Mauri Tu, Mauri Ora: A Process Evaluation

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Abstract

Rates of violent reoffending amongst young offenders has been a cause of concern for those involved in the youth justice (YJ) system in New Zealand (NZ), and across the world. Although, the rates of youth offending in NZ appear to be declining, there is a trend of increasing violent youth offending (Ministry of Justice; MOJ, 2010, 2012). Therefore, the search for effective and generalisable treatment programmes for violent young offenders has been a focus for those involved in juvenile offending research (Caldwell & Van Rybroek, 2013). The Mauri Tu Mauri Ora programme (MTMO; Kilgour & Borg, 2016), was developed in 2014 to provide an "intensive rehabilitation option for youth between 16 and 20 years of age who are deemed to be at a high risk of re-offending" (p. 27). However, since its implementation, there has been no systematic evaluation of its effectiveness. This process evaluation investigated how the MTMO programme was operating so its strengths and areas of improvement could be better understood. This was achieved by detailing the characteristics of the programme; the extent to which it met the needs of key stakeholders; evaluating the specific components of the programme; the working relationship between staff; how well the programme was delivered; and identifying possible areas of improvement. The perspectives of participants resulting in 28 subthemes associated with: initial engagement and assessment; treatment delivery and engagement; the transition phase; unit environment; and staff services. Along with a discussion, these findings identify areas the MTMO programme can build on its strengths and areas it can make improvements.

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Mā ngā huruhuru ka rere te manu

It is the feathers that enable the bird to fly

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Table of Contents

List of Tables

Introduction

Rates of reoffending amongst a high-risk proportion of young people who have offended (YPO) has been a cause of concern for those involved in the youth justice (YJ) system here in New Zealand (NZ), and across the world. For example, although the rates of youth offending in NZ appear to be declining, there is a trend of increasing violent youth offending (MOJ, 2010, 2012). Therefore, the search for effective and generalisable treatment programmes for high-risk YPO has been a focus for those involved in youth offending research (Caldwell & Van Rybroek, 2013).

The Mauri Tu Mauri Ora programme (MTMO; Kilgour & Borg, 2016), was developed in 2014 to provide an "intensive rehabilitation option for youth between 16 and 20 years of age who are deemed to be at a high risk of re-offending" (p. 27). The MTMO programme was developed by the Department of Corrections (Corrections), however, it is now being run by Oranga Tamariki–Ministry for Children (OT). The programme is currently run in the Korowai Manaaki YJ residence in South Auckland. Since its implementation in the YJ context, there has been no systematic evaluation of its effectiveness. As the programme has been running for just over two years, a process evaluation is the appropriate method of appraisal (Patton, 2008). Process evaluations focus on the internal operations of a programme to better understand its strengths and weaknesses (Dehar, Casswell, & Duignan, 1993).

This study aims to investigate how the MTMO programme is operating by detailing the characteristics of the programme; the extent to which it meets the needs of key stakeholders; evaluating the specific components of the programme; the working relationship between staff; how well the programme is delivered; and identifying possible areas of improvement.

This chapter will discuss the prevalence of offending amongst youth, particularly looking at YPO's with extensive offending histories and those who have offended violently, theories of youth offending; correctional rehabilitation frameworks; the assessment and treatment of YPO's; and finally, the NZ YJ system. The second chapter will describe the methodology; consider programme evaluation theory and models, qualitative methodology, thematic analysis, and the way these were applied in the current study. The third chapter will provide a description of the MTMO programme. Chapter four will summarise the participant's views within several themes and sub-themes, and how these relate to the body of literature on youth offending rehabilitation. This will then be followed by a conclusion which summarises the study.

The Prevalence of Youth Offending

In NZ, the overall apprehension rate for youth between the ages of 14 and 16 was 1572 per 10,000 in 2008 (MOJ, 2010). Between 2011 and 2016, there was a 45% decrease in children and youth being charged in court (MOJ, 2017). However, the apprehension rate for violent offending appeared to increase by 13% over this period. While this increase may reflect an increase in violent offending, it may also reflect techniques used by frontline police officers. (e.g., diversion, hot-spot policing, reporting measures).

Recidivism rates show a troubling number of YPO are unable to desist from offending. Of those young people on YJ Supervision with Residence Orders – the most severe YJ order – in 2015 (aged between 14-17 years), almost 90% reoffended within one year of their release (Spier & Sun, 2016). This suggests resources used for reducing offending may best be targeted at YPO who have the highest risk of reoffending.

According to Judge Becroft (May, 2004), in NZ, one fifth of all YPO are responsible for 80% of all offences committed by young people. This is consistent with international

longitudinal studies, such as the Denver and Rochester Youth Development Study (Thornberry, Huizinga, & Loeber, 1995), which highlight a small subset of serious and persistent YPO. In the Denver Youth Study, individuals with persistent and violent offending patterns comprised 14% of the sample, however, they committed 82% of all reported violent offences. Furthermore, longitudinal research (e.g., Moffitt, 1993) shows high-risk youth are likely to offend persistently across the majority of their lifespan. Thornberry and colleagues concluded, "If we do not successfully reach this small group, we will leave the vast majority of the violence problem untouched" (1995, p. 220).

These findings are consistent with much of the youth offending research. That is, amongst YPO's, there tends to be a small group of young people who commit a large proportion of the offending – particularly serious and violent offending (Baglivio, Jackowski, Greenwald, & Howell, 2014). This small group of youth can be distinguished from other YPO's in the amount of harm they perpetrate, their early age of onset, and their longer duration of offending behaviour. Among other difficulties, these young people also have greater substance-use issues, mental health issues, poor self-control, problems in school, and more extensive victimisation histories (Moffitt, 1993). As this group of young people commit the most harm and have the most significant needs, programmes such as the MTMO target their resources at this population.

Theories of Violent Youth Offending

Before evaluating the evidence base for YPO treatment, it is important to discuss the theories of YPO. Ward, Melser, and Yates (2007), suggests a good theory of rehabilitation has three components: (1) a set of principles which underlie rehabilitation practice (see *rehabilitation frameworks* section); (2) etiological assumptions which look to explain offending, help therapists understand what variables to target, and how to go about targeting these; and (3) the specific

treatment techniques used to create change in individuals with offending histories (see *treatment* section). This section will therefore give a brief overview of the theories which look to explain violent offending amongst young people.

Before beginning, it is important to note that no single cause is sufficient to explain offending. Rather, it is a combination of multiple causal processes and their associated mechanisms of influence (Hoge, Guerra, & Boxer, 2008). This section will structure theories according to the Cognitive Behavioural Developmental Systems (CBDS) framework which argues the young person should be viewed in the context of their systems, and that the interaction of cognition, behaviour, and development should all be considered (Mash & Dozois, 2003).

Behavioural theories

Behavioural theories state harmful behaviour is a learned behaviour. Social learning theory (Bandura, 1977) is an example of a behavioural theory. This theory states behaviour is learned through the environment via a process of observational learning. Bandura argues humans can adopt the behaviour of others not only through direct experience (i.e., reinforcement and punishment) but also on a vicarious basis by observing the behaviours of others, and their consequences. Social learning theory has support in the literature (see below). For example, Fox, Perez, Cass, Baglivio, and Epps (2015) examined the history of childhood trauma, abuse, neglect, and offending, in order to understand the differences between serious violent and chronic (SVC), and 'one-and-done' (O&D) YPO. The total number of adverse childhood experiences was double that for SVC YPO compared to their O&D counterparts. Importantly, the prevalence of household violence amongst SVC (39.6%) was nearly double that of O&D YPO. Applying social learning theory, it can be seen that, if a young person is living in an environment where they are commonly observing violence, they may start to imitate those behaviours

themselves. However, this is not to say that there are no other mechanisms underlying this violent behaviour.

Behavioural theories also feature prominently in developmental theories of conduct problems, particularly in relation to the concept of reinforcement. For example, coercion theory argues children learn to respond aggressively towards others by being reinforced for this behaviour (Patterson, 1976; Patterson, DeBaryshe, & Ramsey, 1990). For example, a mother may ask her child to do something, however, after he responds aggressively she withdraws which reinforces the child's aggression by removing the adverse stimuli and increases the likelihood of this occurring in the future. This learned behaviour then generalises to other contexts, such as school (Granic & Patterson, 2006). Although behavioural theories emphasis violence as learned behavioural – it also acknowledges the importance of the systems in shaping this learning.

Cognitive-behavioural theories

Although behavioural theories are helpful in understanding the development of antisocial behaviour, they lack any explanations of the mental processes which underlie behaviour. Cognitive-behavioural theories characterise "a purposeful attempt to preserve the positive features of the behavioural approaches, while also working to incorporate into a model the cognitive activity and information-processing factors of the individual" (Kendall & MacDonald, 1993, p. 387). Cognitive factors are also often implicated as mediators in the relationship between predisposing factors (e.g., genetics) and violence (Calvete & Orue, 2010).

Social information processing theory (Dodge, 1986), is one of the most robust cognitive-behavioural theories of aggressive behaviour in adolescents (Calvete & Orue, 2010). According to Crick and Dodge (1994), when individuals encounter ambiguous social situations, they process these according to a series of biases. Often these situations play out in the following

sequential manner: (a) the individual encodes cues associated with hostile intent; (b) the individual attributes the intent of the other individual as hostile; (c) they then generate aggressive solutions to the situation; (d) the consequences of aggressive are appraised by the individual as positive; (e) the individual responds aggressively (Calvete & Orue). This theory has been supported by cross-sectional (e.g., De Castro, Veerman, Koops, Bosch, & Monshouwer, 2002) and longitudinal (e.g., Lansford et al., 2006) research.

While social information processing refers to the way individuals interpret and act on information, schemas refer to cognitive structures and content used to guide the processing of information (Hayden & Mash, 2014). According to Huesmann (1998) schemas are clusters of beliefs, attitudes and other types of cognitions which are a result of experience and learning. Using grounded theory, Polaschek, Calvert, and Gannon (2009) examined the schemas associated with violent offence narratives. Four schemas emerged from these narratives. Firstly, the schema of 'violence as normal' was identified which informed the other three schemas. According to this schema, violence is perceived as a routine occurrence between people, and is useful in helping achieve personal and social goals. The second schema was 'beat or be beaten' and refers to acting violently for self-enhancement and self-preservation. The third schema was 'I am the law'. Individuals who held this schema believed themselves to be superior to others and entitled to harm others when they felt required to. Finally, the schema 'I get out of control' was held by individuals who felt they could not regulate their own behaviour, which leads them to hold others responsible for their violent behaviour. However, there is no known studies to examine the schemas of YPO's. Therefore, this theory may not be appropriate or at least applied cautiously in explaining antisocial behaviour by young people until research has been conducted in this area.

Systems theories

Although the environment of the individual has been touched on previously, this section will expand on its relevance to the development of antisocial behaviour amongst adolescence. Human development is best seen as a "joint function of the person and their environment" (Bronfenbrenner, 1992, p. 188). More specifically, the characteristics of a person, at any given time point in their life, are a joint function of the processes operating in their environment and their personal characteristics over their life course.

The ecological systems theory (Bronfenbrenner, 1992) is the best known and most applied systems theory for understanding human development. Within this theory an individual's characteristics are not shaped by one setting, but rather by a collection of interconnected settings. The theory states that there are five interrelated systems which operate in the individual's environment; the microsystems (e.g., family), mesosystems (e.g., interaction of peers and schooling), exosystems (e.g., mother's workplace and its impact on the home environment), mesosystems (culture and values), and the chronosystems (the interaction of all systems; Johns, Williams, & Haines, 2016).

Although all are important, the microsystem is the system operating most proximal to the individual and therefore is a good example of how systems impact on the individual. The microsystem is defined as "a pattern of activities, roles, and interpersonal relations, experienced by the developing person in any given face-to-face setting with particular physical and material features" (Bronfenbrenner, 1992, p. 226). Examples of settings include the home, school, and peers. Family relationship and parenting variables such as harsh and inconsistent discipline; low levels of parental warmth; and low levels of supervision have been consistently shown to be strong positive predictors of risk for antisocial behaviour (Gorman-Smith, Tolan, Loeber, &

Henry, 1998; Henggeler, 1989; Pasalich, Dadds, Hawes, & Brennan, 2012). Furthermore, low

parental supervision, coupled with adolescent antisocial peers is a strong predict of adulthood

violent behaviour (Van Ryzin & Dishion, 2013). This interaction between the family and peers

would be included in the mesosystem.

This section has discussed several theories of antisocial behaviour amongst youth within

a CBDS framework. Within a rehabilitation programme, these theories help therapists understand

what factors they should be targeting, and the best way to go about targeting these variables. The

next section, will review two rehabilitation frameworks which incorporate these etiological

assumptions.

Rehabilitation Frameworks

Often in the literature, treatment and rehabilitation have been used interchangeably. As a

result, researchers are at risk of misrepresenting the two concepts as meaning the same thing

(Ward et al., 2007). Ward and colleagues (2007) argue treatment theories relate to "theories that

incorporate psychological principles and concrete strategies that are applied to clinical settings to

change the behaviour of offenders" (p. 212). Whereas, they define rehabilitation theory as "the

overall aims, values, principles, and etiological assumptions that are used to guide therapist"

(Ward et al., 2007; p. 212), and is therefore seen as a broader concept. This section will focus on

the two main rehabilitation frameworks used in correctional settings; The Risk-Need-

Responsivity (RNR; Andrews & Bonta, 2010), and Good Lives Model (GLM; Ward & Stewart,

2003).

Risk, Need, and Responsivity

The RNR principles represent the premier rehabilitation framework used in correctional

settings (Andrews & Bonta, 2010). The RNR framework rests on three core principles. Firstly,

the intensity and dosage of intervention should match the individual's level of risk. More

specifically, higher risk individuals should receive treatment of a higher dosage and intensity

compared to low risk individuals. Secondly, the need principle states that for an intervention to

be most effective, it must target the individual's criminogenic needs (Andrews & Bonta, 2010).

Criminogenic needs are "dynamic risk factors that, when changed, are associated with changes in

the probability of recidivism" (Andrews & Bonta, 2010, p. 49). In the YJ area, these

criminogenic needs include: peers; education; substance abuse; leisure and recreation;

personality and behaviour; attitudes and orientation (Schmidt, Campbell, & Houlding, 2011).

Thirdly, the responsivity principle emphasis the use evidence-based intervention (general

responsivity) which match the individual's characteristics (specific responsivity; e.g., personality

style, level of motivation).

Studies of adherence to the RNR principles show significant differences in recidivism

when each of the three principles are applied. Specifically, when the risk principle is adhered to

there is, on average (across 374 studies), a 10% reduction in recidivism, compared to a 3%

reduction when it is not (Andrews & Bonta, 2010). The effect size of adhering to the need

principle is a 19% reduction, compared to an average 1% increase in recidivism when it is not.

Thirdly, adhering to the responsivity principle results an average reduction of 23%, compared to

0.04% when it is not. Moreover, adherence to all three RNR principles resulted in the largest

reductions in reoffending (Andrews & Bonta, 2010).

However, research on the application of RNR principles in the YJ section is less clear

(Brogan, Haney-Caron, NeMoyer, & DeMatteo, 2015). In a meta-analysis of effective

interventions for YPO, strong evidence for the risk principle was found (Lipsey, Howell, Kelly,

Chapman, & Carver, 2010). However, Vincent, Guy, Gershenson, and McCabe (2012) found

intervention decisions were more often decided based on a judge's decision than a formal risk assessment. For YPO on probation it was found that youth had multiple criminogenic needs in the areas of education, employment, family, substance abuse, peer relationships, personality, anger management, leisure time, and antisocial attributes (Vieira, Skilling, & Peterson-Badali, 2009). Vieira and colleagues found that targeting these criminogenic needs led to significant reductions in reoffending. There is very little research, however, on the degree to which responsivity factors are identified and addressed in the YJ system (Brogan et al., 2015; Luong & Wormith, 2011). Nevertheless, the RNR is the most-researched rehabilitation framework currently utilised with individuals who have offending histories. The next section will focus on the GLM, which has received less research but suggests a more strengths-based approach is required when working with YPO's.

Good Lives Model

The GLM is a strength-based approached which seeks to reduce risk while also helping YPO to develop more meaningful lives through the attainment of prosocial goals in the form a Good Lives Plan (GLP; Fortune, Ward, & Willis, 2012). The GLM assumes everyone seeks the same 'primary goods'. These are: life, knowledge, excellence in work, excellence in play, excellence in agency, inner peace, friendship, community, spirituality, pleasure, and creativity (Ward & Gannon, 2006). However, the importance of each primary good differs between individuals. Secondary goods are the means by which individuals attempt to obtain their primary goods. These means may be prosocial (e.g., going to work as an accountant to achieve excellence in work), or antisocial (e.g., planning and executing a robbery to achieve excellence in work).

The GLM assists the individual to obtain primary goods in prosocial ways by developing intervention plans which target personal capabilities (e.g., skills, knowledge, opportunities), as

well as external resources (e.g., education, employment). By helping individuals to achieve their goals, the GLM suggests we can reduce criminogenic needs through skill-building (e.g., self-regulation, communication skills), and through a change in personal identity once an individual realises they can achieve their goals in prosocial ways.

The Good Lives Model (GLM) considers the evaluation of risks alongside the identification of strengths, needs and goals (Yates, Kingston, & Ward, 2009). According to Yates, Prescott, and Ward (2010), the GLM is underpinned by the assumption that, while risk based models such as those employed within traditional relapse prevention approaches are needed, they are not enough in themselves to address the needs of those with offending histories. Ward and Gannon (2006) argue interventions need to address dynamic risk through fostering the development of both internal and external resources for the individual, in addition to promoting goals which reflect personal identity.

A review of the literature shows the GLM is most commonly used with adults who offend (Willis & Ward, 2011; Willis, Yates, Gannon, & Ward, 2013), adults who are experiencing mental health issues (Barnao, Ward, & Casey, 2015), and adolescents with sexual offending histories (Fortune, Ward, & Print, 2014). The only study applying the GLM to individuals with violent offending histories was a hypothetical operationalisation case (Whitehead, Ward, & Collie, 2007). As a result, little is known about the effectiveness of the GLM with YPO who do not have sexual offending histories. However, Willis and Ward (2013) suggests that as the GLM incorporates each RNR principle, evidence for the effectiveness of the RNR can be seen as support for the GLM. Furthermore, studies showing the effectiveness of 'GLM related concepts' (e.g., focusing on approach goals, fulfilment, and therapeutic alliance), also show indirect support for the GLM (Willis & Ward, 2013).

Recently, Fortune (2017) has explored the theoretical application of the GLM to the rehabilitation of YPO's. It was argued that the GLM has the flexibility and breadth to support young people to develop the internal and external resources they require to achieve their goals in prosocial ways. As argued in the paper, the GLM facilitates a strong therapeutic alliance, and helps to engage young people in treatment as they are motivated to achieve their goals. For both the RNR and GLM to be effective, however, they require a comprehensive assessment of the individual's risk, needs, personal characteristics, strengths, and goals. The next section will outline how this is done in practice.

Assessment

Ward and colleagues (2007) state a good rehabilitation theory should identify clinical targets, and how treatment should advance in respect to these targets. Therefore, assessment and its role in informing intervention is a key part of any rehabilitation programme for YPO. Whyte (2009) identifies a variety of purposes for assessment in the YJ context: (1) to decide the appropriate sentences, interventions, and services; (2) to predict the likelihood of a young person reoffending; (3) to assess the severity of harm caused by any potential reoffending; (4) to identify the specific needs of the young person; (5) to ascertain any potential risk to themselves through their behaviour or the behaviour of others. Assessments are therefore multifaceted; the content of each assessment can vary depending on its specific purpose (Baker, Kelly, & Wilkinson, 2011).

There is an ongoing debate in the literature about the relevant content of an assessment (Baker et al., 2011). Currently rehabilitation focussed assessments tend to focus on risk (e.g., antisocial attitudes) and protective factors (e.g., prosocial peers). Although this approach does emphasise an empirical approach to assessment, it has been criticised in the literature for multiple reasons. Firstly, the identification and subsequent treatment of offence-related risk

factors may by insufficient to meet the developmental needs of young people (Day, Howells, & Rickwood, 2004). More specifically, focusing purely on criminogenic needs can result in a lack of motivation, and neglecting non-criminogenic needs (e.g., low self-esteem), can reduce theraputic alliance (Brogan et al., 2015).

Secondly, assessments which focus purely on risk and protective factors have been criticised for being too narrow in scope (Youth Justice Board; YJB, 2008). More specifically, identifying categories of relevant risk and protective factors does not equate to explaining the causes or underlying mechanisms of a young person's offending behaviour (see Ward & Fortune, 2016 for further discussion). For example, depending on the particular young person, certain risk factors (e.g., substance use), can impact their offending patterns very differently. Understanding the processes by which substance use influences an individual's behaviour can inform the most appropriate intervention for that particular young person. Hayles (2006) argues this 'tick-box' approach results in "the reduction of the offender's unique human story to a catalogue of components, however, offers little insight into the meaning of offending within the offender's life as a whole or into personal desires, goals and ambitions, strengths, and solutions" (p. 69).

By constrast, assessment using the GLM also emphasises the importance of identifying non-criminogenic needs. Assessment using this framework looks to develop an individualised GLP. This plan includes assessment of: the individual's life history; their primary goods attained by offending; their overaching needs, secondary goods; whether they have an adequate scope or any conflicts in their primary goods; what internal and external obstancles there are to reducing their harmful behaviour; and what internal and external strengths they have (Wylie & Griffin, 2013).

In a rehabiliation programme, one of the primary aims of assessment is to inform the planning of treatment. An individualised assessment can inform: (1) the intensity of treatment; (2) the content of an individual's treatment; (3) and how those interventions should be delivered (Baker et al., 2011). It has been argued that practioners should separate the risk assessment process from that of the needs assessments, as one task involves prediction while the other requires explanation (Hamilton, Campagna, Tollefsbol, van Wormer, & Barnoski, 2017).

Individualised case management plans for high-risk youth which are associated with significantly more reductions in reoffending compared to non-individualised plans (Luong & Wormith, 2011). However, there have been weak links shown between assessment and the intervention plans which proceed them (YJB, 2008). This weak link has sizable implications for the likelihood of young people reoffending. When analysing the practices of youth probation officers, Peterson-Badali, Skilling, and Haqanee (2015) found when an individual's needs were not matched to treatment services, there were significantly higher rates of recidivism.

The introduction of RNR into the YJ system has usefully lead to the emphasis on evidence-based tools to guide the process and content used by practioners in their assessments of young people. Some tools have been primarily developed to assess static risk (eg., The Offender Group Reconviction Scale; Howard, 2009) while others incorcerate dynamic risk factors (e.g., the Youth Level of Service: Case Management Inventory; YLS/CMI; Hoge & Andrews, 2002). The main benefit of these tools is that they provide comprehensive and consistent approaches to assessment by incorporating research-based frameworks for practice (Hoge, 2002; Whyte, 2009). More specifically, these tools are most useful for adding transparency to the individual domains that practitioners associate with offending (Whyte, 2009).

In the YJ system, these tools can faciliate: (1) the classfication of risk; (2) the development of an individualised intervention plan; (3) and provide a baseline for measuring changes in an individual's progress (Lipsey, 2009). However, there has been some concern these tools restrict practioner's capacity for professional judgement (Baker et al., 2011). They have also been critised for focusing too much on risk factors while neglecting the welfare of the individual (Field, 2007).

There have been some more practical concerns expressed about the assessment process in the literature (Day & Casey, 2011). As discussed above, risk assessments are used to provide a baseline for monitoring the young person's progress, and to develop a case management plan (Lipsey et al., 2010). Periodic assessments of criminogenic needs help managers to monitor the young person's progress and make adjustments to their individualised treatment plans. However, if these assessments are not completed regularly enough, these treatment plans will not be updated and are therefore lacking in relevance. There are multiple reasons for this, however, the focal issue appears to be time it takes to complete an assessment. The Youth Level of Service: Case Management Inventory (YLS:CMI; Hoge & Andrews, 2002) for example, has 42 questions and requires an interview and file assessment. The interview alone (excluding scoring, and file assessment) can take up to 45 minutes (Campbell et al., 2014). With increasing workloads, the cost/benefit analysis of performing regular assessments becomes increasingly one-sided (VanBenschoten, 2008).

This section has outlined: the content commonly used in assessments, presented a critical evaluation of this content, highlighted the need for an individualised assessment process, discussed the strengths and shortcomings of assessment tools, and the practical concerns of the

assessment process. The next section moves on to look at issues associated with the specific treatment strategies used with YPO.

Treatment

As stated above, treatment theories inform practitioners how to best elicit behavioural changes in individuals with offence histories. Ideally, treatment should be informed by etiological theories, and the individualised assessment process, which sits within a broader rehabilitation framework (Ward et al., 2007).

Before discussing specific treatment models and strategies, it is important to review what Hoge et al. (2008) describes as "critical components for the treatment of youth offenders" (p. 86). Firstly, interventions which are highly structured, and focus on individual skills and beliefs tend to be the most effective. Secondly, treatment which focuses on changing the cognitions and behaviours of YPO has the greatest effect. This can be seen in the Lipsey et al. (2010) meta-analysis where cognitive-behavioural programmes had the largest effect on recidivism, compared to academic, vocational, and purely behavioural programmes. Thirdly, the most effective programmes have family involvement (e.g., multisytemic therapy; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). This principle may be difficult to integrate into treatment programmes with incarcerated youth. However, Hoge et al. (2008) insist that any family involvement is a better option than none at all. Lastly, comprehensive programmes which focus on multiple risk factors (e.g., Multisystemic Therapy) are better than single-component programmes (e.g., anger management).

Treatment modality

The modality of a treatment refers to the manner in which it is delivered. Within YPO programmes, there are three commonly used modes: individual, group, and family therapy.

Group treatment remains the most widely utilised treatment modality with YPO's (Hoogsteder et al., 2015). Although group interventions use less resources (e.g., time, staffing), they may not always be the most effective. This is particularly the case with young people who are too anxious to engage and disclose information in a group setting, or those that may be slower at processing information compared to others in a group. Furthermore, in some cases aggressive behaviour may increase within group settings through 'peer contagion' (Day & Casey, 2012) or 'deviancy training' (Dodge, Dishion, & Lansford, 2006). However, group therapies may serve to facilitate aspects of treatment (e.g., social problem solving).

Individual therapy serves to overcome several of these group therapy issues. However, treating all individuals through one-on-one therapy is operationally difficult given the amount of resources it requires. Often in YPO programmes, a combination of both is used (Stams & van der Helm, 2017). In a meta-analysis of six studies, it was concluded that although group therapy is effective on its own, under the right conditions, effect sizes were larger when they included an individual component (Hoogsteder et al., 2015).

Family involvement in therapy has been described as a 'critical component' of YPO treatment (Hoge et al., 2008). Given the influence of the family system in developing and maintaining offending behaviour, it is no surprise that family involvement in therapy is effective in decreasing offending behaviour. Although family therapy is difficult in a secure setting, home visits have been shown to reduce treatment dropout (Sunseri, 2001), and facilitate a successful return to the community (Huefner, Pick, Smith, Stevens, & Mason, 2015). While modalities deal with the format in which therapy is delivered, the treatment method refers to the specific techniques used by therapists to evoke change.

Treatment method

Research suggests cognitive-behavioural programmes, which focus on cognitive self-control, anger management, social perspective taking, moral reasoning, social problem solving, and attitude change, are the most effective with YPO (Baglivio & Jackowski, 2015; Lipsey, 2009; Mathys, 2017). These results are not surprising given the most promising theories of offending in adolescents have a cognitive-behavioural focus.

However, cognitive-behavioural therapy (CBT) is not without shortcomings. In a recent meta-analysis, the results of 12 studies, including five randomised controlled trials (RCT's), which evaluated the implementation of various cognitive behavioural techniques with YPO in residential treatment were analysed (Armelius & Andreassen, 2007). At the 12-month follow-up, recidivism rates were less in the CBT groups than the control groups. However, recidivism rates were not significantly different at the six or 24-month follow-up periods. The authors note the significant effect for CBT may be present at all follow-up periods, however, there is not enough statistical power for this to show up. It was concluded that although CBT was found to be effective in some cases, these results mean it is "impossible to discern any particular promising individual intervention within the broad concept of CBT" (p. 19). Put simply, as CBT is comprised of so many techniques, it is difficult to identify which specific components are most effective.

Recently, third wave cognitive-behavioural techniques have been introduced into the treatment of YPOV's. These include Aggression Replacement Training (ART; Goldstein, Glick, & Gibbs, 1998; Hollin, 2004), and Dialectical Behavioural Therapy (Berzins & Trestman, 2004; Livesley, 2012). These techniques have been developed in an attempt to elicit change for specific

areas of need (e.g., self-regulation), rather than focusing generally on adaptive thinking patterns, emotion, and behaviour (Hayes & Hofmann, 2017).

Treatment implementation

There are cases where treatment methods appear promising but fail to achieve meaningful results in real-world contexts. This may not be a problem with the treatment method itself, but rather the implementation of the method. It is important to distinguish between *efficacy* and *effectiveness.* In efficacy studies "treatment effects are evaluated under ideal conditions, with motivated subjects, and well-trained therapists who perform the intervention as intended, with high levels of program integrity" (Stams & van der Helm, 2017, p. 2). Effectiveness studies, however, evaluate the effect size of treatments in real-world conditions, where the above characteristics are often not present.

Programme integrity is the degree to which an intervention is delivered in the way it is intended (Goense, Assink, Stams, Boendermaker, & Hoeve, 2016). Although high levels of integrity have been commonly seen as a positive characteristic of a programme, Barber et al. (2006) argues integrity which is too high may reflect a lack of flexibility on behalf of the therapist in responding to their client's needs. However, low programme integrity is often seen as the inability to appropriately translate a therapeutic model into practice. In a meta-analysis containing 17 studies of evidence-based interventions for YPO, high levels of integrity were associated with medium to high effect sizes, while those with low integrity showed low effect sizes (Goense et al., 2016). Therefore, the way in which treatment is delivered may be as important, or more important, as the treatment strategy itself. This highlights the need for having well-trained staff delivering treatment in an environment which supports change.

Living group climate

Recently, the research on treating YPOV has looked at how the environment can support

cognitive and behavioural change within a secure residential facility. The characteristics which

make-up the physical and social environment have been labelled 'living group climate' (Van Der

Helm, Stams, & van der Laan, 2011). The literature suggests that young people benefit most

from an environment which is open and therapeutic, which has high levels of social support from

staff, a prosocial group culture amongst young people, as well as a balance between structure and

autonomy (Souverein, Van der Helm, & Stams, 2013).

 Research conducted in a Dutch youth correctional facility found an open living climate

was strongly correlated with more active coping and greater treatment motivation. Maintaining a

balance between rehabilitation and safety can increase YPO's motivation (van der Helm, Beunk,

Stams, & van der Laan, 2014). As motivation is a key factor in the responsivity principle

(Andrews and Bonta, 2010), it can result in improved therapeutic progress (McMurran, 2002),

and outcomes for young people (Lipsey, 2009). Therefore, developing an open living group

climate is one of the key challenges for secure residential facilities (van der Helm et al., 2014)

Aftercare

Although evidence-based interventions with high levels of integrity, delivered in a

therapeutic environment, can produce positive changes for the YPO (Lipsey et al., 2010), the

effects of these interventions often do not last once they are released into the community

(Altschuler & Armstrong, 1998). The use of the aftercare interventions has been emphasised to

facilitate the YPO's return to the community, and their ongoing desistance from offending. In a

meta-analysis of aftercare interventions ($n = 22$ studies), aftercare services which had an

individual focus and high levels of intensity, in contrast to duration, were most effective (James,

Stams, Asscher, De Roo, & der Laan, 2013). Furthermore, these services were most suited to

YPO who had offended violently and were deemed to be a high-risk of reoffending.

        This section has summarised the treatment modalities and methods commonly used with

young people, the importance of how these are implemented in the real-world, how the young

person's environment can facilitate therapeutic change, and the importance of supporting the

young person through aftercare services. The next section will focus on the NZ YJ System which

has recently attempted to apply these features with young people.

The NZ YJ System

        The Oranga Tamariki Act (1989) is the principal legislation governing the YJ system in

NZ. This system is unique compared to other western countries. The characteristics of the NZ YJ

model include "diversion, community-based sanctions, family decision-making, and cultural

flexibility" (Lynch, 2016, p. 17). According to Morris and Maxwell (1993), the NZ YJ system

attempts to distance itself from the justice approach, without abandoning its need to achieve

positive outcomes for YPO. For those between the ages of 14 and 17, access to the YJ system is

based on a 'criminal culpability model' (Lynch, 2016); where these young people are seen as

liable for their behaviour. In NZ, there are a range of options available in the YJ system, from

diversion to secure residential placements.

        Residential Services

        There are four secure YJ residences in NZ. These are located in South Auckland,

Palmerston North, Rotorua, and Christchurch. The size of these residences varies between 30 and

46 beds (Lynch, 2012). These residences house young people on supervision with residence

order (s311), those on remand (s238 1 (d)), as well as children and young people serving a term

of imprisonment. A supervision order can last between three to six months. Once those on an

imprisonment sentence reach the age of 18, they will be transferred to an adult prison. For young

people serving a sentence of imprisonment, being detained in a YJ residence allows for a safer

community (rather than serving a community sentence), as well as being a more developmentally

suitable environment for the young person (in contrast to adult prison).

All residences operate under a 'structured day' programme. Young people attend school

in residences and are provided with a range of programmes to meet their individual needs

including; vocational training, reducing re-offending, life skills, cultural identity, sporting

activities, sexual health education, driver's licence theory, fitness, and cooking programmes.

While in care, these young people also have access to health services.

Implications of the Literature for the Current Study

Although there is research suggesting the importance of an individualised assessment

process, and cognitive-behavioural strategies, little is known about the best way to integrate them

in practice. Furthermore, the majority of these studies have been carried out in North America,

where the legislative, policy, and cultural context is very different. Currently, there is no proven

residence-based rehabilitation programme for high-risk YPO in NZ.

The MTMO programme is a rehabilitation programme for YPO between the ages of 16

and 20 years. Although, there have been treatment programmes delivered in Young Offender

Units in NZ prisons before, this is the first programme which is specifically designed to meet the

needs of young people living in a secure YJ environment. The programme is run at the YJ

facility, Korowai Manaaki, in South Auckland. The programme is separated into three broad

phases: (1) introduction phase, which includes an assessment and preparation for new

participants; (2) core programme, which includes a range of CBT and DBT techniques, all

embedded in the RNR and GLM frameworks; and (3) the transition phase, which aims to help the young people to transition from the youth unit and back into the community.

Social scientists understand the development of evidence-based intervention is the first step towards improving well-being. However, the next step and arguably the more difficult, is implementing these programmes in real-world settings, and to sustain these programmes over time (Durlak & DuPre, 2008). Furthermore, the appropriate implementation of programmes can have a significant impact on the outcome of programmes (Durlak & DuPre, 2008). By carrying out a process evaluation of the MTMO programme, insight into how the programme is running can be obtained. These insights can help identify the strengths and weaknesses of the programme, and how these may in turn be used to improve the programme.

Evaluation Objectives

The aims of this study were to: (a) describe the context, characteristics, and operation of the programme; (b) evaluate the extent to which the programme met the needs of young people, whānau members and caregivers, with reference to their views; (c) evaluate the programme components with reference to the perspectives of staff and young people, as well as the literature; (d) examine the working relationship between the programme staff, residential staff and external staff; (e) examine the programme's operations and how this may impact on the success of the programme delivery; and (f) identify possible areas of strength and improvement.

Methodology

Programme Evaluation

Programme evaluation has been defined as "… the systematic collection of information about activities, characteristics, and outcomes of programs to make judgements about the program, improve program effectiveness and/or inform decisions about future programming",

(Patton, 2008, p. 39). In New Zealand, social policy has not historically benefited from the same level of research investment which has been seen in the areas of conservation and primary production, for example (Gluckman, 2013). However, given the level of expenditure the government devotes to social programmes, evaluation is critical (Gluckman, 2013). Furthermore, due to the complex nature of humans, when implementing social programmes, it is difficult to predict their direct effects and what long-term consequences they will have. For example, in a meta-analysis of evidence-based youth psychotherapies, it was concluded that empirically supported treatments do not often perform well outside the laboratory, in clinically representative conditions (Weisz et al., 2013). The evaluation of programmes in a natural setting is therefore a critical task in understanding its effectiveness and informing decisions about improvement and future programming.

Programme evaluations have commonly been characterised and labelled by their *purpose, and intended audience* (Spencer, Ritchie, Lewis, & Dillion, 2003). Patton (2002) lists several programme evaluation types (e.g., outcome evaluations, process evaluations, implementation evaluation, prevention evaluation); and programme evaluation models (e.g., goal-free evaluation, responsive evaluation, utilisation-based evaluation). However, there is no single, *best* approach to evaluating a programme. When determining which evaluation type and model to use, evaluators must consider the purpose of the evaluation, what questions need answering, and what method will provide the most useful information (Patton, 2002).

Process Evaluation

The current evaluation is a process evaluation. Broadly speaking, process evaluations are concerned with what happens during programme implementation (Dehar et al., 1993). Focusing on process involves analysing *how* something happens rather than examining what the outcomes

are (Patton, 2002). Process evaluations, therefore focus on the "internal dynamics and actual operations of a programme", to better understand its strengths and weaknesses (Patton, 2008, p. 206).

Process evaluations are likely to analyse the following features of programmes: 1) the programme origins, from planning to implementation; 2) the programme structure, components and delivery system; 3) contextual factors relevant to programme operation; 4) participation of programme participants; 5) levels of community awareness; and 6) resources used for programme operation (Dehar et al., 1993).

To understand these features, the process evaluator attempts to understand and document the daily reality of the setting. Not only must the evaluator understand the formal activities and anticipated outcomes, but they must also understand the informal activities and related outcomes of the programme (Patton, 2008). Process evaluations often include the perceptions of various stakeholders to support these observations. In the current study, the perceptions of staff, whānau, and the young people were collected through interviews. These various perspectives provide unique insight into how the programme is experienced by different individuals (Patton, 2008).

Process evaluations are useful in providing feedback for the improvement of the programme, as well as the future distribution of the programme if it is found to be effective (Dehar et al., 1993; Patton, 2002). In the current study, feedback about how well certain treatment components were operating, or how well they fitted together, for example, can be used to improve these components and processes. Furthermore, if the programme or aspects of the programme are considered worthy of replicating in other sites (i.e., other youth justice residences), then process evaluations can provide critical information for this.

Evaluation Model

Evaluation models provide the framework which structure and support the evaluation process. These models structure methodological decisions, provide directions for managing stakeholders, and identify important issues to consider (Patton, 2002). There are many types of evaluation models, including; goal-free evaluations, illuminative evaluations, and utilisation-focused evaluations. Each of these provide their own unique structure to an evaluation. This study employed a utilisation-focused evaluation model. Utilisation-focused evaluation are "done for and with specific intended primary users for specific, intended uses" (Patton, 2010, p. 37). A utilisation-focused evaluation offers a framework for deciding on the methods, focus, and contents of an evaluation (Patton, 2002). Specifically, these decisions are made by the intended users of the evaluation, who are the *skateholders*. These are people who have a vested interest in the evaluation. In social services these are often programme staff, social workers, social work clients, collaborating organisations, and government officials (Patton, 2010). Therefore, to decide on the methods, focus, and contents of an evaluation, one must consult with the key stakeholders.

Patton (2010) outlines five steps in a utilisation-focused evaluation process. Firstly, the evaluator needs to identify the intended users of the evaluation. These key stakeholders work with the evaluator in making key decisions about the evaluation. Secondly, the evaluator and intended users decide on the focus of the evaluation (e.g., formative, summative, knowledge-generating). The current evaluation was a formative evaluation, as it had a focus on improvement which directed the content of the evaluation towards asking about strengths and weaknesses of the programme. The third stage requires the evaluator and intended users to make methods, measurement, and design decisions. There are many decisions, including (a) whether it will be qualitative, quantitative, or mixed data; (b) whether it will be naturalistic or experimental; (c) the

level of emphasis given to generalisations; and (d) ways to overcome threats to reliability,

validity, and utility. The fourth stage occurs after the data has been collected. The intended users

work with the evaluator to decide how best to interpret the findings, make judgements, and give

recommendations. Finally, the report is disseminated to the intended users to make decisions, and

to a wider system for public accountability.

Cultural Consultation

When conducting an evaluation of a programme involving Māori Tikanga, and Māori

participants, there are a number of challenges Pākehā face in developing competency as an

evaluator. Evaluators must consider, for example; what evaluations should Pākehā practitioners

be involved in and what roles should they play; what weighting should evaluators give to cultural

competency when compared with other evaluator competencies; to what extent does the

evaluator's cultural competency impact on the quality and robustness of the evaluation; how to

evaluators go about developing cultural competency; and who do evaluators turn to for guidance

on these issues? (Torrie, Dalgety, Peace, Roorda, & Bailey, 2015).

As Glynn et al. (1992) suggest, research intended for the betterment of Māori requires

engagement with Māori researchers to share research skills and technologies. Therefore, cultural

consultation occurred with Dr. Tia Neha, lecturer in Māori and Indigenous Developmental

Psychology, and Parris Pidduck, Kaiāwhina, both with the School of Psychology at Victoria

University of Wellington.

These consultations revealed important factors related to the appropriate processes used

when interviewing Māori participants. Firstly, interviewers were advised to take time at the start

to introduce themselves, the research, and the purpose of it. By building strong rapport with

participants, interviewers were following the principal of whānaungatanga, which refers to the

building and maintenance of relationships. Secondly, interviewers acknowledged the importance

of whānau and whakapapa; both in understanding the young person's identity, and through

engaging whānau in the evaluation process. Thirdly, interviewers followed the principal of

wanaakitanga by providing koha for participants; allowing time at the end of the interview to

explain the next steps in the research process and addressing any questions participants had about

the research. By doing so, knowledge can flow reciprocally between participants and the

researcher. Overall, it was the aim of the researcher to be aware of kia tūpato, by being cautious

of insider and outsider status, and how this may impact on research questions, and the interview

style.

Qualitative Methodology

Qualitative methodologies are considered the most appropriate form of analysis when

conducting a process evaluation (Patton, 2002). This type of analysis provides an in-depth

understanding of the programme's dynamics and processes. There are many types of qualitative

methods, for example: grounded theory, discourse analysis, and interpretive phenomenological

analysis. Although the different types of qualitative analysis have many similarities, they all have

distinct features based on the types of analyses used and assumptions made, and therefore are

suited to different types of research. Thematic analysis is the most appropriate method for this

evaluation due to: (a) the level of flexibility needed to analyse different types of data (e.g.,

programme manuals, interviews) and research questions; (b) its procedures are easily accessible

in comparison to other types of qualitative analysis; and (c) thematic analysis does not require

any technical knowledge of language as seen in conversation and discourse analysis (Braun &

Clarke, 2006).

Thematic analysis

The main benefit of using thematic analysis versus other types of qualitative analysis is its flexibility. More specifically, although thematic analysis follows a general set of steps, there is no strict recipe for guiding an analysis (Braun & Clarke, 2006). This is important in a process evaluation, as there will be many parts of the programme to analyse, and diverse groups of participants to interview.

When conducting a thematic analysis, there are several decisions which must first be made and stated explicitly (i.e., inductive vs. theoretical analysis, semantic vs. latent themes, essentialist vs. constructionist view; Braun & Clarke, 2006). Firstly, this research was inductive in its approach to analysis. Analysis involved a bottom-up data-driven approach, where themes were concluded based on the data, and not on any pre-existing theoretical interests. Secondly, the themes generated were semantic in nature. Themes followed a progression from a description, which were based on a pattern within the data, and conclusions which were drawn based on their broader meanings and implications (Patton, 1990). Lastly, the research took an essentialist view of the data. This enabled motivations, experience, and meaning to be concluded based on the experience and language of the participants used (Braun & Clarke, 2006). The application of thematic analysis followed the six-step approach outlined by Braun and Clarke (2006), and will be explained in the section *data analysis*.

Method

Participants

Interviews with those involved in the programme (*n* = 14) provided the primary source of information for the evaluation. The five stakeholder groups comprised of adolescents who took

part in the programme (*n* = 5), caregivers (*n* = 3), facilitators (*n* = 4), unit staff (*n* = 1), and site

social workers (*n* = 3).

Adolescents

As shown in Table 1, there is considerable skew in the ethnicity of the adolescent

participants, with all five participants identifying as Māori. Researchers were constrained by the

limited number of adolescents who took part in the MTMO programme, as well as the difficulty

of contacting these participants. Furthermore, the majority of participants who took part in the

MTMO programme were Māori – consistent with 74% of those living in youth justice residences

identifying as Māori in the 2017 financial year (MSD, 2017).

The programme was developed for young people between the ages of 16 and 20 years.

However, given the nature of YJ residences, all adolescents were between the ages of 16 and 18.

Each individual participated in the programme for a maximum of 14 weeks (42 group sessions).

However, given the nature of the young peoples' orders and sentencing, this length was largely

reserved for those young people on Correction's sentences as they were in the residence for a

longer duration. The OT youth, who were there as part of their Supervision with Residence Order

(S311, OT Act, 1989), were often in the residences for shorter periods, and therefore some only

took part in a portion of the programme.

Caregivers

Two caregivers involved in the study identified as female, and one as male. Two of these

participants identified as Māori, and one identified as a New Zealander. Two of the caregivers

identified as the parent of a young person, and the other caregiver identified as a foster parent.

Table 1. *Demographic characteristics of adolescent participants*

Characteristic	*n*
Male	5
Female	-
Māori	5
Pasifika	-
Pākehā	-
16-years-old	1
17-years-old	3
18-years-old	1
1-2 months on programme	2
2-4 months on programme	3
Corrections Youth	3
Oranga Tamariki Youth	2

Professionals

The professional group was made up of three different groups: facilitators ($n = 4$), who delivered the programme; site social workers ($n = 2$), who supported the young people in the community; and unit staff ($n =1$), who supervised the day-to-day activities in the residence. Of the seven professionals, two were male and five were female.

Of the four facilitators, three were female and one was male. Each facilitator differed in the length of time delivering the programme, while two facilitators delivered for more than six months, one facilitator only delivered a few sessions. However, this individual's role in the residence as a clinical team leader coupled with related work experience meant their participation was valuable.

Interview Schedule Development

A literature review was undertaken regarding theories, assessment, and treatment of adolescent violent offending. This literature review, which is presented in the introduction, highlighted key processes and factors in the assessment and treatment of this group. This literature review formed the primary basis for the development of the interview schedules. The schedule used for adolescent interviews was also based on the assessment of young people previously undertaken by the Department of Corrections following their graduation from the MTMO programme. Many of these open-ended questions were incorporated into the interview schedules for the adolescents.

Interview schedules for each group followed a similar format with four to six sections which corresponded with the key areas of enquiry. Each section contained questions about the specific factors necessary to describe the process (e.g., "What sorts of things did they ask you about in your first interviews?"); as well as broader questions exploring the strengths, weaknesses, and suggestions for improvement (e.g., "What would have made it easier for you?"). Table 2 shows the respective areas of enquiry for each group of participants.

The content of the interview schedule was updated once data collection began. Initial transcripts were analysed to determine whether the content of the research should be expanded, contracted, or refined (Guest, MacQueen, & Namey, 2011). For example, if specific issues in the treatment's delivery arose in an interview, but was not included in the original interview schedule, this would be integrated into the interview schedule and used in future interviews.

Table 2. *The focus of enquiry for each group of participants*

Areas of Enquiry	Adolescents	Caregivers	Social Workers	Unit Staff	Facilitators
Residence environment	✓			✓	✓
Knowledge of the programme		✓	✓	✓	
Referral process	✓	✓	✓		✓
Assessment process	✓	✓	✓		✓
Treatment programme	✓	✓	✓	✓	✓
Cultural services	✓				✓
Staff services				✓	✓
Improvements and Outcome	✓	✓	✓	✓	✓

Procedures

The study was approved by the Oranga Tamariki-Ministry for Children Research Access Committee, and ethical approval was given by the School of Psychology Human Ethics Committee under the delegation of the Victoria University of Wellington Human Ethics Committee. The confidentiality of each individual was maintained by only referring to their group membership (i.e., young person), instead of their names in transcripts. However, as there were a small number staff involved in the study, they were all given a chance to review (withdraw and or/change) quotes included in the report prior to publication as confidentiality could not be assured. In carrying out the research, several approaches were used; each of these will be outlined below.

Programme Documentation

The Mauri Tu Mauri Ora programme manager was approached and asked to provide a copy of the programme manual, session guides, and assessment protocols. However, given the programmes youthful nature, only session guides were available for analysis. These documents provided information about each sessions' rationale, objectives, materials, and procedures.

Interviews

Following a discussion with the programme manager, it was decided they would approach staff working in the residence, while the researcher would approach social workers, whānau, and youth. As the programme was not running at the time of the evaluation, all graduates of the programme were either in the community or in prison. The contact details of relevant social workers were obtained from the programme manager. The contact details of the whānau and young people were obtained from social workers once permission had been given. Potential participants were given a brief outline of the study and its aims, and if they were interested in proceeding, they were given copies of the information and consent forms.

All interviews were conducted by one researcher. The majority of interviews were conducted in person. For programme staff, these were conducted at the residence. For young people in prison; interviews were conducted at the prison. Due to logistical issues; interviews with whānau, social workers, and young people in the community were conducted over the phone as the participants were from all over the country.

The length of the interviews ranged from 30 minutes to an hour and a half. At the start of each interview, interviewees were given a second copy of the information and consent form, given verbal information about the study, and the limitations of confidentiality were discussed appropriately. For all face-to-face interviews, written consent was obtained to take part in the

study and for the interview to be recorded. For those over the phone, verbal consent was obtained

and recorded after the researcher stated and explained each statement of consent.

Interviews with Māori participants, particularly the young people, started with a longer

rapport building period so the necessary connection and level of comfort was achieved. A karakia

was offered to each of these participants, and if requested, was used to commence and conclude

each interview. At the end of the interview, the interviewer explained the next steps of the

research, and addressed any questions the participants had about the research.

Each participant was interviewed according to the interview schedule. However, as the

interviews were intended to be semi-structured, additional questions were asked to follow up

points raised and acquire richer data. Summaries were often given throughout interviews so

participants could verify or correct interpretations of their statements.

In order to thank participants for their time and effort, young people in the community

were given movie vouchers, and whānau were given supermarket vouchers. Koha was used as a

gesture of gratitude. Following the workplace policies of both the Department of Corrections,

and OT, no koha was given to staff. Participating young people in prison did not receive koha as

it was not allowed in the prison.

Data Analysis

All data were analysed using the process of thematic analysis. Although thematic analysis

has been previously described, this section will discuss how it was applied in both interviews and

programme documentation.

Interviews

All interviews were listened to and transcribed in full; removing only the interviewer's

minimal encouragers to reduce unnecessary detail. As in the first step of thematic analysis, this

transcription process provided an opportunity to become familiar with the data (Braun & Clarke, 2006). During transcription, initial thoughts and ideas were noted in the margins. The purpose of doing so was to start thinking about emerging patterns within the data, as well as how the interview questions could be improved for later interviews. The accuracy of these transcripts were maintained by checking them against the audio recordings once each interview had been transcribed. Identifying information was edited, removed, or changed during transcription process in order to protect the confidentiality of participants.

After the interviews were transcribed, the initial ideas generated through this process were used to develop preliminary codes in NVivo. This process reflects the second step of thematic analysis (Braun & Clarke, 2006). Consistent with Boyatzis (1998) definition, these codes reflected a basic segment of raw data used as evidence of a phenomenon. NVivo was used to highlight and categorise segments of data into one or more codes. As the coding was data-driven, emerging patterns within the data were used to develop new codes as the analysis proceeded. The context in which individuals speak is vital to the meaning they are creating (Gibson & Brown, 2009). Therefore, segmentation is an important decision made in the coding process. Using NVivo's built-in segmentation tool, the data was coded using a consistent broad context (surrounding paragraph) to maintain the participants' meaning. The end result was 42 codes which contained one or more data extracts.

Consistent with the third step of thematic analysis, the codes were analysed and sorted into potential themes (Braun & Clarke, 2006). This process involved not only reviewing the codes, but also the literature to understand how to best categorise and combine different codes into themes. As suggested by Braun and Clarke (2006), mind maps were used by placing a potential theme in the centre, and using relevant codes on the exterior to show potential

subthemes, and how they are related. Based on these mind-maps, the themes and sub-themes were entered into NVivo, with their accompanying data extracts.

Consistent with the aims of the study, the overarching themes represented the different elements of the programme (e.g., the assessment process). This resulted in seven overarching themes, and 28 sub-themes. These themes were then evaluated in two ways which reflects the fourth step of thematic analysis (Braun & Clarke, 2006). Firstly, these themes were reviewed against the coded data, and compared with a second coder's coded data. Coders then discussed and agreed on the selected themes and related extracts. Secondly, the whole data set was reviewed through rereading to make sure the themes formed a coherent picture of the data. During this rereading stage, important data which was originally missed was coded and included in the themes' data extracts.

The themes were then defined and reported alongside a coherent narrative, which reflects the fifth and sixth step in thematic analysis (Braun & Clarke, 2006). Each theme was unpacked to make sure the different elements of each were described alongside the relevant extracts. Where possible, a review of relevant literature was included to discuss where the theme fitted within the current research, and suggestions of workable solutions for any issues within the MTMO programme.

Programme Documentation

The only programme documentation available to researchers was the session guides. As a result, there was little information to analyse. However, the analysis followed a similar process to that of the interviews. Where themes developed from participant perspectives were supported by those found in the programme documentation (e.g., appropriateness of treatment strategies), these were included as evidence.

Programme Descriptions

Before summarising the views of participants and the related literature, a description of the programme will be given. This description will be based on information obtained from; agency websites, session guides (as a full programme manual was not available for review), and personal communication with programme staff.

Overview of the MTMO Programme

The MTMO programme offered treatment for up to 14 weeks. However, the programme duration varied depending on the court order or sentence the young person received. For example, those on a Residence with Supervision order (Oranga Tamariki Act, s311) can be in a residence for a maximum of six months, whereas those sentenced in the adult court system, and therefore were under the supervision of the Department of Corrections, may be in a residence for several years until they reach the age of 17 years. Based on risk assessments completed in the residence, all adolescents were deemed to be medium to high-risk, with their index offence being violent or non-sexual in nature.

The programme catered to male adolescents between the ages of 16-20, however as it was run in a youth justice residence, the maximum age of those in the programme was 17 years (Kilgour & Borg, 2016). The programme was offered to those who did not have a significant intellectual disability, and had the ability to work well within a group setting. The programme incorporated Māori and Pasifika cultural approaches to well-being. The modality of the treatment was both individual and group work.

The programme was labelled as having an open or "rolling group" format as young people would join the programme at different times, however, in the practice it operated more like a closed-group as all young people were working on the same modules at the same time.

When young people joined the programme, they began an induction or "starter" group which ideally had one to two other young people who were starting the programme at the same time. However, in practice this was not always the case. Again, there were supposed to be eight starter sessions, but in practice this was reduced to one or two. In the starter sessions, the young people learnt about disclosure of information within a group, the importance of communication in a group setting and safety in the therapy room. They were also introduced to the different core modules and discussed how they felt about working in a group. The young people then joined the "core programme" group which contained a maximum of eight people at a time. At this stage, the sessions focused on: group building, aggression control, violence prevention, safety and wellbeing, problem-solving, relationships, and substance use. The final "transition phase" was designed to facilitate their transition into the community or prison.

Three group sessions occurred a week, with each session being 90 minutes, often with a break at the half-way point where facilitators would lead a physical exercise. Individual sessions lasted for an hour and were run once a week by facilitators or case leaders. Individual sessions were used to reinforce changes made in group sessions and to discuss the young person's offending behaviour in more depth. However, not all young people received individual sessions as they were targeted at the highest-risk youth in the programme.

Programme Goals

The one formalised goal of the programme was to reduce reoffending. However, as one facilitator said, there were '*spin-off' goals*. These goals were summarised by some facilitators:

> *The ultimate goal was reducing reoffending. The second goal would be for the youth to have a positive experience in the therapeutic environment. The third is for early intervention of Corrections clients, so avoiding those Korowai Manaaki ending up here [In Department of Corrections custody]. Fourthly, for there to be that transparency with Korowai Manaaki and Corrections, and for us to be working more consistently together.*

You should see a reduction in incidence, a reduction in secure admissions, a reduction in fights, all of those sorts of things.

Looking at and utilising the good lives, it was really aimed at setting them up and being able to move back into the community in a more prosocial manner and engage in the community prosocially.

Yeah, to basically bring their strengths out a lot more.

Referral Procedures

Referrals were made through two separate processes, depending on whether the young person was on a sentence managed by the Department of Corrections or a Youth Court order overseen by Oranga Tamariki. For those on a Correction's sentence, young people in the residence were referred based on their Risk of Reconviction by the Rate of Imprisonment (ROC*ROI) scores (a static risk assessment tool used by the Department of Corrections). For those on Youth Court orders (s311), referrals were made by Case Leaders once the young people entered the residence, and were often based on their YLS/CMI score – see below for further details. However, in other cases, facilitators who also worked in the residence, referred young people who they believed to be good candidates for the programme.

Assessment Processes

Before entering the programme, assessments were completed to identify the young person's level of risk as well as their criminogenic needs. These assessments were based on self-report information from the young person; a review of their files on the OT database; and in some cases, whānau were consulted. One facilitator also said they found "*unit staff as well were really useful to talk to… great sources of information for day-to-day behaviour*". Assessments for those on Corrections' sentences were completed by a Psychologist employed by the

Department of Corrections, while those on Youth Court orders were completed by a Psychologist employed by OT. No mid or post-programme assessments were completed.

Assessment Tools

To assess level of risk, the psychologists used evidence-based assessment tools and structured judgement. The risk and need assessment tools used were the Youth Level of Service: Case Management Inventory 2.0 (YLS:CMI 2.0; Hoge & Andrews, 2011), and the Structured Assessment of Violence Risk in Youth (SAVRY; Vincent, Perrault, Guy, & Gershenson, 2012). Both tools include primary dynamic risk items, but also include some static items. Both tools have shown good interrater reliability, strong internal consistency, and significant predictive power for both general and violent offending (Hilterman, Nicholls, & van Nieuwenhuizen, 2014). In some cases, the Million Adolescent Clinical Inventory (MACI; Millon & Davis, 1993) and the Structured Assessment of Protective Factors for violent risk: Youth Version (SAPROF:YV; de Vries Robbé, Geers, Stapel, Hilterman, & de Vogel, 2015) were used, however, these were not always possible due to the time it took to complete the assessments and the lack of staff qualified to administer these tools. Furthermore, once the Department of Corrections exited the programme, there was not sufficient resources to purchase these tools. As previously mentioned, ROC*ROI scores were also used as a static risk assessment tool of young people under a Corrections sentence.

Therapeutic Approaches

MTMO sits within both the RNR (Andrews & Bonta, 2010) and GLM rehabilitation frameworks (Ward & Stewart, 2003). The therapeutic approaches used in the MTMO programme were similar to those used in other adolescent treatment programmes. These included: Cognitive Behavioural Therapy (which included Aggression Replacement Training; Goldstein et al., 1998),

Narrative Identity Therapy; The Life Compass (Eifert & Forsyth, 2005); Relapse Prevention;

problem-solving skills building; Dialectical Behavioural Therapy (DBT; Berzins & Trestman,

2004); Mindfulness (as adapted by Linehan, 1993); and Cognitive-Self Change.

Māori Health Models

Although there are no evidence-based Māori models of practice within the treatment of

violent offending amongst adolescents, the MTMO programme incorporated two cultural

frameworks; the Te Whare Tapa Whā (Durie, 1994) and tuakena teina models (Reilly, 2010).

Te Whare Tapa Whā

Te Whare Tapa Whā (four cornerstones of health), is a holistic theory of health developed

by a group of Māori health workers in 1982, and described by Durie (1994). The model describes

four domains of health depicted as a whare (house). The four walls of the whare are:

1. Taha tinana: the physical aspects of health (e.g., level of fitness)
2. Taha hinengaro: the emotional and psychological aspects of health (e.g., mood)
3. Taha wairua: the spiritual and cultural aspects of health (e.g., cultural identity)
4. Taha whānau: the social aspects of health (e.g., family factors)

The Te Whare Tapa Whā reflects the Māori worldview of a balanced universe (Rochford,

2004). The model suggests similarly to a whare, for an individual to be in good health all

domains of well-being must be attended to. Furthermore, the model suggests if an intervention

undermines one of these domains, its effectiveness is reduced. The following descriptions were

given by facilitators to explain how the Te Whare Tapa Whā was used in practice:

> *To understand need. Where they had areas that needed to be looked at or addressed, to understand goals. What are your goals in those areas? So, weaving it through a lot of things we did. If the young person was saying I've got a problem with my anger, well how does it affect you in each of those four areas?*

> *Te Whare Tapa whā works well in getting them thinking about, how are things going emotionally, spiritually etc which is very useful in check-in's.*

Tuakana-teina

The Tuakana-Teina model was a residence-wide strategy which attempted to engage and support young people through a buddy-system, and model of leadership. As one facilitator said:

> *It was about the leadership of the ones that have been there long enough to try and mentor and support the new ones that are coming through.*

Pasifika Health Models

Fono'fale model

The Fono-fale model of health incorporates values and beliefs consistent across Pacific Island nations. Similar to Te Whare Tapa Whā, the model promotes a holistic view of health, where all aspects included in the model share an interactive relationship. The model incorporates the metaphor of a Samoan house, with the floor, posts, and roof; each necessary parts of the home. This was applied in a similar way to the Te Whare Tapa Whā, as stated by one facilitator:

> *It's basically the same as the Te Whare Tapa Whā… the island boys used that, and the other boys used that Whare.*

To summarise this chapter, MTMO aims to reduce reoffending, however, it also intended to reduce incidents in the residence and develop the strengths of young people. The programme has an evidence-based assessment process, which features several assessment tools to measure risk and identity criminogenic needs. The programme uses a suite of therapeutic approaches, underpinned by the principles of RNR, which are delivered in an individual and group format. The programme also caters to the needs of Pasifika and Māori through three cultural frameworks. While this chapter describes the programmes content, the next chapter will discuss the stakeholders' views of the programme implementation, what strengths it had and what requires improvement.

Participant Perspectives of Programme Implementation and Discussion

The thematic analysis on programme implementation yielded several themes which will be summarised below. Each theme will include several quotes, alongside an analytic narrative to describe and discuss the various perspectives. Participants' responses were organised into the following categories: (a) programme manual and resources; (b) programme structure; (c) initial engagement and assessment; (d) treatment delivery and engagement; (e) the transition phase; (f) the unit environment and its impact on therapy; and (g) staff services.

Programme Manual and Resources

Facilitators and young people were asked about their thoughts on how the session guides were implemented and the related resources that were used in the programme. Specifically, facilitators were asked about how well the session guides met their needs, what resources were available to support therapeutic sessions, and how these things could be improved. Four sub-themes emerged from within this theme: (a) a developmentally-appropriate programme manual; (b) mixed views on manual flexibility; (c) prepared material; (d) an appropriate therapeutic space.

Developmentally-appropriate session guides

There are many different types of manuals used in rehabilitation programmes (e.g., management manuals, research manuals). Of interest in this section is the programme manual, which "details each programme session and links the targets for change to the model of change presented in theory manual" (Hollin, 2006, p. 14). A manual is often the vehicle which drives delivery of rehabilitation programmes (Hollin, 2006). Therefore, a manual can have a significant impact on the success of a programme. In the MTMO programme, there was no programme manual, instead the written materials consisted solely of session guides. There was concern by

the majority of facilitators that these session guides were in some areas not developmentally

appropriate for young people. Facilitators had questions relating to the programme origins:

> *It was supposed to be based on the HRPP [High Risk Personality Programme] programme that was run at the Paremoremo, the Auckland prison. The high-risk personality programme. So, it was, you know, my understanding from [developer] was that that was what they were basing it on.*

A specific concern related to the language used in the programme manual. Three different

facilitators commented on this:

> *One thing I found with the material was the language didn't meet the level of our young people. Because it was a programme that was run in the prisons, it captured more of an adult mindset. Whereas these kids were nowhere near that level. So, the biggest trouble for me was trying to figure out ways to kind of bring it to a level where the young people can actually see what we are trying to deliver, and what the message that we are trying to put to them.*
>
> *So, we tried to tailor it very much to their developmental level.*
>
> *I think at times the manual was very high-level with its vocabulary or the ways that it was described.*

The cognitive ability of YPO compared to an adult population are significantly lower

(Frize, Kenny, & Lennings, 2008). Furthermore, their verbal intelligence, which is of particular

importance in treatment programmes, is significantly lower than comparison samples (Snow &

Powell, 2008). The implication of these findings are that the programme manual needs to reflect

this population's developmental and cognitive levels. Otherwise facilitators may have to adapt

language in the manual before or during the session to suit young people. However, this takes

great skill on behalf of the facilitator, not to mention the risk of decreasing programme integrity

if inconsistently (Goense et al., 2016).

The second issue related to the programme manual was the theories used to underpin the

sessions. Although there were no facilitators who mentioned this in the interviews, the

programme manual included reference to violence-related implicit theories (Polaschek et al.,

2009). Implicit theories are "used by individuals to explain and understand aspects of their social

environment, and, therefore, to make predictions about future events" (Ward, 2000, p. 495).

Although this theory has proven to be fruitful in the rehabilitation of adults with violent

offending histories, the sample used to establish these findings had a minimum age of 17 years.

Whereas those in the MTMO programme had a maximum age of 17. These implicit theories are

said to develop during childhood, however, they may be changed gradually if there is sufficient

evidence. Therefore, adults may hold different implicit beliefs given their different interpersonal

and environmental experiences. However one facilitator stated that the theory behind the

programme was developmentally appropriate for both assessment and intervention:

> *Having a developmentally focused theory behind the programme also helped understand*
> *the youth, their behaviour, and what strategies would work best for them given their age?*

For a programme manual to operate effectively, it must be underpinned by a sound theory

manual (Hollin, 2006). Therefore, attention must be given to the developmental appropriateness

of the theories which are included in the manual.

The third issue related to the manual was the way in which the group sessions were

supposed to operate. Two facilitators reflected on this:

> *The main issues that I had with it was an expectation that the young people would be able*
> *to process a lot of stuff within group, particularly from a conflict theory perspective so*
> *that if there were issues between them they would be able to process those within a group.*

> *My understanding was that this was, and I could be wrong, intended to be a process*
> *group, which I found quite fascinating given the cohort.*

To explain the second quote, the facilitator is referring to a process group where the

group will meet and discuss related experiences on a given topic. This contrasts with a skills-

based group where individuals practice new skills (e.g., social skills) within a group setting.

There has been concern in the literature about young peoples' ability to reason autobiographically (i.e., reflecting on one's personal past to make explicit connections between the past and oneself (Habermas & Bluck, 2000). For people with offending histories working in process groups, they require this ability to link their past experiences to their offending behaviour. This commonly occurs during exercises called 'offence chains', where individuals link the characteristics of various events leading up to an offence. However, it has been argued that: (a) early adolescent development of autobiographical reasoning may be associated with lower well-being (McLean & Mansfield, 2011); (b) adolescents require a greater deal of scaffolding to facilitate their emotional regulation skills and reframing of past events (Fivush, Marin, Crawford, Reynolds, & Brewin, 2007); (c) the sharing of stories may not be appropriate in a group setting as it makes people feel uncomfortable (Thorne & McLean, 2003). Therefore, greater care is needed when using autobiographical reasoning with young people; the level of scaffolding required may mean these exercises are only suitable for individual sessions.

Mixed views on manual flexibility

A manual-based programme often includes the sequencing of sessions, the aims and objectives of each session, the content of each sessions, and the methods of delivery within each session (Hollin, 2006). However, there is varying levels of flexibility for which the facilitators can work within. Amongst the facilitators there were mixed views on whether the programme manual was flexible enough or overly-manualised. One facilitator stated the programme was sufficiently flexible:

> *It is designed to be a flexible programme. So, you just pick up the session, if it's got a few pointers and objectives, and then you run it however you want from there… as long as you utilise what is going on for the youth and then link the sessions into that, then it does. As opposed to being like, this is what we are going to do today. Even if you did that, I think it would still work. But when you're using the youth, what's going on for the youth,*

and then tying the youth into that, it does seem to flow much more… I would probably say the flexibility and aim of the programme to be dynamic, and practical.

The main benefits of a flexible programmes align well with the weaknesses of manualised programmes. These weaknesses are: (a) a negation of theoretical principles (e.g., treating groups of individuals based on similar offence histories, rather than their needs); (b) the lack of individual case formulation; and (c) the removal of clinical artistry (i.e., tailoring treatment to meet the needs of each individual; Wilson, 1996). One facilitator stated the programme was overly manualised:

Manualised, like so then you do this and this and this. A, B, and C, and then you ask the young person to reflect back and then you go talk about…I felt like it was manualised…The need there which is about facilitators probably not having much experience as a facilitator and that's needed. But for me coming into the field you should have already have that foundation, knowledge, and skills before you even deliver a programme.

As stated by this facilitator, one of the benefits of having a manualised programme is that it can be a useful resource for non-experienced staff, and may act as a tool for their training (Hollin, 2006). Not only this, a manualised approach also helps in maintaining treatment integrity, and can facilitate the evaluation of the programmes (Hollin, 2006). However, over-manualised programmes can result in a lack of flexibility for therapists in meeting the needs of their clients (Barber et al., 2006).

Clearly there requires negotiation between a flexible and manualised approach. However, the benefits of each depend on the programme itself, and the staff who are delivering it. Within the context of the MTMO programme, some staff lacked experience and training in delivering offending-based rehabilitation programmes for young people (as will be discussed in the sub-theme, *improve facilitator training*). In this situation, a level of structure is necessary for facilitators to deliver an effective programme (Hollin, 2006). However, as expertise or

experience amongst facilitators increases the need for a manualised approach may shift, however

treatment integrity should always be maintained.

Prepared material

Often a programme manual will have supplementary material available for programme

facilitators who need to have background knowledge on the theories and therapeutic techniques

(e.g., a research manual). Facilitators in the MTMO programme stated the relevant material

required to deliver the programme was not available in a structured format. This is explained by

three different facilitators below:

> *As I said there were bits that caught me out. The bits where we were talking about anger issues, it said you had to refer to particular a book, I had to go out and buy the book. There wasn't a lot of lead in time to be able to say well these are all the resources that I need for this session.*

> *Like I said, I asked, "Where's the content?" Like for previous programmes I've run, "here you go, here's the work book, and here's the facilitator's guide", and you'd study it and have supervision around it and then as you run the programme you'd tailor it. There was nothing.*

> *This one here [points out a referenced resource from the programme manual], I didn't actually have the book for that, so just things like that.*

In an effort to identify the features of a good treatment manual, an international survey of

rehabilitation programme trainers was conducted (McCulloch & McMurran, 2007). Of the 32

experts who were interviewed, there was a general consensus that it was essential for a treatment

manual to be accompanied by a theory manual, and if the materials were not available, there was

a well organised materials manual included. Without appropriately resourcing the programme

before it begins, there is a risk of facilitators delivering the programme without the required

integrity. However, as one facilitator states, the next time the programme runs much of the

operational work would have already been resolved:

The other thing, if the programme was to run again, it would now hopefully the logistics and operational stuff would already be sorted, so I wouldn't have to do that, which would free up my time to focus on the therapeutic work.

Although these issues are commonplace amongst pilot programmes; as suggested by participants and the supported by the literature, the MTMO programme would best benefit from having the resources available to facilitators well before sessions begin.

An appropriate therapeutic space

The environmental psychology literature has provided support for the importance of designing an appropriate therapeutic setting. Factors which were important to a counselling environment include comfortable seating, carpet, natural lighting, coordinated colouring, artwork, plants, large windows, and views of nature (Pearson & Wilson, 2012). Due to logistical issues, the MTMO programme used three different rooms to deliver the group therapy. Some facilitators felt the spaces used were not appropriate. One of the rooms was too big as acknowledged by two facilitators below:

We were using the classroom, it was huge. So, when you've got a group of six to seven boys, they were rattling around like peas in a pod.

We moved into this ridiculous bigger room where it was just too big. Where the young people would like spread. One all the way over there, and one over there.

Secondly, one of the rooms used was too small:

Na, the room was way too small. It wasn't… the boys felt too cramped. It wasn't suitable at all. It wasn't an inviting therapeutic room.

It was too small. To have as many youth as we had at one time, in a small room, it didn't allow for much practical work.

Thirdly, two of the rooms used were dual-purpose. One room used was also a classroom, and the other was a room used to watch television:

Because it was a room that was dual purpose, so it was the classroom as well. So, it's like well, are we really here for group or are we here for class. We're not actually going out of our environment into somewhere to do therapy; we're just going into class where we'd normally go. So yeah, it just didn't have the same feel to it.

Although it was still small, and I think that a therapeutic space needs to be solely a therapeutic space, and it was the TV room, and I guess it just kind of contaminates that space when they use it for other things. And then other youth can spend time in there as well, and it's not a like a private safe space.

You were bringing in young people from other units into that unit. You couldn't leave all your stuff up on the wall, we only had a small space to put stuff up, whereas in the group we'd have stuff plastered all over the place. So yeah, just not having our own space.

Consistent with these critiques, the facilitators suggest a comfortable, consistent, single-purpose room which was an appropriate size to deliver therapy in would be ideal:

I would love a group room, I would love a dedicated group room that the young people can feel is theirs to go and do therapy in… It would be the appropriate size. They can decorate it. We think about the furnishings within it. But yeah, it would be a group room, a proper group room.

But somewhere where we have paintings and pictures on the wall, and like, emojis. Things that attract young people.

I think in Korowai, having had a consistent room, a therapeutic space that was large.

These comments about the size and privacy of a room is consistent with recommendations made by participants in other studies. In particular, spaces which are too small create a "claustrophobic feeling", while a room too large creates "insecurity" (Pearson & Wilson, 2012). It is preferred that a soft floored space is provided, with comfortable seating available. The MTMO programme may best benefit from adopting a room which best fits the above criteria suggested by participants and in the literature.

Programme Structure

The previous theme discussed the programme manual and resources which were used to facilitate the delivery of the programme. This next theme, programme structure, will focus on the

programme's model of operation, and will therefore exclusively discuss the rolling group

structure of the programme.

Revising the rolling group structure

The MTMO programme was reported to run as a rolling group or open-group format. A

rolling group means young people can join the group at any time. This is in contrast to a closed-

group programme where there is the same fixed start and end date for all participants. The

application and rationale for the rolling group structure is explained well by a facilitator:

> *The idea was that young people could join at any time and that would pick up what they missed… Yeah just because of the nature of young people being sentenced. They don't all get sentenced at the same time. It's not like the corrections environment where they are with you for a couple years. So, you can get them all started at the same point. Yeah, the turnover is much bigger.*

However, there were some issues related to the application of the rolling group structure.

Firstly, this structure was applied in a way where all young people were working on the same

modules, at the same time as stated by a facilitator; *"they would come in and they would start at*

the point that the group was at". This group structure is seen in closed groups, not in rolling

groups. In rolling groups, at any one time, individuals may be all working on different modules

(Ware & Bright, 2008).

There are several benefits to the rolling group structure. Firstly, it allows for programmes

which have a greater turnover of clients (Marshall, Marshall, Serran, & Fernandez, 2006), which

as mentioned by the facilitators is important in the MTMO programme where young people may

only be in the residence for 2-3 months. Secondly, it allows clients who have been in the

programme to model appropriate behaviour within sessions, and to provide assistance to

individuals who are new to the group. Within the MTMO programme, the tuakana-teina model

was a strategy used to engage and support young people through a buddy-system. This model

may be strengthened through the revision of a rolling group where senior group members can assist others through the modules. Thirdly, rolling groups promote the use of facilitator skill and flexibility in addressing the responsivity factors of each young person. Each individual has differing responsivity issues such as mood and cognitive ability which need to be attended to. Within a closed group, there is often a set of objectives for each session that must be achieved. In some cases, this results in facilitators being rigid in the delivery of the sessions, and unresponsive the needs of each individual (Ware & Bright, 2008).

Fourthly, rolling group structure facilitates the development and maintenance of group cohesion (Marshall et al., 2006; Ware & Bright, 2008). The importance of group cohesion in engaging young people in the MTMO programme will be discussed in the sub-theme *group cohesiveness*. Cohesion may be increased by senior members actively assisting new group members in their modules, as well as emphasising with their fears and reluctance to engage in the group. Scenarios such as the one described by a facilitator, "The Corrections boys were quite influential on the engagement of the other youth. So, when they were both on board and attending, and role modelling in sessions, then that increased [the others engagement]"*,* may be strengthened by revising the structure so it is more consistent with a rolling with a rolling group.

Fifth, a rolling group structure allows for individuals to be suspended from the group without being discharged. For example, if a young person's behaviour is impacting the engagement of others they may need to be removed from the group for one or more sessions. In a rolling group, this is easy to manage as they can resume their modules once they return. However, in a closed group, this individual would re-enter the programme and begin a session without the knowledge of the sessions which have come before it. This is a particular a problem when sessions build on those which have come previously. This relates to a further issue with the

MTMO programme; individuals who enter the programme, enter the session where the group is currently working, without the knowledge of all previous sessions. This is particularly problematic when the starter phase is not comprehensive enough (as will be discussed in the sub-theme, *improving the starter phase)*.

Lastly, but most importantly, a rolling group allows for a more individualised therapy process. The amount of time a YPO spends in treatment is determined by their own criminogenic needs (Ware & Bright, 2008). As will be discussed, some young people in MTMO programme had sessions which were not relevant to their criminogenic needs; or due to the length of their court orders, they may be released *"without having their needs addressed".* In a rolling group, individuals often receive the modules which are relevant to their criminogenic needs. In this way, young people who are only in the programme for two months, for example, can still cover the modules most relevant to their needs. This also reduces over-prescription of treatment, which has been shown to be counterproductive (Marshall & Yates, 2005), and therefore an ineffective use of resources. As one facilitator says, "there might have been some repetition for some of them". Moreover, due to salience of certain criminogenic needs, or the cognitive capacity of a young person, they may require more sessions to complete a module than others. The flexibility of a rolling group allows for these individual differences.

To conclude, many of MTMO programme's issues (e.g., non-individualised therapy) may have arisen as a result of this inappropriately applied rolling group structure. However, many of the problems can be resolved by applying the rolling group structure more accurately.

Initial Engagement and assessment

Adolescents, caregivers, social workers, and facilitators were asked for their opinion on the referral and assessment process. There was a specific focus on their experiences of the

process; what they found to be helpful, unhelpful; what could have made it easier; what information about the programme was supplied to them; and how the process could have been improved. Seven sub-themes emerged within this theme: (a) provide more information about the programme; (b) a more structured approach to the referral process; (c) timely completion of assessments; (d) systems-based assessment; (e) an evidenced-based approach; (f) assessment of readiness for treatment; and (g) complete periodic assessments.

Provide more information about the programme

Initially when the MTMO programme began, an opening was held where the whānau of the young people in the programme at that time were invited to the residence, so they had some understanding of the programme. This is discussed by facilitators below:

When the programme initially started they had a launch and for the young people who were on the programme at that time, they invited the families in.

...it was like grand opening…. It was kind of like "this is what we're doing!". The hype.

We had like an opening day, and the whānau was there. And that's when I thought, yeah!

Although no whānau or young people included in the study were present at the opening, as stated in the above quotes, the facilitators saw this as a great opportunity for families to get an understanding of the programme. However, after this initial opening, there was little to no family involvement; "but next minute, that was it, that was the last time we saw whanau".

When whānau were asked what they knew about the programme, their knowledge was limited:

Look, the only thing they told me was that it is more of a support for whānau that want better for their kids. That is all I know about it.

From what he told me, correct me if I'm wrong, from the top of my head, if I remember rightly, it was to do with getting their views on how to be better, from their point of view, what can be done to help them be better while they were in there.

Furthermore, this information appeared to come from secondary sources in some cases, rather than from programme staff; "I hadn't, other than what [young person] and his social worker had advised me that was going on". Therefore, for whānau, it was important they were given information about the programme and its content, directly from programme staff: "Just actually, what was the content, was it correct information that I got from YP4, and from his social worker, B. That's all really – what it was about actually, you know, not just from what they told me".

This was consistent with the social workers' perspectives. Social workers received little to no information *prior* to the young people entering the programme:

> *I heard about it when I did a visit with [young person] to see where to go from here. So, it was myself, his case manager at the time, and [young person]. The case manager told me about it… While he was in the programme… By the time I visited him he was actually engaging with the programme.*

In general, social workers knew little about the programme:

> *Like I said before, it is jointly run by Korowai Manaaki and it's for high risk offenders.*

> *All I know is what I read on the [current research information and consent] form. It's really sad aye. Yeah, my question was, what residence did he do this in? It's a huge problem with me, and it's a huge problem I've had with the residences, that they were not good at giving me information.*

> *Not on paper, just verbally told me. I still don't remember much about it. But I remember regulating or managing your emotions, and the way you respond to others or situations. I don't know if that's what it's about or not, but it sounded good.*

As one social worker suggests, more information and supporting greater engagement with the programme would be preferable:

> *Just something on paper, or a brochure, yeap… I think it would have been good to be part of it and to know about it a bit more.*

> *I would have liked to have been advised he was doing it, given the information about it, and also how I could support it… For me, I would like something quite specific sent to me, that outlines the programme…So, it's reasonably specific and detailed. I would have*

appreciated a phone call from his case worker, or the person that is providing that, and discussion around how I could support [young person's] learning in that programme.

To summarise these findings, it appears both whānau and social workers lacked information about the programme. Furthermore, both groups felt if they had more knowledge of the programme then they could have supported the young people's progress in the programme. Collaboration with relevant stakeholders (e.g., whānau, social workers) is an important part of any programme (Chinman, Imm, & Wandersman, 2004). For a programme to be most effective, it requires a formal sustained commitment between stakeholders to "enhance each other's capacity for a common mission by sharing risks, responsibilities, and rewards" (Himmelman, 1996, p. 3).

A more structured approach to referrals

As stated in the programme description, for young people on a Correction's sentence, those referred for the programme were firstly screened based on using their ROC*ROI score. Whereas for those on a youth court order, the process was less structured. One case leader commented:

> *I was the referrer, and that would go through F1 and it was really just the one-page kind of just who the young person was… so it would just have like the charges, they would be sentenced young people so 311 supervision with residence that was a criteria.*

However, one facilitator acknowledged this process may not have been structured or consistent enough:

> *I was not advised how Korowai Manaaki selected from the broad population of youth they had there. Maybe transparency on how they identified the youth from Korowai Manaaki, I'm not sure there was a universal procedure for it. I think it was a lot about the youth having to go forward and identify it was a programme they wanted to do. Having a more streamlined approach to all youth being screened for it and having the opportunity to sit down and learn about it may have been helpful.*

This is consistent with a young person's account of how he was referred for the programme: "My bros were on it. My bro's were on the course, and it was boring in the unit without them, and they were telling me about it. I talked to F3, and I got in the course". A more structured and consistent approach to referring young people may mean those entering the programme are the young people who would benefit most from being there. This was reflected by the words of one facilitator, who said; "having it more streamlined, fair process where appropriate youth were identified, and then could move into a therapeutic unit and then engage". This reflects the risk principle of RNR, whereby having a fair process of referral can better lead to the identification of those young people at highest risk of reoffending (Andrews & Bonta, 2010).

Timely completion of assessments

As stated in the programme description, assessments included self-report information from the young people; file information; risk-assessment tools; and in some cases, other psychological tests were used, and whānau were contacted. The benefit of using these sources of information, and structured assessment tools will be discussed further. However, this process does mean assessments take a considerable amount of time to complete. The two facilitators responsible for these assessments discuss this;

> *Done thoroughly in that way, it would take me a whole day to do a thorough file review, interview the young person, and write it up into something coherent.*

> *Maybe two and a half days. That includes the interview with them, and all the other sources, filling out psychometrics, and then putting it all together and completing the assessment summary.*

The length it takes to complete these assessments, is not an issue, as it reflects the importance of getting a full understanding of who the young person is, and help identify what

can be best done to meet their needs. However, an issue with the assessment process is that one

of the facilitators responsible for assessments, also had another managerial position within the

residence. This dual-role is reflected in the below quote by a co-worker: "But F1 was having to

do assessments as well [as her other work] and it's just too much. It was a lot of work".

Therefore, once a referral had been put through, it took a considerable amount of time for

the assessment to be completed, and for the young people to start the programme: "…and having

the assessments done on time… timeliness of those reports that were being done held up a lot of

youth getting onto the programme". As the young people were delayed in starting the

programme, three further issues arose. Firstly, the delay resulted in there being only a small

number of young people in the group: "I think the assessments should be done faster. It got to a

point where we only had three boys in there, or two, because assessments weren't done".

Secondly, those on brief Youth Court orders who were referred for the programme may

miss out on significant time in the programme, and potentially this may result in them missing

the modules which were most relevant to their needs:

> *Obviously, some of the areas, some would be more important than others, and if you've only got them for a small amount of time, are they going to miss what is the most important part, etc.… So, there were times when you felt like someone came in and out without having their needs addressed.*

Thirdly, this delay created operational difficulties for unit staff members. As will be

discussed later, it was seen as beneficial to have all the young people in the MTMO programme

housed within one unit. However, as the turnover of young people coming into the programme

increased, coupled with the delay in assessments, this was not always possible:

> *Trying to get them through the assessment process… kids were being identified for the programme based on their admission processes. Their names were being put forward, but often because that took too long, time would pass and go, and we would still end up with kids that weren't on the programme in the unit, we were still juggling… So, because that*

process was slow, that's what created the lag which then created space and bed [issues] in matai which meant "you've got the bed, put them in there" sort of thing.

As suggested by multiple participants, there was a need for more staff in specialist roles:

I think it was unfair for two facilitators to have to do everything, you know… very clear as what the role is, you know? And that you're not expected to do everything, that you are a programme, you know?

Having more people doing it [assessments]. I was really the only one and it was quite full-on. So, given the extensiveness of everything going on, it would have been helpful to have a few people who were able to help with that.

This sub-theme relates to research on 'waiting time'. Waiting time is defined as the length of time between referral and the first session (Westin, Barksdale, & Stephan, 2014). This length of time is often seen as a key indicator in service access and has been suggested as an important factor in an evaluation of quality assurance (Williams, Latta, & Conversano, 2008). Within the MTMO programme an extended waiting time can reduce the length a young person receives therapy. Research in the youth mental health field suggests longer waiting time into services is associated with decreased motivation for treatment (Westin et al., 2014), increased treatment drop out (Carr et al., 2008), and lower satisfaction with services (Tahhan, Pierre, Stewart, Leschied, & Cook, 2010).

There is a need to improve the assessment process. Practically, young people are often not in the residence for the full duration of MTMO, therefore less waiting time provides the opportunity for more therapy – which is likely to result in improved engagement and outcomes for young people and the community.

Systems-based assessment

In an attempt to avoid the issues related to a long wait time, some adjustments were made to streamline the assessment process. However, as a result, in some cases, systems-based information was not used to its full potential in assessments. Inclusion of the YPO's broader

system would have seen consultation with at least both whānau, and social workers occuring. In

some cases, this was done; *Yes, [systems] is definitely something I always include in working*

with youth, and I understand the importance of it. However, in some cases, as a source of

system-related information, the OT computer database was used: "*I would use what was on*

CYRAS". A social worker explains this can be a useful source of information:

> *There are heaps of report of CYRAS, and there is also psychological assessment done by*
> *the regional youth forensic team, yeah that's a comprehensive report. I think we know*
> *information from his birth, his childhood, adolescent years, it's all in CYRAS.*

However, often there are cases where: (a) information is not available on CYRAS; (b) the

programme had a lot of facts but may lack analysis or content; (c) there may be contradicting

information. These points are explained by two social workers, and a facilitator:

(a) *We don't always have the time to put everything on CYRAS. That's a frontline*
challenge for us. Just keeping our case notes up to date is a challenge… There is a lot
on our mind that is not always on CYRAS. So, I think that [talking to social workers]
would have been defiantly a lot more beneficial than just having a look on CYRAS.
Just having a conversation with social workers.

(b) *But, I mean during discussion you find out what people have missed because CYRAS*
is huge, [young person's] file is huge, so during discussion some of that wouldn't have
been there. And sometimes it's the analysis stuff, a lot of what is reported on CYRAS is
facts, but there is a lot of analysis isn't there.

(c) *I think there is a lot of inconsistency in the information held on file, depending on*
who the worker is and how experienced they are. There can be contradicting
information, misinterpretation of behaviours depending on how well they are
experienced with youth, or how much study they have done.

Given the social worker's role is *to find out the background, the family history, and what*

are the underlying issues for the young people's offending; their involvement in the assessment

process would be beneficial in understanding the young person. Furthermore, whānau are also

capable and in some cases, are pleased to provide as much information as possible. One mother

spoke about giving information to the residence about her son's mood;

> *Well they did ring me, and they asked what is it that affects mood swings in [young person] because he's short tempered. What can they do to talk to him about what's going on for him and that. They were really good about that, because it helped them to know a bit about him, what medicine he could take, and what he couldn't take… I appreciate that they even gave me phone calls saying this is what we need to know.*

Those responsible for completing the assessments acknowledge this issue, and give their

suggestions about ensuring adequate resources are available so as to ensure full assessment

occurred:

> *I think it probably would be better to also bring in the social workers and talk to the family as well. If I'd had more time – if I wasn't doing my other role – then yes, I would have liked to have talked to those people as well… More systems instead of just what is contained within the computer system and talking with the young person.*

> *I think they [social workers] would be really useful.*

> *I think that the site social worker would be key in the referral, the assessment process…*

When gathering and recording information, seeking alternative points of view or sources

of information is important (Baker et al., 2011). For example, talking to a family member to get a

better understanding of their living environment or family dynamics. Many of the factors

associated with violent offending in youth are within their environment. These include: antisocial

peer relationships (e.g., gang involvement); poor parental or family management (e.g., extreme

or inconsistent parental discipline); lack of social support; stress and loss; and neighbourhood

violence (Borum, 2000). Although much of the information relevant to these sources may be

available on CYRAS, social workers and whānau can also provide up-to-date information which

goes beyond what is available on CYRAS.

An evidence-based approach

Among others, a strength of the assessment approach used in the MTMO programme was

its use of evidence-based tools. As stated in the programme description, the programme on all

occasions used the YLS/CMI, the SAVRY, and in some cases, the MACI and SAPROF:YV. The

benefits of doing so were highlighted by those responsible for the assessments:

> *Being able to drill down to what the needs are. You know, the YLS – I like – I think it really does focus down, not only giving you the risk parameters but also being able to pull out against the RNR model what the actual needs are for the individual.*

> *So, the risk measures were useful for highlighting the level of risk, so the YLS/CMI in particular, especially when working with youth that weren't Corrections, so they didn't have ROC*ROI's. The SAVRY is a good measure to use with youth because it kind of fleshes out their violent risk factors. So, it gives you quite a nice idea of what it looks like for them, and it also includes protective factors which is really good with youth.*

Not only did these measures provide a structured approach to understanding the young

person's level of risk, they also provided information on the young people's treatment needs and

strengths. This is consistent with what the literature suggests about the benefits of evidence-

based tools; they provide a comprehensive and consistent approach to assessment by

incorporating research-based frameworks into practice (Hoge & Andrews, 2002; Whyte, 2009).

Use of such tools facilitates; (a) the classification of risk; (b) the development of an

individualised intervention; (c) and provides a baseline for measuring changes in an individuals'

progress (Lipsey, 2009).

However, once the Department of Correction's ceased their involvement with the

programme, only the YLS/CMI and SAVRY were used. As stated by one facilitator, "Corrections

were also using the MACI. We [Oranga Tamariki] didn't have the MACI". The MACI has shown

to be effective at identifying relevant treatment targets, personality patterns, as well as providing

data to assist clinicians in assessing adolescents' treatment amenability (Salekin, 2002). This is

consistent with how a facilitator described its benefits:

> *The MACI was probably the most useful one in terms of responsivity with treatment. So, being able to complete that and look at their interpersonal style and see how that would explain some of their behaviours, really gave me a sense of what would work with them and what wouldn't. Especially when I link that with their formulation. Given that the programme is in the unit as well it's not just seeing how they would engage in the group but seeing how unit staff might best encourage the youth to do well.*

As stated in a quote above, this made the MACI useful for identifying responsivity

factors, and therefore how their needs may be best targeted in therapy and in the unit. For

example, in a factor analysis study it was shown that, for YPO in the US, information from the

MACI was effective in identifying young people with depressed mood, psychopathic personality

patterns, internalising personality traits, acting out characteristics, identity confusion, and social

sensitivity (Salekin, 2002). Internalising personality traits (e.g., conforming, submissive) can

provide important information about how a young person will behave in a therapeutic

environment, and the importance of facilitators keeping them involved and engaged in a group

session. Furthermore, acting out characteristics may also be useful information, not only for

facilitators, but also for the unit staff who monitor the young peoples' behaviour.

A significant strength of the MTMO programme can be seen in its use of evidence-based

assessment tools to identify the risk and criminogenic needs of young people through the use of

the YLS/CMI and the SAVRY. However, this suite of assessments tools may be complemented

by the use of the MACI, which can be useful for identifying responsivity factors. To do this, OT

must employ enough skilled staff so comprehensive assessments can be completed in a timely

manner.

Assessment of readiness for treatment

Although there was always a structured approach to understanding the risk and needs of the young people entering the programme, there was no structured approach to identifying the young people's readiness for treatment; "…not in any structured format, so we didn't particularly choose a stage of change for them at that time". Readiness for treatment can be broadly defined as, "the presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to facilitate engagement in therapy, and which, as a consequence of this investment, are likely to augment the process of therapeutic change" (McMurran & Ward, 2010, p. 78). Therefore, readiness for change requires a young person desires to change their behaviour; is able to respond and engage appropriately in interventions; and possesses the capacities to enter the treatment programme (McMurran & Ward, 2010). Thus, readiness for treatment is broader than simply being motivated for treatment. When young people were asked why they wanted to enter the programme, many stated it was not to make positive changes, but at least initially for other reasons;

> *People do those programmes to look good on their reports for court.*
>
> *I didn't really care, I was going for food and munchies, and to get out of the unit, go talk shit with the boys.*
>
> *To get my early release.*
>
> *Na I did it for [facilitator], I didn't do it for anything else.*

The benefits of assessing readiness for treatment are both pragmatic and ethical. Firstly, if only those selected for the programme are ready, rates of engagement and completion of therapy will be greater (McMurran, 2002), resulting in lower rates of reoffending (McMurran & Theodosi, 2007). Furthermore, a disregard for motivation, as portrayed in the above quote, may

result in coercion which again results in negative outcomes (Parhar, Wormth, Derzen, &

Beauregard, 2008). Therefore, it is important the YPO wants to make changes. This is

highlighted by a caregiver, and young person below;

> *But it comes back again on the child because it's the child that has to want change. That's the biggest thing, is change.*

> *Don't just go there because you get shit out of it. Go there because you actually want to change, go there because you don't want to go back there.*

However, as one facilitator noted, superficial reasons for entering the programme may

gradually have been replaced by more change-related motivations:

> *… that's what we find with youth even on other programmes. It's usually a superficial approach to begin with, and then they actually see the usefulness of it.*

This perspective is supported by a young person who said:

> *Na I just did the course because it was going to look good on my court appearance. But then I got into it, I got stuck into it and I liked it.*

Assessing a young person's readiness for treatment is complex:

> *That's the tricky part with [young person], we don't know whether he did well because of what he got from the programme, or is it just because he wanted to get early release that he was able to get settled…*

Furthermore, assessing readiness can also inform a treatment package which is better

tailored to the individual. For example, a young person's beliefs about violence may be the

primary factor in reducing their readiness for treatment. By identifying this, work may be done to

challenge those beliefs through motivational interviewing. Motivational interviewing is proven

to be an effective pre-treatment intervention (McMurran, 2002), which may be used to increase

an individual's motivation to change, and therefore readiness for treatment (McMurran & Ward,

2010).

There are many measures available to measure readiness for treatment, however, many lack in empirical validation (Mossière & Serin, 2014), particularly with a youth population (Gašević, 2015). In a critique of available measures, it was suggested the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Sharon, Andrew, Kevin, & Tony, 2007) is the best developed measure for assessing readiness. Furthermore, the CVTRQ can be administered quickly by individuals with limited experience. Therefore, case leaders making referrals for the MTMO programme will likely be able to administer the scale; resulting in a more evidence-based decision about the suitability of treatment referrals (Day et al., 2010). However, as with other measures, the CVTRQ has not been validated with a youth population.

Complete follow-up assessments

As stated previously, the programme made effective use of evidence-based assessment tools, but it may be improved by better assessing the young peoples' readiness for treatment. It may be further improved by completing periodic assessments for young people over the course of their rehabilitation. Facilitators stated that there was a need for (a) a mid-treatment measure and (b) a post-treatment measure.

(a) *I reckon there should have been an assessment at the mid-way of the programme. The reason why I say that is just to see how their mindset has changed from when they first started the programme to where they are now. Just so we know if we need to go back and highlight certain areas.*

(a) *I think having them [periodic assessments] would help you to stand back and objectively see [how they are progressing], and I think that could be done by someone else that isn't treating them. It would help you see kind of their progress, and what areas need to be addressed further, and then that can lead into understanding their treatment needs and individualise it within session – it just keeps that focus.*

(b) *I think we need to develop something else which picks up any pre-issues which you can then measure any post issues against.*

(b) *Or was there the YLS that was being reviewed half way? Just kind of that evaluation process. A fuller understanding… I think there should be like a version of the*

evaluation would be how are they coping in the community? What does the YLS look like now?

The above quotes suggest the need for: a mid-treatment measure to monitor progress; a post-treatment measure to look at outcomes; and a follow-up measure in the community. Facilitators state two reasons for this; firstly, to get a better understanding of how an individual's needs may have changed and what needs more attention. By having mid-treatment assessments, the treatment plans of young people can be adjusted to better suit their current criminogenic needs (Baker et al., 2011). However, if these assessments are not completed regularly enough, their treatment plans may be lacking in relevance. Secondly, they can be used to measure changes in risk across time. Without having follow-up measures throughout the duration of the programme, it is impossible to monitor changes in risk over time.

Although this recommendation may appear to be a straightforward one; introducing more assessments generates additional work for facilitators who have already got a heavy work load. For example, the interview for the YLS/CMI alone (excluding scoring, and file assessment) can take up to 45 minutes (Campbell et al., 2014). Therefore, to introduce more assessments, staff would need to have more specialist roles to cope with the additional work load. This need has been explained in the previous section, *assessments completed with urgency.*

There are a number of factors which can be seen as strengths in the initial engagement of adolescents (e.g., evidence-based assessment), as well as areas for improvement (e.g., completing these assessments more regularly). The next section follows chronologically from the initial engagement of participants and will discuss how the treatment was delivered to the adolescents, and what their level of engagement in the sessions was like.

Treatment Delivery and Engagement

After asking stakeholders about the initial engagement, referral, and assessment process, facilitators and young people were asked about their thoughts on the delivery of therapy and the level of engagement within the group. Specifically, facilitators and young people were asked about their experiences of the sessions, what worked well to maintain engagement in sessions and what did not; what therapy modalities techniques were most effective, what were least effective, and how these processes could be improved. Nine sub-themes emerged: (a) improving the starter phase; (b) individualised treatment; (c) strengths-based approach; (d) team-building; (e) value of breaks; (f) use of preparation time; (g) a strong therapeutic alliance; (h) a strong co-facilitation relationship; (i) more whānau involvement.

Improving the starter phase

As explained in the programme description section, before young people began the core phase of the programme, they commenced the starter phase. The programme documentation states that the starter group "consists of eight introductory sessions to prepare new participants". By preparing new participants to join the group, the starter phase tried to mitigate some of the negative effects of having a rolling-closed group hybrid structure. One facilitator described the starter phase as:

> *We basically talk about disclosing information in a group, it's your choice – you don't have to, talk about safety in the room, talk about the different programmes, talk about the communication, talk about your mindset, talk about what kaupapa they bring to the group, and how they feel about working in a group.*

The eight sessions would appear necessary if a young person joined the group and were expected to begin the module which the rest of the group were working on. However, in practice the starter phase did not operate as intended. One facilitator stated that, although for some participants the eight starter sessions were always completed, for others this was not the case:

There is meant to be eight starter sessions although for the OT young people there could have been all of that squished into one or two sessions at times, so I'm unsure whether, or how much of that was actually covered. That would create instability in the group if you don't have those ground skills.

As stated above, one of the negative effects of inadequate preparation of young people for the group is that it creates instability within the group when an individual does not have the skills to appropriately engage in therapy. As will be discussed further, this instability can reduce the treatment gains of the group (Marshall & Burton, 2010).

Preparatory programmes have been designed to enhance the effects of subsequent treatment. Research has shown these programmes can be effective for various psychological problems in both individual (Davidson, 1997) and group treatment (Mayerson, 1984). Not only do studies show a reduction in the symptoms of individuals undergoing the therapy, they have also been shown to increase self-disclosure, investment and participation, and increased motivation (Marshall & Moulden, 2006). The purpose of doing so is to: demonstrate treatment can be a positive experience; prepare individuals to work in a group setting; help individuals to feel comfortable discussing their offending; and enhance motivation.

These preparatory programme should be delivered by therapists in a non-confrontational manner, in an attempt to establish a collaborative relationship with clients, consistent with motivational interviewing (Naar-King & Suarez, 2011). For adult sex offenders, a preparatory programme completed prior to the full treatment programme resulted in greater treatment readiness, completers received earlier parole, and recidivated significantly less (both generally and violently) compared to those who completed the full programme only (Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008).

To conclude, due to the way the MTMO has been practiced as a hybrid rolling-closed group, it requires a sufficient starter phase to prepare the young people for therapy, increase their

motivation and engagement, and increase group cohesion. Similar processes have operated

successfully in other programmes and may serve as a starting point for introducing a more robust

preparatory programme for MTMO. It is possible, however, if the group structure was revised, a

less rigorous starter phase would be required.

Individualised treatment

As discussed previously, the MTMO programme featured an assessment process where

the needs of each individual were identified. In theory, this allowed for the development of an

individualised treatment plan where each YPO had their needs addressed during treatment in a

style which matched their responsivity factors (Stams & van der Helm, 2017). However, in

practice some facilitators felt the programme did not cater to the diverse needs of individuals

well enough:

> *Again, some of my concerns was then how do we translate that into direct therapeutic interventions? And I don't think we did that particularly well, so you know, you pull out these needs and these strengths, but they would all still get the same material.*

> *If the young person hasn't got that issue, they would still get the topic.*

> *I do think that with the amount of things that were going on with treatment planning, as well as the turnover of youth that were in the programme, there was difficulty within sessions, being really attuned to thinking, for example, "this is going to be really relevant to this person for this reason". There were times when that happened, but that would be something that I would personally really like to do more of within a group environment.*

> *It was quite hard to keep track of where all the youth were, and make sure that they all got their needs met. Obviously, some of the areas, some would be more important than others, and if you've only got them for a small amount of time, are they going to miss what is the most important part for them.*

Overall, the facilitators felt assessments were helpful in identifying the young people's

individual needs, but there was a problem in *translating* these into therapeutic interventions

which are tailored to the individual within the group format. Individual sessions, therefore were

the main opportunity for staff to deliver treatment which was specific to the individual's needs

and learning style. As one facilitator says,

> *...you can begin to drill a bit deeper through the individual sessions... they can actually look at how is this impacting on me, on my wider community, how I'm going at home with mum, or how I'm going with the young person I had beef with last night.... They've got more ability to reflect and do that in a safe space.*

However, these individual sessions occurred for one hour a week, and, as suggested by

one facilitator, it may be best to *"bolster that up a couple"*. The need for therapy to be

individualised was promoted by other participants, as shown in quotes from a social worker and

a young person about the relevance of the substance use topic:

> *For [young person], substance abuse had never been a serious concern because no abuse evidence for that. For the last 4 years, I visited him many times unannounced, at different times, and he never appeared to be under the influence of any substance.*

> *I've done so many programmes and all that sort of shit, the alcohol and drug treatment, I don't even know why I was referred to alcohol and drugs because I don't smoke or drink, but I've done so many programmes on it, but I don't remember anything about them.*

Currently, evidence-based treatments for young people who offend are based on CBT,

and often applied in one-size-fits-all fashion (Stams & van der Helm, 2017). Therapeutic

interventions for young people can be individualised in two ways; (a) by targeting the

individual's most salient criminogenic needs, and (b) by tailoring the interventions to suit their

responsivity style (i.e., learning style, level of motivation, strengths, therapist-client match).

Interventions with focus on individual skills and beliefs are seen as critical components for

treatment of YPO (Hoge et al., 2008). In a meta-analysis of individualised treatment for

adolescents responsible for severe aggression, young people best benefited from a CBT approach

which has an individual component (Hoogsteder et al., 2015). Furthermore, when an individual's

criminogenic needs are not matched to treatment services, there are significantly higher rates of

recidivism compared to when they are matched (Peterson-Badali et al., 2015). So, using the young person above, providing substance use treatment where is no need, could actually increase their risk of reoffending.

The perspectives of stakeholders and recent research are consistent on the value of individualised treatment. That is, the MTMO programme would benefit from increasing the use of the individualised therapy to deliver treatment which meets the needs of the young people (e.g., tailoring group therapy to meet individual needs), and is delivered according to their learning style.

Strengths-based approach

The next sub-theme which emerged through the interviews was how strength-based models (e.g., GLM, tuakana-teina) and approaches to therapy increased the young people's engagement in the sessions. Strength-based approaches focus on an individual's personal and interpersonal capacities (Fortune, 2017). More specifically, they focus on building up their skills (e.g., social skills) so they can achieve personally meaningful goals, rather than focusing purely on their deficits (i.e., criminogenic needs). The following quotes by two facilitators illustrate how building an individual's leadership skills through the Tuakana-Teina model became an effective way to engage them and others in the group:

> *Because you know, I'll use [young person], he never said boo in the sessions, and then as the sessions went by his confidence started growing. Next minute, he was the only young person in here that was the old, like, original person. And he became the taukana in the sessions, and all of a sudden, like as soon as we start talking about sessions, and we kind of offered it to the boys, it will all quiet. And then, [young person] do you have anything to say? Yeah so, boys it's like this, and this, and this. And the boys would be like, oh yeah. So, he kind of [led] some of the sessions, yeah, which was awesome.*

> *So, the tuakana-teina, that's not therapeutic as much, but in terms of the group dynamics it was really helpful…I think firstly, the fact that it, with the youth, they are very much more influenced by their peers. So, having a positive influence in the group, that was a*

peer, had a lot more effect on their engagement and motivation, than engaging in motivational interviewing or strategy of choice from a facilitator. Secondly, it provided the youth with a shorter-term goal which also increased their motivation.

This was supported by a social worker and a young person when discussing engagement in the sessions:

So, it seemed like [young person] wasn't, you know, he said [young person] isn't interested in it, he wasn't engaging. But with some work with the team, apparently, he became the leader in it. And he was encouraging others to attend and he came to enjoy it.

Yeah, it's easier to learn because you are explaining it and learning it at the same time. Other people are giving you things that put in your head.

Through these quotes, it appears the tuakana-teina was a strength-based approach that not only increased the leadership skills of those in the group, but also improved the motivation and engagement of young people. Relatedly, it appeared helping young people set goals they could work towards was an effective tool for motivating them. An example of this was the carving work some young people were involved in:

Also, having goals and tasks for them to work towards that were a benefit for them. So, not having the same thing for everyone. For example, with [young person] getting the carving going for him, and him being quite motivated to get that short reward right in front of him and something that he really actually wanted.

It's because they actually invested in the programme. You know, [young person] could never ever say 'boo' in the sessions. So, we choose a special project for him; a carving. And he would spend six hours in that room.

As suggested in these quotes, activities such as carving act as motivators for young people which increase their engagement. The GLM also suggests activities may increase a young person's emotional regulation through these activities, or it may act as a prosocial secondary good in which they can achieve 'excellence in work' (Ward & Gannon, 2006). The GLM offers an approach to rehabilitation which has the potential to be more engaging for young people

because they are working on goals (e.g., carving) which are personally meaningful. Without

directly referencing GLM, one young person described their preference for its use:

> *Life skills. Like, cooking, cleaning, how to save money. Not sitting down reading about it*
> *and stuff like that. If you want to learn about it, you can read about it in your own time,*
> *you know, they should do stuff that actually helps you.*

Strength-based approaches need to be individualised (Fortune, 2017). As one young

person says; "just finding stuff, because some people don't like doing sport, so finding

something they want to do", it does not have to be carving or sport, as everyone has different

goals and meaningful ways to achieve these goals. Many of the current therapeutic interventions

available focus on avoiding further offending, which does not relate to their primary concerns,

and is therefore not particularly motivating (Fortune, 2017). The GLM was used in the MTMO

programme, however when asked, one facilitator said:

> *I use it [the GLM] a lot more now, and I would probably if I was to run the programme*
> *again I would highlight more of the Good Lives Model in there. I think the youth connect*
> *with it easily.*

By focusing on a young person's core values and motivations, there is less need for

alternative approaches such as motivational interviewing (Fortune, 2017). Secondly, by using

approach goals, individuals are likely to maintain changes and continue to pursue pro-social

goals post-treatment.

Session preparation time

Before each session it is common practice for facilitators to meet and discuss the content

and strategies for that session. However, in the MTMO programme, it appeared this was often

not the case. Two facilitators said the following:

> *The other thing would be session planning; that was very minimal. I tried to have it quite*
> *structured at the start, so having like a decent amount to plan and talk about how we*
> *were going to go through things in the pre-session. But, it just didn't really work with*
> *[facilitator]. It ended up being minimal planning, which meant that we weren't able to*

discuss those things in depth… We had scheduled to meet an hour beforehand, and that just wouldn't work out. So, I would turn up and [facilitator] wouldn't be there, or [facilitator would] turn up just in time, and I'd attempt to plan but it wasn't effective. So, I just started doing the session planning, with or without [facilitator], I would make sure I had an understanding of what was going to happen and what we were doing. Then [facilitator] would go along with what was happening in the room.

[We would meet] like five minutes before delivery.

Due to the youthful nature of the MTMO programme, the sessions were often being delivered for the first time by the two facilitators. As facilitators commented:

…it is designed to be a flexible programme. So, you just pick up the session, if it's got a few pointers and objectives, and then you run it however you want from there. So, that part I would do before the programme, and that would take me 1-2 hours, depending on what I was planning.

[Facilitator] had to re-write like sessions every day, the night before. Then we would only sit down and catch up that day…

This amount of flexibility and rewriting within the MTMO programme suggests session planning is a required part of the programme, and a set time to meet and discuss the delivery of the sessions is required by both facilitators. Facilitators need to understand how each session will proceed; the roles each facilitator will take in the sessions; and what content is most relevant for each young person. Although no research was found to support the need for session planning; in such a youthful programme, which in some cases was delivered by inexperienced facilitators; a sufficient preparation time is necessary if sessions are to be delivered effectively.

Group cohesiveness

As the MTMO programme was structured as a rolling group, individuals could join the group at any stage during the programme. As a result, developing a strong group cohesiveness became a central task for the engagement of young people in the sessions. As one facilitator commented:

When we initially started we had some young people who were here for quite a long time so when we got to the point where people were joining, it was quite a cohesive group and that can be difficult for young people. They can feel it's their group, and think who is this person coming in?

Group cohesion refers to a dynamic process whereby a group remains united in pursuit of its goals and objectives (Carron, 1982). To improve group cohesion, one facilitator encouraged the young people in the starter phase to join group activities so once they joined the group they already felt comfortable to engage and join group discussions:

I would do the starter sessions with the boys that would come in before they would actually join the programme… It was good because I was able to bring the young person in a lot earlier, not the sessions, but I was able to get the young person in on the group activities… So, when he does join the sessions, he's feeling like he's a part of the group… he feels more comfortable because he doesn't feel like an outsider.

Two young people described how this affected them once they joined the group:

Yeah, we did little group activities. He prepared us for the group, like what to expect, set down the standards.

[It was] easy [to join the group], because I already knew everyone.

Furthermore, one facilitator stated that *"the tuakana-teina model and process discussions were used to facilitate group cohesiveness"*. Although group cohesiveness in rehabilitation programmes has received little attention, particularly with youth, several authors have claimed group cohesion is essential for achieving treatment gains (Marshall & Burton, 2010). For example, Braaten (1989) found for adults with offending histories, group cohesion was a pre-condition to client engagement in the change process. Given the importance of peers for young people (Day et al., 2004), group cohesion may have more of an impact on treatment gains than it does for adults. However, furt

her research in this area is required.

Increasing group cohesion can benefit the engagement of young people in the sessions. Therefore, it appears to be in the best interest of the MTMO programme to continue to facilitate this process of cohesion through group activities, for example.

Value of breaks

Another sub-theme which emerged through the interviews and can be seen as another strength of the MTMO programme, was the importance of having breaks during sessions. As described by one facilitator, breaks often consisted of a brief period of physical exercise during or after the session:

> *...when it first started they used to do that, they used to play basketball, like they'd do session, I think it was like 40 minutes and they'd go and play basketball. Just as a debrief with the boys and a reward.*

These breaks appeared to serve more than one function. Regardless of whether the break was during the session or afterwards, it served as an incentive for young people to take part in the sessions. This is illustrated by a young person:

> *Just keeps us interested, can give us some incentive to go to the programme. Because no one would go if it was just go in there and get bored for like 40 minutes or whatever it is and then walk out.*

As previously discussed, addressing offending behaviour is not a strong motivator for young people, and therefore including physical exercise may act as a reinforcer for young people to take part in therapy. Additionally, engaging in therapy can also be cognitively taxing – particularly for young people who may have struggled in traditional learning environments. Furthermore, with the high rates of neurodisabilities (e.g., attentional-deficit hyperactivity disorder; Hughes, Williams, Chitsabesan, Davies, & Mounce, 2012), and substance use amongst young offending populations (Chassin, 2008), breaks during sessions may be necessary to keep young people focused. This is supported by the following two facilitator quotes:

...taking breaks when they needed them because they tend to need breaks, more than what the adult groups do.

We do gym time just to get the guys to wind down from all the talking and over-thinking, and probably stressed from talking to us.

Finally, having the group participate in physical team exercises, such as basketball, during these breaks may facilitate group cohesion (Glass & Benshoff, 2002), which, as discussed in the previous theme, may increase engagement in therapy and the change process. However, as one facilitator suggested, there needs to be structure applied to breaks so they do not last too long and disrupt therapeutic sessions:

Having some processes around break time would have been helpful, because at times it would go for quite a long time, and often the youth would enjoy that because they are spending the time playing basketball instead of doing treatment work in the group.

Physical breaks were seen as a positive part of sessions by both young people and facilitators. They helped young people stay focused, and positively reinforce their attendance and engagement. However, as suggested by a facilitator, there needs to be structure around break times.

A strong therapeutic alliance

I remember at one stage we praised a [young person] for how well he was doing, and noted his strengths, and he said "are you trying to be nice or something?" and then he said, "I feel really weird, like warm and fuzzy", like it was something he had never experienced before, and he was like, wow what is this?

A therapeutic alliance (TA) refers to the client-therapist relationship (Marshall & Burton, 2010), and can be defined as a collaborative relationship between therapist and client that can facilitate positive change for the client (Ross, Polaschek, & Ward, 2008). The conceptualisation of TA is not a straight-forward task. Ross and colleagues conceptualise TA as consisting of therapist characteristics, therapy-related interactions, and client-characteristics. Firstly, therapist characteristics consist of personality, attachment style, interpersonal schemas, professional skills,

interpersonal skills, goals and expectations (client, alliance, intervention). Therapist

characteristics were commonly mentioned by participants. For young people, personality and

interpersonal skills were important therapist characteristics. This was evident when discussing

one facilitator:

> *Have someone like [facilitator] to run it. If you have like an old white lady to run it nobody would go because it just would like, "don't do this, don't do that". But if you have like a laid-back Samoan or something, all the boys would go… It doesn't even matter about their culture or anything it's just if they are laid back or not.*

> *He would just sit on the couch with us like normal, lay down and shit, and just crack up and s***. Whereas [facilitator] would just sit there, trying to tell everyone what not to do and s***. Yeah, he's just laid back, blends in pretty much.*

However, in addition to these characteristics, facilitators themselves saw professional

skills and goals of therapy to be important factors in developing and maintaining the TA with

young people:

> *They had a very good therapeutic relationship with [facilitator] so it was like "cool I get to hang out with [facilitator]". But whether they took anything out of the sessions is still a question that I have.*

> *I think actually, facilitator boundaries, me and [facilitator] being consistent with the boundaries, and the rules in the room, and making sure that those things are constantly addressed.*

This suggests having a relaxed facilitator who has clear boundaries was perceived as

being most effective in delivering therapy. Therefore, a combination of both qualities,

interpersonal and therapeutic, is important in the development and maintenance of TA with

young people. There should not be a reliance on one over the other, but rather a balance between

the two.

Although therapist characteristics have been predominately seen as the exclusive focus of

TA, Ross and colleagues (2008) propose client characteristics share equal importance. For

example, Muran, Segal, Samstag, and Crawford (1994) found submissive, isolated and friendly

clients developed stronger TA's than those who were hostile, aggressive and dominant. Client characteristics consist of the same factors as therapist characteristics, however, instead of professional and interpersonal skills, therapy-related competencies (e.g., readiness, intellectual ability) are included under client characteristics, and need to be considered when assessing group dynamics and planning sessions.

Thirdly, therapy-related interactions refer to the interactions between the therapist and client characteristics. Ross et al. (2008) argue that although the characteristics of both therapist and client are important, it is the match between the two that actually predicts TA. For example, Horvath and Luborsky (1993) found the client's perception of the therapists as an empathetic individual is more predictive of TA and treatment outcome than the therapist's behaviour itself. This interaction may explain why the young people developed a strong attachment to one facilitator in particular.

Setting and contextual factors also play a part in TA. These factors often include the physical and social environment in which therapy occurs (as was discussed in the sub-theme *an appropriate therapeutic space)*, the level of systemic support for the programme, and programme characteristics. Systemic support, such as resourcing, was mentioned a number of times by staff. For example, one facilitator stated without the full support from the Ministry, the programme would not be effective:

> *So, I really would want to have a dedicated team and to do it properly. It needs to be something we look at all four YJ residences and resource across all four YJ residences. You can try it here, you can pilot it here, but if you're not doing it elsewhere and there is no consistency then you are actually on a highway to nothing.*

To conclude this sub-theme, TA is a complex phenomenon, with many contributing factors. For behaviour change to occur, it requires a positive interaction between the characteristics of the facilitator and the young people. However, it also requires an immediate environment and

organisational climate which is supportive of change. Some of these factors have been reviewed

and will be discussed further.

Dual-Role

A dual-role is often an issue in programmes for YPO, and can be defined as a "quandary

in which a psychiatrist [or therapist/facilitator] faces the dilemma of conflicting expectations or

responsibilities, between the therapeutic relationship on one hand and the interests of third

parties on the other" (Robertson & Walter, 2008, p. 229). There are many situations in which a

dual-role may emerge, with some having more serious therapeutic and ethical consequences than

others. An example of a dual-role commonly found in rehabilitation programmes are when a

therapist produces a report regarding a client's progress and risk of further offending (Ward,

2013). This raises questions regarding therapist-client confidentiality (an ethical issue) and may

also compromise the TA (a therapeutic issue).

Within the MTMO programme, there appeared to be multiple staff who were operating in

a dual-role position. However, it was one facilitator whose dual-role appeared to create a

significant issue. The first of these issues regarded the TA, as acknowledged below by the

facilitator themselves, and a young person:

> *I think they got it, but I think as I said, when I stepped in there was this bit of, well we've*
> *lost [facilitator], we liked [facilitator], you're our manager so we're actually not going*
> *to listen to you. ... [it was] difficult for the young people seeing me as something other*
> *than the manager.*

> *I don't know, like we couldn't really express our feelings around her... Because she was*
> *management. We weren't used to it.*

As shown above, role conflict has the capacity to cause confusion in clients about how

they should behave (Ross et al., 2008). For their therapeutic benefit, young people were required

to disclose information regarding their offending behaviour and related cognitions within the

context of a therapeutic relationship with facilitators. However, when a facilitator is in a

managerial role, they also have the ability to enforce punishments on young people and make

recommendations which impact their release. This is likely to result in a lack of trust on behalf of

the young people. This is significant issue, as if clients do not trust their therapist, a positive TA

is difficult to attain (Marshall & Serran, 2004). Furthermore, the developmental histories of

young people in these rehabilitation programmes often result in a difficulty in trusting others,

particularly adults in authoritative positions (Grisso, 1997). Not only did the young people find

this difficult, but the relevant facilitator acknowledged this also placed them in a conflicted

position.

The second way this facilitator's dual-role caused issues was through the co-facilitator

relationship. While this facilitator was co-facilitating with two other facilitators, this facilitator

was also their supervisor and manager. This relationship was discussed by two facilitators below:

> *...it was also difficult for [facilitator] to see me as something other than the manager. So,
> it's really difficult when you're trying to deliver a therapeutic programme and be in that
> space and yet your substantive role is actually a manager, so it doesn't really fit very well.*

> *I had to be a facilitator within a case leader role and my lead facilitator was my
> supervisor. So, there was blurred boundaries already within that co-facilitator
> relationship... Yeah, I would have preferred to just have a co-facilitator relationship...
> I was still mindful that she was my manager and I was conflicted in what I would share
> because [the other facilitator] may interpret it more as the supervisor-management level,
> rather than the co-facilitator relationship. This impacted on the transparency of feedback
> within the co facilitator relationship.*

This facilitator's experience, training, and the views of others suggested that they were a

competent supervisor, co-facilitator, and manager. However, the perspectives above suggest

doing all three at the same time created strains in delivering therapy and supervising others. This

dual-role may have disrupted the alliance between the facilitators. For example, the supervisee

stated they felt uncomfortable disclosing information to this facilitator during supervision.

Failure to disclose information within a supervisory relationship has been associated with a poor

supervisory alliance (Ladany, Hill, Corbett, & Nutt, 1996), which can result in an erosion of

professional self-confidence, and increased performance anxiety (Orlinsky & Rønnestad, 2005).

There are ways to overcome this dual-role; this facilitator suggests it would be best

overcome by occupying one role: "I think I wouldn't be doing the facilitation. I would purely be

in the role of supervision or overseeing the programme rather than trying to deliver it.

More whānau involvement

According to programme documentation, "participants are encouraged to build and

maintain whānau support for their programme involvement and ongoing rehabilitation

reintegration", and to "engage prosocial whānau support early and regularly during the

programme" (Kilgour & Borg, 2016, p. 30). Therefore, all participants were asked about whānau

involvement in the programme. This included, what involvement they had, whether this was

sufficient, and how whānau could be more involved in the programme. Firstly, and as stated

earlier, overall whānau involvement was minimal, with no direct involvement in therapy. Many

facilitators commented there should have been more whānau involvement:

> *I would have liked to have seen having a whānau hui where the young person can present their learning, their goals, what support they need, what they're going to do, all of those sorts of things and we didn't have that built into the programme.*

> *Get the whānau in, you know. Get the whānau to see what these sessions look like. Have one on one whānau sessions with the young person, these are the types of things that your young person is learning. What else do you guys want us to have? What's your input into the sessions? What's your areas that you see that your young person needs [help with]? And vice versa, what does the young person see that you guys are missing as parents or caregivers?*

> *And that was the other part, how are we working with the whānau? How are we addressing these issues with whānau? … In the ideal world whānau would be involved. I would love to have a wānanga here, because if we could fit in a whānau weekend then*

one part of the component of the programme could be just with the whānau. That's the ideal.

As suggested by these quotes, there are a range of ways whānau involvement could be improved. This includes: involving them in therapy sessions to understand what the young people are doing, and to meet their needs as caregivers; and involving them in a whānau hui or graduation where the young people can discuss what their goals are before treatment, how the whānau can facilitate them in achieving these goals, and what they have learnt after they finish the programme. However, there are always going to be individual differences in the level of motivation caregivers have to take part in the programme. For example, two social workers said the following:

> *So, it's whether the parents will be able to support something, but obviously it would be beneficial, but in [young person's] case I don't think Mum would have been open to it. She would have been like "get out of my face. He did the offending, not me, kind of thing".*

> *Yeah, in the [young person's] case, his uncle would have been more than happy to attend, at least an introduction section to explain what they cover in the programme, and also they would have got some info from his uncle that would have been helped them to work with [young person].*

Furthermore, as young people are placed into residences based on availability rather than geographical proximity, there are instances where a caregiver's location may result in minimal involvement. Research shows greater distance between a young person's family and the residential facility results in less contact (Robst et al., 2013).

However, although difficult, family therapy and family involvement in a young person's therapy has been associated with better treatment outcomes, and described as a 'critical component' of treatment with YPO (Hoge et al., 2008). The Mendota Juvenile Treatment Centre (MJTC) is an example of a secure residential programme which has attempted to involve family

members in the delivery of therapy. When possible, the MJTC staff locate and contact the family

members of young people in order to re-engage the youth with a supportive adult. Greater family

involvement has been associated with lower readmission (Lakin, Brambila, & Sigda, 2004).

Although difficult, the words of the participants and the latest research suggests involving

whānau more may serve to increase therapeutic gains, facilitate reintegration into the community,

and increase desistance.

The Transition Phase

After the young people completed the core phase of the MTMO programme, they moved

onto the transition phase. The object of this phase was to "move beyond the youth unit and/or

return to the community" (Kilgour & Borg, 2016, p. 31). Although in some cases young people

were transitioned into adult prison, for many young people they were transitioned into the

community. Participants were asked about the content of this phase, how much support was

provided for young people in their re-entry, how successful reintegration was, and how this phase

may be improved. Two sub-themes emerged: (a) improve the transition plan; and (b) introduce

aftercare services.

Improve the transition plan

Once a young person is released from a youth justice residence there are a raft of

challenges they face in the community when attempting to successfully reintegrate. A transition

plan or release plan, whether it be to adult prison or the community, is often created before they

leave the facility to support this process. These plans address the fundamental aspects of life in

the community, such as where they will live and whether they will return to school or what

employment they will seek, and who will support them to do so (Dickson & Polaschek, 2014).

Participants were asked about the transition plans used in the MTMO programme, how detailed they were, and whether they could be improved. There appeared to be two perspectives on this matter. For those young people serving a Corrections' sentence, the plans were said to be sufficiently detailed:

> ...for the Corrections guys, we really focused on having a procedure of transition for them. So, making sure that basically they had a good safety plan and release plan prior to their transition, and make sure that they had the most successful one as possible.

However, for those on a supervision with residence order, there appeared to be minimal planning for release:

> And then having something at the end individually, I think they were trying to do safety plans but I never saw one.

> I think some of that is about having a clear transition pathway for it. So, at the moment, it's you've got your early release – off you go. Whereas I would like to see it, you know, say one month out from early release, having a clear transition pathway, a whānau hui, all of those sorts of things.

Although literature on transition plans for young people is lacking, there is an association between the strength of transition plans and recidivism for adults who have offended both violently (Dickson & Polaschek, 2014; Dickson, Polaschek, & Casey, 2013) and sexually (Willis & Grace, 2008; Willis & Grace, 2009). Those who had better quality plans overall (safety plan, accommodation, employment, prosocial support, release environment, antisocial peers, and release plan total), were significantly less likely to be reconvicted in six months following their release (Dickson & Polaschek, 2014). This suggests by improving the quality of release plans, individuals may be more successful on their return to the community. The importance of quality planning was explained by a facilitator, who said:

> So, if you've got a transition that's just tick box, how is that ever fitting in with the work that we're trying to do with the young person, so it could be whānau life, it could be other goals, they do smart goals. So how does the transitional supervision order fit in with their

smart goal? How do we support [provide] in that way, cause they come here, they do a programme, they've got a supervision order and then it's like "here you go". You know, and I feel that our intentions are never to be tick box. But I find that some community social conditions kind of limit how we do things and some of the constraints.

As discussed in this quote, and reflected in the literature, the intention of a release plan is not to simply tick a box, but to actually facilitate a young person's return to the community through careful and practical planning. As mentioned above, there is no known study which tests the quality of release planning for young people and their outcomes in the community. However, based on ecological systems theory, the environment in which an individual operates has significant impact on the behaviour of a young person (Bronfenbrenner, 1992). For example, low parental supervision coupled with adolescent antisocial peers is a strong predictor of violent behaviour in adults (Van Ryzin & Dishion, 2013). Although the avoidance of antisocial peers may have been a focus of therapy in the MTMO, both these factors operate in the community in which the young person is released. Therefore, careful planning to facilitate a young person's reintegration into the community should not be ignored. For example, in a practical way, how will they cope with their old antisocial friends?

Introduce aftercare services

Interventions for adolescents during their residential placement appear to have positive immediate effects (Lipsey, 2009). However, many of these treatment gains disappear once they are released from the residence, as secure residential facilities provide structure and close monitoring, which is sorely lacking in the environment young people return to (Altschuler & Armstrong, 1998). This same point was raised by a participant in the current study who said; "Yeah, in that environment it [treatment] did [help]. Like, it's easy in there, of course it can. It's like you need structure, but on the outs [outside community], that doesn't really apply". When the same young person was asked about returning to the community, they said: "I forgot about it

[the programme] when I got out, I'll be real. I forgot about everything… I just adapted myself to

the outside world. Forgot about a lot of things". This view has been eloquently summarised in a

theme by musician, and rap idol of many adolescent participants, Kendrick Lamar, who states

"adaption inevitable" when discussing the environmental causes of criminal behaviour in the

song, Duckworth.

The lack of aftercare services in the MTMO programme was a strong theme discussed by

many participants. Two facilitators acknowledged this in following statements:

> *The transition phase was… to be honest I don't even know if it was part of the programme.*

> *The hardest thing about the programme, especially for youth in Korowai Manaaki who are in and out quite a lot and based in Auckland, once they are in the community, I have no authority to contact them. And the research says that the transition to the community has to be successful, it is the most critical part, and it's the part we didn't work on.*

> *That was the other part I didn't really know much about - what was happening in the community?*

As stated by these facilitators, there was minimal aftercare services. In some cases, when

young people were released, there was an informal meeting with a facilitator. This is described

by two facilitators and one caregiver:

> *I took it upon myself. I just met with social workers for these boys' early release, and I started being a lot more involved in what's happening with these boys when they learn and kind of give feedback. The initial thing was I only attended those meetings to give feedback on the MTMO, on how they're going. I took it another step where I wanted to follow the young person in the community.*

> *Again, there was no written process or structure for how that should be; it was a catch-up.*

> *They rung me and caught up with me and asked how he was settling in at home, is there anything that they could do to help. They came out for a visit, and I never heard from them again.*

However, many participants felt that this was not enough, and stated that improvement in this area was necessary. A facilitator, a caregiver, and a social worker stated the following:

> *I would much prefer a clearer structure you know, maybe booster sessions in the community or something like that where we have a clearer process that involves probably family, site social workers to come together... Maybe up to six months. Maybe monthly booster sessions in the community.*

> *I don't know what I would like from them now. But at the time, it would have been nice if they were more in contact with whānau and more involvement of coming to the home environment, and just catching up, you know, not just waiting until your son comes out and saying "Sorry whānau, you're on your own now". I thought that one visit was good, but it should improve by having you know, bring it out to six weeks or something. Just stay in [contact and give] whānau support. That would be very helpful.*

> *But if we had someone who he had, just him and [young person] mentoring... Just maybe to remind him to use, if he did learn any skills in the programme, to remind him how to use those skills, and apply them in his current life.*

The need for aftercare services has been of growing interest in the literature as it presents an opportunity to support long-lasting change by those released from secure residential facilities. There have been many studies looking into the effectiveness of re-entry or aftercare services for YPO. A meta-analysis analysed the results of 22 studies and 5764 participants, accounting for demographic and offence history characteristics, intervention type, intensity, duration, and when the participants began the programme (James et al., 2013). Firstly, aftercare services were found to be significantly more effective for YPO with violent offending histories compared to those without violent offending histories, particularly for those at a high-risk of reoffending. Secondly, aftercare services were more effective when they targeted older adolescents. Interestingly, aftercare services which focused on the individual alone were more effective than those which targeted the system alone, as well a combined individual and system focus. This finding

contradicts much of the literature looking at multisystemic therapy, as Borduin and Schaeffer

(2001) suggest effective community intervention focus on the individual-system interaction.

Thirdly, individually focussed aftercare had significantly larger effect sizes compared to

individual and group therapy. This may be explained by the reinforcement of antisocial beliefs

through group therapy (Dishion, McCord, & Poulin, 1999). Fourthly, and not-surprisingly,

interventions which were 'well-implemented' had significantly larger effects than those which

were poorly implemented. This suggests the fidelity of the implementation is important to

consider. Lastly, the intensity of the aftercare treatment was shown to be more important than its

duration. The duration of aftercare did not have any significant impact on treatment, while more

frequent contact between programme staff and clients was associated with decreased recidivism.

Based on these findings, it is recommended that MTMO programme introduce aftercare

services. These services should focus on high-risk YPO's; providing one-on-one individual

treatment, with contact occurring multiple times a month, using well-trained and supervised staff

to ensure fidelity is maintained.

The Unit Environment

As previously discussed, the MTMO programme operates in a secure residential facility.

For young people living in the residence, this means much of their time is spent in the unit. The

unit environment has the ability to moderate the effects of treatment, with a supportive

environment having the ability to enhance the effects of treatment (van der Laan & Eichelsheim,

2013). In light of this, young people, unit staff, and facilitators were asked about the unit

environment. Specifically, they were asked about the living group climate; how well the unit

staff understood the programme; the level of supervision unit staff received; how well they

reinforced the teachings of the programme; and the level of communication between programme

staff and unit staff. Within this theme, three sub-themes emerged: (a) more unit staff training; (b)

more communication between programme and unit staff; and (c) a strong therapeutic unit.

Improved unit staff and case leader training

If everyone had the same vision and understanding of what the need was, I think that would have made it a very effective programme.

As staff training of facilitators will be discussed in a later section, this section specifically

discusses the MTMO training of unit staff and case leader training. According to Pazaratz

(2003), effective group care is underpinned by the skills, knowledge, and problem solving of care

staff. The staff require skills in: behaviour management, limit setting, monitoring of progress;

problem-solving skills; communication; and the fostering of prosocial attitudes and behaviours

(Pazaratz, 2000). These skills allow for treatment gains to not only occur within the MTMO

sessions, but also within the unit environment.

Both the interviewed unit staff member and facilitators mentioned that unit staff had a

lack of understanding about both the content of the MTMO programme, and how they could

support the programme within the unit. One facilitator, who was formerly in the position of case

leader, said the following about their training:

First off, I'm a residential case leader here, so when the programme started I wasn't a programme facilitator. But my role within that process was supporting the young person practice the skills that they were learning within the programme. In that role itself I didn't really know too much about the programme rather than a trust in Corrections that they knew what they were doing, and they were run by clinical psychologists…We did have a brief overview, but in terms of the actual content, I didn't really know how it was being delivered. I did training, well I wouldn't say training, I did a one-day workshop, we all did as case leaders… I just feel that we need more training for staff.

This view was supported by a unit staff member who stated the following:

So, when we came out of that training session, my staff had a lot of questions… like "what is the programme? What is MTMO? What is our responsibility? What is our role? What does a structured day look like? You've got special projects, what's that?" and then the progress report thing came… and it was like "what is this?"…One staff member, he

was asking "I've had no training in this, so what are you expecting me to do with the boys? And what support am I getting to be able to do that?"

This participant suggested that the training lacked, not only in quantity, but also in

quality. The lack of training was acknowledged by two facilitators below:

I don't think the staff were prepared enough for what the programme was about. I don't blame the staff for the anxieties around the programme.

Some of the staff were really keen to know more and help the youth integrate those skills, but the communication was not there, and some of the staff weren't either keen or didn't understand it enough to be able to apply that. So, I think although it was okay, it could have been better, and that would be through probably more staff training, and more communication from facilitators.

Within the MTMO programme, a lack of staff training led to a number of issues,

according to the participants. One of these issues was the use of behavioural monitoring forms

which were used to observe the young people in the unit, and record observations relevant to

their criminogenic needs (e.g., antisocial attitudes). The purpose of this was to inform

programme staff of any changes along these dimensions. However, two staff stated there was not

enough training around this to be able to appropriately complete the forms:

So, they had to monitor, let's say antisocial attitudes, it might be glorifying crime or something. How often are they doing it in their unit, you know? Like and can't remember off the top of my head how many areas of the monitoring form, and the floor staff were expected to feedback on that. It just went right over their heads… But what was missing, I guess, that would take us back to training, was that the language and the understanding was too advanced for the staff, you know?

So, this happened without any training or anything. Honestly it did. It happened with no training, it was like "here's the form, I need you guys to fill this out so observe client A's behaviour, write down the positives and negatives of it, read these statements, if anything lines up, record that". On top of the usual job they had, that was really over and above to be honest.

This lack of training eventually led to the observation forms being abandoned. The lack of

training also led to: (a) problems in operational work; (b) poor supervision practices; and (c)

poor understanding of communication received from programme staff; and (d) an inability to

reinforce the programmes teachings. This was illustrated by a unit staff member and programme

facilitator:

(a) *You have the MTMO boys and the structured day they have, yeah it got pretty tough out there and it was quite draining, straining on the staff. So, often I got a lot of complaints – "I don't know what's happening with these boys".*

(b) *I was concerned with that too because I was asked to provide supervision that I didn't feel fully equipped with.*

(c) *When we went to go feed information to the staff about the programme, they still didn't know what we meant.*

(d) *I think it was called the breaking ice model, and it was about, I'm not entirely sure, but they were learning things to help manage anger, to utilise time out, to speak to staff. It's kind of like they learnt this in this group space, but as a staffing group in the unit, they only spent stints throughout the day in this [therapy] space, and nothing carried on because the [unit] staff didn't know what they could do to support what the boys had learnt in the sessions... So, it's kind of like all this great work was happening in the sessions, but how were we reciprocating that in the unit, and I don't think we really were capturing it how it should have been to be honest.*

One young person mentioned that the staff did not reinforce the programme's principles in the

unit:

You go to the MTMO, and you come back after into the unit or the classroom, and you just carry on with your day. You just go there and forget about it as soon as you leave… The staff don't even ask about it or anything.

Not only did staff discuss the lack of training and its impact on job performance, but they

also gave recommendations on how to improve the training; including the content and delivery

of training:

I think I needed definitely more training around looking at the different layers, and how that fits in with young people and their behaviours, and how do you deliver that

effectively. So, I just wanted to know what did week 1 to week 20 look like, and what else was happening within that process…

Pretty much wanting to know what the boys had learnt, what they needed to support them, what information could be shared, concerns around the programme, the MTMO structured day, yeah, the operational stuff of having to work with boys that weren't in the programme and boys that were.

I would actually do a three-week training on every office day. The teams have office days every Tuesdays, so the three different teams would have office day. And then, just focus on what the programme is about on those office days…

For unit staff and case leaders to facilitate the cognitive and behavioural changes made through the programme, they require training in psychotherapy and behavioural modification principles (Parataz, 2003). Within the adult correctional literature, a commonly used training programme is called "Core Correctional Training" (CCT; Dowden & Andrews, 2004). The correctional staff in the training are trained in five core components of "Core Correctional Practice" (CCP). These principles are: (a) using a 'firm but fair' approach in their interactions with the individuals they are responsible for overseeing; (b) modelling and reinforcing anticriminal attitudes and behaviours; (c) teaching and encouraging the use of adaptive problem-solving skills; (d) making the best use of community resources (eg., mental health referrals); and (e) the use of open, warm, and enthusiastic communication and development of mutual-respect between staff and those in care. In a meta-analysis assessing the effectiveness of programmes which utilise these principles, programmes which incorporated the elements of CCP had significantly lower levels of recidivism (Dowden & Andrews, 2004). All five principles had a small to moderate effect on recidivism, and importantly, they had more of an impact with individuals deemed to be at a high-risk of reoffending. It was concluded that the use of training and supervision may be enhanced by focusing on these principles.

Overall, both unit staff and programme staff mentioned that unit staff did not have adequate training. This led to problems in operational work, supervision, effective communication with MTMO staff, and reinforcement of the MTMO programme in the unit. The staff suggested that unit staff receive training on session content, how content related to the behaviour of young people, how staff could use this content with the young people, and general operational concerns. As one facilitator said, training would likely be an ongoing feature of the programme:

> *I think it's going to be a longer-term thing of working with the staff because that's not the way that traditionally they have operated here. It's been much more around sort of containment and observing than actually being part of those programmes.*

Improved communication between programme and unit staff

Many participants mentioned that unit staff lacked the training to adequately support the MTMO programme. One facilitator mentioned that this resulted in poor understanding of communication reviewed from programme. However, it was also stated by staff that there was not enough communication between programme staff and unit stuff. The purpose of communication between these groups was explained by a unit staff member and two facilitators:

> *So, it was kind of like, okay, what did he learn and what could we do? It was really getting the facilitators or programme manager to liaise in some way to advise us this is what they have learnt today, this is how your staffing group can support them.*

> *To reinforce the learning, and for them to let us know the types of changes that they see in the unit, and also if they are able to hear the young people use language that we use in the sessions then they would know what that means."*

> *I guess the facilitators and the staff knowing what's been covered in group, knowing what the behaviour of the youth are, what types of behaviours are we seeing, and unit staff understanding the material enough to use it in the unit... I think us working with staff as well and helping them to understand the youth, reduced the staff resistance and difficulty with them as well… And how to best deal with them as well and manage them.*

As stated, the purpose of communication between programme and unit staff was to help them understand what was being covered in the group so they could reinforce the learning in the unit (e.g., encouraging them to use adaptive coping strategies); for unit staff to inform the programme staff about any changes in cognitions or behaviours within the unit; and whether young people were using terms they had learnt in the sessions. However, both facilitators and unit staff felt that this level of communication was not enough. Two facilitators stated the following:

> *I don't think we provided them enough with training, enough with updates, yeah. That was also an area where I felt we lacked as an MTMO programme or facilitator team.*

> *Some of the staff were really keen to know more and help the youth integrate those skills, but the communication was not there.*

The benefits of improved communication between programme and unit staff would likely result in the same benefits as those seen through increasing training for unit staff – that is; improved operational work performance; better supervision practices; and an improved ability to reinforce the principles of the MTMO programme, and ultimately, better outcomes for young people. Nevertheless, more research is required to assess whether improved communication between treatment staff and unit staff does result in improved job performance, and even a decrease in recidivism.

A dedicated therapeutic unit

> *I think the difficulty I did hear from young people and staff was if there were dynamics between young people who had come from different units.*

It has been suggested that the unit environment may be improved by providing staff with more training and better communication from the MTMO programme. To improve the unit environment further, some participants felt there needed to be a unit which solely housed those in the MTMO programme. When the MTMO programme began, all of the young people on the

programme were housed in one unit. However, as young people started being introduced into the

programme, they were increasingly housed across different units. This process is described well

by a facilitator:

> *Okay so, initially when [MTMO] started it was in one unit. That worked really really well. Once we kind of mixed things up as a residence in response to some of the issues we were having with young people, that group was split.*

As the time progressed, those in the MTMO group were made up of young people from

across multiple units. This created a number of issues for staff; both operationally and

therapeutically. A facilitator and unit staff member stated:

> *It's easier for the staff [for young people to be housed in one unit] because then they are much more in tuned with what we are doing, what's in the sessions, it's easier to feedback to one unit staff than trying to spread yourself across three or four. So, you get, I think you get understanding and better buy in from the staff when you do it that way.*

> *Resourcing wasn't thought about that well… when you've got an eight-bed unit and then seven of them are in the MTMO and one isn't, it's quite isolating for that one person. And then you've got two that are MTMO and six that aren't, you can see how the dynamics were continuously changing.*

As stated, there are multiple benefits of housing all the young people in the MTMO

within one unit. Firstly, the training, supervision, and communication between programme and

can unit staff does not need to be given across all units, but just to those working in the MTMO

unit. This may result in more intensive training services available for those unit staff members as

there will be less staff to deliver the services to, resulting in better staff performance in their

duties, and better outcomes for young people. Secondly, having a MTMO unit will likely result

in a more supportive environment where the young people can encourage each other to make

positive changes.

There is little research on this type of setup in a youth justice facility, however, close

comparisons would be both therapeutic communities and the MJTC. The difference with both

these examples is that all residents living in the facility receive rehabilitation services, rather than

those in one unit. Therapeutic communities (TC) "includes both clients (residents) and staff as

participants in the management and operation of a caring community to challenge antisocial and

problematic behaviours and evoke psychological, social, and behavioural change" (Magor-

Blatch, Bhullar, Thomson, & Thorsteinsson, 2014, p. 169). This type of community has

similarities with what Van der Helm and colleagues refer to as an 'open group climate', which is

a structured, safe, and therapeutic environment which fosters support, and a balance between

control and flexibility (Van Der Helm et al., 2011). Importantly this open living group climate is

associated with significantly more treatment motivation amongst adolescents living in secure

facilities (van der Helm et al., 2014).

Within the MJTC, staff are given specialised training, and young people are rewarded for

reinforcing the treatment principles included in the programme. Furthermore, the unit

environment operates according to the 'decompression model', which looks to balance security

and treatment approaches in an effort to facilitate change (Caldwell & Van Rybroek, 2005).

Traditionally, if a young person is acting aggressively in therapy or in the unit, they are isolated

from the group and removed from therapy. However, according to the decompression model, this

only serves to develop a cycle in which the young person is increasingly segregated and deviant

which only reduces their involvement in treatment. Therefore, when a young person becomes

aggressive within MJTC, behavioural principles are introduced to reinforce positive behaviour,

as well as providing the young person with more individualised treatment (Caldwell & Van

Rybroek, 2005).

To summarise, the MTMO programme would benefit from a unit which only contains those in the programme. Whether that is possible is another question. However, one unit staff member believed it would be: "Logistically, I think yes, it is possible, but it would be the logistics and getting a wider buy-in for it". However, the make-up of the unit is not enough on its own. The unit would benefit from having an open living climate to increase treatment motivation and to reinforce the principles of the MTMO programme. Achieving a therapeutic unit will also require staff to receive on-going specialised training, and regular open communication with the MTMO programme staff.

Staff Services

Services for unit staff have been discussed in the previous section. Unit staff would benefit from more training and improved communication with programme staff. The current theme of 'staff services' relates specifically to the programme staff. Staff services, such as training and supervision are crucial for maintaining treatment fidelity (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002), job satisfaction, and reducing staff burnout. Specifically, staff were asked about their previous experience, qualifications, training, and supervision (both clinical and cultural). They were also asked how they thought training and supervision practices could be improved. Within this theme, two sub-themes emerged: (a) increase facilitator training; and (b) increase facilitator supervision.

Increase facilitator training

Although the treatment of YPO has been efficacious, many are not effective. The difference of course being that those shown to be efficacious are tested under ideal conditions, with motivated adolescents, with highly-trained therapists, and high levels of programme

integrity (Stams & van der Helm, 2017). However, when these programmes are implemented in

real-world settings, they often lack these qualities.

Within the MTMO programme, some facilitators felt they, themselves and/or their co-

facilitators, did not have adequate training to effectively deliver the programme:

> *I kind of [have] an idea of what an effective therapeutic group looks like, or psychoeducational group looks like, so I kind of felt that my practice was unsafe in that setting.*

> *No not really [I didn't receive training]. They basically just told me what the programme was about… I don't think I was set up that well. I didn't really receive much training before this programme.*

> *…it probably would have been more ideal to have a trained facilitator.*

As stated above, one facilitator felt that their practice was *unsafe*. This point is consistent

with the idea that facilitators have a responsibility to provide the best possible care for their

clients (Fairburn & Cooper, 2011). One facilitator who was already well-versed in delivering

similar programmes to young people commented that the lack of a trained co-facilitator also

negatively affected their own ability to facilitate: "I don't think actually the programme writing

would have affected it [job performance] but all of the logistics would have, as well as all the

extra work I had to do because I didn't have a trained facilitator". As one facilitator suggests,

there is a trade-off between employing already-trained facilitators and providing intensive

training to those already employed in the organisation: "Having somebody that has experience,

and has the qualifications of and understanding of therapeutic process, such as a programme

facilitator or… training could be useful, but it would be quite a lot of training".

Due to the differing levels of experience, it appears that some facilitators felt they had a

greater need for training than others. Although two facilitators felt comfortable delivering a

treatment programme, they felt there needed to be specialised training in how to deliver therapy

specifically to young people:

> Defiantly, there is always room for more training… I think just, if I was given a material
> around the type of mindset, more on how to capture the young person, delivering that
> certain material.

> I just feel like it's a very specialised area and you have to have the right skills, creativity
> to be able to deliver the same models you would with adults with young people or
> children. So, I don't feel that there's any difference in need, I think there should be
> difference in delivery and process.

Overall, it appears that facilitators felt that there was a need for more training, specifically on

how to deliver to this youth population. In a review of 55 training services for psychosocial

treatments, five commonly used training methods were analysed; reading treatment manuals and

written materials, self-directed training techniques (e.g., web-training), workshops, pyramid

training (e.g., train-the-trainers), and multi-component training (Herschell, Kolko, Baumann, &

Davis, 2010). Firstly, it was found that there is little evidence to suggest reading written materials

and/or attending workshops results in any positive, sustained outcomes (i.e., increases in skill

and competence). This supports the thoughts of one facilitator who said the following:

> I was given books, I was given manuals. But, you know, it is hard for me, like I'm not a
> big-time reader you know? I'm not going to read some material that I sometimes don't
> even understand what the hell it means.

 Workshop attendance does not result in any increases in competence unless it is supported by

workshop follow-ups (e.g., observation, feedback, consultation, and/or coaching). These follow-

ups also appear to benefit outcomes for clients (Herschell et al., 2010). Self-directed training

methods had mixed results and require further investigation. Although web-based training

methods are cost-effective, convenient, and often well-liked by participants, evidence is not yet

sufficient enough to support their effectiveness. The train-the-trainer model also has some mixed

results. There is some evidence of skills being 'watered-down' from supervisor to therapist,

however, this model also requires further investigation. Not surprisingly, multi-component

training packages were the most rigorously studies and were found to be the most effective

training method. This method includes a combination of reading a treatment manual, multiple

days of intensive workshop training, expert consultation, reviews of taped client sessions,

supervisor trainings, and booster training sessions. It is difficult to conclude which combination

of these work best, however, of the 21 studies, 19 showed positive outcomes (Herschell et al.,

2010).

In general, well-trained facilitators have the ability to improve programme effectiveness

and maintain fidelity. The majority of facilitators felt that more training was required –

particularly in delivering a developmentally appropriate programme. Not only did poor training

negatively impact on the practice of facilitators but it may have also created more work for co-

facilitators. Research suggests that multi-component methods of training are most effective, but

they are also the most resource-heavy.

Increase facilitator supervision

Not only did facilitators suggest improving training services, they also suggested the need

for more supervision. Supervision can be defined as, "an intervention provided by a more senior

member of a profession to a more junior member or members of that same profession. This

relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the

professional functioning of the more junior persons, monitoring the quality of professional

services offered to the client, she, he or they see, and serving as a gatekeeper of those who are to

enter the particular profession" (Bernard & Goodyear, 2004, p. 8).

Within the MTMO programme, there were mixed views about supervision practices. The reason for these mixed views were largely a result of facilitators being involved in the programme at differing time points. While the Department of Corrections' were managing the programme, thoughts on supervision appeared to be positive. For example, a facilitator said the following:

> Yes, I did, and that was one thing that I really appreciated. Being in that role I actually got some supervision from people outside this place through Corrections. I felt like I was really supported in my role, kind of always looking at how they can support me, what I can work on… It met my needs one hundred percent because I was able to off load some of the things I wanted to talk about.

However, once OT took over the management of the programme, supervision appeared to worsen in quality and quantity. One of the facilitators stated the following: "To be honest, I didn't get anything after that. I felt that when things fell down, I didn't feel supported at all with the programme".

Traditionally, supervision has been separated into clinical and administrative supervision. Clinical supervision provides guidance on therapeutic techniques and methods, such as: self-report, log review, audio and video tape, live observation, role-playing, and co-counselling. While administrative supervision provides guidance on organisational and management issues, for example: in-service training, professional development, programme development, attendance, progress notes, caseload, fascial issues, and resource allocation (Barletta, 2009). This distinction is described by one facilitator:

> I think that it was definitely supportive. As I was implementing a programme that hadn't been run before, it was helpful to have [supervisor] who was more about logistics, and organizational stuff, as well as [supervisor] who was more focused on supervision of the clinical work. That was really helpful to have that combination of people in the room so that both sides of it were always being monitored because there was a lot going on, on both sides.

In a programme which works with a diverse cultural make-up, cultural supervision is also an

important consideration. The perspectives on cultural supervision appeared to be similar to that

of clinical supervision: they were helpful when offered, but it needed to be offered more

consistently:

> *Like we had cultural supervision, like that was, I never wanted that to end. Every time I went to a session, I was like, is it over already? You know, there was just so much I could have learnt. Just how to apply Māori kaupapa into the training.*

> *Cultural supervision, probably, could have been more frequent to meet my needs more.*

> *It was kind of like, well, do you receive cultural supervision? I know [facilitator] did, as a Māori I would still like to receive cultural supervision, you know?*

There are many aims of supervision, and they include: (a) monitoring client safety and

outcomes; (b) developing self-awareness and evaluation; (c) integrating theory, research, and

skills; (d) ensuring ethical practice; (e) developing a sense of professional support; (f)

encouraging an evidence-based approach; (g) clarifying work preferences and personal priorities;

and (h) supporting self-care and ensuring well-being (Barletta, 2009). Put simply, supervision

facilities more effective service delivery, as well as ensuring quality control for the employer and

client. Supervision is of particular importance when a facilitator is lacking in experience and/or

training – as was the case in some instances in the MTMO programme.

When asked about improving supervision practices, facilitators preferred external

supervision over a co-worker:

> *I would prefer supervision from outside… Somebody that I can offload and actually feel that I'll get proper advice.*

> *I have external supervision from a psychologist and I was attempting to provide [facilitator's] supervision which was kind of really difficult when you are also a facilitator with him.*

The above issue was also discussed in the *dual role* section. Overall, many facilitators felt they could have benefited from more supervision – particularly cultural supervision. However, as in the *dual role* section, it was seen as important that the supervisor was not also the individual's co-facilitator.

General Discussion

This process evaluation aimed to describe the context, characteristics and operations of the MTMO programme; evaluate how well it met the needs of young people and whānau; evaluate its components; examine the working relationship between staff; evaluate the programme's operations and delivery; and identify possible areas of strength and improvement. Analysis of the data identified 28 sub-themes which were categorised into seven overarching themes.

Procedural Cascades

Although there was some discussion of how sub-themes were related to one another in the previous section, the extent of their interconnectedness has largely been untouched. The programme could be separated into two timelines; the first was when the programme was managed by the Department of Corrections, and the second was when management was passed on to Oranga Tamariki. There were opportunities to improve the programme while the Department of Corrections were involved, such as a more developmentally-appropriate programme manual, a consistent rolling group structure; a timelier assessment process; assessing readiness for treatment; more whānau involvement; an improved therapeutic unit. These issues continued under Oranga Tamariki, intensifying in some instances, while new issues also arose.

The majority of the areas for improvement within the MTMO programme could be attributed to under-resourcing through 'procedural cascades'. Similar to developmental cascades

(Masten & Cicchetti, 2010), I will define procedural cascades as changes in one area of an organisation which trigger a sequence of consequences that ultimately have large procedural effects. For example, if an organisation lacks team cohesion, this can lead to a lack of communication (i.e., poor sharing of information), which can result in staff being unaware of others' practices, styles, skills, or behaviours, leading to inconsistent service delivery, and contradictory administrative decisions.

Within the MTMO programme, inadequate resourcing in some cases trigged a series of consequences. Firstly, under-resourcing resulted in a lack of experienced staff working on the programme, and inadequate resources for staff. This led to OT relying on individuals to perform multiple roles. The dual-role negatively impacted the quality of supervision practices, and therapeutic alliance. Poor supervision resulted in staff feeling unsupported and may have worsened treatment delivery. The ultimate consequence of this could be poorer outcomes for young people.

A lack of resources also led to assessments being completed by only one facilitator (who had the relevant skills) who was also occupying a dual-role. As this individual was overworked, it may have resulted in poorer assessment quality (e.g., a lack of information related the young persons' systems), which may have decreased the capacity to individualise treatment. However, this assessor's dual-role also slowed down the assessment process, which resulted in longer waiting times for young people entering the programme, and a 'lag' in the allocation of bedding. The 'lag' resulted in all units having to take MTMO young people, which may have lowered the therapeutic benefits of the unit environment for these young people. Furthermore, waiting times also resulted in some young people going through the programme without having their needs met due to reduced time left on sentences and orders.

Under-resourcing also led to both poor transition plans and a lack of aftercare services, which lowered the support for young people, social workers, and whānau once the young people entered the community, which as suggested in the literature, would decrease the chances of desistance. Under-resourcing may also explain the lack of training for unit staff members. This lack of training resulted in a poor understanding of communication between unit staff and programme staff, problems in operational processes, and an inability to reinforce the MTMO programme in unit settings. Ultimately, under-resourcing triggered these problematic 'procedural cascades', which can contribute to poor or reduced outcomes for young people. Nevertheless, there are many positive features of the MTMO programme. The MTMO programme is the first of its kind in New Zealand, and provides a good starting point to build on for the future. Young people and staff generally spoke positively about the programme. However, study focuses mainly on areas for improvement as its intention is to achieve the best possible outcomes for young people.

Limitations

There are two key limitations to this research, however. Firstly, as the MTMO programme was not operating during the research process, it was not possible to observe the actual operations of the programme. Qualitative programme evaluations often include a combination of interviews, written documents, and direct observation (Patton, 2003). Direct observation includes "fieldwork descriptions of activates, behaviours, actions, conversations, interpersonal interactions, organisational or community processes, or any other aspect of observable experience" (Patton, 2003, p. 3). Without direct observation, the ability to triangulate the findings from written documents and interviews is lacking. For example, if a participant felt

that therapeutic alliance was a concern, this view could be triangulated through session observations.

A further caveat relates to the number of interviewees – particularly unit staff. Although data saturation appeared to be obtained with young people, facilitators, social workers, and caregivers; more unit staff members may have improved the credibility of the data from this group (Shento, 2004). As discussed above, under-resourcing appeared to be an issue of the MTMO programme, and potentially the residential facility itself. This may explain why after several attempts, only one unit staff member participant was obtained. When individuals are overworked, research becomes less of a concern. More unit staff members may have triangulated the findings, given different views on the programme to their colleagues, or provided new insights into the operations of the programme – all of which would have been useful.

Future Research and Applications

Nevertheless, the benefits of the research should not be ignored. An unexpected benefit was the amount of future research ideas that were identified. The results led to discussions in many areas of research, both theoretical and applied; highlighted the real need for understanding YPO's and their rehabilitation. Among others, this research called attention to understanding: the implicit theories of YPO's; the relationship between group cohesion and therapeutic changes for YPO's; the effectiveness of preparatory programmes for YPO's; assessing readiness for treatment with YPO's; and how effective release plans are for YPO's. This strength reflects the fertility of this study, and process evaluations more generally.

Consistent with the purposes of process evaluation, this study provided three main applications: explanations of a potential outcomes evaluation; avenues to improve the MTMO; and providing details for diffusion and dissemination of the programme (Patton, 2008). Secondly,

the results and discussion emphasise a range of strengths and weaknesses which were

highlighted by stakeholders themselves. Where possible, the discussion also used literature to

offer possible solutions to these issues for the programme's future development. These solutions

may enlighten stakeholders in their attempt to make decisions about programme change (Owen,

2007). Relatedly, the results and discussion may inform the design of subsequent offender-based

programmes for young people in New Zealand.

Conclusion

Overall, the findings of this study have provided some insight into how the MTMO

programme could be improved for the future. Within the seven overarching themes, there were

specific areas of strength to be built on, and improvements to be made. These areas are

accompanied by both participant quotes and a review of the literature. Many of the emerging

issues associated with the MTMO programme may be explained by under-resourcing, triggered

through procedural cascades. This study highlights the need for future research in the

rehabilitation of YPO; the need to evaluate the outcomes of young people who graduate from the

MTMO programme; and how the MTMO programme may be best disseminated to other secure

residential facilities.

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