schools and comparison schools. Improvements in student retention until age 17 years and NCEA Level 1 achievement for 15-year olds in PB4L-SW schools has also improved since 2009. The PB4L-SW is currently being trialled in New Zealand by Kingslea school in a secure youth justice residence.

Limitations

Despite strong research evidence, including the use of RCTs and implementation in over 10,000 schools in the United States, there is limited information available describing PB4L-SW in its applicability to the care and protection population in residential care. Further

research using sound methodology is needed in order to draw strong conclusions regarding the efficacy of PB4L-SW among the care and protection population in secure residential care.

11.2 Alternative Education

Mainstream schools and conventional classrooms are not always appropriate for young people with emotional and behavioural problems. Many of these young people end up falling behind their peers academically, or are suspended and excluded from school, leaving them to miss out on education. Alternative education programmes offer these young people a place to re-engage with the education system in an environment which treats them compassionately while still managing their behaviour in a more appropriate setting (Smyth, McInerney & Fish, 2013). Alternative education programmes often focus on vocational training as opposed to the mainstream educational curriculum, and where the mainstream curriculum is used, it is often at a lower level than would be offered in a mainstream school. Importantly, alternative education programmes are not required to employ registered teachers, and do not have to offer NCEA qualifications, which are the mainstream educational standard for high school students in New Zealand (Nairn & Higgins, 2011). Many alternative education programmes are run by community providers with 20 students or less and are not standardised, and therefore it is not possible to offer a specific programme overview.

Evidence

In a review of the literature on alternative educational programmes, Gutherson, Davies and Daszkiewicz (2010) found evidence to suggest that alternative education programmes are associated with reductions in offending behaviours, disruptive and/or violent behaviours, exclusions, and suspensions, improvements in academic achievement, school attendance, and improved sense of direction, self-esteem, confidence and motivation among students.

Limitations

Despite the review by Gutherson et al. (2010) indicating beneficial outcomes of alternative education for young people, a review by Kilma, Miller and Nunlist (2009) found no evidence to suggest alternative education was beneficial in improving school attendance, achievement or programme completion. The AGCP (2013) noted that

this difference in findings regarding the effectiveness of alternative education could be due to different definitions of alternative education used. Due to the limited information in support of alternative education, the AGCP (2013) classified this education programme as having “inconclusive” evidence for addressing conduct problems. Further research using sound methodology, including RCTs, is needed to examine the efficacy of alternative education programmes for the care and protection population.

Criticisms of alternative education have also included the opinion that the curriculum and vocational training in such programmes is at a lower level than necessary for young people to benefit from, compared to what can be achieved in mainstream schooling (Smyth, McInerney & Fish, 2013). It is argued that young people in alternative education still require challenging education, and should be pushed to achieve at the same level as their mainstream school peers, with supports in place, to assist them to learn effectively (Smyth et al., 2013). Unfortunately, alternative education programmes also appear to lack access to educational materials on par with mainstream schools, and often lack sufficient funding necessary to provide a mainstream level education to these young people (Nairn & Higgins, 2011).

New Zealand context

There is a lack of New Zealand based research examining alternative education programmes; however Nairn and Higgins (2011) found that young people in an alternative education programme felt that their alienation from mainstream education was reinforced by their participation in alternative education. However, the young people perceived the alternative education educators more positively and felt that they had a greater sense of control over their actions (Nairn & Higgins, 2011).

11.3 Prevent-Teach-Reinforce

Prevent-Teach-Reinforce (PTR) is a manualised and behaviourally-informed programme designed to assist young people with significant conduct problems to meet educational needs (AGCP, 2013; Dunlap, Iovannone, Wilson, Kincaid & Strain, 2010; Dunlap et al., 2010). The components of the programme are all known to be important for the education of young people with ongoing and serious conduct problems (AGCP, 2013).

There are four components to the PTR programme:

- Undertake a functional assessment in order to determine the factors that are currently maintaining antisocial behaviours.
- *Prevent* or remove the factors that are triggering and maintaining antisocial behaviours
- *Teach* prosocial replacement behaviours and skills
- *Reinforce* by implementing motivational rewards for achievements like attendance, engagement, and progress towards goals.

A more detailed description and explanation of the components of the programme can be found in the AGCP report (2013).

Additional components include moving young people onto tasks and curricula that are suited to their level of ability and learning style. In addition, it is important to use teaching methods that have an evidence base for use with conduct disordered individuals (Johnson & Layng, 1992).

Evidence

One RCT has been implemented examining the PTR programme (Iovannone, Greenbaum, Wang, Kincaid, Dunlap & Strain, 2009). Among 5 to 13 year old students in the United States, Iovannone et al. (2009) found that those who participated in the PTR programme had significantly higher social skills (Hedges' $g = .52$), academic engagement (Hedges' $g = .51$), and reduced levels of problem behaviours (Hedges' $g = .44$) compared to students in the control group.

Limitations

Research investigating the efficacy of PTR is still in emerging phases. Only one RCT has been implemented, and there is no information regarding the feasibility of its use among the care and protection population in secure residential care. Further research using sound methodology (i.e., RCTs) is needed to draw strong conclusions regarding the effectiveness of PTR among this population.

Summary

Comparative to their peers, young people in care and protection secure residences perform at a significantly lower level in regards to their education. Therefore, it is important that young people in care and protection secure residential care are provided with high-quality educational opportunities to re-engage in education and catch-up to their peers. Several promising education programmes have been developed that might be suitable for young people in residential care; however, they have not yet been tested among this population. Any education programme that is implemented in CYF residences should be complementary to the therapeutic environment the residences are seeking to create.

Chapter 12: Crisis Management

Given the complex behaviours and needs of young people in care and protection secure residences, there will inevitably be times where de-escalation needs to occur to ensure the safety of both the young person and those around them. Non-restraint methods are the preferred approach to addressing such behaviours over restraint methods. This is in response to research highlighting the range of negative consequences that result from the experience of physical restraint; physical restraint has been found to demoralise, humiliate, frighten, anger, traumatise and re-traumatise young people who experience it (Smith & Bowman, 2009; Steckley, 2010). The use of physical restraint, in particular where pain is involved, can also seriously damage the therapeutic relationship between young people and staff (Paterson et al., 2003). When implemented incorrectly or in a manner that is not developmentally appropriate, the risk of injury and harm to both the young person and staff increases, and in the most serious cases, death may result (Paterson et al., 2003). Restraint is permitted under the Children, Young Persons and their Families Act 1989, with section 384 stating that the chief executive may, in relation to any child or young person placed in a residence established under section 364, use such means to discipline the child or young person as are both reasonable and within the limits permitted by regulations made under this Act. Two models are prevalent in the literature with regard to de-escalation and non-violent methods of intervening with young people in the care and protection population: Non-Violent Crisis Intervention, and Therapeutic Crisis Intervention. These two models are outlined below.

12.1 Non-Violent Crisis Intervention

Non-Violent Crisis Intervention (NVCI) was developed by the Crisis Prevention Institute, an institution focused on developing strategies for safely resolving situations involving anxious or violent behaviour, all the while protecting therapeutic relationships (Crisis Prevention Institute, 2015). NVCI is a safe, non-harmful behaviour management system for early intervention and de-escalation.

Further information regarding NVCI can be found on the Crisis Prevention Institute website at www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention.

Programme Model

NVCI is based on the philosophy of providing the best care, welfare and security for staff and clients in crisis situations. The programme focuses on the prevention of disruptive behaviour through respectful communication with young people and an overarching concern for their wellbeing. NVCI aims to address crises in a way that is not traumatic for those involved. Components at the core of NVCI are prevention, de-escalation, personal safety and physical intervention. NVCI focuses on early intervention at a stage before behavioural triggers and underlying emotional or psychological issues evolve into violent behaviour. NVCI training provides staff with the skills to safely and effectively respond to situations early, and with the use of non-physical methods for preventing or managing disruptive behaviour. The NVCI model addresses the ways in which a crisis develops, non-verbal behaviours and how they affect the behaviour of others, para-verbal communication, how to recognise precipitating factors, the importance and use of verbal intervention (including how to curb violent outbursts before they turn physical), understanding of staff fear and anxiety (and how these may escalate crisis situations) and personal safety techniques for staff. Under NVCI, physical intervention is only to be used as a last resort when the young person presents an imminent danger to themselves and to others. Any physical intervention must be carried out in a manner that is non-harmful, non-invasive and which ensures the young person's dignity is maintained. Physical intervention is never to be used as a form of punishment. Extensive debriefing is also required after any physical intervention.

Evidence

No RCTs have been conducted examining the effectiveness of NVCI. However, findings from two residential treatment programmes implementing NVCI are available (Crisis Prevention Institute, 2015), as well as findings from two one group pre-test/post-test design studies (Jonikas, Cook, Rosen, Laris & Kim, 2004; Ryan, Peterson, Tetreault & Van der Hagen, 2007). An overview of these findings is provided below.

NVCI has been used at the Boys Town Specialised Treatment Group Homes for young people aged 10 to 18 years, for whom lower levels of care have been unsuccessful (Crisis Prevention Institute, 2015). An

evaluation of this found that safety holds had decreased significantly over a three year period, which in turn reduced the risk of injuries for both staff and young people²⁸.

Teaching Family Homes of Upper Michigan, who provide a range of care services including foster care, residential programmes, education, counselling, juvenile justice diversion, and reintegration alternatives, use NVCI. Reports suggest that compared to the average number of incidents involving physical restraint in the two years prior to implementation, in the two years post-implementation the annual rate had decreased significantly from 250 incidents to 127 incidents (Crisis Prevention Institute, 2015).

In a one-group pre-test/post-test design study, NVCI was associated with reductions in restraint among adolescents admitted to a psychiatric ward (98% decrease two-quarters post-training; Jonikas et al., 2004), and a reduction in the use of seclusion timeout (39.4%). In addition, a reduction of restraint procedures (17.6%) was found in a one-group pre-test/post-test design study among at-risk students in a K-12 special day school (Ryan et al., 2007).

Limitations

There is limited published, peer-reviewed research evaluating NVCI, including a lack of studies using sound methodology (i.e., RCTs). Due to this, the California Evidence-Based Clearinghouse for Child Welfare could not rate the strength of empirical support for NVCI. Further research is needed in order to draw strong conclusions regarding the efficacy of NVCI among the care and protection population in secure residential care.

New Zealand Context

NVCI is utilised in the secure CYF residences in New Zealand. The Ministry of Social Development have outlined in their delivery and guidelines standards for organisations providing care and protection programmes, that in order to ensure the safety of young people, staff are to attend NVCI training (Ministry

of Social Development, n.d.). Staff who work in CYF residential facilities are to be trained in NVCI and must attend regular refresher trainings.

12.2 Therapeutic Crisis Intervention

Therapeutic Crisis Intervention (TCI) is a prevention and intervention model, developed by the Family Life Development Center at Cornell University. TCI was developed after evidence of neglect and abuse incidents, resulting from bad management and unmonitored disciplinary measures, in child care agencies came to light (Cornell University, 2015). Further information regarding TCI can be found in The Residential Child Care Project's information bulletin (2010)²⁹ and on their website at rccp.cornell.edu.

Programme Model

At the core of TCI is the assumption that successful resolution of a young person's crisis is dependent on an adult staff member's ability to respond in the most therapeutic and developmentally appropriate manner. Under TCI a young people's aggressive and violent behaviours are viewed as an expression of needs and are treated as such. The physical safety of the young person is the key consideration at all times. The goals of TCI are to prevent crises from occurring through de-escalation, effectively managing acute crises, reducing potential and actual injury to young people and staff, and by teaching constructive ways to handle stressful situations, as well as to develop a learning circle within the organisation. Young people learn more constructive ways of dealing with negative emotions and pain, and coping with distress. TCI aims to do all of this while maintaining the dignity of all relevant parties.

Staff trained in the TCI model learn to interpret young people's aggressive behaviours as an expression of needs and learn to reduce the likelihood of responding with their own counter-aggression. Staff aim to help the young person gain self-control and to later use the experience as an opportunity for learning and growth. Staff under the TCI model use strategies including active listening, caring gestures, and managing the environment in an attempt to verbally de-escalate a situation.

28 Details regarding these findings were presented on the Crisis Prevention Institute website at <http://www.crisisprevention.com/Resources/Success-Stories/nonviolent-crisis-intervention-training/Youth-Juvenile-Services>. To the best of the authors' knowledge, there is limited information regarding the methodology of this research.

29 See: http://rccp.cornell.edu/assets/TCI_SYSTBULLETIN.pdf

Under TCI, physical restraint should only be used in situations where there is a clear indication of danger to the young person or to others. Safe, evidence-based methods of physical restraint are provided under the model.

Evidence

No RCTs have been conducted examining the effectiveness of TCI. However, findings from residential treatment programmes implementing TCI are available (Cornell University, 2015), as well as findings of a one-group pre-test/post-test design study (Nunno, Holden & Leidy, 2003). An overview of this research is provided below.

The Registration Council for Clinical Psychologists have conducted evaluations of TCI in residential treatment settings in both the United States and the United Kingdom (Cornell University, 2015)³⁰. Data was collected through records of critical incidents, pre/post-tests and surveys and interviews with both staff and young people in the residential settings. Results indicated a decrease in physical restraints, fighting incidents, physical assaults, runaways and verbal threats. Reports of increased staff confidence in their ability to manage crisis situations were also found, as well as reduced fear in handling crisis situations.

Similar results were found in an earlier study conducted by Nunno et al. (2003), who used a one group pretest-posttest design study to evaluate the implementation of TCI in a medium sized facility catering to a variety of young people aged 5 to 18 years referred by child welfare agencies or the courts. A large increase in staff knowledge was found, as well as consistency and confidence around managing crisis situations, a reduction in critical incidents, and significantly fewer physical restraint incidents (by 66%) in one of the four units.

Limitations

There is limited published, peer-reviewed research evaluating TCI, including a lack of studies using sound methodology (i.e., RCTs). Due to this, the California Evidence-Based

Clearinghouse for Child Welfare could not rate the strength of empirical support for TCI. Further research is needed in order to draw strong conclusions regarding the efficacy of TCI among the care and protection population in secure residential care.

Staff in Nunno et al.'s (2003) study reported that in some instances there is not time to implement all of the recommended pre-crisis intervention strategies.

30 Details regarding these findings were presented on the Cornell University website at <http://rccp.cornell.edu/tcimainpage.html>. To the best of the authors' knowledge, there is limited information regarding the methodology of this research.

Summary

It is inevitable that crises will occur and de-escalation will be required in secure care and protection residences to ensure the safety of the young person and those around them. However, it is important that methods of de-escalation and crisis management are non-violent due to the risk of demoralising and re-traumatising the young person when using physical restraint. Two non-violent methods of crisis management are NVCI and TCI. Despite these interventions providing alternatives to the use of force and restraint, there is a significant lack of peer-reviewed research on the efficacy of these models. When considering which model of non-violent crisis management to use, as with any model implemented in a secure residential facility, the model should complement the therapeutic environment the residences are seeking to create.

Chapter 13: Addressing the Needs of the Client Types in Care and Protection Secure Residential Care

As outlined in Chapter One, there are a range of client types among the care and protection population in secure residential care in New Zealand. These client types include females, child offenders (< 13 years), young care and protection children (\leq 12 years), and those with significant trauma and neglect histories. It is important that the distinct needs of these client types are recognised and addressed in order to promote the best possible outcomes for these young people. In this chapter, a brief overview is provided of how the needs of these client types can be best met within secure care and protection residences.

It is important to note that there is a lack of aggregated data concerning the demographics and characteristics of the general care and protection population in secure residential care and the aforementioned client types. As such, understanding of the needs of these young people, and consequently how we can best meet these needs, is limited.

Information regarding what “works best” for the general care and protection population in secure residential care based on literature and national and international best practice is outlined in Chapter Fifteen.

13.1 Addressing the Needs of the Female Population

As mentioned in Chapter One, comparative to males, females in residential care are seen to have more extensive behavioural and emotional problems, including higher suicide threats and attempts, and self-injurious behaviour. In addition, females are more likely to have histories of sexual abuse than their male counterparts. Therefore, it is important to consider what care and management approaches may be most appropriate in meeting the needs of the female population in care and protection secure residences. However, there appears to be no comprehensive publications or guidelines concerning “what works” for this population. It is only with further understanding of these young people and future research examining the rehabilitative process that a tailored approach to meeting the needs of females placed in residential care can be developed. Nonetheless, given the high rates of sexual abuse found among females, it would be important to ensure that trauma-focused recovery programmes are available for this group.

Due to sexual and physical safety concerns and vulnerability of the female population, gender separation in residence may be considered. However, it is acknowledged that this may result in a number of system issues, including the number of spaces available in secure residences that would allow for such separation. These factors need to be taken into consideration when assessing the service provision for females in secure residences. Furthermore, with regards to the vulnerability of, and complexity of presentation among, some female young offenders, it should be questioned whether the care and protection secure residential care environment is the most appropriate setting in which these young people can have their needs met. Alternative community-based services may need to be considered for this population.

13.2 Addressing the Needs of Child Offenders

To the best of the reviewers’ knowledge, it is unclear what proportion of young people in care and protection secure residences have been specifically placed in residence due to offending behaviour. In addition, given the lack of national aggregated data concerning child offenders in care and protection secure residences, there is limited understanding of the differing demographics, characteristics and needs between children with and without offending histories in residence. However, the factors associated with the young person’s engagement in offending behaviour should be identified through assessment and addressed in their individualised rehabilitative plan utilising evidence-based approaches.

13.3 Addressing the Needs of Young Care and Protection Children

Due to the lack of national aggregated data regarding young care and protection children (i.e., \leq 12 years) admitted to secure residences, there is limited understanding concerning the differing needs between child and adolescent care and protection young people, beyond the developmental differences between the two groups. However, as outlined in Chapter One, one significant concern identified regarding this population concerns the mixing of children and adolescents in residence, resulting in the ‘peer contagion effect’

(Dodge, Dishion & Lansford, 2006; Osgood & Briddle, 2006; Warr, 2002). Indeed, children may be exposed to older adolescents in residence who can present as being more aggressive and having more extensive offending histories or behavioural difficulties. Therefore, as a preventative measure, separating children and adolescents in secure residences could be considered.

Research concerning how to best meet the needs of these younger care and protection children in secure residences is needed.

13.4 Addressing the Needs of Young People with Significant Childhood Maltreatment

Due to the vulnerability and complex presentations and needs of young people who have significant childhood maltreatment, it is essential that such maltreatment and victimisation histories are identified during assessment so appropriate rehabilitation, care and management strategies are utilised to best meet these needs. In their review regarding young people with significant trauma and victimisation histories placed in residential treatment settings, Zelechowski et al. (2013) outlined policy implications and current evidence-based intervention strategies for this population. Zelechowski et al. (2013) noted that given the impact of trauma, utilising trauma-focused interventions in residence is crucial. In addition to a trauma-based framework, focus should also be placed on the strengths and resilience of the young person. Staff should have an understanding of trauma and subsequent attachment issues, and be informed of the young person's potential triggers or feelings when interacting with types of individuals who may have characteristics similar to their perpetrator (Baker et al., 2009). With regards to the physical environment, a home-like and soothing environment should be provided, with large areas to separate young people when necessary (Zelechowski et al., 2013).

Evidence-based models of treatment outlined by Zelechowski et al. (2013) that could be implemented in residence for traumatised youth included the Sanctuary Model (see Chapter Six, Section 6.1) and Trauma-Focused CBT (see Chapter Nine, Section 9.1.2). However, effective implementation of evidence-based and manualised treatment models in a residential setting is faced with multiple barriers including young people who have treatment-resistant co-morbid disorders and multiple traumatic exposures.

With regards to policy implications, Zelechowski et al. (2013) note that it is essential that there is collaboration between all agencies involved with the young person in order to provide successful intervention. To help facilitate collaboration and close the divide between agencies providing services to these young people, Zelechowski et al. (2013) suggest using trauma-informed practices across agencies. Finally, to help promote successful outcomes post-residence, focus should be on providing smooth transition and future rehabilitative planning, including the continued use of trauma-informed care as opposed to a focus on control (Zelechowski et al., 2013).

13.5 The Importance of Staff

Frontline staff are the catalysts for change in young people in residence. In addition, staff attributes, including professionalism, education, training, and the ability to form prosocial relationships, have been found to moderate treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm, Boekee, Stams, & Vander Laan, 2011). Therefore, it is important that staff working in care and protection secure residences have a thorough understanding of the needs and complexities of the general care and protection population in residential care and each client group, and have the training and personal attributes required for working with these young people. There are limited guidelines regarding what attributes staff working with at-risk and high-needs young people should possess; however, some literature suggests that prosocial attitudes and behaviours, warmth, communication skills, and values aligning with the programme model, are attributes seen among effective staff working with these vulnerable young people (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000). With regards to working with traumatised youth, it is suggested that staff should be informed about trauma and subsequent attachment difficulties, as opposed to control (Brown et al., 2012; Dvir et al., 2012; Levin, 2009).

Summary

There are several distinct client types in the care and protection secure residential population who have unique needs that should be recognised and addressed to help promote best possible outcomes. These client types include females, child offenders (< 13 years), young care and protection children (≤ 12 years), and those with significant trauma and neglect histories. Currently, there is limited understanding and knowledge regarding the demographics and characteristics of the client types in New Zealand care and protection secure residences. Obtaining such information is essential in order to provide a more thorough review of how the needs of these different client types in care and protection secure residences can be met, and to consequently establish practice guidelines.

Chapter 14: Transition and Aftercare

Young people transitioning from residential care to the community, either into independent care, a new caregiving environment or into the care of their family, experience changes in physical living arrangements accompanied by various psychological processes. Three psychological phases were identified by Van Ryzin, Mills, Kelban, Vars and Chamberlain (2011) that describe the loss, acceptance, uncomfotability, confusion, chaos, anxiety and development of new identity that is experienced by young people when they transition.

Young people who are transitioning from out-of-home care to independent living or to an unfamiliar caregiver are a particularly vulnerable group. The transition to adulthood is difficult for all young people; however this will be particularly so for those transitioning from out-of-home care given they will likely be doing so without familial support. Young people transitioning from out-of-home care are more likely to experience negative life outcomes including homelessness, unemployment, lower educational attainment and early parenthood (Courtney & Dworsky, 2005; Courtney, Piliavin, Grogan-Kaylor & Nesmith, 1998), and have been found to be at a higher risk for arrest (Cusick, Courtney, Havlicek & Hess, 2010).

For all young people transitioning from residence, it is essential that transition planning is inclusive of young people, their families (where possible) and significant others, and that planning processes are well coordinated and tailored to the individual needs and circumstances of the young person to promote best possible outcomes. Comprehensive and well-planned transitions may also help generalise any treatment gains from residence when the young person is transitioned back into the community. In New Zealand, young children in CYF youth justice and care and protection systems interviewed in the Office of the Children's Commissioner *State of Care 2015*³¹ stated that they wanted to have the number of movements between placements kept to a minimum. Similarly, one theme identified from young people interviewed in the interim report of the Expert Advisory Panel³² concerned them requiring help, support and nurturing beyond the age of 17 years³³. In their interim report, the Expert Advisory Panel concluded that

vulnerable young people need and deserve far more support to make a successful transition to adulthood. The transition planning process for young people in CYF care and protection secure residences in New Zealand is outlined in Chapter Three, Section 3.1.1. Following transition from residential care back into the community, aftercare is another essential part of the residential care framework to help maintain and sometimes improve on positive outcomes gained from residential treatment. One important aspect of successful aftercare programmes is the ability to fit support to the needs of the young person (Fontanella et al., 2008; Trout et al., 2010). Few intensive models for transition and aftercare have been developed and validated. One programme is the Intensive Aftercare Program for Serious, Violent Juvenile Offenders. Although developed for the youth justice population, features of the model may be of use in a modified model for those in care and protection secure residences.

14.1 Intensive Aftercare Programme

The Intensive Aftercare Programme for Serious, Violent Juvenile Offenders (IAP) was developed by Altschler and Armstrong (1994) and funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). IAP was designed for use with those institutionalised young people who pose the greatest risk of repeat offending on return to the community.

Programme Model

IAP aims to identify and help high risk young offenders make a gradual transition from secure care into the community and independent living in order to decrease their likelihood of reoffending.

Five key principles for reintegration underlie the IAP model. These are: preparing youth for progressively increased responsibility and freedom in the community, facilitating youth-community interaction and involvement, working with both the young offender and community support systems on qualities needed for constructive interaction and the young person's successful return to the community, developing new

31 See: www.occ.org.nz/state-of-care/

32 See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

33 In New Zealand, young people remain in formal State care until the age of 17 years. Consequently, young care leavers fall into a 'no-man's land' between care and full independence.

resources and supports where needed, and monitoring and testing the young person's and the community's ability to work productively together (Altschuler & Armstrong, 1994).

Aftercare planning begins when a young person first enters the youth justice system and involves cooperation between institutional staff, community aftercare staff and community service providers. In addition, Wiebush et al. (2005) talk of the importance of building a family perspective into aftercare planning. Under the IAP model, successful reintegration requires intensive supervision services after release from incarceration, as well as a focus on reintegration while incarcerated (Wiebush et al., 2005). Aftercare plans include information on the young person's living arrangements, educational needs, medical/mental health needs and job skills.

Evidence

The National Council on Crime and Delinquency published a report presenting findings from a 5-year multisite evaluation of IAP (Wiebush, Wagner, McNulty, Wang & Le, 2005). Youth were randomly assigned to either the experimental or control group. Findings suggested that in each site there was no difference between IAP and controls with regards to recidivism.

Limitations

The IAP model was designed for use with the young offender population. However, features of this model may be beneficial for the care and protection population in secure residential care. There is a lack of published, peer-reviewed research evaluating IAP, including studies utilising RCTs.

IAP and intensive aftercare generally tends not to be successful with young offenders who are low risk for re-offending (Altschler & Armstrong 1994). Risk-screening devices are required to determine which young offenders would benefit from IAP. Implementation of these may be time and resource costly while only providing benefit to a small group of young people in CYF residences.

14.2 Transition from Secure Residential Care to Out-of-Home Placements

Young people may transition from care and protection secure residences into out-of-home placements, including homes or residences implementing the Teaching Family Model (TFM) or Therapeutic Foster Care (MTFC) models (see Chapter Seven, Sections 7.2 and 7.3, respectively). In addition, Multisystemic Therapy (see Chapter Seven, Section 7.1) may be utilised for young people exhibiting emotional and behavioural difficulties while residing in their family home. To the best of the reviewers' knowledge, there appear to be no clear assessment models to guide the transition of a young person from secure residence into one of these evidence-based models, or to decide when a young person is considered "ready" to be transitioned back into the community. Instead, it appears that TFM, MTFC and MST each have admission/transition and discharge guidelines (e.g., see Ministry of Social Development's (2014) document concerning the TFM services in New Zealand). In addition, to help inform best possible placements for each young person based on their needs, decision-making models have been developed (see Chapter Four, Section 4.1.3, and Chapter Eight, Section 8.2).

Developing effective transitions and referral pathways between secure residences and alternative out-of-home placements in the community is essential in providing best possible outcomes for the care and protection population transitioning from secure residential care.

Summary

Comprehensive transition planning is important for the successful reintegration of the young person back into their community or into an out-of-home residence from secure residence. There appear to be no clear guidelines about how to promote the successful transition of young people from secure care back into the community, or clear assessment models to guide transition into evidence- and community-based models (e.g., TFM, MTFC) post-residence. Effective transitions and referral pathways between secure residences and community-based out-of-home placements need to be developed to promote best positive outcomes for these young people.

For more discussion regarding transition planning for these young people, see Chapter Fifteen (what ‘works best’ for secure residential care for the care and protection population).

Part B: Summary

Part B has provided an overview of the international care and protection systems and continua of care, frameworks to guide care and protection services, models for secure care and step-down care, assessment, rehabilitative models, cultural frameworks, educational programmes, crisis management models, how the needs of different care and protection client types can be met while in secure residential care, and transition and aftercare models. Having an understanding of the national and international research and best practice literature regarding services for the care and protection population is essential to help guide service delivery in New Zealand and enhance current service provision.

In an attempt to summarise the effectiveness of each model and intervention presented in Part B, a classification system was implemented whereby each model and intervention was assigned a rating of effectiveness based on their research evidence. This classification system of research evidence is outlined below, and the rating of each model and intervention is presented in Table 5.

The classification of models and interventions

The frameworks, models of care and range of rehabilitative interventions outlined in this chapter were classified into seven groups, depending on the evidence for their effectiveness among the care and protection population in secure residential care. The rating scale used to evaluate each model and intervention on the available research evidence was based on the California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale³⁴. This scale was chosen for this summary review due to its international reputation, ease in usage, and breadth of criteria.

The rating scale is as follows:

1. Well-supported by research evidence

Criteria:

1. Multiple Site Replication and Follow-up
 - a. At least two rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice.

- b. In at least one of these RCTs, the practice has shown to have a sustained effect at least one year beyond the end of treatment, when compared to a control group.
- c. The RCTs have been reported in published, peer-reviewed literature.

2. Supported by research evidence

Criteria:

1. Randomized Controlled Trial and Follow-up:
 - a. At least one rigorous RCT in usual care or a practice setting has found the practice to be superior to an appropriate comparison practice.
 - b. In that same RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
 - c. That same RCT has been reported in published, peer-reviewed literature.

3. Promising research evidence

Criteria:

1. At least one study using some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.

3a. Promising research evidence among comparable youth populations

1. The current review also classified models and programmes as having “promising research evidence” (3a) where at least one rigorous RCT has been conducted and found the practice to be superior to an appropriate comparison practice among non-care and protection populations who have comparable behavioural and/or mental health difficulties comparable to those of the care and protection population.

34 More information is available at: www.cebc4cw.org/ratings/scientific-rating-scale

4. Evidence fails to demonstrate effect

Criteria:

1. Two or more RCTs have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.
2. If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice. The overall weight of evidence is based on the preponderance of published, peer-reviewed studies, and not a systematic review or meta-analysis. For example, if there have been three published RCTs and two of them showed the programme did not have the desired effect, then the program would be rated a “4 - Evidence Fails to Demonstrate Effect.”

5. Concerning practice

Criteria:

1. If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
2. There is case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent; and/or
3. There is a legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR - Not able to be rated

Criteria:

1. There is no case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent.
2. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
3. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it.
4. The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.

5. The practice does not have any published, peer-reviewed study using some form of control (e.g., untreated group, placebo group, matched wait list study) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.
6. The practice does not meet criteria for any other level on the rating scale.

Additional criteria

For a programme to be classified as a being well-supported by research evidence (1), supported by research evidence (2), or promising research evidence (3) the following criteria must also be met:

1. There is no case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent.
2. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
3. The practice has a book, manual, and/or other available writings that specify components of the service and describe how to administer it.
4. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
5. If multiple outcome studies have been published, the overall weight of the evidence supports the benefit of the practice.

Please note that the Advisory Group on Conduct Problems (AGCP) uses a different process to classify the effectiveness/efficacy of each programme reviewed in their 2013 report. An overview of the ACGP's process for classification and how it compares to the scale used in this review is provided in Appendix B.

Table 5. Summary of Evidence for Frameworks, Secure Care, Step-down Care, Rehabilitation, Culture, Education, Crisis Management, and Transition and Aftercare Models for the Care and Protection Population

Type	Intervention/Framework name	Evidence ¹
Frameworks	Trauma, Attachment and Neurodevelopment	NR
	The Neurosequential Model of Therapeutics	NR
Secure Care Models	The Sanctuary Model	3
	Behaviour Modification – Token Economy and Point Level System	5
	Positive Peer Culture	3a
	Stop-Gap	3
Step-down Care Models	Multisystemic Therapy	1
	Teaching Family Homes	2
	Therapeutic Foster Care (Multidimensional Treatment Foster Care)	2
	Children and Residential Experiences (CARE)	NR
	Spiral to Recovery	NR
Rehabilitative Programmes	Cognitive-Behavioural Therapy Approaches	
	Aggression Replacement Training	3a
	Trauma-Focused CBT ³⁵	3a
	Dialectical Behavioural Therapy	3a
	Alcohol and other Drugs	
	Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5	3a
	Seeking Safety	NR
	Therapeutic Communities	3a
	Sensory Modulation	NR

Culture	Meihana Model	NR (S)*
	Te Pikinga ki Runga	NR (S)*
	Te Hui Whakatika	NR (E)**
Education	Positive Behaviour for Learning – School Wide	3a
	Alternative education ³⁶	4
	Prevent-Teach-Reinforce	NR
Crisis Management	Non-Violent Crisis Intervention	NR
	Therapeutic Crisis Intervention	NR
Transition and Aftercare	Intensive Aftercare Programme	NR

1 The California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale, for the care and protection population in New Zealand.

Note:

* These models have limited empirical evidence; however, they were considered a “sustained” programme by the AGCP (2013), ie, they have been continued over a period of time, met user expectations and received endorsement from Māori, overcome constraints (e.g., funding) and accessed on-going support from national or regional resources (p. 47).

** This model has limited empirical evidence, and was considered an “emerging” programme by the AGCP (2013). The characteristics of emerging programmes were: recently developed and gained initial support from local communities and whanau; expanding and refining content, method and supporting resources; yet to be reproduced in other sites or may be unique to local needs and opportunities; and seeking wider endorsement from Māori (p.47).

35 Trauma-Focused CBT presents as a particularly promising programme for the care and protection population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

36 Note: concerns regarding Alternative Education, as reported in this review, were identified by the Advisory Group on Conduct Problems (2013).

Conclusion

The care and protection population in secure residential care presents with a variety of complex needs. Evidence-based frameworks and models that have demonstrated positive outcomes among this population should be used to enhance the care and management of this at-risk and high-needs population while in secure residential care and post-transition. In line with holding a holistic view of a young person, multimodal interventions that involve family/whānau are essential for appropriately addressing the needs of these young people across multiple domains and systems.

As summarised here, models designed as an alternative to residential care that have demonstrated positive effects among the care and protection population include Multisystemic Therapy, Teaching Family Homes, and Therapeutic Foster Care (MTFC). Secure care models and rehabilitative programmes that show promising research evidence for the care and protection population include The Sanctuary Model, Positive Peer Culture, Stop-Gap, Aggression Replacement Training, Trauma-Focused Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5, and Therapeutic Communities. Positive Behaviour for Learning - School Wide is a school-based intervention which has also shown promising research evidence. For secure care and protection residences in New Zealand, any interventions implemented should be complementary to the therapeutic environment the residences are seeking to create.

As outlined in Chapter Nine, it is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in secure residence for the shortest period of time possible. Only when interventions can continue with minimal disruption and with the same therapist/clinician post-residence should therapeutic and rehabilitative models be started when the young person is in a secure care and protection residence. For young people who have identified needs and/or risks that require intervention, rehabilitative programmes that target such needs should be incorporated into their

individualised plan for post-residence implementation. It is likely, however, that providing skills related to anger management (e.g., ART) and emotion regulation (e.g., DBT) while in secure care and protection residences would provide some benefit for these young people. Alternatively, rehabilitative programmes could be implemented in a modular-based manner, where one or several modules are delivered in residence, and the remaining modules post-transition.

Part C: What “Works Best”

Thus far, this report has outlined the national and international research and best practice literature in relation to the care and management of the care and protection population. Drawing from this literature, this section summarises what appears to “work best” regarding the services provided to the care and protection population to help promote the best outcomes for these young people. However, it is important to acknowledge that, as outlined in Part B’s Summary, there is limited empirical evidence for models and programmes among the care and protection population, including those in secure residences.

In this section, emphasis will be placed on the services provided to the care and protection population in secure residential care. However, it is important to take into consideration that secure residences do not operate in isolation and comprise one part of the wider continuum of care that provides services to the care and protection population. Therefore, commentary is also made in relation to what “works best” regarding the wider continuum of care for this population.

Chapter 15: What “Works Best” for Secure Residential Care for the Care and Protection Population

Young people in care and protection facilities present with a complex array of needs and risks. Therefore, the continuum of services provided to this population should be aimed at minimising risk to themselves and to the community, and maximising positive and long-lasting outcomes. This continuum of services includes care and protection secure residences, the Youth Services Strategy, and preventive interventions for young people exhibiting early signs of problematic behaviour. Based on the current research, best practice, and communication with experts in the field of care and protection / child welfare, this section outlines what “works best” regarding the care and management of the care and protection population in secure residential care. This chapter is structured to address each of the Terms of Reference that guided this review.

The New Zealand care and protection secure residences are operated by CYF and governed by the CYPF Act 1989 and the Children, Young Persons, and Their Families (Residential Care) Regulations (1996). It is important that all services and programmes are implemented with the interests of the young people (i.e., child-centred)³⁹ and community at the forefront, and are delivered in a culturally safe manner. Furthermore, services should be implemented based on the following set of philosophies:

1. The safety and well-being of children and young people is paramount (CYPF Act 1989).
2. Detention in custody should only be seen as a last resort (CYPF Act 1989, Section 4(f)).
3. Secure care should only be used if such a placement is necessary to prevent absconding and to prevent the child or young person from behaving in a manner likely to cause harm to them or another (CYPF Act 1989, section 368).
4. Intervention ideally should be community-based, using evidence-based strategies.
5. Family/whānau should always be seen as a central part of any residential placement.
6. The physical environment should help facilitate therapeutic and rehabilitative work.
7. Staff are viewed as prosocial adults.
8. Young people who engage in risky and disruptive behaviours should not be viewed as ‘naughty kids’, but rather as a product of their background, environment, and their experiences of past trauma.

Terms of Reference 1

When secure residential care is appropriate and necessary for children and young people with care and protection needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of children and young people to similar sorts of residences in other jurisdictions.

The New Zealand care and protection population in secure residential care is a diverse group with a range of complex needs, who bring with them a myriad of difficulties and negative life experiences to the care and protection system. The purpose of secure care and protection residences in the larger continuum of care is to address acute care and protection needs when it is determined that other care alternatives within the community or family/whānau are inadequate or inappropriate. Drawing comparisons between New Zealand and international care and protection systems and the use of secure residential care is limited due to the differing standards and philosophies regarding the purpose of secure care and the availability of community-based alternatives.

Internationally, the literature recommends that secure residential care should be reserved only for the most high-needs and at-risk young people, be used as a last resort when all other alternatives have been tried, and only for a limited amount of time. This is because young people may experience a range of negative impacts while in secure residential care. These negative impacts include increased levels of antisocial behaviour due to exposure to other high-risk peers (i.e., the peer contagion effect; Dishion & Dodge, 2005; Dodge, Dishion, & Lansford, 2006; Warr, 2002), and difficulty in adapting to the residential environment due to being separated from their families and communities (see Lambie and Randell (2013) for an overview). The latter is particularly applicable to the New Zealand context with only four care and protection secure residences nationwide, consequently resulting in many young people being placed away from their families and support networks. This is likely to impact on the amount of family work that can be implemented, which is essential to generalising treatment gains when the young person transitions back into the community.

A number of factors should be taken into consideration when assessing what placement type may be most appropriate for a young person, the rehabilitative/treatment programmes to be provided, length of time the young person should be in State care, and expectations regarding outcomes post-transition. Such factors include, but are not limited to, the young person's maturation and vulnerability³⁷, risk to and from others, risk and/or history of absconding, identified needs from assessment (including mental health needs), and what difficulties may be presented in the young person's family/home environment.

Terms of Reference 2

Whether there are effective alternative community care models for children and young people who currently enter care and protection residences that are more likely to provide better care, improve outcomes and/or constitute better value-for-money.

In light of the literature concerning the negative impacts secure residential care can have on young people, there has been a shift internationally toward the increased use of community-based services as an alternative to secure residential placement, where possible. The use of less restrictive step-down residential care, such as TFM, have been shown to demonstrate better outcomes than those in more restrictive secure facilities (i.e., successful reintegration into their family home and number of placements following residential care; Ringle et al., 2012).

Community-based and evidence-based models of care that can be used as an alternative to secure residential care, and as step-down homes (i.e., out-of-home care) that young people from secure residential placement can transition to, include Multidimensional Treatment Foster Care (MTFC) and Teaching Family Model (TFM; see Chapter Seven, Sections 7.3 and 7.2 respectively). In addition, Multisystemic Therapy (MST; Chapter Seven, Section 7.1) is an efficacious community-based multimodal treatment used to address serious conduct problems, offending behaviour, and social, emotional, and behavioural problems in children and adolescents. These community-based models are cost-effective,

with every one dollar spent on MST and MTFC treatment returning \$5.04 and \$43.70 in benefits (e.g., savings to taxpayers and crime victims 25-years post-treatment) respectively.

Reprioritisation of resources into evidence- and community-based services can help strengthen the robustness and effectiveness of resources provided to the care and protection population throughout the continuum of care. This can help ensure that those who exhibit early signs of conduct problems and other problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of reoffending and being re-admitted into a secure residence.

Terms of Reference 3 and 7 question what services should be implemented in residence, and request a commentary regarding how to use the time a young person spends in residence to help inform next steps. Therefore, these TOR are addressed together below.

Terms of Reference 3

Where secure residential care is required, the right mix of services within care and protection residences that would:

- a. *Improve short and long term outcomes*
- b. *Ensure a safe and positive residential environment for children/young people and staff.*

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

³⁷ Note: we have used the word 'maturation' as opposed to 'age', given age does not necessarily equate with maturation for this group. Young people may be deemed 'vulnerable' for a range of reasons, including mental health difficulties, intellectual and/or developmental disabilities, and developmental maturation.

Terms of Reference 7

Using the time a young person spends in residence to inform the next steps (i.e., use of assessment and the appropriateness of each assessment model, programmes, and interventions).

As previously mentioned, secure residential care for the care and protection population should be used as a last resort. Furthermore, as outlined by the Stop-Gap model of care (see Chapter Six, Section 6.4), the time a young person is detained in residential care should be limited, with focus on stabilisation, assessment of needs, and transition back into community care.

Based on the literature and current best practice, what “works best” in relation to the length of time in secure residential care, the assessment process, framework and model of care for secure residences, cultural models and practices, education programmes, vocational development, crisis management, and physical environment are outlined below. In addition, a brief summary is provided of what appears to “work best” in meeting the differing needs of the variety of client types seen in care and protection secure residences (i.e., females, child offenders, young care and protection children and those with significant trauma and neglect histories; see Chapter One and Chapter Thirteen).

Please note that, to the best of the reviewers’ knowledge, there is a lack of information regarding what interventions or combination of services help promote the short- and long-term outcomes of young people in care and protection secure residences.

Length of Time in Secure Residential Care

At the time of writing this review, the reviewers were unaware of any clear and empirically-based guidelines regarding the maximum length of time a young person should be placed in secure residential care. However, the Stop-Gap model (see Chapter Six, Section 6.4) suggests young people should only be held in residence for up to 150 days.

Overarching Framework and Model of Care

The benefits of implementing an overarching framework and model of care include the fostering of a common understanding between all staff and professionals as to the aims, goals and philosophies of their services provided to young people in residential care, consequently promoting consistency in approach

between staff. Here, a framework is described as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as principles to guide the assessment and treatment of individuals. A model of care is a therapeutic or rehabilitative model implemented in residential services, and sits underneath the overarching framework.

Given many young people in care and protection secure residences have experienced trauma during histories of abuse and neglect, implementing a trauma, attachment and neurodevelopmental framework (e.g., the Neurosequential Model of Therapeutics; see Chapter Five Section 5.1.1) could be utilised in these residences. In addition, components of The Sanctuary model (see Chapter Six, Section 6.1) could be utilised as a model of care in secure care and protection residences. The Sanctuary model is an evidence-based and trauma-informed model, which aligns with the trauma, attachment and neurodevelopmental framework.

Assessment process

Assessment of young people in care and protection secure residences has two purposes: to identify the immediate acute needs of the young person at admission, and to guide the individualised intervention/rehabilitation plan. Assessment should therefore begin when a young person first has contact with CYF services, with reassessment conducted periodically right through to the young person’s exit from CYF services. Reassessment is important given a young person’s needs and circumstances change over time.

With regards to the assessment process for the young person’s individualised plan, this should involve standardised identification of a wide range of risk and protective factors of the young person, their family/whānau, and other supports. This systemic and holistic approach to assessment is in line with the understanding that behavioural and mental health issues are often contributed to by the young person’s childhood experiences and environment, including their family/whānau, peers and community; therefore, assessment should identify such factors that may need to be addressed through intervention. This includes family/whānau intervention.

As part of the assessment, each young person should be screened for physical and mental health problems, educational needs, cognitive deficits, substance use, and any immediate risks to self, to others and from others,

including self-harm or suicidal ideation. Comparable risk and needs assessments for each young person are also conducted by the Kibble Education and Care Centre. As noted by the Royal Australasian College of Physicians (2011) there appears to be no guidelines outlining the recommended standards for healthcare among incarcerated adolescents in New Zealand.

Many models of care have an assessment component included; however research examining such components is scarce. The Stop-Gap model employs the use of a functional assessment in order to determine the basis of the young person's ongoing issues (The Naturalistic Functional Assessment; Repp, 1999; Repp & Karsh, 1994).

Standardised assessment tools are those that have been designed to measure an individual's abilities comparative to those of others their age (i.e., based on normative data established from large samples of individuals). Having a standardised assessment process and measures can help facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. Standardised assessment tools identified in Chapter Eight included the MAYSI-2 and Strengths and Difficulties Questionnaire.

For young people placed in care and protection secure residences who have engaged in offending behaviour, the assessment should also include identification of criminogenic risk and needs. One such standardised assessment tool, the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), is widely used as a risk assessment and case management tool, which provides assistance in the planning of intervention and risk management. The YLS/CMI has strong predictive validity among male and female young offenders (Olver et al., 2009; Luong & Wormith, 2011; Vitopoulos et al., 2012), including among New Zealand young offenders (Mooney, 2010).

Using a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

Models to inform placement-type decisions

There appear to be two main models with regards to placement decision-making in child welfare: The Multidisciplinary Team Model and the Decision Support Algorithm Model (see Chapter Eight). The

Multidisciplinary Team Model involves the client, the client's caregiver, and experts from a range of disciplines collaborating to come to an agreement over the most appropriate placement. The Decision Support Algorithm Model involves the matching of a young person's needs and strengths to an appropriate placement-type.

There is limited research examining these decision-making models; however, this is an important area of research that requires further examination to help facilitate the most appropriate matching of a young person with a placement option, in order to promote best possible outcomes for these young people.

Rehabilitative Programmes

To facilitate good outcomes for a young person post-residence, it is important to plan and implement appropriate, individualised and effective interventions which align with the young person's identified strengths and difficulties from assessment. This parallels practice implemented by Kibble where the level of service a young person receives is determined based on the comprehensive risk and needs assessment. Furthermore, the importance of follow-through of practice from assessment to intervention has been highlighted by research, where the appropriate matching of interventions with the individual's identified difficulties is associated with enhanced outcomes (Luong & Wormith, 2011; Vieira et al., 2009).

In light of the fact that childhood experiences and environmental factors contribute to the development of problematic behaviour and mental health issues (Caldwell & Van Rybroek, 2013), interventions should not only target the behaviours of the young person, but also their social and environmental context. Therefore, multimodal approaches, including educational, mental health, cultural, medical, speech and language, and family-based interventions, are important to ensure that the wide array of difficulties the young person may experience is addressed. This is in line with strategies implemented by Kibble and Stop-Gap in residence, and models such as Multisystemic Therapy and Multidimensional Treatment Foster Care in step-down community-based care. Furthermore, working with the young person's family/whānau and caregivers, to whom the young person may return to post-residence, is seen as essential to ensure that any rehabilitative gains obtained in residence (or community-based out-of-home care) are maintained in the long term (Caldwell & Van Rybroek, 2013).

Kibble and the Stop-Gap provide useful models with their deployment of a suite of evidence-based programmes both in residence and in the community to target the range of difficulties young people in residential care often present with. Evidence-based rehabilitative programmes identified in this report included Aggression Replacement Training, Trauma-Focused Cognitive Behavioural Therapy, and Dialectical Behavioural Therapy (see Chapter Nine, Sections 9.1.1, 9.1.2 and 9.2, respectively). ART is a group-based programme, TF-CBT is an individual (i.e., one-on-one) programme, and DBT has both individual and group components. The use of evidence-based interventions and rehabilitative models within residential secure care has been shown to improve the outcomes comparable to those in non-residential out of home care (De Swart et al., 2012). In addition, the use of evidence-based models ensures access to empirical data from other implementations of the model, and also facilitates ease of evaluation of the model (Caldwell & Van Rybroek, 2013).

The ongoing monitoring and evaluation of rehabilitative outcomes for each young person is essential in order to provide a tailored rehabilitative service. This ensures that clinical staff can modify interventions which are ineffective (Caldwell & Van Rybroek, 2013). In service of this, the literature suggests that regular multidisciplinary meetings are conducted and daily progress monitored via some form of rating system, which is then reviewed by senior clinical and leadership staff (Caldwell et al., 2008).

It is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of placing young people in secure residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started in secure residence unless a young person is transitioning back into the community where this intervention can continue with minimal disruption and they see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in secure residence, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical Behavioural Treatment). Alternatively, rehabilitative programmes

could be implemented in a modular-based fashion, where one or several modules are delivered in residence, and the remaining modules post-transition.

Based on current research, knowledge about “what works” in relation to rehabilitative programmes for the care and protection population is limited. Further research using sound methodology, such as RCTs, are needed to help identify what interventions work best for whom and under what circumstances (e.g., institutionalised versus non-institutionalised care). However, good outcomes are more likely to be achieved when interventions are implemented that target identified risks and needs from the young person’s assessment.

Ethnicity and Culture

Māori are significantly over-represented in the care and protection population, and comprise 57% of those admitted to secure care and protection residential care in New Zealand. Given that a significant proportion of young people in care and protection secure residences are Māori, there is a need for services to ensure that they are implementing culturally responsive evidence-based practices for Māori rangatahi, and that their staff are culturally informed and sensitive. All agencies should align their practices in a manner that is consistent with and upholds the Treaty of Waitangi’s principles of partnership, protection and participation. In addition, cultural competency and safety is a requirement of all health practitioners and professional regulatory bodies, as outlined in the Health Practitioners Competency Assurance Act (2003). Cultural responsiveness may include the incorporation of Māori beliefs and customs into all services, such as karakia, mihihihi, pepeha, and waiata, among others (AGCP, 2013). This will help to provide a smoother transition into residential care for Māori rangatahi, and a learning environment for non-Māori (AGCP, 2013).

Cultural models, such as the Meihana Model (Pitama, Robertson, Cram, Gillies, Huria & Dallas-Katoa, 2007), provide a useful framework and practice model to guide health professionals in the assessment of and intervention with Māori clients and their whānau. Additional kaupapa Māori frameworks and interventions that are recommended in the literature for use with young people include Te Pikinga ki Runga, Te Hui Whakatika, Huakina Mai, and He Awa Whiria, all of which are described within this review (see Chapter Ten). However, at the time of writing these models are lacking evidence as to their effectiveness.

Education

There are multiple studies which show that compared with their peers in the community, young people in out-of-home care, including secure residential care, are often behind in their educational achievement, progress through the education system at a slower rate, and have less qualifications (Gharabaghi, 2011; Zeller & Köngeter, 2012). This can be due to disruption of education by breakdown of placements, and can also be related to neurobiological sequelae of trauma and abuse such as developmental delays, brain injury, and mental health difficulties (Gharabaghi, 2011; Zeller & Köngeter, 2012). The impact of poor educational achievement can disadvantage a young person throughout their life, leading to low paying jobs, unemployment, and sometimes homelessness (Gharabaghi, 2011). Therefore, it is important that these young people are provided with a comprehensive educational screening assessment, and high-quality educational opportunities tailored to their identified needs to help them re-engage in education and catch-up to their peers. Where possible, one appointed education provider should provide services for young people both in residence and in the community post-transition, to help ensure minimal disruption to the young person's education. Access to education, vocational training, or structured learning activities is a requirement outlined in the CYPF (Residential Care) Regulations (1996).

As outlined in Chapter Eleven, some promising education programmes have been developed, such as Positive Behaviour for Learning - School Wide. However, this is an area in need of further research. Streamlining and follow-through of education services post-transition can help ensure the young people have stability in schooling, which can maintain positive educational outcomes for these young people in the long term (Gharabaghi, 2011).

There appears to be no research or guidelines on the specific mix of professionals required in residential care education settings; however it seems likely that the presence of an educational psychologist, medical support for issues such as hearing loss, and the use of registered teachers would all be beneficial in terms of supporting young people in making the most of educational opportunities while in residence. In addition, given the overrepresentation of speech, language and communication difficulties present among the care and protection population, it is important to ensure speech-language therapy services are provided (Snow et al., 2015).

With regards to class size, there is limited research or guidelines on the optimal number of children per classroom to achieve positive outcomes. However, Leone (2006) found that having small class sizes, year-round operation of the school, and curriculum aligned with state standards were common characteristics among the most effective education programmes for young people who have engaged in offending behaviour.

The use of Dialectical Behavioural Therapy (DBT) among adolescents is well researched, and incorporating DBT in the school setting has been recommended to help reduce levels of aggression, distress intolerance, and interpersonal conflict (Mazza, Dexter-Mazza, Murphy, Miller & Rathus, in press). This addition of DBT to the education curriculum could enable young people to receive further benefits from their time in education during residential care.

Vocational Skills

There is a lack of research regarding the benefits of vocational and pre-employment training for young people in the care and protection system and secure residential care. However, the recognised benefits of young people being engaged in education could be generalised to include vocational and pre-employment training, where the acquisition of real-world skills can increase the young person's chance of employment, consequently fostering positive outcomes in the long-term. Transitional staff could help a young person engage in such training programmes in the community post-discharge. A community liaison group consisting of community leaders could actively facilitate the development of connections to training programmes.

Crisis Management

Although restraint may be necessary in rare instances to ensure the safety of the young person and staff, in general non-violent methods are both appropriate and necessary as an alternative. This is because physical restraint has been found to demoralise, humiliate, traumatise and re-traumatise the young people who experience it (Smith & Bowman, 2009; Steckley, 2010). Furthermore, the use of physical restraint or other potentially violent methods of de-escalation may serve to damage the therapeutic relationship between staff and young people (Paterson et al., 2003).

There are two de-escalation and non-violent models of crisis intervention that could be used for intervening with young people in care and protection secure residences.

These are: Non-Violent Crisis Intervention (NVCI) and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Sections 12.1 and 12.2 respectively). However, there has been limited published peer-reviewed research conducted evaluating NVCI and TCI.

Physical Environment

Research indicates that providing a warm and home-like environment in residence helps support the transition of the young person into residential care and to assist them to cope within the restrictive care environment (Bailey, 2002). In addition, providing kitchens, dining areas, lounges and individual bedrooms can ease the young person's transition into residential care and help them feel more "normal." Individual bedrooms offer the young person a private space where the young person can feel safe and contained, which can be therapeutic, particularly when living in a group situation (Bailey, 2002). Such an environment helps normalise the experience of the young person in residential care, and emulates the rehabilitative ideal. Furthermore, residences should have large areas to help separate young people when necessary (e.g., when a young person is triggered) (Zelechowski et al., 2013).

Kibble has small residential facilities with a maximum of six young people residing in one residence. Having small facilities allows for 24/7 eyes-on supervision, provision of specialist attention, and the formation of one-on-one relationships between young people and staff.

Particularly for those who will transition from residence back into their family home, family/whānau are seen as being an integral element of the rehabilitation of the young person. Therefore, to help increase the likelihood of family/whānau involvement in the treatment or intervention process, the young person should be placed in a secure residence that is as close to their home as possible. Family/whānau involvement in therapy or intervention programmes may allow for any identified issues in the young person's family and community environment to be addressed, which can help to maximise the generalisability of rehabilitative gains post-transition into the community. Being detained in a secure residence close to home can also allow the young person to develop and maintain relationships in their family and community.

Addressing the Needs of Different Client Types

There are several distinct client types in the care and protection secure residential population: females, child

offenders (< 13 years), young care and protection children (≤ 12 years), and those with significant trauma and neglect histories. An overview of how to best address the needs of these client types is provided in Chapter Thirteen.

Currently, there is limited understanding or knowledge regarding the demographics and characteristics of these client types in care and protection secure residences in New Zealand. Only with this information could a more thorough review be undertaken into how the needs of these different client types in care and protection secure residences can be met, to subsequently establish practice guidelines. However, it appears that due to the vulnerability and complexity of presentation among some female and younger care and protection children, considerations should be made concerning whether females should be separated from males, and children separated from adolescents.

There is likely to be a proportion of young people who have significant trauma and maltreatment histories. Such maltreatment is associated with complex presentations, including a range of psychiatric and behavioural difficulties. Therefore, it is essential that maltreatment and victimisation histories are identified during assessment. To help address the needs of these young people, incorporating trauma-informed models of care and services within secure residences and across the continuum of care should be considered. Implementing trauma-informed practices across agencies and the continuum of care can help smooth transitions from residence and close the divide between agencies that provide services to these young people (Zelechowski et al., 2013). Trauma-informed models discussed in this report include The Sanctuary Model (see Chapter Six, Section 6.1), and Trauma-Focused Cognitive Behavioural Therapy (see Chapter Nine, Section 9.1.2).

Terms of Reference 4

Where secure residential care is required, the optimal service delivery model for care and protection residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes. We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.

Professionals in residential care

At the time of writing this review, the reviewers were unaware of any research or guidelines concerning the ideal mix of professionals for a secure residential care facility. However, the “best mix” of professionals within care and protection secure residences is likely to include qualified frontline staff with extensive training in how to work with young people with offending histories, and mental health and behavioural difficulties. In terms of specific roles, there should be medical and mental health staff on site, as well as education staff (preferably registered teachers), vocational staff, and at least one cultural advisor per site, given the high numbers of Māori young people in care and protection secure residences. With regards to physical health, a general practitioner, dentist, hearing specialist and optometrist are considered core professionals for meeting the physical health needs of the young people. With regards to mental health, the presence of a registered psychologist, child psychiatrist, psychiatric nurses, and occupational therapists are considered essential within a residential care environment, in order to adequately assess and manage the various mental health, emotional, and behavioural issues present among young people in secure residential care.

Staff attributes, capabilities, and qualifications

It is important to remember that staff, and particularly frontline staff, are the catalysts for change among the young people in secure residence. Staff can provide positive attachment figures and undertake effective therapeutic interactions, if they are skilled and are trained to do so. Interpersonal skills seen among effective staff who work with at-risk and high-needs young people include prosocial attitudes and behaviour, warmth, communication skills, and values aligning with those of the programme model (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000). Furthermore, characteristics of staff working with young people, including professionalism, education, training, and the ability to form prosocial relationships, have been found to mediate positive treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm, Boekee, Stams, & Vander Laan, 2011).

Internationally, there has been a shift toward increasing the level of professionalism of staff in residential care (Dekker et al., 2012; Fendrich et al., 2012; Lappi-Seppälä,

2011). In Nordic countries at least 50% of residential care staff have tertiary qualifications (Lappi-Seppälä, 2011). Although voluntary and unqualified staff can do excellent work, may have relevant life experience, and may be extremely motivated, they may have limited understanding of how to manage and care for difficult clients.

To the best of the reviewers’ knowledge, there appears to be no guidelines concerning the optimal staff-client ratio in secure residences. However, it is likely that having a high staff to young person ratio will help ensure staff are not overworked, consequently reducing staff burn-out and turnover, and allowing for appropriate distribution of tasks across staff.

Training, Support and Supervision

It is essential that staff are trained in how to effectively manage and care for the young people in care and protection secure residences, and are highly trained in the framework and rehabilitative model that is used within the residence to ensure consistency in the implementation of the model. Staff should also have a belief in, and ongoing training in the use of, group care as a rehabilitative intervention (Bullock, 2000; Church, 2003; McLaren, 2004; Miskimins, 1990; Singh & White, 2000). Furthermore, staff should be provided with professional development training to extend and develop their skills in the effective management and care of young people in secure residences. Such training aligns with that provided to staff employed by Kibble. In particular, Kibble provides a useful model for training of staff in secure residence. Staff are provided with training related to trauma, emotion regulation, harmful sexual behaviour, social skills training, and self-harm and suicide.

Staff employed in care and protection secure residential care should also have ongoing training in how to work with Māori and Pasifika young people, in order to provide culturally appropriate services.

Supervision and oversight of implemented practice by experienced programme leaders and management, including consultation and mentoring, is essential to ensure the programme is being delivered with fidelity, and that assessment and programme delivery are standardised across all staff.

Staff that are well-supported, feel appreciated, and are provided with frequent supervision are less likely to experience burn-out, and are more likely to stay

motivated in delivering a high-level of service to the young people in residence. A high-level of staff turnover due to burnout can exacerbate the attachment issues prevalent among the care and protection population in secure residential care, and cause disruptions to consistency in care and rehabilitative work. In addition, supervision is essential for intensive and demanding roles in order to assist staff to maintain and develop their rehabilitative work (Lyman & Barry, 2006; Mendel, 2000; Church, 2003). Therefore, supervision should be offered to all staff on a regular basis, including individual and peer supervision.

Social Workers

Social workers play a critical role in the care and management of the care and protection population. However, the current training for social workers in New Zealand does not include clinical skills training. It is felt that additional training in clinical skills provided to a targeted group of social workers (approximately 40) across New Zealand would be beneficial in order to deliver adequate care and management for the care and protection population.

This group of social workers should be trained in: family therapy (e.g., Functional Family Therapy adapted model), behaviour management and skills teaching (i.e., practical application of social learning theory), basic CBT and DBT, motivational interviewing, transference and countertransference, supervision and personal development, how to engage youth and their families, how to work in a trauma-informed manner, how to administer and score psychometrics, and DSM-5 criteria. In addition, these social workers should have a basic understanding of research and applying knowledge, be trained in understanding the complex aetiology of behaviour problems, including neurodevelopmental/brain related issues, attachment/relationships with significant others, complex trauma, social context and learning, and how to use this knowledge to support parents/caregivers and other adults working with the care and protection population.

Management/Leadership

To ensure consistency of rehabilitative interventions and a united and motivated team of staff working in secure residences, it is essential that the residential organisation has strong and consistent leadership (Hollin, 2001). In addition, the use of clinical and community advisory groups can be an important support

for the management and leadership of the organisation, and can provide informed outsider opinion to ensure that the organisation does not become insulated and “institutionalized” in the way it operates.

Organisational Culture

The best opportunity for effective rehabilitative and therapeutic interactions between staff and young people is within an organisation with a clear therapeutic philosophy, as well as a united vision which all staff are committed to. Organisations with a clear culture, and one which is driven by qualified and committed leadership, can improve outcomes for the young people admitted to secure care and protection residences. It is important that all staff are qualified and committed to the model of care and the culture of the organisation, as inconsistent staff behaviour can become counterproductive and may undermine treatment integrity (Hollin, 2001).

Terms of Reference 5

Effective social work transitions into and from care and protection residences so that young people are well supported when leaving and returning to the community.

Transition and Aftercare

Transitions in and out of residence can be a difficult and unsettling experience, and young people coming into residence often have backgrounds that include abuse, neglect, and other trauma that can render the move into a restrictive and unfamiliar setting a challenging process. If there is a lack of engagement within the residential facility for the young person, then they may find it very difficult to adjust to the residential care setting, which consequently limits their ability to engage and gain benefits from the rehabilitative interventions provided (Moreno Manso et al., 2011). For this reason the smooth transition of young people into residence is deemed to be a priority.

In addition, there is evidence to suggest that the planning for transition from residence should commence shortly after admission to the residence, for two main reasons. Firstly, the length of stay for a young person is often unknown at the outset, and therefore the transition plan should be in place as early as possible in order to avoid gaps should the young person depart from residential care earlier than expected. Secondly, young

people tend to have better outcomes when they have a clear transition plan in place (Lindqvist, 2011), as this likely reduces uncertainty about their future, allowing them to better focus on their current situation. This can also increase motivation to achieve goals in residence if they are beneficial for their post-residence plan. Planning for transition as soon as the young person enters residence is an element of the Stop-Gap model.

For all young people transitioning from residence, it is essential that transition planning is inclusive of young people, their families (where possible) and significant others, and that planning processes are well-coordinated and tailored to the individual needs and circumstances of the young person to promote best possible outcomes. If possible, transition plans should involve the young person returning home to their biological family/whānau if appropriate, out-of-home care, or to a foster family or appropriate caregiver. These options are known to result in better outcomes than transition to living independently, or in other types of care, where the young person may struggle to remain in school or employment, and lack necessary support (Bruil & Mesman Schultz, 1991; Bullock et al., 1998; Embry et al., 2000).

Young people often find it difficult to maintain positive gains that they have made in residential care once they have transitioned back into their home environment (Narendorf, Fedoravicius, McMillen, McNelly & Robinson, 2012). Therefore, it is important that a young person's transition from residence be well-supported with a continuity of services in place before, during, and after transition to allow for successful implementation of their individualised intervention/rehabilitation plan. In addition, movement between placements should be kept to a minimum. The transition plan should be regularly reviewed before, during and after transition, and if the needs of the young person and/or their family change then services should also be adjusted accordingly.

Given the importance of a smooth transition both in and out of residential care, the employment of staff who are dedicated solely to facilitating the young person's transition could improve outcomes post-discharge. A young person's transition plan could be monitored by one person with clinical knowledge to ensure all services are working together collaboratively, with the young person and their family's best interests at the forefront. It may also be beneficial for the young people leaving a secure residence if they can maintain a connection with staff from the residence that they have developed

an attachment to. This may help avoid exposing the young person to what may feel like further rejection in a life which may have often been marred by attachment issues and rejection by parents and foster parents (Ward, 2009).

Following transition from residential care back into the community, aftercare is another essential part of the residential care framework. As previously noted, any positive outcomes gained from time spent in residential treatment may be lost if transition and post-residence support are not available to the young people (Guterman, Hodges, Blythe & Bronson, 1989). Aftercare services have been shown to maintain and sometimes improve on positive outcomes from residential treatment, likely due to extending the effects of evidence based treatment models (De Swart et al., 2012; Harder, Kalverboer & Knorth, 2011; James, Stams, Assher, De Roo & de Laan, 2012). An important aspect of successful aftercare programmes is the ability to fit support to the needs of the young person (Fontanella et al., 2008; Trout et al., 2010).

Terms of Reference 6

Broaden the literary review to inform transitions (i.e., the use of assessment and the appropriateness of each assessment model).

As stated above, a proportion of young people may transition into an out-of-home placement post-residence. Out-of-home models of care described in this report include the Teaching Family Model (TFM) and Therapeutic Foster Care (MTFC; Chapter Seven, Sections 7.2 and 7.3 respectively). In addition, Multisystemic Therapy (Chapter Seven, Section 7.1) is another efficacious model to address emotional and behavioural problems while the young person is living in their family home. For young people who are identified as requiring these services post-transition, planning for their implementation should be clearly outlined in their transition plan that is developed while in secure residential care.

To the best of the reviewers' knowledge, there appear to be no clear assessment models to guide the transition of a young person from secure residence into one of these evidence-based models, or to decide when a young person is considered "ready" to be transitioned back into the community. However, it appears that each model may have admission criteria with regards to the

eligibility of young people for the programme or out-of-home care model, as well as admission/transition and discharge guidelines. For example, as outlined in the Ministry of Social Development's (2014) document concerning the Teaching Family Model services in New Zealand, there are established admission and discharge processes. The admission process includes the Ministry providing the TFM provider with information regarding the needs and behaviour of the young person, including a comprehensive psychological assessment or psychiatric assessment, where possible, and a Tuituia assessment/report. The Provider will then either accept or decline the referral. With regards to discharge, the process and date for discharge is negotiated and agreed upon between the provider and Ministry social worker (Ministry of Social Development, 2014).

To ensure young people have access to the best appropriate services to meet their needs and allow for seamless transition, clear and established referral guidelines and processes between services is essential.

To help guide and inform the best possible placement for each young person, two main decision-making models have been developed internationally: The Multidisciplinary Team Model and the Decision Support Algorithm Model (see Chapter Eight, Section 8.2). Although these models are not assessment models for the transition process, they may be useful in guiding the best possible placement option for each young person based on their identified needs.

Terms of Reference 8

Commentary on Residences as a "service", as part of a continuum of services.

Residential-based services are typically situated within a wider continuum of care that comprises step-down homes (i.e., out-of-home care), multimodal family and community-based interventions (e.g., Multisystemic Therapy; MST), rehabilitative interventions (e.g., cognitive-behavioural therapy, Aggression Replacement Training, Dialectical Behavioural Therapy etc.), and interventions aimed at prevention (i.e., young people aged less than 12 years who present with conduct problems). As outlined in Chapter Three, the New Zealand care and protection continuum of care comprises the Youth Services Strategy, specialist group homes, and CYF Family Home pilot services. Secure

residential care should be utilised as an absolute last resort, after all community-based alternatives in the continuum of care have been tried.

It is important that each part of this continuum of care uses evidence-based models and interventions ranging from preventative work to those placed in care and protection secure residences, to help ensure that the needs of these young people and their families are met. Furthermore, having robust and effective resources throughout the continuum of care can help ensure those who begin to exhibit problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of offending and/or being re-admitted into a secure residence.

As stated previously, to help address the maltreatment histories experienced by many young people in care and protection secure residences, incorporating trauma-informed models of care and services within secure residences and across the continuum of care should be considered. Implementing trauma-informed practices across agencies and the continuum of care can help smooth transitions from residence and close the divide between agencies that provide services to these young people (Zelechowski et al., 2013).

Internationally, the Kibble Education and Care Centre (See Chapter Four, Section 4.3.1) is a well-run and highly-regarded agency that provides a continuum of care for the care and protection population. Aspects of this model could be beneficial for implementation in the New Zealand context to strengthen the current care and protection continuum of care. For instance, the combination of a trauma, attachment and neurodevelopmental framework and a trauma-informed model of care (e.g., The Sanctuary Model) could be situated within a continuum of care similar to that provided by Kibble Care in Scotland. Kibble Care is briefly described below.

The Kibble Education and Care Centre (Kibble)

Kibble is a social enterprise in Scotland with the goal of providing a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences, and training to allow them to be successful in independent life. Kibble provides secure care, residential services, day services, intensive fostering,

education and training, and transitional support all on-site. Evaluations have been positive with findings that young people feel cared for and secure, and benefit from having their curriculum tailored to their individual needs (Education Scotland, n.d.). Staff have also been found to be highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.). It is important to note that there has been no external research conducted examining the effectiveness of Kibble.

Terms of Reference 9

A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry. This should include, for example, MoE specialist residential schools, forensic mental health facilities and examples of disability and other mental health residences/homes. This should include:

- a. The model of care used*
- b. The staffing arrangements*
- c. The kinds of clients and their needs*
- d. The intervention programme offered*
- e. Information on the physical restraint approaches used.*

Please refer to Chapter Three, Section 3.3 where an overview of the new Youth Forensic Mental Health Unit, Ministry of Education, Barnardos, Spectrum Care, Hohepa Trust, and Ministry of Health's Disability Support Services' contracted residences is provided.

Summary

The care and protection population in secure residential care exhibit multiple difficulties that require a multi-pronged response to their care and management. The overarching framework, model of care and rehabilitative programmes for secure residence need to be evidence-based, culturally appropriate, implemented by highly trained professional staff, and located within a continuum of care so that pre- and post-residential placements are planned for systematically. This larger continuum of care should provide evidence-based resources for the care and protection population, including alternatives to residence and step-down services (e.g., MTFC, Teaching Family Model), as well as preventive interventions for young people presenting with early signs of conduct problems (e.g., Functional Family Therapy, MST, Parent-Child Interaction Therapy). Multimodal interventions which involve family/whānau are essential for appropriately addressing the needs of these young people across multiple domains and systems.

These literature reviews were written with the philosophy in mind that the population of young people in care and protection secure residential care is a vulnerable group that we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care based on the literature and evidence-based practice presented in this review so that current service provision can be enhanced, consequently promoting best possible outcomes for this population, their families, and the community.

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Appendix A: People interviewed or consulted

People interviewed and/or consulted with as part of this project:

Nova Salomen – General Manager, Residential, High Needs and Care Services, CYF

Chris Polaschek – General Manager, Youth Justice Support, CYF

Bernadine Mackenzie – Deputy Chief Executive, CYF

Denise Tapper – Manager Clinical Services, CYF

Phil Dinham – Manager Youth Justice Support, CYF

Jean MacDonald – Manager High Needs Services, CYF

Sharon Thom – Regional Director, Auckland Region, CYF

Ana Su’a Hawkins – Manager Operation Support, Residential, High Needs and Care Services, CYF

Andrew Beattie – Manager Social Work Quality Assurance, CYF

Rebecca Barson – Lead Strategic Advisor, CYF

Ken Hand – Principal Analyst, CYF

Jo Smith – Manager, Engaging Challenging Youth Team, CYF

Sean Twomey – Practice Leader, Southern Rural, CYF

Dr John Church – Department of Psychology, University of Canterbury

Professor David Fergusson – Professor of Psychology, University of Otago, Christchurch; Christchurch Health and Development Study

Professor Angus McFarlane – Faculty of Education, University of Canterbury

Dr Sonja McFarlane – School of Health Sciences, University of Canterbury

Dr Louise Webster – Child and Adolescent Psychiatrist and Paediatrician, Starship Hospital, Auckland

Jemma Stephens – Team Leader, Regional Youth Forensic Service and Taiohi Tu Taiohi Ora

Dr Julia Ioane – Clinical Psychologist, Regional Youth Forensic Service

Clinical Team – Regional Youth Forensic Service, Kari Centre

Sarah Bramhall – Principal psychologist, Department of Corrections

Suzanne Lee – Psychologist, Department of Corrections

Belinda Seymour-Wright – Clinical Director, Youth Horizons Trust

Colin Hamlin – Principal Advisor, Ministry of Health

Pamela Greenlee – Contract Relationship Manager, Disability Support Services, Ministry of Health

Brian Coffey – Group Manager Special Education Strategy and Service Improvement, Ministry of Education

Karina Phillips – Professional Teaching Fellow, Psychology Department, University of Auckland

Bernie Holden – Barnardos Residential Services Manager, Wellington

Paul Deacon – Barnardos Residential Team Leader

Spectrum Care

Hohepa Services Ltd

Miller Matangi – Behaviour Support Manager, Te Roopu Taurima O Manukau Trust

Barry Dunh – Paukura Hauora o Tainui

Anita Balhorn – Manager, Ivita Health Services Ltd

Hazel Audain – Team Leader, AoD Practitioner, Primary Care Services

Betty Anderson – Principal, Creative Learning Scheme

Tina Lomax – Principal, Kingslea school

Mark Stephenson – Operations and Team Leader (Transitions), Creative Learning Scheme

International Experts:

A range of experts from the United States, United Kingdom, Scotland, and Australia were consulted.

Kibble Education and Care Centre:

Dan Johnson – Psychology Manager
 Claire McCartney – Specialist Interventions Service Manager
 Jennifer Copley – Psychology Team Member
 Claire Reilly – Psychology Team Member

Appendix B: Classification system of the Advisory Group on Conduct Problems

The Advisory Group on Conduct Problems' (AGCP) classification of programmes process is outlined in their Conduct Problems: Effective Programmes for Adolescents 2013 report (see pages 8 to 10).³⁸ To provide context for comparison with the scale used in this report, the AGCP's four-fold classification system is outlined below.

Recommended Programmes

These were programmes for which there was generally strong evidence of programme efficacy and which met all of the following inclusion criteria:

- The intervention was founded on a clearly articulated theoretical model and the protocol for implementation of the intervention had been manualised.
- The intervention had been evaluated by multiple randomised trials and/or single case experiments, with the majority of these showing evidence of efficacy.
- The intervention was widely regarded in the literature as being an effective treatment for antisocial behaviour.
- After reviewing the evidence, members of the AGCP were unanimously of the opinion that the intervention should be recommended as a method for treating and managing conduct problems in adolescence.

Promising Programmes

These were programmes for which there was substantial evidence of programme efficacy for children under 13, with these programmes meeting all the criteria for recommended programmes. However, for these programmes, the evidence of the efficacy of the programme for adolescent population was limited and not sufficient for the AGCP to classify these programmes as recommended. Programmes classified as "Promising" met all of the following criteria:

- The intervention was founded on a clearly articulated theoretical model and the protocol for the implementation of the programme had been manualised.

- The efficacy of the intervention had been evaluated by multiple randomised trials and/or single case experiments on children under 13 and had been shown to be effective for this population.
- There was limited evidence available to show that the intervention could be successfully applied to 13–17 year olds.
- After reviewing the evidence, members of the AGCP were unanimously of the opinion that the approach should be classified as a "Promising" rather than "Recommended" approach to addressing adolescent conduct problems.

Programmes for which the Evidence was Inconclusive

These were programmes or interventions for which there was evidence of programme efficacy on the basis of randomised trials or quasi-experimental designs, but for which the evidence was not conclusive for any one of a number of reasons, including:

- The intervention had not been manualised, making translation of the programme to a new context difficult.
- There was substantial heterogeneity in the way that intervention had been applied in terms of methods of programme delivery, target population or outcome measures.
- Evidence on programme efficacy was variable, with some studies showing positive effects and others failing to find such effects.
- There was not wide agreement in the literature that the intervention was effective for the treatment and management of conduct problems and antisocial behaviours in adolescence.
- There were concerns that the evidence of the efficacy of the intervention may have been influenced by other interventions which were delivered at the same time.
- After considering the evidence, the AGCP was of the view that the evidence on programme efficacy was not sufficiently strong to recommend the programme, nor was the evidence sufficiently strong to conclude that the programme was ineffective.

38 See: <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/effective-programmes-for-adolescents.html>

Not Recommended

These were interventions for which there was strong and consistent evidence to suggest that the programme was either ineffective or harmful. Interventions classified as “Not recommended” met all of the following criteria:

- The intervention had been evaluated in multiple randomised trials, with the majority of these trials finding that the intervention was ineffective or potentially harmful.
- There was general agreement in the literature that the approach was either ineffective or increased antisocial behaviour.
- After reviewing the available evidence, the AGCP was of the view that the programme could not be recommended as an effective or safe intervention for the management of conduct problems and antisocial behaviour in adolescence.

Comparison between the AGCP’s Classification of Programmes and the California Evidence-Based Clearinghouse’s Rating Scale

California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale is similar to the AGCP’s classification system, as follows:

- AGCP’s ‘*recommended programmes*’ is comparable with Clearinghouse’s rating 1 (well-supported by research evidence).
- AGCP’s ‘*promising programmes*’ is comparable with Clearinghouse’s ratings 2 and 3 (supported by research evidence and promising research evidence, respectively).
- AGCP’s ‘*not recommended*’ is comparable with the Clearinghouse’s rating 4 (evidence fails to demonstrate effect).

The Clearinghouse’s rating 5 (concerning practice) and Not able to be Rated (NR) are not equivalent with any of the ACGP’s classifications. In addition, the Clearinghouse does not have a comparable rating to the AGCP’s ‘evidence inconclusive’.



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