He Waka Eke Noa at Korowai Manaaki: A Process Evaluation of a Dialectical Behaviour

Therapy-informed skills programme for young people in a secure youth justice residence

By

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Abstract

Dialectical Behaviour Therapy (DBT) aims to help people live a life worth living. It has increasingly been developed and adapted to address a range of mental health symptoms across different ages, cognitive abilities and environmental contexts; however, its popularity in implementation has outpaced empirical research. The current study was a Process Evaluation which assessed professionals' perspectives about a DBT-informed skills group called He Waka Eke Noa operating at Korowai Manaaki – a youth justice secure residence in New Zealand (NZ). The study involved 11 interviews with professionals across two organisations involved in facilitating He Waka Eke Noa and/or supporting the young people who participated. Thematic analysis was used to analyse the interviews and three overarching themes were identified. The first theme, '*Factors influencing practical effectiveness*', explored areas which professionals highlighted as having a significant impact on how He Waka Eke Noa worked and had three subthemes: '*Generalisability*', '*Cultural Responsivity*', and '*Criminal Justice Environment*'. The second theme, '*Theoretical application of DBT to young people in NZ*' investigated the compatibility of DBT with young people in secure youth justice residences in NZ. The final theme, '*Motivation*', considered the role that motivation played in engagement and continuation of treatment for people involved in He Waka Eke Noa. The findings from this study shed light on how the group was operating and highlighted the importance of the relationship between facilitators and young people. It identified the challenges He Waka Eke Noa faced including the difficulty of balancing a risk-reduction approach with creating a therapeutic environment. Further developments are considered that would assist He Waka Eke Noa in maximising its effectiveness through increasing resources and ensuring diversity amongst the clinicians (e.g., increasing cultural diversity). The thesis concludes with recommendations for the future direction of operation,

for example, rolling out DBT-informed skills groups in other residences and the community; and potential research avenues.

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Glossary

Te Reo Māori or the Māori language is used throughout this thesis. Definitions have been provided below to reflect the meaning of each word however in Te Reo Māori, words may have more than one meaning, some of which may not be reflected in this glossary.

Awa	River, stream
Karakia	Incantation, prayer, ritual chant
Kaupapa Māori	Māori strategy, theme, principle philosophy
Kia Tupu	To be cautious
Hapu	Kinship group, subtribe
Iwi	Extended kinship, tribe
Manaakitanga	The process of showing respect, generosity and care for others
Māori	To be Māori, indigenous New Zealander
Marae	The courtyard of a Māori meeting house where a person affiliates tribally through genealogy
Maunga	Mountain
Mihi Whakato	Traditional Māori formal welcome
Pākehā	Non-Māori, European
Rangatahi	To be young, young people
Taiaha	Long wooden weapon
Te Ao Maori	Māori worldview
Tika	To be correct, accurate, appropriate
Tikanga	The customary system of values and practices
Waiata	Songs

Wairua	Spiritual Health
Wairuatanga	Spirituality
Whāikorero	To make a formal speech
Whakama	Shame, embarrassment
Whakawhanaungatanga	Process of establishing relationships, relating well to others
Whakapapa	Genealogy
Whānau	Family
Whanaungatanga	Relationship

<center>**Chapter One: Introduction**</center>

Young people who enter the youth justice system are part of an extremely vulnerable population. Although best practice recommends using alternatives to incarceration whenever possible, there is still an alarming rate of young people entering secure youth justice residences worldwide (Lambie, 2016). Internationally, the structure and management of youth justice secure residences varies dramatically, however it is consistent across the literature that young people from this population are presenting with numerous mental health symptoms and experiences of previous trauma, amongst other issues. The following chapter will outline the literature on mental health and youth justice internationally and their treatment needs and access. It will then explore Dialectical Behaviour Therapy (DBT) by discussing the philosophy and modules involved before moving into the adaptations, effectiveness, and limitations of DBT. Finally, this chapter will discuss mental health and youth justice in New Zealand (NZ) culminating in the application of DBT in NZ and the present study.

Mental health and youth justice internationally

This section will explore the mental health issues that are most prominent in the youth justice population internationally, their prevalence rates and some potential factors that cause or exacerbate their mental health issues. It will also identify the barriers to addressing mental health within the youth justice demographic.

The most prevalent mental health issues in the youth justice population include Post-Traumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (ADHD), Substance Use Disorder, Major Depressive Disorder, other mood and anxiety disorders, as well as high suicidal rates (Banks, Kuhn, & Urbano Blackford, 2015; Bickel & Campbell, 2002; Burckhardt, , et al., 2018; Russell & Marston, 2009; Stathis, & Martin, 2004; Tuakoi, 2010; Vermeiren, Jespers, & Moffitt, 2006).

In the youth justice system, approximately 65-70% of young people meet the criteria for at least one mental health diagnosis (compared with an estimated 20-30% of the 'general' adolescent population; Banks et al., 2015), which illustrates how prevalent mental health issues are within the youth justice population. In secure youth justice residences specifically, as many as 70% of young people present with at least one psychiatric disorder (Tuakoi, 2010), 83% have a history of drug and alcohol abuse (Shelton, 1998) and roughly 20% experience a major depressive disorder and/or experience suicidal thoughts (Skowyra & Cocozza, 2007). It is hardly surprising then, albeit worrying, that 25% of young people in a secure residence are unable to function adequately on a daily basis due to their mental health difficulties (Skowyra & Cocozza, 2007). When compared to the general adolescent population, young people in secure residences were 10 times more likely to suffer from psychosis (Tuakoi, 2010). Young females, in particular, present with high levels of suicidality with over 50% in one study reporting at least one previous suicidal attempt (Goldstein et al, 2003). Young females, in secure residences, have been found to be 20 times more likely to attempt suicide than the general youth population (Russell, & Marston, 2009).

Prior to entering the youth justice system, there are a broad range of factors that can contribute to the development and maintenance of the mental health symptoms listed above. These include reduced academic/employment opportunities, adverse familial events, exposure to physical and/or sexual abuse, high peer tolerance for deviancy, as well as individual factors such as difficult temperament and low self-esteem (Stathis & Martin, 2004; Tuakoi, 2010). These factors are consistent with Bonta and Andrews (2016) 'Central Eight' risk factors. The 'Central Eight' are static and dynamic criminogenic needs consistently and most strongly associated with criminal behaviour. Some of the risk factors such as 'pro-criminal associates', 'family/marital factors', and 'lack of achievement in education or employment', which increase the likelihood to commit crime, may also increase the

likelihood of mental health difficulties in the youth justice population (Stathis & Martin, 2004). Although mental health difficulties are not one of the 'Central Eight', it is considered a risk factor for adolescents (Underwood & Washington, 2016). Research has found that young people presenting with symptoms such as aggression, impulsivity, hyperactivity and disinhibition, which meet the threshold for clinical diagnosis may be at increased risk of offending (Underwood & Washington, 2016; Stoddard-Dare, P., Mallett., & Boitel, 2011). In addition, the presence of a mental illness has been linked to increased negative justice system outcomes (Kutcher & McDougall, 2009). This is reflected in higher rates of arrests and longer sentencing periods.

Experiencing mental health symptoms causes extreme personal distress for the individual, and it can also have more wide-reaching effects and reduce a young person's ability to function safely within society (Stathis, & Martin, 2004). Although the nature of the relationship between youth offending and mental health is not clearly defined, the literature suggests a relationship does exist between youth offending and mental health issues. This means it would be beneficial to focus on improving the mental health of young people involved in the youth justice system.

There is a further need for agencies and professionals involved in the youth justice system to address this as the complexity of mental health presentations in the youth justice population can be heightened simply by involvement with youth justice. Being required to reside in a secure residence can exacerbate both internalising and externalising mental health symptoms for young people (Hipwell & Loeber, 2006; Banks & Gibbons, 2016). Simply put, the environment of a secure residence does little to reduce pressure on the mental wellbeing of an individual. Placement inside a secure residence leads to increased seclusion and separation from social supports which immediately reduces a sense of connection for young people (Hipwell & Loeber, 2006). It can make it difficult for young people to look positively

toward the future as they struggle to see opportunities beyond their incarceration. Young people may also experience a loss of privacy and become susceptible to victimisation both from other young people in the residence or staff (Kutcher & McDougall, 2009).

Mental health treatment needs and access

Addressing the mental health concerns of young people in secure residences creates several difficulties, which span across the needs they present with and their access to resources. A key difficulty in addressing the mental health needs of a youth criminal justice population is their treatment motivation (Burckhardt et al, 2018; Stathis & Martin, 2004). Across the general adolescent population, help-seeking behaviour is often already low, which can result in mental health issues developing more quickly and becoming severe (Burckhardt et al., 2018). Within an adolescent criminal justice population this can be amplified due to young people feeling an increased lack of autonomy attributable to being institutionalised; as well as being influenced by potentially negative previous experiences with institution-led interventions (Banks & Gibbons, 2016). Managing and changing this low level of treatment motivation is vital as it is well recognised that youth criminal justice populations often have reduced familial support which means entry into a secure residence might be the first legitimate opportunity to provide young people with the help and support required to overcome mental health challenges (Andrew, Williams & Waters., 2014; Banks & Gibbons, 2016; Burckhardt et al., 2018). There is also a need for treatment interventions to be shorter than community-based, or adult-run programmes. This is due to young people typically having shorter lengths of incarceration resulting in an inability to complete, or even start, a full treatment programme (Burckhardt et al, 2018; Stathis & Martin, 2004; Tuakoi, 2010).

An additional challenge relates to the care a young person may receive after they have completed a mental health intervention. Individuals who are placed in secure youth justice residences are a highly transient group whose living situation can be changed by external

factors beyond their control (Andrew et al., 2014). These young people are often moved around to different secure residences, caregivers or homes, depending on capacity. This can have a significant impact on treatment outcomes as it impacts the continuum of care able to be provided to participants of interventions making it difficult for these young people to complete treatment and/or develop healthy and safe routines following treatment (Andrew et al., 2014; Banks & Gibbons, 2016; Burckhardt et al., 2018).

Finally, facilities are not provided with adequate funding or training to deliver mental health treatment (Tuakoi, 2010). This can impact the level of care that therapists are able to provide their participants. The ramifications of this can extend to individuals not receiving a complete programme and high levels of staff burnout due to unmanageable caseloads. These difficulties have been found in numerous studies and are likely experienced by most staff who work with this population group (Andrew et al., 2014).

In line with a strengths-based approach, a key aspect of preparing young people who have been placed in secure residences for their return to the community must be acknowledging all of the concerns discussed above and working with them (Tomlinson, 2018). There have been a variety of methods utilised for those with mental health issues and those in criminal justice care that have found success to varying degrees. The treatment of mental health needs are complex and requires services which are able to cater to the individual whilst utilising robust empirically-based interventions. Cognitive Behaviour Therapy (CBT) models have received much empirical support for their ability to effectively address a variety of mental health issues (Butler, Chapman, Forman, & Beck, 2006). CBT has evolved since its induction and there are now considered to be 'waves' of CBT. Most recently, 'third wave' therapies have increased in popularity with their main contribution being a merge of Cognitive and Behavioural therapy (Byrne & Ghrada, 2019). They seek to

provide psychological flexibility and acceptance; and emphasise learning through context rather than solely through cognitive change, e.g., changes in thoughts, attitudes or beliefs (Roberton, Daffern, & Bucks, 2012). One third wave therapy which has received heightened attention is DBT (Linehan, 1993; 2014). As a model, DBT combines cognitive behavioural therapies with a dialectical philosophy and aspects of Buddhist principles of mindfulness; together with acceptance and change techniques (Tomlinson, 2018; Zapolski & Smith, 2017). It is also underpinned by Biosocial theory (Linehan, 1993; MacPherson, Cheavens & Fristad, 2013). The following section will further examine the theory of DBT and how it has developed.

Dialectical Behaviour Therapy philosophy/theory

The dialectical philosophy proposes that when examining two opposing viewpoints or perspectives, there are elements of 'truth' in each; and individuals should work to find common ground between the two (Andrew et al., 2014). It suggests that rather than there be one 'ultimate' truth, instead, two opposing constructs or 'dialectics' may exist within a person simultaneously (e.g., the desire to live and the desire to die; Rizvi, Steffel, & Carson-Wong, 2013). Dialectical change or progress occurs by recognising the truth in each view and forming a resolution (Hunnicutt Hollenbaugh & Lenz, 2018; MacPherson et al., 2013). There are many different dialectics and DBT therapists work to continuously engage and manage all of them. This involves balancing "acceptance and change, flexibility and stability, nurturing and challenging, and focus on capabilities and deficits, with the goal of achieving syntheses" (MacPherson et al., 2013, p. 66). However, the most important dialectic in DBT is considered to be that between acceptance and change (Linehan, 2014). This dialectic allows for maximum growth while an individual still accepts themselves for who they are.

The use of dialectics allows DBT therapists to target extreme behaviours and thoughts of individuals through highlighting alternative viewpoints and questioning. This helps

therapists to assist individuals to reduce polarised thoughts; for example, questioning the gaps between how a person may express the desire to live and the desire to die (Rizvi et al. 2013). In addition, dialectical philosophy allows for multiple positions to be true e.g., an individual may be "apparently competent AND emotionally vulnerable; acceptance of suffering AND recognition of a need for change; adult AND child [in reference to young people]; independent AND dependent; I get it AND I don't; this is difficult and change seems impossible AND you must change" (Andrew et al., 2014, p. 510). By understanding there is truth in each of these statements, the tension between these opposing viewpoints can be used in a beneficial way through encouraging synthesis. DBT therapists also use dialectics for their own consultation meetings with one another. This encourages therapists to focus on their interactions with clients rather than using these meetings to solely discuss their clients maladaptive behaviours (Walsh, Ryan & Flynn, 2018).

The utilisation of dialectics draws on Buddhist principles such as the compassionate acceptance of an individual as they currently present, alongside encouraging behavioural growth (Banks & Gibbons, 2016). This is exemplified in a DBT mantra that a person is doing the best that she or he can in the moment, and that the person can always do better (Swales & Heard, 2009; Trupin, Stewart, Beach & Boesky, 2002). An extension of this is the concept of radical acceptance which helps individuals to radically accept events, memories, experiences and emotions that cannot be changed, instead of responding with dysfunctional behaviour (MacPherson et al., 2013). Acceptance also encourages the utilisation of adaptive strategies such as mindfulness techniques, instead of using substances to self-soothe after experiencing a negative emotion (Gorg et al., 2017; MacPherson et al., 2013).

DBT integrates Biosocial theory into its philosophy. Biosocial theory is a developmental framework for understanding psychopathology (Banks & Gibbons, 2016). It suggests there is a transactional relationship between a person's biological abilities to

regulate and withstand difficult emotions and how responsive a person's social environment

is to their expression of emotion. An invalidating social environment will result in emotion

dysregulation due to a person's biological, emotional development being negatively

influenced by social interactions. It is used in DBT to provide context to the treatment and to

help individuals understand the origins of their behavioural and emotional concerns. This

understanding is helpful for conveying the message that their difficulties are present for a

reason, and they can be changed (Galietta, 2018). The application of Biosocial theory also

illustrates how DBT can provide an individualised approach for all participants. This is

through clinicians being able to explore with the person what experiences they have had in

the past, and what motivations they currently possess, in order to apply the skills

meaningfully to the individual.

As well as Biosocial theory, Buddhist mindfulness principles underpin the

development and execution of DBT. The philosophy of DBT clearly focuses on acceptance,

change and a person's reactions to intense emotions. The practical application of these

philosophies are explored further below. At its core, DBT aims to improve emotion

regulation and behavioural difficulties through utilising four skills modules (Frazier & Vela,

2014). The next section lays out these four modules: Emotion Regulation; Distress Tolerance;

Mindfulness; and Interpersonal Effectiveness.

Four skills modules

The first module is *Emotion (dys)Regulation* which has been identified as an

important factor in the aetiology and maintenance of many mental disorders (Burckhardt et

al., 2018) which is why it is important to address as part of DBT. As is explained by

Biosocial theory, emotional dysregulation can arise as a result of the interaction between a

person's biological abilities to regulate their emotions and their social environment's

reactions to their emotions, i.e. validating or invalidating. An invalidating environment would

be one in which a person's expression of emotion may be met by inappropriate or extreme responses resulting in an individual learning to internalise their emotions in the future (Heard & Swales, 2016). For example, a young woman recalls an event that occurred when she was a child, and she was being bullied by another child at school. When she told her mother about how upset she was, her mother hit her and told her to get over it. An inappropriate and extreme response such as this impacts a person's ability to identify and communicate their emotions adequately and appropriately, thus resulting in emotion dysregulation. As emotional dysregulation develops, it can result in more regular and higher intensity emotional displays; or a suppression of emotion; or a slow return to a neutral emotional state (MacPherson et al., 2013). The Emotion Regulation model in DBT gives an individual grounding in anticipating intense emotions, understanding their emotions and identifying or naming their emotions (Tomlinson, 2018). This develops into learning how to reduce heightened emotionality, change their emotional responses to situations or triggers, as well as increasing an individual's ability to accept and manage difficult, prolonged emotions (Banks & Gibbons, 2016; Tomlinson, 2018). Over time, the Emotion Regulation module used in DBT will aid an individual in the decision making process of determining appropriate emotional reactions and increase their problem solving abilities; with an ultimate aim of reducing an individual's "vulnerability to unwanted negative emotions and increasing experiences of positive emotions" (MacPherson et al., 2013, p. 66). A key aspect of this is the concept of validation. DBT therapists work to create a validating environment that is accepting of a person's current emotional and behavioural experiences by recognising the individual's current emotional abilities (Banks & Gibbons, 2016). The use of validation helps a person to feel safe which allows space for them to learn and practice healthy ways of regulating their emotions in their future.

The second module utilised in DBT is *Distress Tolerance*. There are two key aspects to the skills training in this module. First, the module teaches skills pertaining to impulse control; withstanding emotional distress; self-soothing; and tolerating painful events, emotions and urges (Andrew et al., 2014; Banks & Gibbons, 2016; Lynk, McCay, Carter, Aiello & Donald, 2015). Second, Distress Tolerance focuses on ways to tolerate these distressing emotions, without making the situation worse, through employing the use of acceptance strategies that may reduce displays of dysfunctional behaviour (MacPherson et al., 2013; Tomlinson, 2018). Distress Tolerance alongside the Emotion Regulation module has also generated theoretical support for targeting both mental health and criminal behaviour risk factors such as substance use (MacPherson et al., 2013; Tomlinson, 2018). As the skills taught in Emotion Regulation and Distress Tolerance focus on reducing heightened emotionality, developing healthy emotional responses and positive self-soothing techniques; the acquisition of these skills can, for example, reduce the likelihood of a person using substances as a form of self-medication to manage their emotions (Tomlinson, 2018).

As previously mentioned, DBT incorporates Buddhist principles which are strongly reflected in the third module, *Mindfulness*. Mindfulness is used throughout DBT and often will be the activity used to begin sessions. The skills training in this module help an individual to focus their attention on the present, largely through observation and participation (MacPherson et al., 2013). It actively encourages individuals to intentionally 'be in the moment' to facilitate this (Lambie, 2016). One of the fundamental aspects of mindfulness is assuming a non-judgmental stance toward both their own internal and external experiences; as well as toward others (Tomlinson, 2018; Trupin et al., 2002). In addition, the skills developed during mindfulness can aid an individual's level of self-awareness through its focus on the present situation and focussing on one thing at a time. This increased awareness is able to help people to mentally be in a headspace in which they can participate

fully in other modules, such as Emotion Regulation and Distress Tolerance, as they are suitably prepared (Banks & Gibbons, 2016).

The final module of DBT is *Interpersonal Effectiveness* skills training. DBT recognises that an individual's ability to interact effectively with others is influenced by factors across multiple domains including pathological learning patterns, developmental processes, previous trauma as well as family and peer influences (Andrew et al., 2014; Lang, Edwards, Mittler, & Bonavitacola, 2018). Negative or hostile interactions between these factors can result in an individual failing to regulate themselves internally, which may manifest in maladaptive external behaviours, which in turn can negatively impact their ability to effectively engage with others. The Interpersonal Effectiveness module is therefore designed to help individuals cope with interpersonal conflict (Lambie, 2016); develop, improve and maintain relationships with others; navigate and end unhealthy relationships (Tomlinson, 2018); and provide individuals with assertiveness skills so they may interact in a way that positively impacts their social interactions while also preserving their own self-respect (MacPherson et al., 2013). This is an important module for DBT as it develops the therapeutic alliance through improving communication and understanding. In addition, DBT typically occurs in a group setting and this module can help to create strong, supportive group dynamics.

Development and adaptations of DBT

DBT was initially created by Marsha Linehan in 1993 to treat Borderline Personality Disorder (BPD) and has since developed into an empirically supported intervention for a wider range of presentations (Andrew et al., 2014; Linehan, 1993). One of the main characteristics of BPD is chronic, severe emotion dysregulation (e.g., mood disturbance, affective liability, uncontrolled anger) and associated behavioural difficulties (e.g., self-harm, violent aggression; Frazier & Vela, 2014). DBT was specifically designed to target these

maladaptive traits. This section explains the initial design and purpose of DBT, before exploring how DBT has adapted to service a wider range of symptoms and demographics.

'Standard' DBT is comprised of individual therapy sessions for each individual, group skills training sessions, phone coaching for individuals and consultation meetings for therapists on the DBT team (Flynn et al., 2017; Linehan, 1993). Individual therapy sessions allow time for therapists to address a person's treatment motivation, understand the goals of a person and plan a treatment programme that will target an individual's specific skills deficits (Robins, & Rosenthal, 2011). Group skills training sessions are usually 2 to 2.5 hours and are run by two facilitators. The first half of these sessions are devoted to homework review, with the second half focussing on learning new skills covered by the four modules (i.e., Emotion Regulation, Distress Tolerance, Mindfulness and Interpersonal Effectiveness). Mindfulness is often used to begin all group sessions as a means of grounding individuals (MacPherson et al., 2013). Phone coaching is usually provided on an 'as needed' basis for people. The purpose of this is to help people with problems in their daily life and is typically a brief conversation of 10-15 minutes (Galietta, 2018). Finally, the consultation meetings for therapists are an integral aspect of DBT as they provide peer support for therapists to collaborate and discuss any problems that may have arisen during treatment (MacPherson et al., 2013; Tomlinson, 2018). Emotionally dysregulated individuals can take a significant emotional toll on therapists which needs to be managed in order to reduce the risk of staff burnout (Ashworth & Brotherton, 2018). It also ensures adherence to DBT principles and helps to maintain therapist motivation. It has been reported that consultation meetings create a team dynamic which positively impacts the delivery of DBT, further emphasising the importance of regular support and supervision for DBT therapists (Walsh et al., 2018).

Standard DBT is delivered over a 12-month period with the skills sessions typically being repeated 2-3 times (e.g., in 8 week or 12-week cycles). Although this is a lengthy

treatment period, due to the high levels of emotion dysregulation that DBT addresses, this duration is viewed as the optimal amount of time for skills to develop (Burckhardt et al., 2018; Linehan, 1993; MacPherson et al., 2013). The timeframe helps to address all of the aims of DBT. These aims are:

> *"1) to enhance a client's capability to change his or her emotional, behavioural, and cognitive experiences by increasing skilful behaviour;*
>
> *2) to improve and maintain a client's motivation for, and engagement in therapy;*
>
> *3) to ensure that skills are being translated into the client's life in a way that results in positive change;*
>
> *4) to improve and maintain the therapist's motivation to deliver therapy; and*
>
> *5) to assist the client in restructuring or changing his or her environment in a way that best promotes the generalisation and effective use of skills"*
>
> (Tomlinson, 2018, p. 4)

Empirical research has indicated that emotion dysregulation plays a central role, not only in BPD, but also in many other areas of psychopathology. The comprehensive and integrative nature of DBT means it can be effectively applied to a range of complex symptoms which allows it to be effective across a variety of severe and multiple psychopathologies (Banks & Gibbons, 2016; Lang, et al., 2018; MacPherson et al., 2013; Ritschel, Miller & Taylor, 2013). This transdiagnostic aspect of DBT has resulted in it being adapted for use to help treat other emotional and behavioural problems beyond BPD.

DBT has been applied to a wide range of mental health issues. These include depression, suicidal, para-suicidal and non-suicidal self-injury behaviours (Banks et al., 2015; Cook & Garraiz, 2016; Lynk et al., 2015; McCay et al., 2017); addictive/impulsive behaviours, co-morbid Substance Use Disorders and Eating Disorders (Burckhardt, et al., 2018; MacPherson et al., 2013, 2013; Tomlinson, 2018); ADHD, Oppositional Defiant

Disorder and Anxiety Disorder (Lynk et al., 2015; MacPherson et al., 2013; Zapolski & Smith, 2017); Antisocial Personality Disorder and Psychopathy (Tomlinson, 2018); as well as aggression, Externalising Disorder symptoms and PTSD (Burckhardt et al., 2018; Frazier & Vela, 2014; Zapolski & Smith, 2017). Most of these mental health challenges were identified earlier as being prevalent amongst the youth justice population.

Furthermore, the development of DBT has extended its use with an increasing range of populations. Although initially created for an adult population, DBT has now been applied to adolescent, intellectually disabled, adult criminal justice and adolescent criminal justice populations, in both outpatient and inpatient settings (Ashworth & Brotherton, 2018; Frazier & Vela, 2014; MacPherson et al., 2013; McDonnel et al., 2010; Tomlinson, 2018). The below discussion will focus on the adaptations made for youth and the criminal justice setting.

Youth Adaptation

Following the success of DBT in adult populations, the intervention was quickly adapted for adolescents presenting with various problem behaviours across multiple settings. Research emphasises the need for youth-based services to support young people to develop a range of problem solving and interpersonal skills during their development (Lynk et al., 2015). The theoretical underpinnings of DBT are supportive of this as they are consistent with developing a range of skills related to emotion regulation. It was believed that by adapting DBT to address the mental health challenges facing young people, interventions would be able to help "improve emotional well-being, strengthen resilience and social integration and ultimately their capacity to thrive" (McCay et al, 2017, pp. 123-124). DBT has been adapted for use with adolescents in a number of different ways, varying from programme to programme. Rathus and Miller (2014) created a manual for 'Dialectical Behaviour Therapy – Adolescents' (DBT-A) in an attempt to provide a 'standard' adolescent

DBT programme, although deviations are still common, particularly as DBT-A was created for an American population.

The first distinctive difference between DBT for adolescents and adults, is a focus on family inclusion (Carr, 2016; Miller, Rathus & Linehan, 2006; Tomlinson, 2018). This is in line with evidence-based practice for working with young people and means that family members are able to understand and support their young person more effectively (Carr, 2016). As DBT theory posits that the social surroundings of an individual can impact their ability to regulate emotions, the inclusion of family can help in creating a validating environment for the young person. This relates to the second adaptation which is the development of the dialectical dilemmas originally proposed by Linehan (1993). MacPherson et al., (2013) suggested there were three additional dilemmas when working with young people. These are: excessive leniency versus authoritarian control; normalising pathological behaviours versus pathologising normative behaviours; and forcing autonomy versus fostering dependence. Finding synthesis between these dilemmas extends beyond the capability of a young person and emphasises the need for their families to be involved too. This has developed considerably in more recent adolescent programmes including an additional module called "Middle Path" which aims to give young people skills to support their learning to consider multiple perspectives in a situation (Lenz & Del Conte, 2018). This is particularly relevant for young people who often express difficulty with authority (Galietta, 2018).

An additional common difference for adolescent DBT programmes is treatment length. It is unlikely a young person would remain part of a community, outpatient or inpatient programme for a full year. Instead DBT programmes for young people are often a lot shorter, with some being as short as eight to 12 weeks (MacPherson et al., 2013). This

typically allows time for skills modules to be taught once, with the hope that the ongoing maintenance will be supported by the families of young people (MacPherson et al., 2013).

The final difference between DBT programmes for adolescents and adults is terminology. In order to better cater to the understanding of young people, many programmes have made small changes to the names of the modules e.g., changing 'Emotion Regulation' to 'Difficulties in Controlling Emotions" and 'Interpersonal Effectiveness' to 'Relationship Skills'. To further assist young people to understand the full DBT programme proficiently, some programmes have also changed the way group sessions are run. This has occurred through spending more time at the beginning of sessions to go through the homework provided, and by utilising the 'phone call sessions' for both young people and their families (Tomlinson, 2018).

By providing DBT to young people, the opportunity is created to help target problem behaviours before they reach elevated levels of risk. This could prevent young people from developing and maintaining more extreme levels of dysfunctional (and diagnosable) behaviours (Zapolski & Smith, 2017). The skills taught in DBT are suitable for young people even without the presentation of particularly problematic behaviours as it is argued DBT targets the normal developmental needs of this population (Banks et al., 2015).

Criminal Justice Adaptation

DBT has been implemented, and at times adapted, to suit its use with a criminal justice population. The terminology used across international literature varies, but for the purposes of this thesis, the term 'criminal justice' will be used to capture 'criminal justice', 'correctional', and 'forensic'. The application of DBT to people in criminal justice facilities has occurred for several reasons.

One of the key reasons DBT has been used prominently in criminal justice settings is due to its compatibility with existing models of correctional treatment (Galietta, 2018).

Currently, the most prominent risk-reduction model used in criminal justice rehabilitation is the 'Risk-Need- Responsivity' (RNR) model which aligns with the theory underlining DBT (Tomlinson, 2018). This model posits that offenders should receive intervention services which match their level of risk to re-offend (Risk principle), target their criminogenic needs e.g., the 'Central Eight' (Need principle), and are responsive to the individual by developing a treatment approach suitable to the person's learning style, motivation and abilities (Responsivity principle; Bonta & Andrews, 2017). Theoretically, DBT is consistent with the RNR, across all three aspects. The flexibility of DBT allows the programme to be adjusted dependent on the level of risk of an individual and provides an individualised approach which can be used for high to low risk individuals in accordance with the Risk principle. The skills modules taught in DBT can target some of the most significant risk factors for criminal behaviour. The Emotion Regulation module assists in managing emotions which can reduce antisocial behaviour such as aggression and impulsive behaviours. In conjunction with the Distress Tolerance module, which teaches self-soothing, research suggests the Emotion Regulation module can also target the criminogenic need of substance use. The Interpersonal Effectiveness module specifically targets maladaptive interpersonal styles and navigating ending unhealthy relationships, which targets the criminogenic need of antisocial associates and therefore addresses the Needs principle. Tomlinson (2018) suggests reducing these specific needs can increase the of likelihood an individual maintaining employment or school attendance and engaging in more pro-social leisure activities which are all identified as protective factors by Bonta and Andrews (2016). DBT is also embedded in the positive psychology movement which focusses on utilising an individual's strengths and working with their abilities to help fill deficits thus addressing the Responsivity principle. There is clear overlap between the requirements of RNR, and what DBT provides, which indicates DBT may be viewed positively as a potential "risk reduction programme" (Tomlinson, 2018).

In recent years, the Good Lives Model (GLM) has gained attention as another rehabilitation framework for use in criminal justice treatment (Ward, Yates & Willis, 2012). The GLM provides a strengths-based approach to offender rehabilitation. It works with the offender to create a 'good life' which is goal oriented and aims to assist them in achieving these goals in pro-social ways. The GLM identifies 11 'primary goods' which are goals (all) people seek in order to gain well-being (Ward & Gannon, 2006). They include goods such as 'excellence in agency', 'inner peace' and 'friendship or relatedness'. The GLM conceptualises criminogenic needs (e.g., Central 8) as barriers to achieving these goods. DBT clearly maps onto the premise of GLM in that it encourages people to create a life for themselves that is "worth living" (Flynn, et al., 2017; Galietta, 2018). DBT works to motivate individuals from the beginning and throughout treatment to make changes that will increase their ability to achieve their primary goals.

DBT also provides criminal justice organisations with an alternative way of managing crisis behaviours and addressing mental health symptoms (Galietta, 2018). Currently, across most criminal justice institutions, the custodial policies for preventing crisis behaviour (e.g., suicide and self-harm) typically involve a person being placed into solitary care with custodial officers closely monitoring them. This is a significant strain on correctional resources and can impact negatively on the person's wellbeing generally. The policy acts to physically reduce the opportunity for an individual to commit these behaviours however it does not address any of the underlying symptoms or causes. The use of DBT to target these symptoms, instead of simply managing the physical manifestation of them, not only reduces the harm to the individual, but it also allows correctional resources to be used more effectively, thus making DBT a more cost-effective option to crisis intervention. The cost-effectiveness of DBT can also be seen through its ability to target aggressive behaviours

which further reduces the strain on staff resources by reducing aggressive behaviour in individuals (Galietta, 2018).

As noted above, DBT can be applied to criminal justice facilities in a way that aids rehabilitation and prison culture. DBT has also been modified to suit criminal justice populations. The language is often adapted so that it is better understood by the criminal justice population and 'gender neutral' terms have been applied. Programme duration has been reduced to reflect the level of intensity required and accommodate the often-reduced level of resourcing/funding that is available. Due to practical considerations, telephone coaching is not offered in criminal justice treatment contexts. For some programmes, facilitators have also added a 'Pre-Treatment Stage' in order to increase motivation levels among participants (MacPherson et al., 2013). This is used to ascertain what the person identifies as the particular issues they face, and to begin introducing the individual to the ideas of DBT and change.

It is evident then, that the way DBT is implemented has evolved overtime and continues to do so. One of the key characteristics of DBT is its flexibility which allows therapists to deliver treatment in a way that caters to people with varied diagnoses that accounts for age, location, symptomology and cognitive ability (MacPherson et al., 2013). This flexibility means treatment integrity is maintained despite changing the application of the four skills modules, depending on the level of intensity required for specific individuals (McDonnel et al., 2010). One of the outcomes of this flexibility is that DBT programmes have, at times, been modified so significantly to suit specific groups that not all skills modules are taught. This has occurred for reasons such as time constraints, an executive decision that one or more of the modules may not be useful, or a lack of training of DBT therapists. There is growing evidence that even when all four modules are not

taught/completed, DBT can still be effective (Tomlinson, 2018). The overall effectiveness of DBT across different demographics will now be discussed.

Effectiveness of DBT

The increasing popularity of DBT has led to it being implemented across many different jurisdictions within a short period of time. This popularity however has outpaced empirical research. In recent years, researchers have begun to critically analyse the effectiveness of DBT programmes internationally in order to ensure evidence-based practice. A key limitation of the research, as a result of the way programmes have consistently been adapted to suit the specific population, is low levels of fidelity across DBT programmes. This will be discussed more extensively below; however, it is important to bear in mind in any analysis of the empirical evidence available for the effectiveness of DBT, as the results are often not directly comparable.

The growing body of literature, which attests to the effectiveness of DBT programmes, initially focussed on its use with adults with BPD; however, as the modifications have developed and the range of populations it is used with has expanded, the literature has developed too. The purpose of this section is to give a broad understanding of the scope of the effectiveness of DBT – it is not a meta-analysis, nor is it intended to be an in-depth review. On account of DBT being used across multiple demographics, this review will briefly cover: the use of DBT for adults with BPD (the population it was developed for) before moving onto two directly relevant bodies of literature; DBT for young people; and DBT within criminal justice populations.

DBT for adults with BPD

As DBT was initially created for the treatment of BPD, the most evidence-based research resides in that space with over 40 randomised controlled trials (RCTs) conducted to date (Galietta, 2018). In their meta-analysis, Kliem, Kröger and Kosfelder (2010) examined

the efficacy and long-term effectiveness of DBT as a psychosocial intervention for BPD. Through the analysis of 16 studies (eight of which were RCTs). They found a moderate effect size for a reduction in suicidal and self-injurious behaviour following DBT treatment. This finding was echoed in a more recent meta-analysis and systemic review by Panos, Jackson, Hasan and Panos (2014). Panos et al's meta-analysis included two additional studies not included in the previous meta-analysis. Their findings were consistent in not only finding a reduction in suicidal and parasuicidal behaviour, but also a marginal effect size in improving individual compliance with treatment.

DBT for young people

The use of DBT with young people, beyond those diagnosed with BPD, is wide-spread due to the understanding that emotion dysregulation may play a role in other areas of psychopathology. For young people, DBT has been implemented in schools, community programmes, inpatient, outpatient, residential and correctional facilities (MacPherson et al., 2013). One of the most consistent findings is the effectiveness of DBT for depression and Non-Suicidal Self Injury (NSSI) behaviours in young people. A meta-analysis of twelve studies (all 12 reported on depression and six reported on NSSI), which reported on pre- and post-treatment measures, found a small, positive effect size for reports of depression and a large, positive effect size for the reduction of NSSI behaviours (Cook & Gorraiz, 2016). Support for this has been echoed in other studies and meta-analyses (e.g., Fleischhaker et al., 2011; James, Taylor, Winmill & Alfoadari; 2008; Woodberry & Popenoe, 2008).

There is further evidence of DBT reducing other problem behaviours of young people including reducing symptoms of Anxiety (Hunnicutt Hollenbaugh & Lenz, 2018), Oppositional Defiant Disorder (Nelson-Gray et al, 2006), Bipolar Disorder (Goldstein et al., 2015), Post-Traumatic Stress Disorder (PTSD; Lang et al., 2018), eating disorders including Anorexia Nervosa and Bulimia Nervosa (Safer, Couturier & Lock, 2007; Salbach-Andrae,

Bohnekamp, Pfeiffer, Lehmkuhl & Miller, 2008), and Trichotillomania (Welch & Kim, 2012). In most programmes, the DBT treatment implemented offered was adaptations of 'standard' DBT designed to be more understandable and applicable to young people.

DBT in a criminal justice population

The most comprehensive theoretical and empirical review of DBT in the criminal justice setting to date is by Tomlinson (2018). This review analysed a total of 34 DBT programmes implemented in criminal justice facilities around the world. This meta-analysis found that 23 of these programmes had conducted an outcome evaluation demonstrating the effectiveness of the intervention. As these programmes ranged in their delivery of treatment and the treatment aims, it is difficult to quantify the exact effectiveness of DBT with criminal justice populations. However, most of the studies indicated a small decrease in antisocial personality traits, anger and aggression following treatment; and a small increase in psychological functioning (e.g., lower levels of depression, anxiety and self-harm; Tomlinson, 2018). The effectiveness of DBT with criminal justice populations extends to youth criminal justice populations. Although there is limited research, preliminary reviews indicate a reduction in behavioural problems can be found following DBT treatment for youth in both community and residential settings (Banks et al., 2015; MacPherson et al., 2013; McDonnel et al., 2010; Shelton, Kesten, Zhang & Trestman, 2011; Trupin et al., 2002). It is important to stress that, although these are promising findings, it is premature to draw strong conclusions. Further robust studies are required to strengthen support for DBT as an evidence-based treatment programme for the youth offending population.

Limitations of DBT research

The flexibility of DBT is a strength, but it has immense impacts on DBT treatment fidelity. The range of adaptations which have been discussed raise some doubt about the overall effectiveness of DBT as very few of the studies reviewed strictly adhered to standard

DBT practice. The evidence suggests individual modules can be effective (Tomlinson, 2018), however researchers agree that more robust, rigorous testing of these DBT programmes is required (Banks & Gibbons, 2016). This is certainly possible. Initiatives such as DBT-A (Rathus & Miller, 2014), which includes a newly developed manual for implementing DBT with adolescents, can help to provide some level of conformity across adolescent programmes. For criminal justice populations, particularly youth criminal justice, the issues discussed at the outset relating to funding, treatment motivation and sentence lengths will continue to influence how rehabilitation programmes are conducted. However, as criminal justice facilities further develop their rehabilitative practice, research and funding for interventions that work may increase.

A key gap in the DBT literature pertains to a lack of empirical evidence to support the use of DBT with different populations and diagnoses. Currently, the American Psychological Association (APA) has only deemed DBT to be an empirically supported treatment for BPD (Tomlinson, 2018). While there have been many studies reviewed here which indicate support for the use of DBT; an overall lack of both RCTs and robust comparisons between treatment groups coupled with small sample sizes means that far more thorough evaluations are required (Banks & Gibbons, 2016; Banks et al., 2015; MacPherson et al., 2013). This is particularly salient for DBT with adolescent populations, including in criminal justice settings. In addition, the minimal universality across these programmes is exacerbated by the low level of resource sharing as well as the limited availability of process and outcome evaluations of these programmes (Ougrin, Tranah, Stahl, Moran & Asarnow., 2015). As DBT has been implemented across communities, schools, correctional institutions (residential and outpatient), and psychiatric care; far more research into DBT across each of these settings is required with clear explanations as to what modifications have been employed and why (Hunnicutt Hollenbaugh & Lenz, 2018). Taking this into account, it is logical that there is a

large gap in the literature relating to the use of DBT in adolescent criminal justice populations. This vulnerable population have a specific set of complex treatment needs which require a high level of attention and maintenance. Young people involved in youth justice have the opportunity to receive support, ideally including evidence-based interventions, for their problematic behaviours at a young age which means that this gap in the literature must be addressed.

The DBT literature also lacks international depth with a recent meta-analysis of 34 studies sourcing 85% of their data from the United States of America (47%), the United Kingdom (26%) and Canada (12%; Tomlinson, 2018). This is a significant gap as recognising cultural differences, and how this may impact the implementation of DBT around the world, would strengthen our understanding of how DBT programmes work and whether they work effectively cross-culturally.

Mental health and youth justice in New Zealand

The relationship between mental health and youth justice that is recognised internationally is also mirrored in NZ. In 2016, the Ministry of Social Development (NZ) reported that, on average, 542 young people are admitted to a youth justice secure residence each year and this is expected to increase (Lambie, 2016). These are vulnerable young people who have typically been involved with youth justice for a significant amount of time prior to entering a secure residence. As well as criminal behaviour, these young people frequently present with many of the mental health concerns discussed earlier, such as PTSD, ADHD, Substance Use Disorder, mood/anxiety disorders and high suicidal rates (Bickel & Campbell, 2002; Vermeiren et al., 2006). The Ministry of Health (2012) estimated that mental health issues affect between 40% and 60% of the youth justice population in NZ, which is significantly higher than the general population.

Within NZ, several key studies have examined the prevalence of mental health issues within the youth justice population. McKay and Bagshaw (2009) investigated mental health within one of the youth justice secure residences in NZ. They reported that 20% had attempted suicide, 25% reported depressive symptoms, 30% had self-harmed and 49% reported feelings of anger/irritability. These findings were echoed by McArdle and Lambie (2015) who found that within a population of previous youth justice residents, 38% experienced difficulty with anger, 30% experienced depression/anxiety and 17% experienced suicidal ideation. The literature clearly suggests the prevalence of mental health issues amongst the youth justice population in secure residences in NZ is high. Research also suggests mental health issues are a predictor of reoffending among youth (Ioane, Lambie, & Percival, 2016).

Rehabilitation for youth should focus on both direct criminogenic needs and mental health issues. As the youth justice system in NZ adopts a two-pronged approach which incorporates both care and protection, as well as accountability and public safety; working effectively with those presenting with mental health issues is an essential component of youth justice secure residences programmes.

Dialectical Behaviour Therapy in NZ

Over the course of 2017 to 2019, a team from Auckland District Health Board (ADHB) named Taiohi Tu Taiohi Ora has run a DBT-informed skills group called He Waka Eke Noa at Korowai Manaaki. This is a new programme which, at this stage, has not had any formal evaluation. Korowai Manaaki is one of four youth justice secure residences in NZ and houses up to 40 young people who are involved with youth justice.

This thesis presents the findings from a process evaluation of this programme. This includes analysing how the programme worked; assessing whether it was operating as

intended; providing input for future planning and programme development; and providing evidence within a NZ demographic.

The introduction of DBT at Korowai Manaaki aimed to address many of the skills deficits experienced by those with a range of mental health difficulties in the youth justice population in the youth justice secure residences in NZ. This thesis involved exploratory research and aimed to assess how the DBT programme was being implemented. It specifically asks:

- What is the context, what are the characteristics, and what is the operation of the programme?
- How well do young people understand the key modules of the programme?
- How do key stakeholders view the programme and do they believe the programme meets the needs of the young people?
- What are the possible areas for improvement?

 This will address gaps in the literature pertaining to the effectiveness of DBT in secure youth justice residences in NZ as well as exploring what adaptations have been made and why.

<center>**Chapter Two: Methodology**</center>

This chapter will describe the methodology used in this study. To begin, it will explain the background to He Waka Eke Noa to provide relevant contextual information. It will then discuss the type and model of evaluation, before exploring the qualitative approach used and cultural considerations. The chapter will then focus on the details of the methodology such as describing some of the process issues experienced, participants, the interview schedule, procedures, and finally, the data analysis plan.

Background

Taiohi Tu Taiohi Ora is a treatment sub-team of the Regional Youth Forensic Service, Auckland District Health Board (ADHB). In 2017, it began running a DBT informed skills groups named He Waka Eke Noa at Korowai Manaaki, the youth justice secure residence in Auckland. Since its inception, various versions of the group have operated, and the facilitators of the group have made changes over the years to adapt to the population and environment. Currently, each group is run in four-week blocks, with five young people and two facilitators in each session. The group meets for an hour, twice per week to assist young people in learning new skills. During a commitment session prior to a group starting, young people are provided with a workbook which outlines the session, and their homework for each week. During the programme young people have three sessions on Mindfulness, two sessions on Emotion Regulation, two sessions on Distress Tolerance, and one session on Interpersonal Skills. All young people are required to sign a contract which reflects their commitment to the programme. Once young people have completed the programme, a final graduation session is held to acknowledge and celebrate their completion.

Programme Evaluation

A programme evaluation has been defined as "the systematic and objective assessment of an on-going or completed project or programme, its design, implementation

and results. The aim is to determine the relevance and fulfilment of objectives, development efficiency, effectiveness, impact and sustainability" (Austrian Development Agency, 2009; p. 1). There are different types of programme evaluation (e.g., process evaluation, prevention evaluation, implementation evaluation, outcome evaluation); and programme evaluation models (e.g., utilisation-based evaluation, responsive evaluation, goal-free evaluation; Patton, 2002). It is important for an evaluator to consider the purpose and intended audience of their evaluation when deciding which method will be most appropriate. Programme evaluations are typically conducted by individuals who are independent from the programme to increase objectivity and transparency. It is a key feature of programme evaluations that the findings aim to help participants and other stakeholders in order to improve and certify the service provided (Stufflebeam & Shinkfield, 2007).

In NZ, over recent years, there has been an increased recognition that scientific evidence should play a larger role in policy formation and implementation (Gluckman, 2017). Programme evaluations can have a direct impact on enhancing evidence-informed policy making. They allow decision-makers to better understand how programmes are operating in their natural setting, in order to make informed decisions around improvements and future direction. The following section will explore the type of evaluation selected for the current study; and evidence for the model and methodology used.

Process Evaluation

The current study is a process evaluation. The focus of a process evaluation is to review what happens during programme implementation, with an aim to understand why a programme is working well or not so well, and how improvements can be made (Dehar, Casswell & Duignan, 1993). The focus is not on programme outcomes, but rather, its strengths and weaknesses (Patton, 2002). In addition, process evaluations allow for a level of accountability to stakeholders (Stufflebeam & Shinkfield, 2007). It ensures a review of how

accurately operation plans are being implemented and analyses why changes have or should occur.

There are seven features outlined by Dehar et al, (1993) that a process evaluation is likely to analyse: 1) the programme origins, and the sequence of events in programme planning and implementation; 2) the programme structure, components, and delivery system; 3) contextual factors relevant to programme operation; 4) the participation rates and characteristics; 5) the perceptions of programme participants; 6) the levels of community awareness; and 7) the resources used for programme operation (Dehar et al., 1993).

One of the key objectives of process evaluations is to provide feedback directly and throughout the evaluation to staff in order to improve the programme. In the current evaluation, feedback about the programme will improve aspects of the programme and provide information to decision-makers as to the value of the programme and whether it is worth replicating across the country in other youth justice secure residences.

Evaluation Model

The purpose of an evaluation model is to provide a framework which will guide the structure and process of the evaluation. Evaluation models typically indicate important issues to consider and guide methodological decisions (Patton, 2002). There are several different evaluation models, including; utilisation-focused evaluations, responsive evaluations, goal-free evaluations, and participatory/collaborative evaluations (Patton, 2002). The present study employs a utilisation-focused approach to process evaluation.

Patton (2002) developed a utilisation-focused evaluation approach based on the principle that an evaluation should be judged on its usefulness to its intended users. This approach suggests the best way to evaluate a programme is to design the goals of the evaluation to align with what the stakeholders see as the most practical use of the evaluation.

A utilisation-focused approach simply means the needs of the primary users of the evaluation, Oranga Tamariki and Taiohi Tu Taiohi Ora in this study, determine the goals which then inform the decision about the best methods and data analysis techniques to select. Based on discussions with Oranga Tamariki and ADHB (particularly the Taiohi Tu Taiohi Ora team), the goals of this evaluation included identifying the context, characteristics, and operation of the programme, how well young people understood the key modules of the programme, whether other key stakeholders (e.g., whānau, programme staff and allied professionals in mental health) believed the programme met the needs of the young people, and identifying possible areas for improvement. This theoretical approach best allows us to capture the information required to continue development of the DBT skills programme.

Qualitative Approach

Process evaluations draw primarily on qualitative methodologies. As the use of qualitative research increases, it is important it is "conducted in a precise, consistent, and exhaustive manner through recording, systematising, and disclosing the methods of analysis" (Nowell, Norris, White & Moules, 2017, p. 1). There are several types of qualitative analysis methods, for example: thematic analysis, grounded theory, discourse analysis, and interpretive phenomenological analysis; each of which have distinct features which are specific to different types of research. Thematic analysis was the most suitable method for this evaluation due to:

1) The level of flexibility and ease of use.

2) Its suitability for use when working with participants as collaborators.

3) Its usefulness in summarising key features of a large body of data.

4) Its ability to highlight similarities *and* differences across a data set.

5) Its utility in generating unanticipated insights.

6) Its ability to allow for social and psychological interpretations of data.

7) Its suitability for producing analyses suited to informing policy development.

(Braun & Clarke, 2006)

The use of qualitative methodologies is typically considered the most appropriate method to use when conducting a process evaluation (Patton, 2002), which is why the use of quantitative materials (e.g., demographic information and programme documents) will only be utilised as an additional source of information. The application for quantitative analysis will be discussed further in the *data analysis* section.

Thematic Analysis

Thematic analysis is an inductive methodology which allows for key themes to develop naturally during data collection (through semi-structured interviews). Open coding was used to analyse the interviews. Open coding is an analytical process used to discover ideas, concepts and theories by analysing written text (e.g., transcripts; Strauss & Corbin, 1998). Open coding occurs by reading through a transcript, line by line, to establish overarching themes and concepts. Labels or codes are given to these concepts and these codes are later used to draw attention to specific phenomena. It is called 'open coding' due to the codes being directly derived from the data (Strauss & Corbin, 1998). There are six steps involved in conducting thematic analysis which are well recognised:

1) Familiarising yourself with the data (often done through transcription of interviews).

2) Generation of initial codes. These are features of the data that are interesting or meaningful to the analyst.

3) Searching for themes. This involves sorting the codes into potential themes which represent patterns in the data.

4) Themes are then reviewed and refined. Firstly, extracts within each theme need to form a coherent pattern. Secondly, the themes need to be valid in relation to the entire data set.

5) The themes are then defined and named so the scope and content of the themes can be easily understood.

6) Finally, the report is produced which includes themes, sub-themes and the extracts which illustrate the themes in the participants own words.

(Braun & Clarke, 2006)

Technology, specifically qualitative data analysis software programmes are commonly used to facilitate thematic analysis as they can help to clearly code raw data and translate it into themes.

Cultural Considerations

This project involved a number of Māori participants and it is important for evaluators to consider that element to ensure cultural competency in their work. There are some key questions evaluators must consider, such as, how they develop cultural competency; the extent to which an evaluator's cultural competency may impact on the quality and robustness of the evaluation; what evaluations should Pākehā practitioners be involved in and what role should they play; and who do evaluators turn to for guidance on these issues (Torrie et al., 2015)? Consultation around cultural considerations occurred with Dr. Tia Neha, lecturer in Māori and Indigenous Developmental Psychology, Victoria University of Wellington and Patrick Mendes, Cultural Advisor at Regional Youth Forensic Services, ADHB. The project was also reviewed by the Waitematā and ADHB Māori Research Committee and given approval.

Consultation focused on the appropriateness of processes when interviewing Māori participants and during data analysis. Firstly, the evaluator operated in a manner which was

consistent with the principle of 'tika' through regular Māori consultation (Hudson & Russell, 2009). Secondly, the interviewer was advised that it was important to take the time to introduce themselves, the research and the purpose of it. It is important to build rapport with participants, and to follow the principal of whanaungatanga, which refers to the building and maintenance of relationships (Pere, 1994). Thirdly, the evaluator acknowledged the importance of whānau and whakapapa, and how this may shape a person's identity. Fourthly, the evaluator followed the principal of manaakitanga, which captures philosophies around hospitality and showing respect, generosity and care for others, including taking time at the end of the interview to answer any questions participants had. By doing so, knowledge can flow reciprocally between participants and researchers. The researcher was practiced and comfortable using Māori protocols during the interview process, for example, offering a Karakia to begin and end the interview (Royal, 2003). Manaakitanga was an important part of the overall approach, informing decisions about how to conduct this research, but was also integrated into the little things, such as learning the correct pronounciation of names, and ensuring participants felt comfortable with the research and with the evaluator (Mead, 2003). Overall, the evaluator aimed to be aware of kia tupato, which is being cautious and reflective of insider and outsider status, and how this may impact on research questions, interview style and participant experience.

In addition, this project involved Pasifika participants. Consultation discussions did consider involvement by Pasifika participants as well as Māori participants. The researcher also has personal experience within the Pasifika space. These factors helped facilitate a safe process for all cultural groups participating in the research.

Method

Process Issues

In the initial plan for this project, participants were intended to represent three key stakeholder groups; (1) the young people involved in the programme currently, as well as recent graduates of the programme, (2) caregivers of the young people involved in the programme, and (3) professionals, including programme facilitators, cultural advisors, residential professionals, social workers and case leaders. The process for this thesis project required the researchers to take the following steps, 1) obtain ethics approval in the first instance from the Health and Disability Ethics Committee (HDEC). Once this has been obtained, the researcher needed to, 2) apply to ADHB for Research Approval; and 3) to Oranga Tamariki for Research Access Approval. Both ADHB and Oranga Tamariki require HDEC approval prior to a submission being made to them. The following section outlines the process issues this project faced in obtaining the three requisite approvals, which resulted in it only covering one third of the stakeholder groups; i.e., the professionals' perspective.

Health and Disability Ethics Committee (HDEC):

Three applications were made to HDEC. Due to HDEC's process of applications being reviewed by the next available subcommittee, irrespective of it's geographical location and whether it had previously considered that application, the applications were reviewed by three different regional subcommittees. HDEC has a final decision timeframe of 35 days.

The first application was made on the 8th of June 2018. It was given a decision by the HDEC Central subcommittee of 'Provisional Approval' with requested changes primarily focussed on the Participant Information Sheets (PIS). The changes were re-submitted, and a final decision was provided on the 24th of August 2018 of 'Declined'. Overall, the application was in the hands of HDEC for 50 days (outside the specified timeframe).

The second application was made on the 29th of August 2018. It was given a decision of 'Declined' by the HDEC Southern subcommittee. Again, the main requested changes were to the PIS's. The letter outlining this decision was received on the 28th of September 2018. Overall, this application was in the hands of HDEC for 30 days total (within the specified timeframe).

The third and final application was made on the 11th of October 2018. It was given a decision of 'Provisional Approval' by the HDEC Northern subcommittee. The requested changes were re-submitted, and a final decision was provided on the 7th of February 2019 of 'Approved' (see Appendix A). Overall the application was in the hands of HDEC for 67 days (outside the specified timeframe). HDEC approval was obtained 7 months after the first application was submitted.

The researchers worked hard to incorporate all of the requests made by HDEC. Originally pamphlets had been created as PIS's to accommodate the age and cognitive abilities of the young people in the youth justice secure residences. The Committee stated the pamphlets were not suitable for PIS's and referred us to prescribed consent forms on their website. In the second application, the researchers submitted PIS's which were created using the HDEC prescribed forms on their website, however this application was declined and requests were made for more information to be added to the PIS's. Prior to submitting the third application, we ran a small focus group in the community with four young people aged 14 to 16 years old. This included Māori participants and one with a mild intellectual disability. The overwhelming feedback was that it was too long. We used resources from ADHB and Talking Trouble Aotearoa to create a new pamphlet which incorporated as much of the HDEC PIS content as possible and included pictures. The feedback from ADHB clinicians was that this would be more suitable. The final HDEC subcommittee agreed to a compromise of providing the young people with the pamphlet (see Appendix E), on the

condition researchers would also read aloud the HDEC version of the PIS. This is just one example of the work the researcher did to work within the HDEC requests.

ADHB:

We submitted our application on the 12th of March 2019. That same day it was submitted for review to the Waitematā and Auckland District Health Boards Māori Research Committee. ADHB fully approved the study and provided Locality Access on the 2nd of April 2019 (see Appendix B & C).

Oranga Tamariki:

In July 2018, the researcher contacted the Oranga Tamariki Research Access Committee (OT RAC) to enquire about the process for obtaining Research Access and asked about timeframes. We were advised that the process could take 6-8 weeks. Mindful of the time delays experienced in obtaining HDEC ethics approval, and of the looming deadline of this project, the researcher submitted the Oranga Tamariki Research Access application at the same time we submitted the HDEC provisional approval changes in January 2019. This was submitted on the 11th of January, 2019.

After the first timeframe of 6-8 weeks had passed, the researchers followed up with Oranga Tamariki 10 times requesting updates. The final approval letter, which was conditional on a police check, was provided to the researchers on the 14th of May, 2019 (see Appendix D). This was 17 weeks after the application had been submitted. Oranga Tamariki had only one query in relation to the application, which was responded to within one working day.

The information required for a full police vetting check was requested on the 1st of May and provided to OT RAC on the 2nd of May 2019. On submitting the information for the police vetting check, OT RAC advised this would take about "7 to 10 days". The police

vetting check was received on the 14th of June 2019 (31 working days after we provided the necessary documents).

As the project deadline drew closer, the researchers tried to adapt the project as much as possible to work within the constraints but still gain valuable data. Once ADHB had provided approval, we began organising the interviews with ADHB staff which included Team Leaders, Facilitators and Cultural Advisors. Once the conditional Approval Letter was received and clearance was provided by OT RAC to interview Korowai Manaaki staff (provided it was offsite or over the phone), we contacted 27 Oranga Tamarki staff members, inviting them to take part in an interview over the phone. Follow up requests were made to each of them a further three to five times each. We only received four responses, and ultimately only three Oranga Tamariki staff members were available for an interview.

Overall, the OT RAC process on its own took 17 weeks. Adding the time taken to complete the requisite police check, it took 22 weeks (14th June) to gain permission to interview the young people at Korowai Manaaki. This has resulted in the young peoples' voice (and by extension, their whānau) having to be excluded from this process evaluation as there simply was not time to arrange, conduct and transcribe interviews with the young people, then analyse the results prior to the extended project deadline of 4th of July 2019. Instead, this evaluation is based on the professional's perspectives only.

As a consequence of the process issues, the scope of this project significantly changed. The researchers therefore reassessed the appropriateness of the method used, specifically, the use of a Process Evaluation that employs a utilisation-focused approach as well as the use of Thematic Analysis. The researchers decided that although the project is only from the professional's perspective, this perspective does provide an overview of the programme's origins and how it is implemented, as well as information about the programme structure and contextual information about the programme operation. In addition, the

professionals were able to speak to their perceptions of how the young people participated and what interactions they have with the community; and what resources are needed for the group to be operational. This is well suited to a Process Evaluation. The researchers also believe the results will be useful to the key stakeholders of the programme, thus meaning a utilisation-focused approach is still suitable. Finally, the diversity in the roles across the professionals and organisations means the use of thematic analysis is valuable as the participation group has enough variation to provide alternate viewpoints which means themes which are developed are not simply due to all participants having the same experience. The researchers concluded that while input from young people, their whānau, and a higher proportion of Korowai Manaaki staff would have been infinitely preferred, the planned approach remained valid and appropriate.

Participants

Interviews with professionals involved in the programme or involved with young people who have participated in the programme ($n = 11$) provided the primary source of information for the evaluation.

Professionals

The professionals interviewed comprised five different groups: Experienced Facilitators ($n = 5$), who delivered the programme or previously delivered the programme; Training Facilitators ($n = 2$) who had recently completed training to start delivering the programme, Cultural Advisors ($n = 1$) who assisted in supporting the staff and helping to develop the programme; Case Leaders ($n = 2$) who work with the young people at Korowai Manaaki; and Social Workers ($n = 1$) who work with young people in the community who have graduated from the programme. Of the 11 professionals interviewed, ten were female and one was male.

Of the combined seven facilitators interviewed, six were female and one was male. There was a marked difference between the experience and length of time in the facilitator role.

Four of the facilitators identified as having been involved with the group since its inception (approximately three years), one had just recently rejoined the programme after being involved nearly a year ago, and two facilitators had joined the team in the past six months to a year. Three of the facilitators identified as NZ Pākehā, one as Māori, one as Fijian Indian, and one as Filipino.

The cultural advisor interviewed was female. She had been in this role for less than six months. The cultural advisor identified as Māori and European.

The individuals who had only been in their roles for less than six months provided valuable additions to the research as part of training included recent exposure to the group as a participant while they also all brought previous experience working with rangatahi and represented a range of cultural backgrounds.

There were two Case Leaders interviewed in this project and both were female. Both case leaders had worked at Korowai Manaaki for eight years. Their ethnicities were South African and Pākehā. There was one Social Worker interviewed for this project who was female. She had been in her role for eight months. Her ethnicity was not recorded.

Interview schedule development

The interview schedule was developed drawing on a combination of research about the use of DBT with an adolescent, criminal justice population; collaboration with relevant stakeholders (e.g., key people at Oranga Tamariki and Facilitators from ADHB); and a review of previously developed and used interview structures. These resources formed the basis of the interview structures which aimed to shape the interviews conducted. As the interviews were semi-structured, the interview structures were updated throughout data collection depending on what themes began to emerge. This structure also allowed for follow up questions to be asked during interviews.

Interview schedules for each participant followed a similar format, with six sections corresponding with the key areas of enquiry (see Appendix G). Each section contained questions about the specific factors necessary to describe the process (e.g., "Can you tell me about the way you received referrals?"); as well as broader questions exploring the strengths, weaknesses, and suggestions for improvement (e.g., "If you could change three things about the programme, what would they be?"). The focus for professionals was on their perception of programme processes, theoretical effectiveness and improvements for the future.

Procedures

Programme Documentation

The facilitators of He Waka Eke Noa created a workbook for their young people. This workbook began by outlining the session timetable for young people over the four weeks of the programme. Each session corresponded with one of the modules of DBT, and each session was clearly explained. The workbook integrated te reo Māori throughout and regularly used acronyms intended to help young people remember the sessions' content. At the back of the workbook, there was space for the young people to do their homework. The homework typically focused on ways the participant had utilised the skills they learnt in session in their daily life. For some modules (e.g., Distress Tolerance), young people were encouraged to think about future distressing situations they may be involved in and how they would like to handle it. This workbook also included a 'Diary Card' which asked participants to rate their highest level of emotion per day; and to outline which learned skills they had used during the week. It is understood the workbook is an ongoing project and continues to be adapted.

Interviews

Initial contact with two of the facilitators (including the team leader) of the group at ADHB had occurred several months prior to data collection starting. It was decided these

facilitators would approach additional professionals at ADHB to invite them to participate in an interview. Initial contact with professionals at Oranga Tamariki were made via email and invited all professionals at Korowai Manaaki with some involvement with the He Waka Eke Noa group to participate. All participants were provided with a Participant Information Sheet and Consent Form (see Appendix F). Interviews were either conducted face-to-face at the participants workplace or they were conducted over the phone. For face-to-face interviews, written consent was obtained to take part in the study and for the interview to be recorded. Food was provided during the interview for participants, facilitating the process of manaakitanga. For those over the phone, verbal consent was obtained and recorded after the researcher stated and explained consent, followed up by the participants scanning their signed Participant Information Sheet and Consent Form and emailing it to the researcher. This consent covered participation in the study and recording of the interview.

All interviews were conducted by one researcher. Six were conducted in person. Due to logistical issues; two interviews were conducted over the phone with group facilitators and all three interviews with Oranga Tamariki staff were conducted over the phone. The length of the interviews ranged from 15 - 103 minutes. At the beginning of each interview, interviewees were given a copy of the information and consent form, given verbal information about the study, and the limitations of confidentiality were discussed.

Interviews with Māori participants started with a longer rapport building period to develop whānaungatanga. A karakia was offered to every participant, 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 further data. The interviewer regularly provided summaries to participants in order to provide them with an opportunity to verify or correct interpretations of their statements. After the completion of the interview, the researcher and a Research Assistant (RA) transcribed each interview. The RA who assisted with transcription signed a confidentiality agreement prior to starting transcribing. A copy of each participants' transcript and a copy of their signed Consent Form was emailed to each participant and they were invited to correct any perceived inaccuracies in their transcript. This was to ensure correct interpretations following the interview.

Following the workplace policies of Auckland District Health Board and Oranga Tamariki, no koha was given to staff.

Data Analysis

Quantitative

Programme documentation

The workbook, in its current state, was provided to the researcher prior to interviews beginning. The workbook was used to develop the interview structure with appropriate questions. Questions about the workbook were included in the interviews and are a part of the themes developed. No further analysis was conducted on the workbook.

Demographic Information

Demographic information was collected on the professionals including ethnicity, gender, qualifications, previous relevant experience and length of employment in their current role. This data is descriptive and was not further analysed.

Qualitative

Interviews

For the qualitative analysis, the researcher used thematic analysis which is a fully qualitative approach that highlights how meaning is contextual and emphasises the active role the researcher plays in the "knowledge production process" (Braun, Clarke, Hayfield, & Terry, 2019, p. 5). Thematic analysis is appropriate for this sample size of 11 interviews as it is generally recognised that for a NZ Master's thesis, 10-20 interviews will provide a rich amount of data for analysis (Braun & Clarke, 2013). The following section will outline how the analysis occurred in reference to Braun and Clarke's (2006) six steps of thematic analysis outlined above.

Phase One: Familiarisation

After the interviews, the researcher transcribed the majority of interviews which increased familiarity. Before sending each transcript back to the participants to ensure credibility of the transcripts, the researcher listened to each of them again for accuracy. Each transcript was saved in an electronic password protected folder with an assigned interview number and all names were removed at this point. The file name also noted the date the interview occurred. Once the audio recordings had been converted to a transcript using Microsoft Word, the transcripts were uploaded to NVivo (Version 12) to be analysed. The researcher read through the interviews once more before starting analysis and to ensure familiarity with the data. The researcher also made notes during and immediately after conducting interviews.

Phase Two: Generation of initial codes

As the sole interviewer for this thesis, the researcher came to the analysis with a level of prior knowledge of the data. During the course of the interviews, the researcher had noted down themes, or points that the researcher anecdotally had noticed as being important to the

participants or had been raised numerous times. In some instances, these notes resulted in edits to the interview schedules. The researcher was aware of the impact this level of familiarity could have in relation to allowing personal interpretations to guide the initial coding process (Braun et al., 2019). The researcher felt it was important to this methodology the coding process utilise an inductive approach in which the meaning is drawn from the data first and foremost and therefore the researcher needed to minimise this active role in the initial stages of coding generation. In a bid to counteract this, the researcher began the coding process by reading through each transcript, line by line, and assigning semantic level codes which captured meaningful but surface level features of the data. By starting with semantic coding, the researcher developed a diverse range of codes which allowed them to take a step back from some of the preconceived themes and ideas that had developed naturally during the first phase. As the data was being coded in detail, this resulted in a number of hierarchical codes, and data typically being coded several times across different codes. Data that was not directly related to the specific research questions were still included in codes during this phase.

Phase Three: Searching for themes.

The reseracher began analysing the codes that had been created and found that many overlapped or were redundant. The codes were refined and organised into 'domain summaries' which corresponded to the research questions. See Figure 1. Through the use of Nvivo software programme, a Codebook was created and given alongside the transcripts to a secondary coder which enhanced the credibility of analysis. The second coder analysed half of the transcripts in detail, and read others in less detail to ensure nothing was missed. Any discrepancies between the two coders was discussed until resolution was adhered. It is well recognised that thematic analysis is not a linear methodology but one that tends to move back and forth across the phases (Nowell et al., 2017). When the data had been reorganised

according to the domain summaries, the researcher re-coded the data, starting from scratch with the transcripts but with the intent of looking beyond the descriptive qualities of the data and instead into patterns that were across the data to identify a more conceptual level of meaning; thus moving into latent coding. At this point the purpose was to theorise the broader meanings and implications of the data.
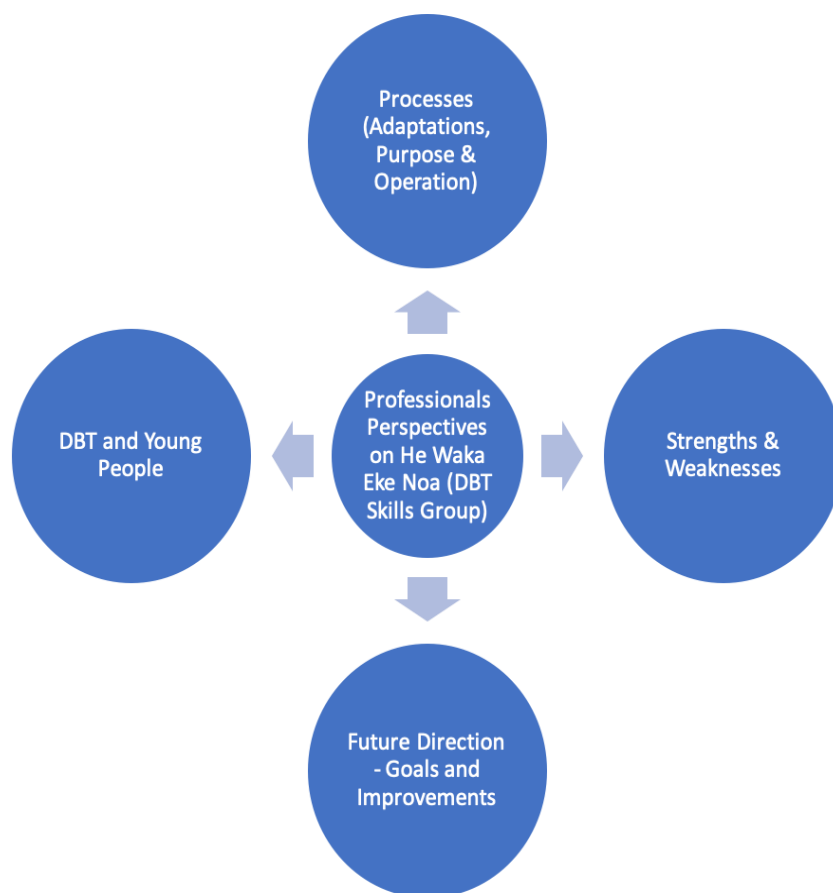
Figure 1. Domain Summaries corresponding to research questions.

A common source of debate in thematic analysis is the understanding of how a theme is conceptualised (Braun et al., 2019). For this analysis, 'domain summaries' were not viewed as themes, but rather as a helpful source of organising the data in the initial coding process. In a way, they did inform theme development as the researcher looked to create themes that united data across these domains; and in one instance, did promote a domain summary to a fully-fledged theme. The researcher constructed themes by utilising her own

experience and subjectivity, "making judgements about coding, theming, decontexualising, and recontextualising the data" (Nowell et al, 2017, p. 2), in equal measure to the data analysis and research questions (Braun et al., 2019). The impact of this was the generation of three distinct themes that weaved across the domain summaries. These were 'Generalisability', 'Cultural Responsivity' and 'Criminal Justice Environment'.

From the early stages of familiarisation with the data, the researcher believed 'Generalisability' and 'Cultural Responsivity' were significant themes. The words 'generalisability' and 'cultural responsivness' in various forms (e.g., 'generalise' and 'culture') are written several times on the interview schedules used for note-taking during the interviews.

There was an awareness by the researcher that their own subjective biases could be influential (Weenink & Bridgman, 2017). As a NZ Pākehā, who has spent 11 years living in the Pacific Island of Rarotonga, Cook Islands, and a further 12 years living in NZ, the role of cultural responsivity, particularly the Māori and Pasifika cultural interaction with Western culture, has been of interest to the researcher. Prior to starting the second round of coding where the researcher progressed from semantic descriptive coding, to interpretative latent coding, the researcher took time to reflect on this and the possibility that it was pushing the researcher toward the Cultural Responsivity theme more strongly than it should. Upon completing the second round of coding, although there were slightly fewer codes relating to cultural responsivity, it still stood firmly as a strong pattern reflecting broader meanings and implications of the data. Generalisability also withstood the second coding to stand as a strong theme. In addition, three other themes were added due to the rich patterns they showed across the data. Criminal Justice Environment became a coherent theme. Following the second round of coding, the researcher decided that 'DBT and Young People' was developed enough to move from a Domain Summary to a theme. Finally, Motivation was promoted

from a humble code to a fully fledged theme as it captured valuable data missed by the other themes. This was also supported by the second coder.

Phase Four: Reviewing themes

For this phase, the researcher began by reviewing the coded data extracts for each theme and re-organised them to form a coherent pattern. Through consultation with the secondary coder and experienced supervisor we revised and defined themes, as well as identified extracts which were rich and representative of the dataset. In some instances, this resulted in extracts being removed, and others being added. During this process, the researcher created a clear name and definition of each theme which highlighted the overlapping of three themes, Generalisability, Cultural Responsivity and Criminal Justice Environment, in particular. These themes (shown in Figure 2) signficantly interacted with each other and therefore became part of the overarching theme 'Factors influencing practical effectiveness'
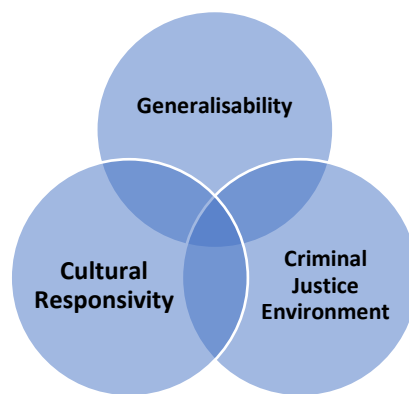
Figure 2. Factors influencing practical effectiveness.

This came alongside two other themes: 'Theoretical application of DBT to Young People in NZ Youth Justice Residences' and 'Motivation'. Following this, the researcher returned to the transcripts and compared it to the themes to ensure the conclusions were grounded in the data (Nowell et al, 2017).

Phase Five: Analysis

After the themes were clearly named and defined, the researcher wrote a detailed analysis for each theme which identified the story each theme told and how they fit into both the dataset and the research questions. Through this process, the researcher developed further sub-themes which illustrated what the themes portray.

1. Factors influencing practical effectiveness

    1.1. Generalisability

    1.2. Cultural Responsivity

    1.3. Criminal Justice Environment

2. Theoretical application of DBT to young people in NZ youth justice residences

    2.1.1. Limitations of DBT

    2.1.2. DBT targeted needs that match this specific population

    2.1.3. DBT skills that match this specific population

3. Motivation

    3.1.1. Young people's motivation

    3.1.2. Professional's motivation

    3.1.3. Motivation about the space they want to create

The researcher then returned to the raw data after this analysis was complete with the purpose of checking the names of the themes in relation to the words used by the participants. This was to ensure the transferability of the themes in accordance with the participants voice and perspective.

Phase Six:

The final step, which is the reporting of themes with extracts to illustrate, is outlined in the results section below.

Chapter Three: Results

The interview data identified three main themes that relate to the research questions this thesis set out to answer. The following chapter will illustrate each theme and subsequent subthemes using quotes from the participants. The main findings will then be discussed in the following chapter. Within sections of quotes, ellipses (…) are used in instances where nonessential words have been removed for cohesiveness. There are also words in square brackets to illustrate instances where the researcher has added words to clarify the meaning (based on contextual information in the full transcript). The first theme is 'Factors influencing practical effectiveness'. The second theme is 'Theoretical application of DBT to young people in NZ youth justice residences'. The final theme is 'Motivation'.

1. Factors influencing practical effectiveness

The first theme, 'Factors Influencing Practical Effectiveness', captures a vital part of a process evaluation in analysing how a programme is being implemented. Within this, three clear subthemes were developed, 'Generalisability', 'Cultural Responsivity', and 'Criminal Justice Environment'. This theme encompassed a complicated set of subthemes as, while all three stand independently, they also interact with each other significantly, and there are aspects woven throughout all three.

1.1. Generalisability

Generalisability describes how young people are able to generalise the skills they learn and use them in their daily life. At the forefront of this, is the young peoples' ability to relate and understand the content they are learning. It was identified that the original DBT programme, created in America, was not directly compatible with the young people held in youth justice secure residences in NZ.

> *P7: We need to tailor this group to language that the young people understand and basically be a more interactive programme.*
>
> *P3: We have high portion of Māori [in the group] so we have tried to tailor it somewhat for some Māori focus... we've also had high numbers of Pacific young people through who don't feel so connected to the bi-cultural aspect of it.*

In order to obtain generalisability, the professionals expressed the view that adaptations were required, and that this would be an ongoing process to reflect the make-up of the youth justice population in NZ.

> *P7: Some of the language can't change, just given how the processes are... but I just think we still need to find a way of communicating on their level.*
>
> *P5: Of course you've got to change it up for each young person who is different and has different understandings of things.*
>
> *P6: Make it a little bit more user friendly in the sense that it's not as wordy.*

In particular, the need for relevant examples that young people in NZ could connect with was identified, to increase their understanding of the skills being taught.

> *P8: We're trying to, not like dumb it down, but almost like make it relatable to our young people.*
>
> *P6: Hulk is your emotional mind... Captain America who's like your wise mind... Iron Man who's quite calculated... so just having three circles, mindfulness, and having the pictures there.*
>
> *P2: Making the practical examples match what we're talking about, because I think sometimes that can be too abstract too.*

Many participants explained that an important aspect of increasing relatedness for the young people was to create a space in which young people felt validated.

> *P5: If they didn't understand word for word what was going on, they get the nature and the culture that the team's trying to bring into it.*

> *P2: Providing the space that's validating and challenging enough... So that's reinforcing enough for them to come back so that they're getting some kind of mastery and that they're getting support and validation.*

> *P3: I'd say 70-80% of them take something away from the group and there's probably 10-15% of the young people we've seen that maybe took away that they felt listened to, engaged and had a good time.*

As He Waka Eke Noa is a skills group, the influence of peers on young peoples' ability to generalise was also highlighted as a significant factor. In some instances, the presence of their peers had a negative impact as the young people were influenced by their (potential) perceptions.

> *P8: It was more the influence of others. But when those people weren't there, he did really well... We found out later it's because he had to live up to that because that's his status within the unit.*

> *P2: It can be really unsettling for other young people if there's someone who's sitting at the back not wanting to participate.*

> *P11: I know that they [the girls] do feel whakama and shame when they have to do stuff in front of the boys.*

The influence of their peers also operated in a beneficial way . This is because it allowed them to learn from each other, and hold each other accountable. It also aided in socialisation.

P2: I think it's useful when there's enough young people to pair up and I like that there's something reinforcing for the young people.

P9: Being with others with similar situations and being able to talk about it with other young [people]... hear everyone else's stories or feedback strategies.

P8: At least they can go back and use these skills with each other.

P11: The girls and boys learn how to interact with each other, in a normal way, so it normalises that.

The He Waka Eke Noa group requires involvement from two key professional organisations: ADHB Taiohi Tu Taiohi Ora team and Oranga Tamariki, Korowai Manaaki Case Leaders and Care Team. The ability of these organisations to work together as well as with external organisations is integral to the effectiveness of this group as generalisation needs to occur across all the spaces the young people are present in.

P5: I think it's important so everyone's on the same page and so that the skills continue to be encouraged in different spaces.

P4: A lot of the youth workers they look up to and they're good role models and they're respected and it's great but I think we should all be on the same page. It seems like we're quite disconnected from that.

It was clear that this does not always occur. Some Korowai Manaaki staff have not had training in DBT and therefore are less able to support the young people to generalise their new skills.

P6: There needs to be a little bit more synergy between the two... Each organisation has the same goal.

P2: Skill use not being reinforced by others would be one of the bigger things.

P3: I think more intensive training for staff at the residence so that it can be generalised rather than just a stand alone group.

It was recognised that Korowai Manaaki staff had a valuable influence over the young people in the residence, however the impact of this was sometimes negative, depending on the staff members view of the He Waka Eke Noa group.

P1: If the case leaders are encouraging them to come... supporting them to do their homework I think that has a big impact...Having [Korowai Manaaki] staff support [ADHB] staff in the session is really important.

P2: When we've got staff who are participating and throwing out answers and joining in, then that has a hugely positive impact on the group, it's really great.

P11: I've heard a couple of care team people say, when they've got upset, use your DBT skills, what can you do in this situation? But if we can get more of that transfer of learning for the kids... they can see how we do it in real life, that would be really cool.

P1: Staff have a big bearing on whether that continues or gets worse or even starts. I think often floor staff ... without meaning to, encourage the antisocial behaviour towards us facilitators.

When there was synergy across the organisations, it appeared that generalisability was able to be increased.

P10: We trained the [Korowai Manaaki] staff in the DBT skills so they were all able to support the young people... The [Korowai Manaaki] staff would sit in group with the young people, so when something happened they would be able to refer back to group and remind them of the skills that they had learnt and how to use them.

P6: Another staff member coming up to me and saying they're saying this, can you tell me what this is so that I can encourage them to do more.

P11: It helped that me, as her case leader, being in that group with her, helped as well.

Professionals' did express improvements they believed could help the different organisations work together, as well as specific improvements to provide more effective support for professionals.

P1: We're going to need ADHB and Oranga Tamariki ... to commit more resources.

P3: In terms of training for the facilitators, more linking in with other people internationally who have set up similar groups within similar institutions.

P11: It would be really cool to see if we could ... get Care team more involved so that there's more transfer of learning outside of the group.

P7: I think that the supervisor for He Waka Eke Noa should be someone neutral.

P11: Maybe having more debriefs at the end of the session, just sitting down and actually talking about how group went.

An extension of this was the role that individual sessions could have on the groups' ability to generalise. Currently, some young people involved with He Waka Eke Noa will see an individual DBT counsellor as well, however this is only available if they have a specific mental health issue. The professionals discussed the benefits of having individual sessions as a way to provide a more indiviudalised treatment which would make it easier for young people to apply the skills.

P8: Most of our young people are very "I'm just going to act cool in front of the group, but really, I really get this stuff"... so in the individual sessions they're able to learn that stuff.

P2: I think when a young person's doing their homework, this is made a lot easier when they've got an individual clinician... I think it's much better able to be matched because they can talk about their homework, they can talk about how the skill relates to them in the unit or the community.

P1: I think the skills don't stick as well, they don't understand them as well and I think they don't implement them as frequently or as well if they don't have an individual clinician.

P7: Making it mandatory to have individual [sessions] – I think that would increase their ability to practice the skills.

The group is run for one hour, twice a week for four weeks. This is significantly shorter than the 'standard' DBT programme and the impact of this on generalisability was discussed as a limitation. It was acknowledged that young people who had the opportunity to do the programme twice did well.

P1: I worry that we go over it too fast and don't think we have time to reinforce homework or troubleshoot...how they've integrated it... we don't have time to go over skills over and over again.

P6: I think repetition would be key... reinforcing the same things.

P6: It needs to be practiced... People have done a lot better when they've done the group second time around.

An expanded timeslot was also identified as a potential improvement.

P2: I think having more time, like especially at the start and at the end so including like a mihi whakatau or a more robust like a whakawhanaungatanga process.

P1: Resources, like time, so longer session times, longer commit- longer and more thorough commitment sessions.

A goal of the professionals is to see the young people reintegrate into the community. The difficulty of generalising 'life' skills while incarcerated is a difficulty the group navigates.

P11: Getting the young people to come up with [examples] of their own personal life for each skill...makes them see how they use it in other areas of life.

P2: I'm not sure how much they can fully grasp that because ... we're asking them to think ahead... I don't know how much that can generalise to the unit and the community.

One professional in particular highlighted how the impact of incarceration impacted on generalisability negatively and the ongoing role that family plays could have in the programme's success.

P1: Poor generalisation to the community... That's the reason why the parents are traditionally included in adolescent DBT programme, for generalisation.

P1: I don't think it's able to be generalised even in Korowai Manaaki...I just think it's such a drop in the ocean and then moving out into the community where their parents and stuff aren't trained... I'd be very surprised if there was any long term effect.

Many professionals discussed what they would like to see in the future to increase generalisability to the community. Inclusion of family or whānau and continuation of therapy during reintegration into the community were identified.

P6: It'll be cool if the parents could come to Korowai and we can do like a parent group and teach them the same skills.

P4: I think it would be cool to roll this out all over the place, to different places.

P3: I would like to see a DBT programme that... young people could start whilst in residence and they could continue when they're out.

P2: We could eventually have something similar possibly running in the community... or like a drop-in kind of space where people could ask questions or learn some skills.

However, notwithstanding those challenges, it became apparent many young people were generalising the skills they learnt in He Waka Eke Noa. Some professionals discussed how it looked for the young people in the unit.

P10: When he first was admitted he really struggled to regulate his emotions; he'd get really angry really quickly...Now he's at a point where he's got his sensory modulation box, he's got his plan up in his room, and now I can't even remember the last time he's been involved in an incident... He's such a different young person to the one who first came to us and I think a large part of that is the programme ...Learning the skills to help him to not just regulate his emotions, but understand his triggers and being able to recognise them as well.

P2: Turned up with his homework ready to go... encouraged other young people to use skills, used skills himself... Was using language with floor staff and case leaders.

Other professionals discussed how the young people were able to use the skills in their hobbies.

> *P3: One young person who did particularly well... he was also playing in a chess*
> *tournament whereby he was able to report that some of the skills learnt in He Waka*
> *Eke Noa, he was able to use to further his game in chess.*
>
> *P1: He was able to say like this skill was really helpful and ways in which he'd*
> *integrated it... like playing basketball he was able to regulate his emotions and*
> *respond in a much more validating way towards himself and other people.*

It was also being generalised in the community.

> *P9: She's talked about having strategies on how to manage her emotions and she can*
> *identify that, like, exercise is something that is good for her and a bit of mindfulness.*

1.2. Cultural Responsivity

Subtheme two explores the current role culture plays and ideas for improvement. In NZ, the merging of Te Ao Māori – a Māori world view, and Western practice is an ongoing and highly necessary conversation.

> *P1: There's not enough of a cultural base. I think it's very difficult for us in NZ... to*
> *bring in Te Ao Māori with this western therapeutic modality... I think if we don't do that*
> *then it's gonna continue to be not as effective as it could be.*
>
> *P4: Any advancement to try Te Ao Māori is always going to be difficult in the health*
> *system.*
>
> *P5: We all get caught up in this, it's a Pākehā thing, over a this isn't how we do it, Māori*
> *and Pasifika do it, it's kind of awkward.*
>
> *P4: I find non-Māori just really reluctant in giving [up] a space that they've occupied for*
> *so long, but you know the same spaces have given the same results and that's direct*
> *impact on me and my people.*

There was a commitment however to explore ways that the group could integrate Te Ao Māori within Western practice.

> *P7: Theoretically I think they can co-exist... I don't think we can adapt them as well as others would want, to put in a cultural spin.*

> *P4: I think just develop their understanding of more... what is DBT and what is our goal and then kind of delivering it in a way that is more culturally appropriate without straying away from the core values.*

One participant used a story to explain how an intervention that may work in one culture cannot be directly applied to another. It does not mean to say that they cannot help at all, but highlights the need to look at things differently and adapt.

> *P5: There's the monkey in the tree... monkey sees that there's a flood, and the water starts rising, he sees this fish is swimming and it's going against the current and all the monkey can see is the fish struggling, and he's like oh no, we need to help the fish, and so he picks the fish up out of the water and he puts it on the tree safe where he is. So the monkey meant well but sometimes it isn't the best option. But if someone asks the monkey why did you do that, you killed the fish and like "no I tried to save the fish". ... It's about whether or not it has to be done this way or that way and not getting offended if it wasn't the right way.*

In NZ, there is a need to move beyond cultural acknowledgement and into actual content integration. Cultural acknowledgement can be understood as the use of karakia or other Māori protocols during an intervention, however content integration refers to creating an intervention that is rooted Te Ao Māori.

P4: Cause there's a difference between working in a culturally safe space and there's a difference between acknowledgment of Māori and treating in a holistic way with Māori, and we need to move beyond acknowledging and kind of let Māori lead some of intervention and lead some of these processess.

P5: How do we make that fit into Te Ao Māori and if it was mindfulness stuff, how do you put that in taiaha, how do you put that through jumping in the water, so you get a sense of your awa, and you go up the maunga? ... So how does that link into DBT so that we're on the same page with our clinicians?

P5: Yeah, different world views come out with different examples of how the skills might support you... If anything, being relatable.

It was noted that the group did use kaupapa Māori protocols well, however more was required for integration.

P10: In terms of running the group they try to incorporate karakia and waiatas and stuff like that, but I think content wise, in terms of... including more cultural aspects within the group, that could be something that's worked on.

P4: I'd really like to be confident sharing this model with our people and I'd really like to see this model of DBT skills being taught in a way that is culturally responsive to our people, not just through words but through the different tools and practices we do from a kaupapa Māori approach.

One participant discussed the usefulness of resource sharing within this space.

P5: If we're doing this in Aotearoa, if there was actually a network for Māori who are kinda styling it up for DBT to make it work for their group because we're working with the same population.

One area which needs active improvement is increasing the diversity of staff to support the group. This is because a diverse staffing group would be better able to provide an increased level of understanding for the young people.

> *P1: Having more diverse ethnicity; ethnic make up of clinicians I think is gonna be helpful.*

> *P2: Think having other clinicans ... who are Māori or Tongan or Samoan, to be able to come up with examples and make the content relevant from that cultural perspective will be useful... I think having someone like that supporting the group as well and making sure ...we've got how to be adherent to DBT but I think, how to be culturally responsive and sensitive to the young people's needs.*

> *P3: Ideally we'd have a Māori and Pacific DBT supervisor so that they're able to comment on both aspects and how they integrate.*

> *P5: I think it was a cultural thing in terms of this young person was a Samoan young boy and he did really well when there was another Samoan caseworker that was there.*

> *P1: There's other people in the team I think have much less clinical experience but have a lot more knowledge of Te Ao Māori or have grown up in Pasifika families and so... trying to bridge our own personal gaps is difficult, let alone integrating those two things so they're seamlessly woven into treatment is very difficult.*

> *P8: Communicating with people that have the expertise in that field... Letting people with cultural knowledge lead.*

The importance of Cultural Responsivity was emphasised by the way the majority of participants identified it and noted more development was required as well as an openness to

it. A final aspect that was highlighted was the need to recognise there are many different cultures in NZ such that it is not only limited to NZ Māori and NZ Pākeha. In addition, it was noted that individuals from different cultural backgrounds will connect at different levels and it is important for interventions to take this into account.

> *P6: There's a fine line between really trying to be culturally appropriate to actually being... so much so that you're actually having a negative impact on them... There's a lot of urban Māori and they love being Māori but they might not be connected to the te reo and the tikanga of it as much... sometimes it can be quite shameful for them because they feel like, they indirectly are being judged if they don't know this... I think it just needs to be assessed on a case by case basis.*

> *P8: They do identify [with a cultural group] but they don't associate their life with it... For example, I know there's Tongan young offenders in there...They're quite disconnected [from] their culture... It's good to deliver but if we can kinda add in a bit of connection and things like that, we can ...make more of an impact.*

1.3. Criminal Justice Environment

Subtheme three evaluates the impact a prison-like environment can have on a therapeutic programme across a range of domains. At the forefront of this is the young people themselves, in relation to the circumstances they are in, their offending behaviour, and the prevalence of lower cognitive abilities in a youth justice population. The criminal justice environment was noted to present particular challenges for the programme.

> *P8: We had multiple people with sexualised behaviour, or inappropriate comments, and that made the people that were facilitating the group, really vulnerable... I think that could've all been filtered out in the beginning if they were to look at the risk properly.*

P2: Often there's a few underlying antisocial attitudes that are kind of always there...They're always pushing a little bit.

P2: Mainly we've used behavioural markers, so any kind of violence or aggression or emotion dysregulation and if people are getting into fights, if young people are self-harming... We've also got an exclusion criteria, so if intellectual disability, although we've had a few on the cusp... We've just had to work a lot harder with them in tailoring the content, but active psychosis, things like that.

P7: I think we need to do a bit more vetting around, ID's [intellectual disabilities] and exclusions... It also changes the way everyone needs to work with them because it needs to be adapted.

The fact that all of the young people involved in a group are there as a result of the criminal justice system, impacts everything from their motivation levels, their ability to generalise and the way they present in the group on the day.

P11: Some kids do it so that they can tell the judge they did it.

P3: It can be participated in at any time of their stay so they might be on remand and then they might get a sentence and so reintegration into the community is therefore a long way off for them. Some of them are going on to prison after.

P7: It's what's happened at the residence prior to us being there and how they're feeling because if you had to go to court the day before and you were expecting to be released and you're still back there I can understand you'd be pissed off.

P4: We do have kids come in straight from secure... A lot of the kids are quite guarded and may be interested but because it's in a prison and there's a certain kind of culture and a youth prison as well, a lot of those dynamics come into play.

P3: Gang affiliations. Any recent incidences in the unit ... Lots of things influence it.

A highly significant impact of the Korowai Manaaki environment, being a criminal justice environment, is that these young people live and operate in a space with an intense focus on risk management. The difficulty of balancing the safety of the young people and the staff on the one hand, with providing a therapeutic environment in which these young people can develop their skills on the other, is immense.

> *P11: We come in at two different spaces, we at Korowai have to be containment, risk and control focussed... just to make sure everyone's safe... I know we do our best to make sure that we are on time but sometimes that isn't always possible.*
>
> *P6:. They were 10 minutes late, and we had facilitators complaining about that... and I'm like we can't restrain ... We can't do any of that kind of stuff... they have a responsibility to protect us, protect the kids and protect themselves.*
>
> *P11: Probably about six-eight young people [per group], just in terms of managing the risk and everything else on site and... our ability to make sure that everyone's safe and we make sure that we're not putting anyone at risk, including the facilitators.*
>
> *P6: A room perhaps that's more sensory orientated... where they've got ... a nice chair, some sensory stuff so that people, so when they're doing things, talking and stuff they can still have a chat with you. In saying that I can totally see why they don't have that, because if someone's angry and they're destroying everything... it's not gonna be very good.*
>
> *P1: They [Korowai Manaaki staff] can't tolerate that little bit of anger, they completely try and distract it ... And that's not, I don't think conducive to any long term change. Same with their risk management as well. They won't tolerate any level of risk... Obviously which makes sense ... But the young person has to start- under DBT framework, they have to start to tolerate that anger.*

P3: There's barriers to young people being able to access their rewards. Unable to be able to access things that they might need to be able to do the skills in their way at the time of distress.

P8: They're not allowed like pens and stuff... And they can't do their homework so they can't get a homework prize so they can't get validated.

It is clear the participants understand the difficulty of balancing this, but the direct counteraction to a therapeutic environment that the incarceration facility brings, means that the effectiveness and ability to generalise is at risk.

P5: Oh, horrible. It's in a prison ... I am pushing like so much to get them out and do something outside but I know that's a whole other ball game... they don't do it in Korowai.

P10: For example ... the sensory modulation boxes, we're not always able to provide them for every young person because ... operational risks sometimes supersede clincial needs; ... at residence, there's a real focus on operational risk; even to the point some people are not allowed... pens or pencils... so it's really hard in those cases to suppport them when you're not giving them any of the tools that they may require.

P11: One of the challenges for the DBT group is that it is pretty much the only therapeutic programme that we have on site so getting the Care team on board, and kind of changing their thinking ... towards more therapeutic ways of working with young people as opposed to... containing control kind of thinking.

P6: They are in a really controlled secure environment and as much as we wanna be able to generalise, so we try and give them scenarios but it's really hard as well because half the time we do not know where they're going.

The criminal justice environment also has an impact on family engagement. As has been highlighted previously, the standard DBT programme with adolescents involves a family component. He Waka Eke Noa does not incorporate family at this stage. This is due to a lack of contact with the families and the difficulty for families to participate or be involved from a logistical perspective.

> *P2: I think care and protection status, whether their families are in the country, whether the young person wants us to have contact with them, whether we asked about it, time, energy and effort which isn't ... good enough but probably plays into it for lots of us.*
>
> *P1: Some of the kids are from out of Auckland... Not to mention that they'll be very difficult to engage... often the kids aren't visited by their partents, while they're in Korowai anyway.*
>
> *P6: We don't have much contact with families at all. And most of the times we don't even know sometimes, or we find out the day before where they've been.*

In addition, some participants found that families could be difficult to engage with.

> *P4: I think the population group is quite difficult engaging with whānau in general, but I don't think that's a good excuse.*
>
> *P7: If we were to involve family we need to do that face to face...there's no way we could properly explain things on the phone to a family member... will the families be willing to participate because I would argue that some of these young people are in the circumstances they're in, because they don't have family support.*

2. Theoretical Application of DBT to Young People in NZ Youth Justice Residences

The second theme explores the use of DBT more specifically in relation to how the theoretical application of it suits young people in a youth justice secure residence in NZ. There are three subthemes comprised within this. The first is 'DBT targeted needs that match this specific population', the second is 'DBT skills that match this specific population' and the third subtheme is 'Limitations of DBT'.

2.1. DBT targeted needs that match this specific population

The first subtheme highlights which needs DBT theoretically has been found to manage effectively and whether they match the needs of young people in a youth justice secure residence in NZ. Participants, not surprisingly, identified emotion regulation as a presenting need in the majority of young people at Korowai Manaaki. Professionals expressed how important the *development* of emotion regulation was as a base from which young people could start to develop other skills.

> *P1: I'd say that the group is set out for a large portion of the young people in Korowai. It's for young people that have difficulties with emotion regulation so I'd say that's the vast majority ... Usually it's quite obvious in their offending. Or their behaviour at Korowai.*
>
> *P7: It's more about how to help them with their emotion regulation in the sense of the anger, not in the self-harming perspective.*
>
> *P6: The most important thing is being able to regulate their emotions... after that it's being able to communicate that in a productive way... that's where they struggle and that's where fights happen... a lot of the times they don't even know why they're feeling the way they're feeling.*

Professionals expressed how important it was for young people to not only develop emotion regulation skills but to also learn how to *identify* their emotions.

> *P7: They need to obviously learn different emotions and what different emotions are because sometimes what I find is that they just label everything as angry or sad when there's actually more to it... then after being able to understand that, we can start to dissect those emotions and basically learn about different ways of approaching certain emotions.*

> *P2: Young people in Korowai have a really hard time recognising emotions within themselves or in others until they [the emotions] are so, so strong... they feel that [they] have to act on the emotion... One of the first things is around being able to recognise emotions and then tolerate emotions and then also being able to regulate them... There's possibly a culture within their family or within Korowai where emotional expression has been punished.*

Professionals' also highlighted other needs the young people presented with that DBT was able to target, such as interpersonal effectiveness, distess tolerance and self-awareness.

> *P1: With those things that they all wanna achieve, we can link those with each of the skills that we teach... For example, yeah I wanna have a better relationship with my mum, we actually teach a whole group on skills ...around managing relationships... it's just a way of making the group relevant to them.*

> *P2: We talk about validation and not just towards each other... I think them being able to have a better understanding of who they are and how being able to do things that are important and meaningful can impact your emotional ... resiliency and ability to reduce vulnerabilities to, or susceptibility to big emotions that feel like they take over.*

P6: A lot of the times it's [to] do with having a better relationship with family or being able to tolerate their anger so that if something happens... they can actually regulate themselves and get on with it.

P8: It's actually being aware... for the young people to be aware of the impact of their behaviour and the influences they have surrounding them... If they are aware of it they're more receptive to ... getting support.

The theoretical relationship between DBT and criminal behaviour is not extensive, however, professionals did express some potential benefits of DBT in targeting criminogenic needs.

P1: I do think that DBT is very good at addressing issues that are likely to shift some of the criminogenic risk factors.

P2: Any kind of violence or aggression or emotion dysregulation and if people are getting into fights, if young people are self-harming, ... if they're having difficulties in their interpersonal relationships... often [that's] what's led to young people ending up in Korowai.

P6: Their offending's related to their emotions and their avoidance of it... so we're hoping that by getting them to deal with their emotions and be[ing] able to tolerate it better, that [will] impact on their rates of offending, or reoffending.

P3: It depends on what their offending was and the underlying factors in terms of causation of offending. For the ones that might have assault charges, and that came from a place of high emotion, then I'd say yes, we do. For someone that has a pre-meditated, really well planned offence, no.

Ultimately, professionals expressed a positive view on the usefulness of DBT in meeting the needs of young people in a youth justice secure residence in NZ.

P10: It's amazing in supporting young people to give them skills to help regulate their emotions better. I think there's a definite need especially at residence …I would love every young person to go through the programme.

P11: The content is good and they're important skills that the young people do need to learn.

P4: What we're doing is adding value to them, adding value to their knowledge base, how to manage their emotions.

P2: We had so many thoughts around "Is this the right thing, is this what we should be doing, is this what this population of young people needs?" and it is the best that I feel that we've got right now in terms of how others can help, it's got a really robust evidence base, not for our young people, but it's got lots of the challenges that our young people, the young people present with, [that] match the skills that we can be teaching.

P5: If anything I wish it was a bit more broader rather than people who fit in this particular category because I think all the skills learned in there should be for everyone.

2.2. DBT skills that match this specific population

Each of the four modules in DBT contain a range of skills which facilitators teach to help young people develop the skills to target the needs discussed above. One of the strengths is offering a variety of different skills to support each need which provides young people with choice to decide what works for them.

P11: The content and the skills that the young people learn is a really big strength.

P4: I think the kids like engaging in different activities that relate to certain topics that we teach.

P2: Matching their goals and their difficulties with the skills and what we can provide... We cover a broad range of skills, there's something in there that... makes it meaningful.

P10: The practical aspects of teaching how to identify their emotions, their triggers... I think the practical skills of how to deal with things, they give them a lot of different tools... So whether it's the breathing techniques, whether it's using the TIPP[1] skills so they're changing temperature ... They give them a lot of skills to find things that work for them.

Overall, the professionals identified a range of skills across all four modules as holding some value for this population.

P8: To be honest I feel like all the skills are needed. Like they're all useful.

P2: If there's confusion around self and identity then there's skills like mindfulness...if there's interpersonal conflict then we've got a skill that can match with that... If they're becoming really distressed a lot of the time ...or they're finding they're really impulsive.

P2: States of mind is really useful ... lots of young people say that they were better able to make a decision ... TIPP... I think that one's really useful... They struggle to understand mindfulness but... we get instant feedback from the young people that they feel calmer and that they feel more grounded and centred... They get a lot out of the GIVE[2] skill, the interpersonal effectiveness skill and that also feels meaningful for them because often they love talking about relationships.

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[1] A skill from the Mindfulness Module: Temperature, Intense exercise, Paced breathing, Progressive muscle relaxation.

[2] A skill from the Interpersonal Effectiveness Module: be Gentle, act Interested, Validate, use an Easy manner.

P6: The other really important thing is one we teach as GIVE skills... I think the distress tolerance ones are really really good because we've given them physical skills to deal with this stuff.

In particular, the skills which were part of the Mindfulness module were identified as being most useful for young people.

P10: The mindfulness practice, that's really cool for them because things like the body scan and getting them to be present in the moment, recognising what happens to their bodies when they start to escalate, and recognising their elevated heartbeat… Also identifying their triggers and emotions that come with it…Still being able to stay in control even when their emotions are heightened.

P4: Mindfulness is an important skill; I think it's important for them to separate emotions.

P8: Skills used in the programme that are most useful … mindfulness …They have the option to choose that they can either accept it or not actually gives them power … It's giving them those choices.

P6: The radical acceptance one is really good because it is, it is you are here in the now… How can you make the most of that?

Although one participant did highlight how the abstract nature of Mindfulness can lower its effectiveness.

P3: Actually, mindfulness is really useful but they're least able to use it if that makes sense… it turns out to be least useful for them because they're not able to access it.

One participant commented on how the skills can align with Māori values which increases the appropriateness of DBT with this population.

> P4: Some of the skills align quite closely. A lot of the states of mind and the meditation stuff is really, and just being in the moment, speaks to some core Māori values, karakia connecting to the environment, wairua of the space.

2.3. Limitations of DBT

The final subtheme of theoretical effectiveness explores the limitations of DBT for this population. The full DBT programme is extensive and requires resources which are currently beyond the capabilities of a youth justice programme in NZ. One of the key limitations therefore, is that in order to be delivered to this population, the DBT programme has been significantly adapted.

> P6: I think the skills that we're teaching, which is DBT informed, meets the skills of these young people... the whole DBT I don't know if they'll be able to do the full 12 week course. We'd need the buy in from the parents... again needs to be tailored in a different way.
>
> P3: Theoretically the DBT programme which we were taught, no. I think it's too hard. But the concepts and our adapted versions, yes.
>
> P2: It doesn't really necessarily completely match up because there's nothing like this that really exists at the moment... Trying to make it match a population where there's very little research to be guided by, there's been lots of little things that have cropped up and yeah that has made it harder.
>
> P1: They're skills taken from DBT... the language is adapted to NZ and this population... we initially started by just using the handouts from the adolescent DBT manual but they're just so difficult for the kids to understand.

As has been previously identified, cultural responsivity is an important influence on the effectiveness of DBT in NZ. The lack of cultural factors in standard DBT has meant that significant adaptations have been, and will continue to be made in order to better support young people in the NZ context. Culture is not a part of standard DBT but the current programme is making efforts to integrate it.

> *P7: Theoretically I think they can co-exist... Some of the concepts, from a theoretical point of view, I don't think we can adapt them as well as others would want, to put in a cultural spin.*
>
> *P4: I think it's not necessarily part of the programme, but I think to help a young person's psychological needs and development there's a level of connection to whānau, hapu, iwi that needs to happen and understanding wairuatanga which all kind of plays a part.*
>
> *P8: I don't think it was a factor that was factored in when DBT was brought in. But ... we're trying to adapt it into our cultural norms.*

In addition, professionals highlighted that DBT cannot meet all the needs of these young people. It was recognised that DBT was a useful intervention but was just one form of intervention. Ideally, it would be part of a broader therapeutic package available to young people.

> *P7: In its pure form? No, not on its own. I think there needs to be a component that looks at their other criminogenic needs of these young people.*
>
> *P1: I think we're good at pulling out the kids that have intellectual disabilities and that aren't suitable in that sense because... the group is not going to be appropriate...*

I'd say the other kids that possibly don't benefit... the ones that aren't emotionally

dysregulated, they're very calculated. They're using instrumental violence.

P8: We're giving them skills for one part of their life... In terms of emotional and

psychological needs we're fulfilling that part of the young person but if we're to look

at it holistically we're just doing one part... we're not capturing all the young people.

3. Motivation

The final theme explores the motivation surrounding the group and why it operates. It also has three subthemes which are 'Young people's motivation', 'Professional's motivation', and 'Motivation about the environment'.

3.1. Young People's Motivation

The first subtheme demonstrates the professionals' perceptions of young people's motivations for attending the group. Motivation is an important factor from the outset which facilitators look to identify prior to a young person joining.

P2: We look for what is their motivation to be doing this, is there something in it for

them that will get them through the 4 weeks.

P3: Their ability to identify goals and why the group might be helpful.

P6: I find that respect is really really important to them ... respect and loyalty.

One of the key ways that professionals are able to establish whether young people are motivated is by how they present when they come to group. They stated the majoirty of young people show a willingness to be there.

P6: I think the majority of them come wanting to learn actually.

P1: Some are really keen to learn, and some are willing to be a bit vulnerable. Some, not as many, but some continue to be present as continually antisocial in the group and disrupt the group and are less willing to try skills.

P2: Overall most of the young people there have always come with a lot of willingess to at least try.

An important aspect of motivation in this context is ongoing motivation. This is a group that runs twice a week for four weeks which is a long time for these young people to commit to. Professionals highlighted how their teaching style, and utilising the young people's intrinsic motivation and enjoyment, was key to this.

P1: I think we validate and reinforce the kids really well. And I think that keeps them coming back.

P8: It's almost building a memorandum of understanding in order to be effective... If they're telling us things like... 'we want to learn how to stop being angry', then cool we can look at trigger points and things like that. But if we don't spend enough time on that then, you know, they're never going to learn what they want to learn.

P7: A lot of them are saying 'I want things to change when I get out of here, I want the skills to learn, I don't want to resort to using violence'. Like their internal drive from the young people.

P2: His own internal like, like intrinsic motivation.

P11: Most of the girls actually genuinely enjoy going, are quite motivated to do the homework... I think the group's enjoyable; I think they enjoy doing it. I think they have fun.

P3: The contingency management and expectation of young people. I think young people really rise to the challenge of completing it and graduating.

The group does also provide physical incentives. These are through meeting one on one with the young people prior to starting group, providing food during the sessions, and giving out a homework prize to individuals who have completed their work.

> *P10: They have one on one sessions with them to get a commitment... so, I think that also keeps them motivated and because it's ... voluntary so the young people want to be there.*

> *P10: I think the third thing is using incentives and getting the buy in from the young people, so from the commitment interviews, to get the young people to agree to the continuous, giving homework prizes and food during group… keeps the young people interested and coming back as well.*

> *P2: Motivation, I think it's funny how like a small homework prize can get all of the young people motivated to be doing their homework.*

The professionals' identified things that can be disengaging for young people as well. Sometimes, the young person's motivation may be external such as boredom or to impress the criminal justice system. In addition, sometimes the group may be run at a time when there is something more enjoyable on.

> *P5: I think it's always a conflict between, 'oh here we go, another programme, or yay, this is something I can do instead of doing nothing'.*

> *P11: For some of them they just want it for court so they can get out.*

> *P11: And if they've got other programmes running at the same time that they really want to do, that's [the groups] going to come second.*

At times, the group itself may be disengaging if it is not providing the young person with the safe space they needed to benefit from it.

> *P10: I know we had a couple where it was very very difficult for this young person to make themselves vulnerable or to share in front of the group.*

> *P11: I've only really had one that didn't want to do it and that's because she was the only girl in the group and she really struggled big time.*

3.2. Professional's motivation

This subtheme explores why the professionals support and facilitate the group. The professionals perceived strength in how the team was very committed to the group and to developing it as best they were able.

> *P4: Our team is very resilient and very passionate about the young people that they work with, and clinically our team is very sound.*

> *P7: I think the strengths are the clinician's willingness to keep doing it.*

> *P6: I absolutely love it. It's frustrating at times when you try and teach someone and then you have to remind yourself that they're teenagers at the end of the day.*

> *P4: If you're in a position like mine you're always just motivated by my people.*

In addition, the ability to connect with the young people in the group appeared to have a significant impact on facilitator's motivation.

> *P2: We reach a lot of young people. That we're providing a group and an opportunity for young people who wouldn't normally get this opportunity. Really willing clinicians… To keep it going, who are passionate about working with young people and hoping for really positive outcomes.*

P6: I really enjoy teaching them, I enjoy spending time with them… I see the little difference it makes in them and for me those are the big moments … The strength is at the end of the four weeks seeing the kids standing up there and receiving their certificates and seeing their proud feeling… It's a strength because that motivates me to keep doing it even when you have those shitty days.

P2: When they turn up with their homework all completed, when there was expectations of them that they wouldn't even turn up, or when they say that they've made a wise decision or use the language … That's what keeps us, or keeps me going.

One participant spoke about how they have seen positive outcomes which was a source of motivation for them.

P2: It's been a few years of lots of work and loads of amazing things have come out of it which has been super meaningful for us to keep it going.

P2: If on one occasion a young person doesn't engage in violence or they don't hurt themselves following a really stressful event or when they're really distressed then I feel like we've done our job in that moment for that young person… Despite all of the challenges that we've come up against there's something that's been reinforcing enough.

3.3. Motivation about the space they want to create

The final subtheme of motivation looks at the relationships and environment the group aims to create for the young people. Creating a positive relationship between the facilitator and young person was identified as an important target for professionals.

P8: When we're doing commitment with the young people... I'd say it gets us, that relationship happening.

P1: I think they're also a by-product of that prolonged commitment, is them feeling ... more trusting of you maybe and more attached to you or also more accountable to you.

P5: I think our relationship with them as facilitators and keeping that space like, safe ... Like if we don't have a group that is safe ... then it just gets a bit harder and we're doing less of developing them and more just trying to keep them on track or on task which I don't think is necessarily the best way to support these kids.

P5: We're in a space right now where we are in the developing stages of making things more relatable so overall a strength that the team have of learning how to be open to make them culturally appropriate or youth focused.

By creating a strong relationship between facilitator and young person, the professionals are better able to create a space in which young people can understand the culture and safety of the group so they can begin to develop their skills.

P5: When you bring a particular behaviour into the space, and are genuine about it, of course the young people will feed off that... Positive relationships and creating that safe space is incredibly important.

P5: If they didn't understand word for word what was going on, they get the nature and the culture that the team's trying bring into it.

P8: Validation and communication and allowing them the space, so in Pacific terms they call it vā. And giving them the relationship, the space to develop, to form.

The Results has explored the three main themes with additional subthemes using quotes to show how these themes were developed. The following chapter will develop this further by analysing the findings in relation to previous research and practical implications.

<center>**Chapter Four: Discussion**</center>

The findings of this research enhance our understanding of the application of DBT skills with young people in NZ who are in a youth justice secure residence. Young people are placed in a secure residence either because they have been charged with an offence and are on remand or they have been found responsible for an offence and received a custodial order. Access to the DBT skills group does not differentiate between the two groups. The research explored the context, characteristics, and operation of the programme; how well young people understood the key modules of the programme; how key stakeholders viewed the programme and whether they believed the programme met the needs of the young people; and identified possible areas for improvement. Interviews were conducted with 11 professionals across five job roles in connection with He Waka Eke Noa. Thematic analysis produced three overarching themes: 1) Factors influencing practical effectiveness, 2) Theoretical application of DBT to young people in NZ youth justice residences, and 3) Motivation. This section will discuss each theme in relation to previous research and the initial research questions and consider the clinical relevance of the findings. It will then provide a reflection on the policy issues identified and discuss the strengths, limitations, and future direction for He Waka Eke Noa and for research.

Major Findings

The findings from this study are primarily consistent with previous literature. The first theme 'Factors influencing practical effectiveness' identified three major factors: Generalisability, Cultural Responsivity and Criminal Justice Environment; which impacted the effectiveness of this therapeutic group. The findings from this theme will be discussed separately as each sub theme was highly important. The second theme is 'Theoretical application of DBT to young people in NZ youth justice residences. This theme analysed how

the theory and international evidence for DBT, which was previously discussed, matched the needs and skillset of the NZ youth justice population. The final theme, 'Motivation', explored why the group was engaging for young people and professionals; and what they wanted to achieve.

Factors influencing practical effectiveness

The first theme of *Factors influencing practical effectiveness*, encompassed three major subthemes, *Generalisability, Cultural Responsivity,* and *Criminal Justice Environment,* which resulted in a number of important findings. The following section will explore specific findings from each subtheme in turn.

Generalisability

The ability for young people to generalise the skills taught in He Waka Eke Noa is clearly a vital aspect in DBT having a positive long-term effect. Generalisability occurs when young people can learn the skills, apply them to their own life and experiences, and practice the skills until they develop into regular behaviours. The findings regarding Generalisability are integral to understanding the long term potential effectiveness of DBT. The first key finding is the importance of implementing adaptations to increase the level of understanding and relatedness for young people in the NZ youth justice secure residence setting.

As the results highlighted, the DBT programme had to be adapted to enable young people to simply understand the concepts. This is consistent with previous literature that noted adolescent DBT needed to be more interactive and engaging (Rathus & Miller, 2014). He Waka Eke Noa did this through adapting the content and teaching style, acknowledging however that it is an ongoing process to 'get it right' for the NZ youth justice population. Creating a DBT programme that works in the NZ cultural context will be discussed further in Cultural Responsivity.

The time available to be dedicated to the group also impacts the young peoples'
ability to learn the skills. He Waka Eke Noa is significantly shorter than a typical DBT
programme due to it being adapted so it could run in a criminal justice environment where
young people are incarcerated for shorter periods of time and where it has to compete with
other programmes and the school programme. This means young people only have two one
hour sessions per week for four weeks to learn these skills. Professionals noted young people
benefitted from repeating the group which is consistent with previous literature which has
found repeated 'rounds' of DBT increases generalisability of skills (Linehan, 2014).

The third key finding in the Generalisability subtheme is the need to make the skills
personal through connecting them to the young person's own life. Being able to apply the
skills to the young people's own life and experiences appeared to be a crucial link that was
not developed as well as it could be. This ability was impacted by the nature of the criminal
justice environment, resource and practical issues; and the absence of continued treatment
when transitioning from the residence to the community. Many professionals noted they felt
individual sessions would be useful to allow one on one time however more resources would
be required for clinicians to be able to facilitate this. The need for individual therapy to
support generalisability is well recognised (Gill, Warburton, Simes & Sweller, 2017). In
addition, links to cultural responsivity and the benefits of diversity of staff to help young
people apply the skills to their own life was acknowledged. Professionals spoke of the benefit
of having staff members from a similar cultural background as the young people. One
participant, for example, spoke of a Samoan caseworker who worked with a Samoan young
person, and how the staff member helped the young person think of ways the skills could
apply to their own life, based upon shared experiences of their Samoan background.

The final key finding of Generalisability is how important it is to provide young
people with the environment and support to practice the skills. The group environment was

identified as both enhancing and hindering this process. When peers are supportive it allows individuals more time to practice with each other and learn from each other, which is a huge benefit of group learning (Gill et al., 2017). However, the importance of managing group dynamics and individual's personal motivation is a crucial factor to ensure the presence of others does not hinder an individual's ability to learn and practice. Aspects such as gender balance need to be noted here, as one participant spoke of a young woman who did not feel comfortable participating in the group as she was the only female. Practicing the skills can only occur if people around the young person are both familiar with, and supportive of, the skills being taught; and therefore, create a space in which every young person feels comfortable. The role of professionals in using their influence to either support, or not support, the group was discussed. Previous literature has explored how professionals running a therapeutic programme in a criminal justice environment need to work together to help young people generalise the skills. This includes referrals to the group coming from the staff who work with them every day (Banks & Gibbons, 2016); and all staff who interact with the young people having DBT training (Andrew et al., 2014; Banks & Gibbons, 2016). This allows all staff to communicate with the young people in a way that is conducive to, and consistent with, their learning and supports them in practicing their DBT skills. Significant resources are required to provide all professionals with this training and support. For these same reasons, although family involvement was discussed under the Criminal Justice Environment theme, it does naturally impact the ability for young people to generalise. The absence of familial involvement was identified and highlighted as a potential area for improvement. It is viewed as an important part of DBT-A internationally (Stathis & Martin, 2004). The challenge of engaging the families of young people has been found in other jurisdictions in youth justice secure residences (Hunnicutt Hollenbaugh & Lenz, 2017).

Cultural Responsivity

Cultural responsivity is a wide-reaching theme that crossed several domains. NZ is officially a bi-cultural nation (although anecdotally considered multi-cultural; Sibley & Liu, 2007). However, our psychological treatments are heavily rooted in Western research and practice. It raises an important question about how we can utilise the benefits of previously developed and evidence-based Western practices, while catering to the individual needs of our young people. Cultural responsivity overlaps significantly with generalisability as it facilitates a space in which young people's learning opportunities will be maximised. The first key finding under this subtheme is the need to move from cultural acknowledgement through the use of Māori words and protocols to content integration, which requires an in depth understanding of Māori and Pasifika culture. The introduction of Māori stories and Pasifika legends can increase engagement, as well as the use of whaikōrero or metaphor, which will allow clinicians' teaching methods to be better rooted in a culturally responsive manner (Bennet, Flett & Babbage, 2016; Lee, 2005). Professionals also discussed more specifically incorporating an individual's connection to the physical environment into the skills modules, for example, their connection to wairua, te maunga, te awa or marae. It is beyond the scope of this thesis and of myself as an individual Pākehā researcher to develop this further, however these findings do suggest that incorporating increased cultural components could have immense impact on the capacity of NZ young people to relate to DBT in the youth justice environment. It has been discussed how the DBT programme required adaptations due to the age of the participants, with one facilitator likening the 'wise mind' skill to the Avengers characters to increase relatability. Making such adaptations is supported in the previous literature (MacPherson et al., 2013; Miller, Rathus & Linehan, 2006). It can be reasoned, using the same rationale, that as adaptations to accommodate age are useful, adaptations should also be made to accommodate diverse cultural groups.

The second key finding in the Cultural Responsivity theme highlighted the value of connecting with others in the field with relevant expertise. This would aid in developing a culturally appropriate model of DBT which could be shared across the country. A previous study found professionals in NZ wanted to know how to make DBT "a better fit within the Aotearoa/New Zealand context and biculturalism" (Gawith & Batchelor, 2005, p. 17), indicating that the issues He Waka Eke Noa are facing are not unique. In addition, professionals noted how He Waka Eke Noa could build on this by diversifying their own clinicians to strengthen the cultural knowledge within He Waka Eke Noa, while assisting those clinicians to upskill in DBT. Once again, increased resources would be required to achieve this.

The final finding from the Cultural Responsivity subtheme was the need to acknowledge that being culturally responsive does not mean providing a blanket approach to all. Professionals working with Māori and Pasifika need to be provided with the skills and support so they can work with young people across different cultures and different levels of connection within their culture. There are diverse Māori and Pasifika realities, and it was noted that some Māori and Pasifika young people did not strongly identify with those cultures or had experienced a disconnect with their culture at some point. Further, NZ is becoming an increasingly multicultural population, for example, it has a rising Asian and Muslim representation, so it is important that cultural responsiveness does not act as a replacement for individualised treatment or is used as a 'checklist' for treatment (Bennet et al., 2016). The programme needs to be flexible enough to be responsive to individuals varying cultural needs.

Criminal Justice Environment

The impacts of the criminal justice environment on practical effectiveness are far reaching. The first key finding in this subtheme indicates professionals need to take into

account offending behaviours and cognitive difficulties which are representative of the youth justice population (MacPherson et al., 2013). These features can significantly impact the way DBT can be taught or the effectiveness of it, and that stricter boundary setting, or exclusion criteria may be required. A particularly interesting finding was the impact the criminal justice environment had directly on the young people's motivation, as at times, participation was motivated by external factors such as to 'tick boxes' at upcoming court hearings or simply to have something to do as they have limited freedom in the residence. It can be difficult to manage this type of motivation. The literature indicates therapy can be effective in criminal justice environments even if the motivation is external, provided the treatment is appropriate to the need level of the individual (Hogan, Barton-Bellessa & Lambert, 2015). Although He Waka Eke Noa is voluntary, there is an argument that, regardless of their motivations to join the group, as long as facilitators can find something for the young person to connect with, treatment could be beneficial.

The third key finding in the Criminal Justice Environment subtheme was how young people were experiencing immense pressures, unique to a criminal justice environment, such as disappointment around not being released, coming out of 'secure' (which is a separate space to 'calm down'), and having their guard up due to being in a prison-like environment and believing they have to act in a manner that is consistent with their perceived 'image' in that environment. These factors can influence how much someone may share in group or whether they will even attend. These factors would affect individuals differently and facilitators would need to be aware and accommodating of the variability this would cause between and within individuals. The impact of these factors is acknowledged across other literature (Tuakoi, 2010).

Finally, the finding of conflict between a risk-reduction environment as opposed to a therapeutic environment is also well supported in the literature (Banks & Gibbons, 2016;

Tomlinson, 2018; Tuakoi, 2010). Professionals in this study explained how at times young people are not given the resources to practice DBT due to Korowai Manaaki staff approaching the situation from a risk containment frame of mind i.e., a young person not being given a pen to do their homework due to safety reasons. This is understandable but is nonetheless, a significant barrier to the effectiveness of DBT in practice. The balance between risk-reduction and therapeutic is very important for organisations to manage and ensure that practice is in-keeping with the strategic goals of the organisation.

Theoretical application of DBT to young people in NZ Youth Justice Residence

An important part of this thesis was to ascertain whether DBT met the needs of young people in youth justice residences in NZ. The first key finding under this theme indicates DBT targets some of the needs of young people at Korowai Manaaki. There was great emphasis placed on the usefulness of emotion regulation to help young people process their emotions and change their responses. The benefits of targeting emotion regulation for young people is well supported in the literature (McCay et al., 2017; Tomlinson, 2018). Professionals identified all of the skills modules as having relevance for this population as young people presented with a range of behavioural difficulties such as an inability to understand and tolerate emotions, which corresponded with the Emotion Regulation and Distress Tolerance modules. Their motivations for change seemed related to the people around them which indicated the usefulness of the Interpersonal Effectiveness module. In particular, the Mindfulness module and skills relating to it appeared to be useful for immediate changes in behaviour for young people in He Waka Eke Noa. There is growing evidence for the use of specific skills modules leading to positive improvements in an individual's functioning even in isolation i.e., using the Mindfulness skill on its own (Tomlinson, 2018). Mindfulness has been cited in other literature as being particularly useful for young people (Banks & Gibbons, 2016; Trupin et al., 2002). An additional benefit of

DBT for this specific group was the introduction to the young people of a range of skills. For example, He Waka Eke Noa would present several tools for each module to target one need. This provided young people with options to work out what works best for them. For example, the TIPP skill which includes using tools to change temperature and Progressive Muscle Relaxation. This provides flexibility and individualisation within the group which is a strong feature of DBT (Cooper & Parsons, 2005).

The second finding relating to this theme highlights the limitations of DBT for young people in secure residences in NZ, in relation to targeting criminogenic needs and cultural factors. The ability of DBT to target criminogenic needs was contentious. Some professionals felt it could address criminogenic needs in instances where offending directly related to their (in)ability to control their emotions; while others also believed there needed to be something else which targeted non-emotion based needs. Ultimately, the goal of He Waka Eke Noa was to help young people create a life worth living, rather than targeting specific criminogenic needs. Similar to the theoretical underpinnings of the Good Lives Model, the premise that helping young people to develop the skills they need to improve their life will inevitably aid them in targeting their criminogenic needs (Fortune, 2018; Ward & Gannon, 2006), has merit.

The second limitation that was discussed was the space for culture in DBT. This has already been discussed under Cultural Responsivity. However, it is important to acknowledge and recognise the degree of work involved with injecting a cultural component to an intervention that does not initially include such a component. It is not an easy task, and the amount of work, through adaptations and continued consultation, undertaken by He Waka Eke Noa is significant. As adaptations are occurring in DBT to accommodate features such as age and environment, it is quite likely future adaptations to address cultural needs will be increasingly occurring internationally.

Overall, the professionals were positive about the usefulness of DBT skills for young people in secure youth justice residences in NZ. As DBT in NZ develops, and research and resources are both increased and shared amongst organisations, the effectiveness in a NZ setting is likely to increase.

Motivation

Motivation is clearly a fundamental part of the question, why does this group operate? It is important to understand why the young people participate and why the professionals have chosen a DBT-informed skills group to operate at Korowai Manaaki as this will increase our understanding of the operation of He Waka Eke Noa. The first key finding is a general perception young people want to learn DBT skills and have their own personal motivations for attending He Waka Eke Noa. The professionals discussed the importance of spending time with young people to understand the young people's motivation so they could cater to it within the group. This also ties into aspects of GLM as it enlists an individual's motivation to change into treatment (Tomlinson, 2018). Part of this finding is recognising that a combination of internal (e.g., wanting to improve) and external motivations (e.g., court ordered attendance) appeared to be influential for young people. Intrinsic motivation is important to identify as the professionals commented on how having others in group who were not as engaged could derail other participants. This reinforced the benefit of checking motivation and commitment prior to starting each group and each session. As some professionals discussed, a young person's motivation could also be impacted by external events such as court appearances which, provided facilitators are aware of, can be managed. In addition, the usefulness of food and homework prizes to appeal to immediate motivation was identified as helpful. This is an effective technique with young people as their ability to rationalise long term reward over immediate rewards is not as developed as adults (Steinberg,

2005). By utilising short term rewards, professionals can engage young people in each session to teach them skills that will benefit them long term.

The second key finding for this theme is the positive relationship between the young person and professionals, which is clearly an important motivation for both parties. For young people, the need for a facilitator to create a space in which they feel comfortable practicing skills and are positively reinforced for their functional behaviour is well documented (Andrew et al., 2014; Lynk et al., 2015). Validation was highlighted as a reason young people had sustained attendance, which is supported as being effective in creating an environment free of judgment (Banks & Gibbons, 2016). It is also clear that professionals were motivated by seeing change in young people and felt a deep sense of satisfaction when young people completed the programme and generalised the skills. This finding highlights the importance of having time for the young people and the professionals to get to know each other and create goals together.

The main findings present twelve key 'take home' messages about He Waka Eke Noa. These are displayed below, in Table One to illustrate how they concur with the original research questions.

Table 1

Research Questions and Corresponding Key Findings

Research Question	Key Findings
1) What is the context, characteristics, and operation of the programme?	• The criminal justice environment creates barriers for the operation of the group including managing antisocial tendencies in the group and managing external influences. • The group facilitates both internal and external motivations of the young people. • The relationship between facilitator and young person is important. • There is an ongoing need to balance the inherent conflict between a risk-reduction approach and creating a therapeutic environment.
2) How well do young people understand the key modules?	• Adaptations in relation to age, criteria for admission, and culture are required to make DBT generalisable. • Professionals need to make the skills personal through connecting it to the young person's own life. This comes through relatedness, individual sessions and cultural connectedness.
3) What do key stakeholders think of the programme and do they believe the programme meets the needs of the young people?	• There are limitations to DBT's ability to address culture and criminogenic needs (directly). • Overall, there is a positive view of the theoretical application of skills taught to assist in addressing the needs of young people in NZ youth justice secure residences.
4) What are the possible areas for improvement?	• Moving from cultural acknowledgement to content integration. • Diversity of professionals within He Waka Eke Noa and connecting with more external organisations. • Individuals need to be able to practice DBT skills to make it generalisable across time, space and people. • Significant resources are required to develop He Waka Eke Noa.

Clinical Relevance

In the following section I discuss the clinical relevance of these findings. Firstly, contributions to our understanding of DBT with young people in youth justice secure residences in NZ are discussed, followed by an acknowledgment of the need for future research in combining Māori and Western practices. Finally, I will explore the practical implications of this research.

In the first instance, this thesis provides information about how DBT has been adapted to suit young people within a criminal justice secure residence. He Waka Eke Noa has taken into account their target population's age, cognitive ability, and restricted environment, and these impacts have been discussed. In particular, the difficulties of creating a therapeutic environment in a criminal justice space, as well as managing the impacts of

involvement with the criminal justice system on a young person was well understood by the participants in this study. This adds to the extant literature, on implementing DBT within a criminal justice youth population.

Secondly, it builds on our understanding of what is required for young people to be able to generalise the skills they learn in DBT. This thesis has discussed the need for time to learn the skill, a teaching style that aids understanding the skills, and an environment in which they can practice it. It is important for research to show how a participant can generalise a therapeutic programme in order to aid longevity in the learning. It does raise the question however; how helpful is a programme of this length? The professionals identified that the generalisability into the community is a concern which highlights the need to consider the continuum of care provided to young people after they have left a secure residence and transition into the community. The period of re-entry is a high-risk time for young people as they have to adjust from rigid routines and supervision to operating within the realities of the community (Altshuler & Brash, 2004). The risk of recidivism is high during the initial re-entry period and research shows young people are better equipped to manage re-entry when they have thorough plans and support to guide them (Altshuler & Brash, 2004).

Thirdly, this research adds to our understanding of motivation. It explored why young people may be interested in changing their behaviours and what clinicians can do to encourage and support this. Young people in secure justice residences are a high risk, and highly vulnerable group. These findings show that a mixture of internal and external motivations exist. It is important that clinicians are aware of this. It also increased our understanding of why professionals continue to work in this area and the immense impact of seeing a young person succeed. He Waka Eke Noa uses a graduation ceremony at the end of the four weeks to recognise and celebrate the work the young people have done. This

graduation ceremony clearly provides a moment of satisfaction for the professionals to also recognise the impact they have had.

The omission of the rangatahi, or young peoples' voice is important to note here as their input would have provided a clearer, direct from source, insight into the thoughts of that group. The young persons' perspective would likely have provided rich data. Ensuring ethics consent and research access processes enable and support young persons' participation is crucial.

Finally, this thesis adds to our knowledge of combining Māori and Pasifika culture with a Western therapeutic intervention. There is a growing body of literature which explores this relationship in far more detail than is conducted here (eg., Bennet et al., 2016; Tamatea & Brown, 2011). This thesis has only acted to 'flag' the relationship in this instance as this is an area of research that can, and should be, Māori and Pasifika led; and to provide support for further discussion and development in this area.

There are key implications for this research that relate to He Waka Eke Noa itself. It has identified areas of development within the programme and therefore has provided an opportunity to change aspects of the implementation of the group. In order to do this, it is evident that increased resources are required for aspects such as increasing the training and support for professionals not directly involved in the delivery of the programme, but who have contact with the young people who have participated in the group. The research has also identified strengths of the programme, such as the usefulness of the DBT skills with young people in NZ secure residences, which will allow for its continued development and the potential for the programme to be implemented across other youth justice secure residences or as a community or school based programme. To do this effectively, it is essential staff are well trained and supported (Tomlinson, 2018).

Alternative Explanations

It is important to consider alternative explanations for some of the findings stipulated here before accepting the practical implications. Here, I will discuss four main findings and explore potential alternative explanations. The first finding I will discuss is that some professionals at Korowai Manaaki were not always supportive of the group and this could be increased by providing more training in DBT. Other explanations may be that those staff members who are with the young people 24 hours per day do not view the DBT group as being effective, or they may not support providing young people with equipment (for example, when a young person is getting angry and wants a cold cloth to calm down), as it may be seen as 'rewarding' elevated behaviour.

A second finding is the difficulty of engaging with family members of this youth justice population. It was suggested that this difficulty arose at times because the young people were from all over Auckland and beyond which made it difficult logistically, and sometimes family were disconnected from the young person for various reasons. An alternative explanation is perhaps this difficulty came from an administrative failure of the organisations to contact family, as opposed to there not being engagement from family. Previous research has highlighted the need for criminal justice environments to reduce barriers to family involvement through providing treatment in the family home, ensuring space is available at the facility for treatment and engaging family members by addressing how the behaviour has impacted them personally (Perkins-Dock, 2001). Potentially, if more attempts are made to reduce barriers to treatment, some family members may engage.

An interesting alternative explanation to the cultural responsivity findings is the possibility that the philosophy of DBT is inherently not conducive to being integrated with Māori cultural beliefs. DBT is rooted in Biosocial theory which is at odds with Te Ao Māori which views an individual as being part of something much bigger than themselves. In Te Ao

Māori, a person is an accumulation of all that has come before them. As Biosocial theory focuses on the individuals' experiences, it may not be able to capture the necessary 'whole' of a young Māori person and what they and their forebears have gone through and represent. For example, Lawson-Te Aho and Liu (2010), stated "in a traditional Māori conceptualisation, individual well-being is sourced and tied to the well-being of the collective cultural identity. Therefore, individual pain is inseparable from collective pain", which, within this context, highlights the potential restrictions of Biosocial theory to appropriately address the needs of a young Māori individual.

The final alternative explanation to consider is whether there are other explanations for why young people may be benefitting from this group. Is it simply from having adults who are engaged and willing to work with them every week, irrespective of content? As the relationship between the facilitators and the young people was rated as highly important, perhaps it is not the skills themselves that are benefitting these young people, but any programme that involves committed and enthusiastic facilitators would yield similar results. Another possibility could be the impact of other programmes available to the young people while at Korowai Manaaki e.g., the school programme. By providing these young people with routine and an education, that may be what is primarily influencing any change in behaviour. Finally, as the young people get older, the threat of adult prison may become a motivator in itself for changing their behaviour. To look at the DBT group in isolation may not accurately identify what this group of individuals need. Instead, we need to consider a wide range of possibilities and solutions to understand how they might work together to achieve the same result.

Strengths and Limitations

The present study has several strengths and limitations. The following section will discuss four strengths, followed by four limitations of the thesis.

Strengths

When explaining the evaluation model I would use for this thesis I outlined seven features by Dehar et al, (1993) which described what a Process Evaluation should analyse. The first strength of the thesis is how it analysed five out of the seven. It explored the programme origins by interviewing the creators of the group; the programme structure by creating an interview structure which outlined the questions about the group from referral, to assessment, to running the group; contextual factors relevant to programme operation such as exploring the impact of the criminal justice environment; the levels of community awareness, for example, through interviewing Oranga Tamariki staff who worked both internally and externally of Korowai Manaaki; and the resources used for programme operation such as using the He Waka Eke Noa Workbook to inform interview structure development.

This ties in with the second strength which is the approach I used. The use of a Process Evaluation at this stage of the programme development was useful as it was able to capture what aspects were working well and what aspects require further development. By using a utilisation-focused evaluation approach, and providing this information to the key stakeholders, it allows them to make informed decisions about the future of the programme. As the programme continues to develop, future Process Evaluations would be beneficial.

The third strength is the support this project had from Oranga Tamariki National Office and ADHB Taiohi Tu Taiohi Ora team. Oranga Tamariki National Office first suggested this project and were integral to connecting the researcher with the ADHB team. Their guidance during the initial stages of the ethics applications and ongoing support over the 16-month project was valuable. The Taiohi Ora Taiohi Tu team went above and beyond by allowing their staff to be available as participants, they assisted in early discussions about the methodology and interview schedule development and have had continued engagement

throughout the research process. The research was significantly strengthened by the experience and guidance both organisations provided.

The final strength is that the current study occurred, and the research was able to go ahead with input from 11 participants over two key stakeholder groups. Considering the array of process issues and barriers the study faced, this is a strength of the study as it provides an overview of professionals' view of He Waka Eke Noa.

Limitations

The first limitation of this process evaluation is that it fails to address two features outlined by Dehar et al, (1993). These are: the participation rates and characteristics; and the perceptions of programme participants e.g., the young people themselves. As has been previously highlighted, the original plan for this project included interviewing young people and their whānau. The exclusion of their voice directly impacts the level of understanding this project was able to develop and is a limitation.

An extension of this is the second limitation. As was highlighted by the 'Alternative explanations' sections, this research is unable to rule out some alternative explanations due to the limited scope. Speaking to family or whānau could have provided insight into their understanding of the group and whether involvement by them was desired or possible.

Although the workbook was used to develop the interview structure, ultimately due to the timing of the process evaluation and access to young people, no formal analysis was conducted on the programme documentation which limited the overall analysis. The process evaluation took place when the facilitators of He Waka Eke Noa were adapting the workbook and therefore the data gathered about the workbook was based on a previous version. In addition, the research was unable to learn whether the young people involved found the workbook useful or if it was useful across different cultural groups.

The final limitation is although this project does meet the generally recognised threshold for participant numbers, the total number was smaller than initially planned. This is a limitation, particularly in the area of participation from Oranga Tamariki staff, and of course the young people. Although the analysis of the interviews by Oranga Tamariki professionals only produced two new codes which indicated there was not a lot of new content gained from the interviews; we cannot confidently state that saturation was reached due to the small number of participants and limited variety of roles within Oranga Tamariki specifically. Although numerous efforts were made to contact staff via email, face to face contact may have been beneficial in the recruitment of Oranga Tamariki staff. This was not possible due to the delays in the approval process. If we had been able to include more Oranga Tamariki participants, this would have provided for more robust findings.

Notwithstanding these limitations, the number of interviews conducted provided a wealth of rich information and we have a strong indication of how professionals view He Waka Eke Noa. The knowledge gained from the professionals' perspectives will help to shape this group in many ways moving forward.

Process Issues

The process issues that I faced during this project were incredibly difficult. After each ethics application, we had a conversation about whether this project was simply too difficult, and if we should change topics. I did have another project available that I could join. Each time, we decided that this research was important enough to persevere because of the lack of research in this area and the value of the research to key stakeholders. By the time the third ethics application was submitted, my literature review was complete, and my research had led me to understand the potential benefits of DBT as the international evidence was so promising. I was eager to find out whether DBT could have a place in NZ, and if so, what that may look like. I also understood the barriers of providing this type of therapy in a

criminal justice environment and how important it was that research continue in order to provide a basis from which DBT could be more effective in that context. A key aspect to this is the transfer of knowledge from research to practice. Knowledge transfer between universities and industries is important as it drives innovative growth (Wit-de Vries, Dolfsma, van der Windt & Gerkema, 2018). In this instance, the industry inspired the research and the research was an opportunity to inform key organisations in NZ.

I am very disappointed the voices of young people have not been included in this study. The idea of providing young people in youth justice residences, one of the most vulnerable population groups in our society, with a voice about a programme that has a direct impact on them, was my main motivation throughout the ethics and approval process. Both personally, and professionally, I learnt a lot during this time that will not be shown in theme development or through quotes. I learnt there is a delicate line between being polite and patient, and being necessarily direct. In hindsight, I would have pushed the ethics committees to have more in-depth conversations with me so that I could understand what they wanted earlier, and I needed to voice my concerns more strongly. I would have started following up with people much earlier. I have learnt that while research is valued in these organisations at a theoretical or strategic level, enabling practical participation in it is difficult, and not necessarily a priority; perhaps due to internal capacity or resource issues, rather than actual personnel commitments.

I believe wholeheartedly that we need processes in place that protect potential participants, and ensure that everybody is being looked after when it comes to research. There are two outcomes that I believe need to be looked at in order to improve the process for conducting research with young people who have offended in NZ. Firstly, in-keeping with extant research which outlines the need for cognitive differences or levels of understanding to be shared and resolved during early stages of collaboration (Wit-de Vries et al., 2018), ethics

committees need to have a baseline understanding of the needs of these particular young

people, and be open to innovative ways of encouraging their participation and understanding

of research. More flexibility is required. Secondly, timeframes need to be clear, and adhered

to. During this process, both HDEC and Oranga Tamariki operated outside of their own

stated timeframes. The need for clear timeframes that are adhered to in order to increase

competency in university-industry knowledge transfer is well documented (Wallin et al.,

2014; Wit-de Vries et al., 2018). Masters theses are a resource that could contribute

positively to an evidence base for organisations such as Oranga Tamariki, but due to the time

required to gain the necesssary ethics consent, research access and approval, Masters students

are effectively impeded from conducting such research.

Future Direction

Based on the findings of this research, early indications are the DBT skills group, He

Waka Eke Noa is suitable for young people in a NZ youth justice secure residence.

Professionals' viewed the group as targeting needs that were prominent within this

population and providing young people with a range of skills that will benefit them in the

future. The findings highlighted the need for these skills to be generalised and professionals

offered ideas around how this can occur across a range of environments (e.g., in the residence

and in the community), people (e.g., facilitators, Korowai Manaaki staff and family), and

levels of understanding (e.g., due to age or culture). The role of increased resources was

highlighted as an important factor in achieving this. The findings also indicated further

development is required to maximise cultural responsivity of the programme. Potential

recommendations to achieve this could extend beyond the cultural diversification of

clinicians, to the addition and/or development of a Cultural Advisor/Facilitator who is both

skilled in DBT and able to assist in developing and supporting the cultural competency of

other clinicians. The following section will outline possible future directions for the group; and research.

Firstly, this project has identified a number of strengths of He Waka Eke Noa, as well as some areas for improvement. Key stakeholders should consider these in order to continue to develop He Waka Eke Noa. This may include rolling out:

1) A DBT skills group at every secure youth justice residence. This would allow for young people who move across different residences to continue treatment and will provide the opportunity to all young people in secure youth justice residences in NZ to learn these skills. This would require collaboration between Oranga Tamariki and ADHB to create, train and support further development and implementation of He Waka Eke Noa.

2) A DBT Parent/Caregiver Programme. The involvement of parents/caregivers in a DBT-A programme has been identified in the literature as an important aspect of generalisability. By providing a DBT parent programme, it may provide additional learning and effectiveness for the young people. Most relevant to the findings of the present study, it would assist in generalisability of skills beyond the residence.

3) A DBT Community Programme. The current programme length is significantly shorter than standard DBT due to the criminal justice environment in which it is run. The potential addition of a DBT Community programme; which young people could join when they are released to the community, may allow young people with more time to learn and generalise the skills.

Second, more research is required in order to build on these findings. It will be unsurprising that the first suggestion is a further qualitative project which evaluates He Waka Eke Noa with the perspective of the young people involved and their family or whānau. This

will provide a more thorough overview of the key stakeholders' views and opinions of the group. The insights of young people and their families will be particularly useful for understanding how the skills are being generalised and the role of family involvement in DBT. It would be critical to understand the young peoples' values and beliefs as this understanding would potentially increase the responsiveness of He Waka Eke Noa to their needs. It would also be valuable to analyse the usefulness of the workbook He Waka Eke Noa has created as a resource.

The next step would be to conduct an outcome evaluation which measures young peoples' behaviour prior to beginning the group and their behaviour once they have graduated. This would no doubt be a lengthy research project, as for optimal results a longitudinal study which followed young people through to the community would be most effective. As outcome evaluations are typically quantitative, this could also examine the number of incidents in the residence, admissions to 'secure' holding prior to starting group, during group, and upon graduation; and recidivism rates.

The final aspect of research that could be considered in the future is the movement from cultural acknowledgement to content integration. This is an important body of research in NZ that requires development and resource sharing. Western therapies continue to have a stronghold in criminal justice environments and mental health despite Māori being disproportionately affected in NZ. Research into how this can be more effective, or whether it could even occur, must be a priority for organisations and professionals in this domain. In addition, this research can look at succession plans that explore how this can develop and grow within He Waka Eke Noa.

Conclusion

The aim of this study was to conduct a process evaluation which analysed how He Waka Eke Noa was implemented, identify what was effective or what constituted barriers to

its effectiveness, the future direction of the group and whether DBT was the right option for young people who have offended or are held on remand in youth justice secure residences in NZ. This was achieved through interviewing 11 professionals involved with He Waka Eke Noa; or involved with young people who had participated in the group. Three themes were identified which answered the key questions. The first theme, '*Factors influencing practical effectiveness',* addressed three key influences of effectiveness within this population group. These were, '*Generalisability, 'Cultural Responsivity',* and '*Impact of Criminal Justice Environment'.* The second theme, '*Theoretical application of DBT to young people in NZ youth justice residences'*, is a theoretical discussion of the needs and skills DBT targets which align with the needs of these young people, as well as the limitations of DBT with this population. The third theme, '*Motivation'* explored perceptions of why the young people are engaged or disengaged with the group, and why the professionals' involved run the group. These main findings illustrated that while professionals are positive about the theoretical application of DBT with young people in secure youth justice residences in NZ, there are a number of barriers which He Waka Eke Noa has worked to overcome and needs to continue to do so. These are in relation to increasing the ability of young people to generalise content, increasing cultural responsivity; and working successfully within the constraints of the criminal justice environment. In addition, the findings show the importance of understanding and utilising motivation in treatment. Overall, the study contributes to our understanding of DBT with young people who have come into contact with the youth justice system in NZ and highlights what areas require more development in order for it to be more effective. Furthermore, this thesis concludes with ideas for future direction and research.

References

Altschuler, D. M., & Brash, R. (2004). Adolescent and teenage offenders confronting the

   challenges and opportunities of reentry. *Youth Violence and Juvenile Justice*, *2*(1), 72-

   87. doi: 10.1177/1541204003260048

Andrew, E., Williams, J., & Waters, C. (2014). Dialectical Behaviour Therapy and

   attachment: Vehicles for the development of resilience in young people leaving the

   care system. *Clinical Child Psychology and Psychiatry*, *19*(4), 503-515. doi:

   10.1177/1359104513508964

Ashworth, S., & Brotherton, N. (2018). "We can feel good": evaluation of an adapted DBT

   informed skills programme in medium security. *Advances in Mental Health and*

   Intellectual Disabilities, *12*(5/6), 184-194. doi: 10.1108/AMHID-06-2018-0031

Austrian Development Cooperation (2009). Guidelines for Project and Programme

   Evaluations. *The Operational Unit of the Austrian Development Cooperation.* Vienna:

   Austrian Development Agency.

Banks, B., Kuhn, T., & Urbano Blackford, J. (2015). Modifying Dialectical Behavior

   Therapy for incarcerated female youth: A pilot study. *Journal of Juvenile*

   Justice, *4*(1), 1-17.

Banks, B. P., & Gibbons, M. M. (2016). Dialectical Behavior Therapy techniques for

   counseling incarcerated female adolescents: A case illustration. *Journal of Addictions*

   & Offender Counseling, *37*(1), 49-62. doi: 10.1002/jaoc.12015

Bennett, S. T., Flett, R. A., & Babbage, D. R. (2016). Considerations for culturally

   responsive cognitive-behavioural therapy for Māori with depression. *Journal of*

   Pacific Rim Psychology, *10(8),* 1-11. doi: 10.1017/prp.2016.5

Bickel, R., & Campbell, A. (2002). Mental health of adolescents in custody: The use of the

'Adolescent Psychopathology Scale'in a Tasmanian context. *Australian and New Zealand Journal of Psychiatry*, *36*(5), 603-609.

Bonta, J., & Andrews, D. A. (2016). *The psychology of criminal conduct*. New York: Routledge. doi: 10.4324/9781315677187

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. sage.

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic analysis. *Handbook of Research Methods in Health Social Sciences*, 843-860. doi: 10.1007/978-981-10-5251-4_103

Burckhardt, R., Manicavasagar, V., Shaw, F., Fogarty, A., Batterham, P. J., Dobinson, K., & Karpin, I. (2018). Preventing mental health symptoms in adolescents using dialectical behaviour therapy skills group: A feasibility study. *International Journal of Adolescence and Youth*, *23*(1), 70-85. doi: 10.1080/02673843.2017.1292927

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17-31. doi: 10.1016/j.cpr.2005.07.003

Byrne, G., & Ghrada, Á. N. (2019). The application and adoption of four 'third wave' psychotherapies for mental health difficulties and aggression within correctional and forensic settings: A systematic review. *Aggression and Violent Behavior*. doi:10.1016/j.avb.2019.01.001

Carr, A. (2016). Family Therapy for adolescents: A Research-informed perspective. *Australian and New Zealand Journal of Family Therapy*, *37*(4), 467-479. doi: 10.1002/anzf.1184

Cook, N. E., & Gorraiz, M. (2016). Dialectical behavior therapy for non-suicidal self-injury

    and depression among adolescents: Preliminary meta-analytic evidence. *Child and*

    Adolescent Mental Health, *21*(2), 81-89. doi: 10.1111/camh.12112

Cooper, B., & Parsons, J. (2009). Dialectical Behaviour Therapy: A social work

    intervention?. *Aotearoa New Zealand Social Work*, *21*(4), 83-93.

de Wit-de Vries, E., Dolfsma, W. A., van der Windt, H. J., & Gerkema, M. P. (2018).

    Knowledge transfer in university–industry research partnerships: a review. *The*

    Journal of Technology Transfer, 1-20. doi:10.1007/s10961-018-9660-x

Dehar, M. A., Casswell, S., & Duignan, P. (1993). Formative and process evaluation of

    health promotion and disease prevention programs. *Evaluation Review*, *17*(2), 204-

    220.

Fleischhaker, C., Böhme, R., Sixt, B., Brück, C., Schneider, C., & Schulz, E. (2011).

    Dialectical Behavioral Therapy for Adolescents (DBT-A): A clinical trial for patients

    with suicidal and self-injurious behavior and borderline symptoms with a one-year

    follow-up. *Child and Adolescent Psychiatry and Mental Health*, *5*(1), 1-10..doi:

    10.1186/1753-2000-5-3

Flynn, D., Kells, M., Joyce, M., Corcoran, P., Gillespie, C., Suarez, C., Weihrauch, M., &

    Cotter, P. (2017). Standard 12-month Dialectical Behaviour Therapy for adults with

    Borderline Personality Disorder in a public community mental health

    setting. *Borderline Personality Disorder and Emotion Dysregulation*, *4*(1), 1-11. doi:

    10.1186/s40479-017-0070-8

Fortune, C. A. (2018). The Good Lives Model: A strength-based approach for youth

    offenders. *Aggression and Violent Behavior*, *38*, 21-30. doi:

    10.1016/j.avb.2017.11.003

Frazier, S. N., & Vela, J. (2014). Dialectical Behavior Therapy for the treatment of anger and

aggressive behavior: A review. *Aggression and Violent Behavior*, *19*(2), 156-163. doi:

10.1016/j.avb.2014.02.001

Galietta, M. (2018). Adapting Dialectical Behavior Therapy for use in correctional settings.

In E. L. Jeflic & C. Calkins (Eds), *New Frontiers in Offender Treatment* (pp. 147-

169). New York: Springer. doi: 10.1007/978-3-030-01030-0_8

Gawith, J., & Batcheler, M. (2009). *Dialectical Behaviour Therapy: An outline for the future*

direction and development of New Zealand. Auckland, New Zealand: Te Pou o Te

Whakaaro Nui.

Gill, D., Warburton, W., Simes, D., & Sweller, N. (2018). Group Therapy for Emotional

Dysregulation: Treatment for Adolescents and Their Parents. *Child and Adolescent*

Social Work Journal, *35*(2), 169-180. doi: 10.1007/s10560-017-0510-8

Gluckman, P., & FRS, O. K. F. F. (2017). Using evidence to inform social policy: The role of

citizen-based analytics. *Office of the Prime Minister's Chief Science Advisor,*

Auckland. Retrieved from http://www. pmcsa. org. nz/wpcontent/uploads/17-06-19-

Citizen-based-analytics. pdf.

Goldstein, N. E., Arnold, D. H., Weil, J., Mesiarik, C. M., Peuschold, D., Grisso, T., &

Osman, D. (2003). Comorbid symptom patterns in female juvenile offenders.

International Journal of Law and Psychiatry, 26, 565-582. doi:10.1016/S0160-

2527(03)00087-6

Goldstein, T. R., Fersch-Podrat, R. K., Rivera, M., Axelson, D. A., Merranko, J., Yu, H.,

Brent, D.A., & Birmaher, B. (2015). Dialectical Behavior Therapy for adolescents

with Bipolar Disorder: Results from a pilot randomized trial. *Journal of Child and*

Adolescent Psychopharmacology, *25*(2), 140-149. doi: 10.1089/cap.2013.0145

Görg, N., Priebe, K., Böhnke, J. R., Steil, R., Dyer, A. S., & Kleindienst, N. (2017). Trauma

related emotions and radical acceptance in Dialectical Behavior Therapy for
Posttraumatic Stress Disorder after childhood sexual abuse. *Borderline Personality
Disorder and Emotion Dysregulation*, *4*(1), 1-12. doi:10.1186/s40479-017-0065-5

Heard, H. L., & Swales, M. A. (2016). *Dialectical Behaviour Therapy: Distinctive features*.
London: Routledge. doi:10.4324/9781315544540

Hogan, N. L., Barton-Bellessa, S. M., & Lambert, E. G. (2015). Forced to change:
Staff and inmate perceptions of involuntary treatment and its effects. *Applied
Psychology in Criminal Justice*, *11*(1), 19-39.

Hipwell, A. E., & Loeber, R. (2006). Do we know which interventions are effective for
disruptive and delinquent girls?. *Clinical Child and Family Psychology Review*, *9*(3-
4), 221-255. doi: 10.1007/s10567-006-0012-2

Hudson, M. L., & Russell, K. (2009). The Treaty of Waitangi and research ethics in
Aotearoa. *Journal of Bioethical Inquiry*, *6*(1), 61-68. doi: 10.1007/s11673-008-9127-0

Hunnicutt Hollenbaugh, K. M., & Lenz, A. S. (2018). An examination of the effectiveness
of Dialectical Behavior Therapy skills groups. *Journal of Counseling &
Development*, *96*(3), 233-242. doi: 10.1002/jcad.12198

Ioane, J., Lambie, I., & Percival, T. (2016). A comparison of Pacific, Māori, and European
violent youth offenders in New Zealand. *International Journal of Offender Therapy
and Comparative Criminology*, *60*(6), 657-674. doi: 10.1177/0306624X14560725

James, A. C., Taylor, A., Winmill, L., & Alfoadari, K. (2008). A preliminary community
study of Dialectical Behaviour Therapy (DBT) with adolescent females demonstrating
persistent, deliberate self-harm (DSH). *Child and Adolescent Mental Health*, *13*(3),
148-152. doi: 10.1177/0306624X14560725

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical Behavior Therapy for Borderline
Personality Disorder: A meta-analysis using mixed-effects modeling. *Journal of*

Consulting and Clinical Psychology, 78(6), 936-951. doi: 10.1037/a0021015

Kutcher, S., & McDougall, A. (2009). Problems with access to adolescent mental health care can lead to dealings with the criminal justice system. *Paediatrics & Child Health*, *14*(1), 15-18. doi: 10.1093/pch/14.1.15

Lambie, I. (2016). *Youth Justice Secure Residences: A report on the international evidence to guide best practice and service delivery*. Wellington, New Zealand. Ministry of Social Development.

Lang, C. M., Edwards, A. J., Mittler, M. A., & Bonavitacola, L. (2018). Dialectical Behavior Therapy With prolonged exposure for adolescents: Rationale and review of the research. *Cognitive and Behavioral Practice*, *25*(3), 416-426. doi: 10.1016/j.cbpra.2017.12.005

Lawson-Te Aho, K., & Liu, J. H. (2010). Indigenous suicide and colonization: The legacy of violence and the necessity of self-determination. *International Journal of Conflict and Violence (IJCV)*, *4*(1), 124-133. doi: 10.4119/unibi/ijcv.65

Lee, J. (2005). Māori cultural regeneration: Pūrākau as pedagogy. In *3rd International CRLL Conference: What a difference a pedagogy makes: Researching lifelong learning and teaching.* Stirling, Scotland.

Lenz, A. S., & Del Conte, G. (2018). Efficacy of dialectical behavior therapy for adolescents in a partial hospitalization program. *Journal of Counseling & Development*, *96*(1), 15-26. doi: 10.1002/jcad.12174

Linehan, M. (1993). *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York: Guilford Publications.

Linehan, M. (2014). *DBT skills training manual, second edition*. New York: Guilford Publications.

Lynk, M., McCay, E., Carter, C., Aiello, A., & Donald, F. (2015). Engaging street-involved

youth in dialectical behaviour therapy: A secondary analysis. *Journal of the Canadian*

Academy of Child and Adolescent Psychiatry, *24*(2), 116.

MacPherson, H. A., Cheavens, J. S., & Fristad, M. A. (2013). Dialectical Behavior Therapy

for adolescents: Theory, treatment adaptations, and empirical outcomes. *Clinical*

Child and Family Psychology Review, *16*(1), 59-80. doi: 10.1007/s10567-012-0126-7

McArdle, S., & Lambie, I. (2018). Screening for mental health needs of New Zealand youth

in secure care facilities using the MAYSI-2. *Criminal Behaviour and Mental*

Health, *28*(3), 239-254. doi: 10.1002/cbm.2067

McCay, E., Carter, C., Aiello, A., Quesnel, S., Howes, C., Beanlands, H., & Lord, C. (2017).

Training frontline community agency staff in Dialectical Behaviour Therapy:

Building capacity to meet the mental health needs of street-involved youth. *The*

Journal of Mental Health Training, Education and Practice, *12*(2), 121-132. doi:

10.1108/JMHTEP-07-2015-0034

McDonell, M. G., Tarantino, J., Dubose, A. P., Matestic, P., Steinmetz, K., Galbreath, H., &

McClellan, J. M. (2010). A pilot evaluation of Dialectical Behavioural Therapy in

adolescent long-term inpatient care. *Child and Adolescent Mental Health*, *15*(4), 193-

196. doi: 10.1111/j.1475-3588.2010.00569.x

McKay, S., & Bagshaw, S. (2009). The health needs of young people in CYF residential care.

The Collaborative for Research and Training in Youth Health and Development.

Ministry of Health: New Zealand.

Mead, H. M. (2003). *Tikanga Māori: Living by Māori Values*. Wellington, NZ: Huia

publishers.

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with*

suicidal adolescents. New York: Guilford Press.

Ministry of Health. 2012. *Office of the Director of Mental Health Annual Report 2011*. Wellington, New Zealand: Ministry of Health.

Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T., & Cobb, A. R. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behaviour Research and Therapy*, *44*(12), 1811-1820. doi: 10.1016/j.brat.2006.01.004

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1),. doi: 10.1177/1609406917733847

Ougrin, D., Tranah, T., Stahl, D., Moran, P., & Asarnow, J. R. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *54*(2), 97-107. doi: 10.1016/j.jaac.2014.10.009

Panos, P. T., Jackson, J. W., Hasan, O., & Panos, A. (2014). Meta-analysis and systematic review assessing the efficacy of Dialectical Behavior Therapy (DBT). *Research on Social Work Practice*, *24*(2), 213-223. doi: 10.1177/1049731513503047

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed). Thousand Oaks, CA: Sage.

Pere, R. (1994). Ako: Concepts and learning in the Māori tradition, monographie. *Wellington, NZ: Te Kōhenga National Trust Board.*

Rathus, J. H., & Miller, A. L. (2014). *DBT® skills manual for adolescents*. New York, NY: Guilford.

Ritschel, L. A., Miller, A. L., & Taylor, V. (2013). Dialectical Behavior Therapy for emotion dysregulation. In J. Ehrenreich-May, B. Chu (Eds.), *Transdiagnostic Mechanisms and Treatment for Youth Psychopathology*, 203-232. New York: Guilford.

Rizvi, S. L., Steffel, L. M., & Carson-Wong, A. (2013). An overview of Dialectical Behavior Therapy for professional psychologists. *Professional Psychology: Research and Practice*, *44*(2), 73-80. doi: 10.1037/a0029808

Roberton, T., Daffern, M., & Bucks, R. S. (2012). Emotion regulation and aggression. *Aggression and Violent Behavior*, *17*(1), 72-82. doi:10.1016/j.avb.2011.09.006

Robins, C. J., & Rosenthal, M. Z. (2011). Dialectical behavior therapy. In J. D. Herbert & E. M. Forman (eds.), *Acceptance and Mindfulness in Cognitive Behavior Therapy: Understanding and applying the new therapies* (pp. 164-192). Hoboken, NJ: Wiley. doi: 10.1002/9781118001851.ch7

Royal, T. A. C. (2003). The woven universe: selected writings of Rev. Māori Marsden. *Educating Māori*, 187. Masterton: The Estate of Rev. Mäori Marsden.

Russell, M. A., & Marston, E. G. (2009). Profiles of mental disorder among incarcerated adolescent females. *Court. Review.*, *46*, 16-23.

Safer, D. L., Couturier, J. L., & Lock, J. (2007). Dialectical Behavior Therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice*, *14*(2), 157-167. doi: 10.1016/j.cbpra.2006.06.001

Salbach-Andrae, H., Bohnekamp, I., Pfeiffer, E., Lehmkuhl, U., & Miller, A. L. (2008). Dialectical Behavior Therapy of anorexia and bulimia nervosa among adolescents: A case series. *Cognitive and Behavioral Practice*, *15*(4), 415. doi: 10.1016/j.cbpra.2008.04.001

Shelton, D. (1998). Estimates of emotional disorder in detained and committed youth in the Maryland Juvenile Justice System. *Report to the Maryland Juvenile Justice Advisory Council*. Baltimore: Maryland.

Shelton, D., Kesten, K., Zhang, W., & Trestman, R. (2011). Impact of a Dialectic Behaviour

Therapy—Corrections Modified (DBT-CM) upon behaviorally challenged

incarcerated male adolescents. *Journal of Child and Adolescent Psychiatric

Nursing*, *24*(2), 105-113. doi: 10.1111/j.1744-6171.2011.00275.x

Sibley, C. G., & Liu, J. H. (2007). New Zealand= bicultural? Implicit and explicit

associations between ethnicity and nationhood in the New Zealand context. *European

Journal of Social Psychology*, *37*(6), 1222-1243. doi:

Skowyra, K. R., & Cocozza, J. J. (2007). Blueprint for change: A comprehensive model for

the identification and treatment of youth with mental health needs in contact with the

juvenile justice system. *Policy Research Associates*. Delmar, NY.

Stathis, S., & Martin, G. (2004). A transdisciplinary approach to adolescent forensic mental

health. *Australian & New Zealand Journal of Psychiatry*, *38*(9), 746-752. doi:

10.1080/j.1440-1614.2004.01447.x

Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in

Cognitive Sciences*, *9*(2), 69-74. doi: 10.1016/j.tics.2004.12.005

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Thousand Oaks,

CA: Sage.

Stoddard-Dare, P., Mallett, C. A., & Boitel, C. (2011). Association between mental health

disorders and juveniles' detention for a personal crime. *Child and Adolescent Mental

Health*, *16*(4), 208-213. doi: 10.1111j1475-3588.2011.00599.x

Stufflebeam, D. L., & Shinkfield, A. J. (2007). Evaluation theory, models, and applications.

San Francisco: Jossey-Bass. doi: 10.1177/1098214007308902

Swales, M. A., & Heard, H. L. (2009). Distinctive characteristics of Dialectical Behaviour

Therapy. London: Routlege. doi: 10.4324/9780203886403

Tamatea, A., & Brown, T. (2011). Culture and offender rehabilitation in New Zealand:

Implications for programme delivery and development. *Effective interventions with offenders: Lessons learned*, 168-190.

Tomlinson, M. F. (2018). A theoretical and empirical review of Dialectical Behavior Therapy within forensic psychiatric and correctional settings worldwide. *International Journal of Forensic Mental Health*, *17*(1), 72-95. doi: 10.1080/14999013.2017.1416003

Torrie, R., Dalgety, M., Peace, R., Roorda, M., Bailey, R., Goodwin, D., & Cram, F. (2015). Finding our way: Cultural competence and Pākehā evaluators. *Evaluation Matters— He Take Tō Te Aromatawai*, *1*, 47-81. doi: 10.18296/em.0004

Trupin, E. W., Stewart, D. G., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behaviour therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health*, *7*(3), 121-127. doi: 10.1111/1475-3588.00022

Tuakoi, M. V. S. (2010). *Dialectical Behavior Therapy for Transitioning Juveniles: From Correctional Facilty to the Community* (Doctoral dissertation, University of the Rockies).

Underwood, L., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health*, *13*(2), 228. doi: 10.3390/ijerph13020228

Vermeiren, R., Jespers, I., & Moffitt, T. (2006). Mental health problems in juvenile justice populations. *Child and Adolescent Psychiatric Clinics*, *15*(2), 333-351. doi: 10.1016/j.chc.2005.11.008

Wallin, J., Isaksson, O., Larsson, A., & Elfström, B. O. (2014). Bridging the gap between university and industry: Three mechanisms for innovation efficiency. *International Journal of Innovation and Technology Management*, *11*(01), 1440005. doi: 10.1142/S0219877014400057

Walsh, C., Ryan, P., & Flynn, D. (2018). Exploring Dialectical Behaviour Therapy

  clinicians' experiences of team consultation meetings. *Borderline Personality*

  Disorder and Emotion Dysregulation, *5*(1), 3. doi: 10.1186/s40479-018-0080-1

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The

  comprehensive Good Lives Model of treatment for sexual offenders. *Aggression and*

  Violent Behavior, *11*(1), 77-94. doi: 10.1016/j.avb.2005.06.001

Ward, T., Yates, P. M., & Willis, G. M. (2012). The Good Lives Model and the Risk Need

  Responsivity Model: A critical response to Andrews, Bonta, and Wormith

  (2011). *Criminal Justice and Behavior*, *39*(1), 94-110. doi:

  10.1177/0093854811426085

Weenink, E., & Bridgman, T. (2017). Taking subjectivity and reflexivity seriously:

  Implications of social constructionism for researching volunteer

  motivation. *VOLUNTAS: International Journal of Voluntary and Nonprofit*

  Organizations, *28*(1), 90-109. doi: 10.1007/s11266-016-9824-y

Welch, S. S., & Kim, J. (2012). DBT-enhanced Cognitive Behavioral Therapy for adolescent

  trichotillomania: An adolescent case study. *Cognitive and Behavioral Practice*, *19*(3),

  483-493. doi: 10.1016/j.cbpra.2011.11.002

Woodberry, K. A., & Popenoe, E. J. (2008). Implementing Dialectical Behavior Therapy

  with adolescents and their families in a community outpatient clinic. *Cognitive and*

  Behavioural Practice, *15*(3), 277-286. doi: 10.1016/j.cbpra.2007.08.004

Zapolski, T. C., & Smith, G. T. (2017). Pilot study: Implementing a brief DBT skills program

  in schools to reduce health risk behaviors among early adolescents. *The Journal of*

  School Nursing, *33*(3), 198-204. doi: 10.1177/1059840516673188

Appendix A: Health and Disability Ethics Committee Approval Letter

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011

hdecs@moh.govt.nz

07 February 2019

Dr Clare-Ann Fortune
School of Psychology, Easterfield Building
PO BOX 600
Wellington 6140

Dear Dr Fortune

Re:	**Ethics ref:**	**18/NTB/182**
	Study title:	He Waka Eke Noa at Korowai Manaaki: A Process Evaluation

I am pleased to advise that this application has been _approved_ by the Northern B Health and Disability Ethics Committee. This decision was made through the HDEC-Full Review pathway.

<u>Conditions of HDEC approval</u>

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Northern B Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at _any_ locality in New Zealand, all relevant regulatory approvals must be obtained.

2. Before the study commences at _each given_ locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

<u>Participant access to ACC</u>

The Northern B Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

Ms Kate O'Connor
Acting Chairperson
Northern B Health and Disability Ethics Committee

Encl: appendix A: documents submitted
        appendix B: statement of compliance and list of members

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Appendix A
Documents submitted

Document	Version	Date
PIS/CF: PIS/CF for Professionals e.g., facilitators, social workers, case managers, residential staff etc	1	26 September 2018
PIS/CF: PIS/CF for Family Members of Young People involved with He Waka Eke Noa programme.	1	26 September 2018
PIS/CF: Participant Information Sheet for young people under the age of 16 with Assent Form for young people, and Consent Form for their legal guardain.	2	26 September 2018
PIS/CF: PIS/CF for young people aged 16 and over.	2	26 September 2018
CV for CI: CV for CI - Dr Clare-Ann Fortune	1	26 September 2018
CVs for other Investigators: CV for other Investigator - Molly Weenink (MSc Student)	1	26 September 2018
Evidence of scientific review: Peer Review form by Louise Dixon	1	26 September 2018
Protocol: Protocol	1	26 September 2018
Transcription/Coding Confidentiality agreement	1	26 September 2018
Interview (semi) Structure for Young People currently doing the DBT programme.	1	26 September 2018
Interview (semi) Structure for facilitators.	1	26 September 2018
Interview (semi) Structure for Young People who have completed the DBT programme.	1	26 September 2018
Interview (semi) Structure for Social Workers	1	26 September 2018
Declined letter for previous application in respect of the same (or substantially similar) study: Declined letter from first application	1	11 October 2018
Declined letter for previous application in respect of the same (or substantially similar) study: Declined letter from second application	1	11 October 2018
Covering Letter: Cover Letter addressing previous ethical concerns	2	11 October 2018
Alternative PIS in pamphlet form for young people under 16 years	2	11 October 2018
Alternative PIS in pamphlet form for young people over 16 years	2	11 October 2018
Staff debriefing pamphlet	1	11 October 2018
Young People and Whānau debriefing pamphlet	1	11 October 2018
Interview (semi) Structure for Staff e.g., residential staff	1	26 September 2018
Interview (semi) Structure for Whānau	1	26 September 2018
Application		11 October 2018
Covering Letter: Cover Letter outlining outstanding ethical issues	1	11 January 2019
Document outlining Māori Consultation	1	11 January 2019
PIS/CF: PIS/AF for Young People (in HDEC version)	1	11 January 2019
PIS/CF: PIS/AF for Young People (pamphlet)	1	11 January 2019
PIS/CF: PIS/CF for Guardians of Under 16s	1	11 January 2019
PIS/CF: PIS/CF for Professional	1	11 January 2019
PIS/CF: PIS/CF for whānau	1	11 January 2019
PIS/CF: PIS/CF for Young People (HDEC version)	1	11 January 2019
PIS/CF: PIS/CF for Young People (Pamphlet)	1	11 January 2019
Protocol: Updated protocol	1	11 January 2019
Letter of support from Dr Tia Neha (Māori Consultant)	1	11 January 2019

Appendix B
Statement of compliance and list of members

Statement of compliance

The Northern B Health and Disability Ethics Committee:

— is constituted in accordance with its Terms of Reference
— operates in accordance with the *Standard Operating Procedures for Health and Disability Ethics Committees*, and with the principles of international good clinical practice (GCP)
— is approved by the Health Research Council of New Zealand's Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990
— is registered (number 00008715) with the US Department of Health and Human Services' Office for Human Research Protection (OHRP).

List of members

Name	Category	Appointed	Term Expires
Mrs Maliaga Erick	Lay (consumer/community perspectives)	01/07/2015	01/07/2018
Mr John Hancock	Lay (the law)	14/12/2015	14/12/2018
Dr Nora Lynch	Non-lay (health/disability service provision)	24/07/2015	24/07/2018
Miss Tangihaere Macfarlane	Lay (consumer/community perspectives)	20/05/2017	20/05/2020
Mrs Kate O'Connor	Lay (ethical/moral reasoning)	14/12/2015	14/12/2018
Mrs Stephanie Pollard	Non-lay (intervention studies)	01/07/2015	01/07/2018
Mrs Leesa Russell	Non-lay (intervention studies), Non-lay (observational studies)	14/12/2015	14/12/2018
Mrs Jane Wylie	Non-lay (intervention studies)	20/05/2017	20/05/2020

Unless members resign, vacate or are removed from their office, every member of HDEC shall continue in office until their successor comes into office (HDEC Terms of Reference)

http://www.ethics.health.govt.nz

Appendix B: Auckland District Health Board Approval Letter

Auckland DHB
Research Office
Level 14, Support Bldg
Auckland City Hospital
PB 92024, Grafton, Auckland
Phone: 64 9 307 4949 Extn. 23854
Fax: 64 9 307 8913
Email: mwoodnorth@adhb.govt.nz
Website:
www.adhb.govt.nz/ResearchOffice

2nd April 2019

Clare-Anne Fortune
School of Psychology
Victoria University of Wellington

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Institutional Approval
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Dear Clare-Anne,

Re: Research project A+ 8421 (HDEC 18/NTB/182) He Waka Eke Noa at Korowai Manaaki: a process evaluation

The Auckland DHB Research Review Committee (ADHB-RRC) would like to thank you for the opportunity to review your study and has given approval for your research project.

Your Institutional approval is dependent on the Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure you have kept Ethics and the Research Office up to date and have the appropriate approvals. ADHB approval may be withdrawn for your study if you do not keep the Research Office informed of the following:

- Any communication from Ethics Committees, including confirmation of annual ethics renewal
- Any amendment to study documentation
- Study completion, suspension or cancellation

More detailed information is included on the following page. If you have any questions please do not hesitate to contact the Research Office.

Yours sincerely

On behalf of the ADHB Research Review Committee Dr Mary-Anne Woodnorth
Manager, Research Office
ADHB

c.c.   Molly Weenink, Jemma Stephens, Andrew Cox

Welcome *Haere Mai* **|** Respect *Manaaki* **|** Together *Tūhono* **|** **Aim High** *Angamua*
adhb.govt.nz

Appendix C: Waitematā and Auckland District Health Boards Māori Research Committee Approval Letter

He Kamaka Waiora
Waitematā and Auckland DHB
Level 2, 15 Shea Terrace,
Auckland 0740,
New Zealand
Private Bag: 93-503

02/04/2019

Jemma Stephens
Greenlane Clinical Centre
Auckland

Re: He Waka Eke Noa at Korowai Manaaki: a process evaluation.

Thank you for providing the following documents the:
- RRC application
- Study protocol
- PIS/CF
- HDEC application

The study is a regional evaluation of He Waka Eke Noa (DBT skills-based programme – Youth Justice). There will be 15-25 participants recruited from within the Auckland region. It is estimated that the number of Māori participants may be approximately 10-17.

Māori responsiveness:

The researchers note that Māori youth are over-represented among the youth justice population.

While the researchers believe that the relatively high numbers of Māori youth in this area automatically translates to the study producing benefits for Māori youth, the study will not include ethnicity sub-analysis and will not produce information about Māori youth experiences specifically.

The research team plan to engage in on-going Māori consultation and will continue to work with the Cultural Supervisor at the Regional Youth Forensic Services who will be assisting to support rangatahi who are participating in the study.

On behalf of the Waitematā and Auckland District Health Boards Māori Research Committee, the study has been approved.

Heoi ano

Kim Southey
Kaupapa Māori Analyst
Waitematā and Auckland DHB
Level 2, 15 Shea Terrace, Auckland 0740,
New Zealand
Private Bag: 93-503
p: +64 021 828 651
email kim.southey@waitematadhb.govt.nz

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Appendix D: Oranga Tamariki Conditional Approval Letter

14 May 2019

School of Psychology
Victoria University of Wellington
PO Box 600
Wellington 6040
NEW ZEALAND

Tēnā koe Molly,

LETTER OF RESEARCH APPROVAL
"He Waka Eke Noa at Korowai Manaaki: A Process Evaluation"

Thank you for submitting your research access application to the Oranga Tamariki–Ministry for Children Research Access Committee (RAC).

I am pleased to inform you that your research access application for "He Waka Eke Noa at Korowai Manaaki: A Process Evaluation" has been given <u>full</u> approval.

There are a number of research access <u>conditions</u> and <u>requirements</u>. These are set out in detail below. Your research must maintain fidelity with your RAC application and the HDEC ethics approval. Please notify us if there are significant changes.

Should you have any concerns or questions about the research approval, or for other research related matters, please continue to contact the RAC's Research Access Coordinator.

It should also be noted that the Oranga Tamariki research access process is changing shortly. After 1 June 2019, correspondence to the Coordinator should be directed to the email address research@ot.govt.nz.

Good luck with your research.

Nāku noa, nā,

Dr James McIlraith

Research Access Coordinator (Acting)
Principal Advisor | Research and Evaluation

The Aurora Centre
56 The Terrace
Wellington, 6011

PO Box 546
Wellington, 6140

Phone 04 916 3300
research@ot.govt.nz
www.orangatamariki.govt.nz

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Oranga Tamariki
Research Access Committee Approval

RAC CONDITIONS

Research access for "He Waka Eke Noa at Korowai Manaaki: A Process Evaluation" is subject to the following research access conditions.

- Ensure there is clear discussion about the project with young participants as well as their parents or guardians, and other participants. This includes talking with young participants and making sure they clearly understand:

    - why they are participating
    - who is involved
    - what their involvement is all about
    - that they can choose not to participate or decide to stop participating at any time
    - that they can access the information they give and the outcomes from the research
    - the upsides and downsides of participating
    - what confidentiality means and how their confidential information will be treated.

- The researchers must ensure all steps are taken to minimise any distress or discomfort to participants, including offering the option of having a support person where appropriate, and addressing specific cultural needs.
- All information collected from participants and to ensure confidentiality and privacy must be treated with care and suitably de-identified and stored a) separately from any materials that could identify the person(s) and b) in a secure (encrypted/locked) manner.
- Direct CYRAS access is not permitted for project researchers. Arrangements must be made for file data identification and gathering with Korowai Manaaki staff. This includes risk assessment information. This file data access must be based on participant's informed consent.
- The data from this study cannot be used in future research, or given to another researcher if they request it, without first gaining Ministry approval. Transcriptions, and an electronic database, with no identifying information, cannot be kept indefinitely. The information collected should only be kept for a maximum of 5 years (not 10 years). A clear procedure and person / party responsible for destroying the data at the end of the storage period must also be established. Statements in the consent forms and information sheets must be amended to reflect these conditions.
- The research must otherwise maintain fidelity with the details provided in the RAC application and with the HDEC ethics approval.

RAC REQUIREMENTS

Research changes and review

RAC application approval is based on the proposed research design and the commitment to good research practice. It is important that the Research Access Coordinator is informed of any significant changes or delays to the research (and research access). The RAC may also stipulate periodic reviews of the research.

- The researchers are required to inform the RAC if there are significant changes that impact upon their research access request (approval).

Confidentiality agreement

RAC research access is contingent on the researcher(s) (and other parties if applicable) signing the

Oranga Tamariki **Research Access Committee Approval**
Deed of Confidentiality. This is an acceptance of the way information for which research access has been granted will be used. It also reflects the <u>seriousness of any breach</u> of the information privacy principles contained within the Privacy Act 1993. • The researchers will sign and return confidentiality agreements to the RAC. Confidential research information gathered will not be shared or disclosed to anyone else.
Safety checks
Safety checks are carried out as a matter of course. Safety clearance 'Police Vetting' forms are ordinarily submitted with the application form. • The primary researcher will undergo a safety check. Please provide a copy of a safety check approval from another agency if this is being undertaken elsewhere. This must be completed prior to being the research.
Final report or findings
Researchers are also required to submit final copies of all primary research outputs for which research access was granted, for the RAC's records and wider dissemination if appropriate. • The researchers are required to send to the Research Access Coordinator at National Office (Wellington) a copy of their final report or findings.

Submission details

Confidentiality agreement(s) and the safety check form(s) are to be completed and returned by email (scanned) to the Research Access Coordinator.

Please ensure that separate PDF files are sent for each individual submitting electronic confidentiality forms and safety check form(s).

Penultimate drafts are to be sent via email to the Research Access Coordinator in Microsoft Word or Rich Text Format (in a single file).

Final copies are to be sent via email to the Research Access Coordinator in PDF, Microsoft Word or Rich Text Format (in a single file). Hard-copies of the draft or final versions may also be requested.

Research Access Coordinator (contact)

Research Access Coordinator
Evidence Centre
Oranga Tamariki –Ministry for Children
PO Box 546
Wellington 6140
NEW ZEALAND

Email: research@ot.govt.nz
Phone: +64 4 916 3300

Appendix E: Young Person Participant Information Sheet Pamphlet Version

He Waka Eke Noa at Korowai Manaaki:
A Process Evaluation

He waka eke noa.

We're all in this together.

What is this research project about?

He Waka Eke Noa aims to help young people with their behaviour and the way they deal with hard situations. We want to know what you thought about the He Waka Eke Noa skills group. This information will be used for a Masters' research project.

Why is this research important?

We want to know what works well and what doesn't. This helps us make the group better for other young people who do the group.

Who are the participants?

We want to interview you because you have done the He Waka Eke Noa group.

We will also interview some of the families of young people who have done the group; and some professionals (e.g., the group facilitators who worked with you or your case leader) to see what they thought about it.
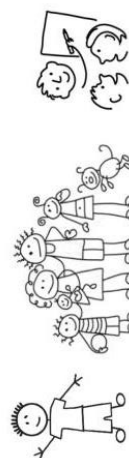
Who can I contact?

If you have any questions, concerns or complaints about the study at any stage, you can contact the people below. You can call between 9am – 5pm to speak to someone or leave a message. You can email at any time.

Dr Clare-Ann Fortune Senior Lecturer in Clinical Forensic Psychology Phone: (04) 463 5788 Clare-Ann.Fortune@vuw.ac.nz Forensic Psychology Masters': Student: Molly Weenink Molly.Weenink@vuw.ac.nz	For Māori health support please contact: Patrick Mendes Cultural Advisor, Regional Youth Forensic Service, Auckland District Health Board Phone: (09) 623 4646 pmendes@adhb.govt.nz
If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on: Phone: 0800 555 050 Email: advocacy@hdc.org.nz	You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on: Phone: 0800 4 ETHICS Email: hdecs@moh.govt.nz

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Locality: Victoria University of Wellington
Ethics committee ref: 18/NTB/182

This research has been approved by Health and Disabilities Ethics Committee, Oranga Tamariki and Auckland District Health Board.

A summary of the results will be published on Dr Clare-Ann Fortune's website in mid 2019: http://youthfpsy.com/

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

HWEN at Korowai Manaaki – Young Person PIS/CF

Interviews

Interviews with you will either be done in face-to-face or over the phone. If you are still at the residence, the interview will probably be done there.

If you are not at the residence anymore, the interview will probably be done over the phone or somewhere public which suits you.

The interviews will last between 20-40 minutes. They will be about what you thought about the group.

40 min

We will also look at the information on your file. We will look at your Oranga Tamariki file and your Taiohi Tu Taiohi Ora file. This will include your age, ethnicity, charges, sentences, and risk assessment information.

We will ask you to consent (agree) to be part of this study which includes collecting this information and interviewing you.

Are there any risks?

We don't expect the study will harm you in any way. We will be asking you what you thought about the group.

If anything emotionally difficult comes up for you, we will work with Korowai Manaaki staff or social workers to support you.

No one in Oranga Tamariki or Korowai Manaaki or Taiohi Tu Taiohi Ora will be told what you say unless it is information about you, or someone else being unsafe.

If you tell us something that makes us worried about you or someone else being unsafe, we will talk to someone like staff at Korowai Manaaki, your social worker, or the Police to make sure you and other people are safe.

SAFETY FIRST

We will try to tell you what we are going to do first.

Consent

Being in this study is completely voluntary (up to you). If you do not want to be in this study, you do not have to give a reason why. It will not change how you are looked after by Youth Justice.

☐ YES
☐ NO
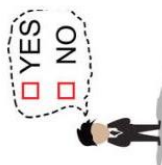
Can you change your mind?

You can pull out from the study without giving any reason, at any time up until two weeks after your interview has ended. You can let us know if you would like to pull out in person, email, or by phone with the help of your Case Leader.

We will also check at the start of the interview that you are still happy to go ahead. If you do not want to, or want to stop at any time, then we will do so.

What happens to the information collected?

1. The interview with you will be voice recorded. The voice recordings will be typed out (called transcripts) and then the recording will be destroyed.

2. We will try to contact you to ask you to review your transcript and you may change or remove any statements if you wish. You may also contact the researchers if you wish to make changes. You may do this up until two weeks after the interview.

3. We will keep the typed out copies of the interviews in a secure computer file. There will be nothing on the file that will be able to show who you are.

4. We will keep the forms that you sign for at least 10 years after we print this study. They will then be destroyed.

5. The computer file will be kept for at least 10 years after you turn 16. It might be used for future research or given to another researcher if they ask for it. They won't know who you are but will just be able to read what you said.

6. The researchers, and others may want to show what we find out about the programme e.g., in presentations and reports.

7. Who you are will be kept private. We will not use your name at all.

Appendix F: Participant Information Sheet and Consent Form (Professional)

Participant Information Sheet/Consent Form - Professional

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Study title:	*He Waka Eke Noa at Korowai Manaaki: A Process Evaluation*		
Locality:	Victoria University of Wellington	Ethics committee ref.: 18/NTB/182	
Lead investigator:	**Dr Clare-Ann Fortune**	Contact phone number:	**04 463 5788**

You are invited to take part in a study on He Waka Eke Noa at Korowai Manaaki. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. The decision whether to take part or not will not impact the care of any of the young people participating in the research, nor will it affect your employment.

This Participant Information Sheet will help you decide if you'd like to take part. It tells you why we are doing the study, what you would do as a participant, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, programme staff or other staff at the residence. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

This document is six pages long, including the Consent Form. Please make sure you have read and understood all the pages.

WHAT IS THE PURPOSE OF THE STUDY?

The He Waka Eke Noa programme is designed to help young people address behavioural problems and improve a young person's ability to cope with challenging situations. It is the first of its kind in New Zealand to be used with youth in a youth justice residence. However, we don't know how well it's working or what the people involved with the programme think about it. The research from this study will be collected and used as part of a Masters' thesis.

It is important to look at the programme's strengths and areas where it can be made better. This includes helping us better understand what you think about the programme and what you think could help make it better.

WHAT WILL MY PARTICIPATION IN THE STUDY INVOLVE?

The people involved in the study will be made up of three groups:
(1) The young people still in the He Waka Eke Noa programme, as well as those who have just finished it.

HWEN at Korowai Manaaki: Process Evaluation

Staff PIS/CF

Page 1 of 6

Dated: December 2018

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(2) Families/whānau and caregivers of the young people involved in the programme.
(3) Professionals e.g., facilitators, case leaders, social workers and residential staff.

We would like to conduct an interview with you. This will either be done in person, over the phone, or via an Audio-Visual Link. This will be dependent on whatever is easiest for you. The interviews will last between approximately 20-40 minutes. They will cover topics such as what you knew about the programme, how you were supported, and what you think about it. These interviews will be audio recorded and transcribed.

WHAT ARE THE POSSIBLE BENEFITS AND RISKS OF THIS STUDY?

This study will contribute to our understanding of the He Waka Eke Noa programme at Korowai Manaaki. We will be asking about your thoughts on the programme but if anything distressing comes up for you, please feel free to contact us. It may also help to seek support from a friend or family member you feel comfortable with. Alternatively, you may contact your local GP or access your employee assistance programme, with details available on your staff Intranet or through your manager.

Your participation in this study will not impact your employment. You need to be aware that although your name will not be published, due to the small number of professionals taking part, others may identify you from your role and/or what you say so it is advisable to consider this. As stated below, we will provide you with an opportunity to review your transcript.

The benefits of this project will include gaining an increased understanding of the He Waka Eke Noa programme in order to make it better in areas where this is needed.

WHO PAYS FOR THE STUDY?

You will not incur any costs for this study. We will provide you with a koha to thank you for your participation.

WHAT ARE MY RIGHTS?

You will be asked to take part in the project voluntarily (by choice), providing informed consent. You will be given information about the project.

Your name will never be included in any published from (e.g., thesis or articles) nor will it be used in presentations at conferences, etc. Participant confidentiality will be maintained for young people and their caregivers. However, due to the small number of professionals involved, their identity may become obvious based on their role and comments. Therefore, we will make reasonable attempts to contact you in order to provide you with the opportunity to review your transcript before it is disseminated. You may also contact the researchers if you wish to change or remove any statements you made during the interview. You may do this up until two weeks after the interview.

Consent forms will be kept securely for at 5 years after publication, then destroyed. Audio recordings will be transcribed and then destroyed. Transcriptions, and an electronic database, with no identifying information, will be kept indefinitely. Results, including (anonymous)

quotations, may be used in publications and/or presentations. The anonymous database may be used in future research, and may be shared with other researchers upon request.

A summary of the overall results of this study will be made available on Dr Clare-Ann Fortune's website in mid 2019 - http://youthfpsy.com/.

Additionally, Oranga Tamariki, Regional Youth Forensic Services and Auckland District Health Board will be presented with a summary of the research in a manner that suits them, such as through a poster, summary report, and/or a short presentation. A copy of the thesis will also be given to all organisations and lodged in the university library.

WHAT HAPPENS AFTER THE STUDY OR IF I CHANGE MY MIND?

You can withdraw from the study without giving any reason, at any time up until two weeks after the interview has ended. You can let us know if you would like to withdraw in person, email, or over the phone. We will also check before beginning the interview that you are still happy to go ahead. If you do not want to, or want to stop at any time, then we will do so.

HWEN at Korowai
Manaaki: Process
Evaluation

Staff PIS/CF   Dated: December 2018

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WHO DO I CONTACT FOR MORE INFORMATION OR IF I HAVE CONCERNS?

If you have any questions, concerns or complaints about the study at any stage, you can contact the people below. You can call between 9am – 5pm to speak to someone or leave a message. You can email at any time.

Molly Weenink, Forensic Psychology Masters Student or her supervisor,
Dr Clare-Ann Fortune
Telephone number: 04 463 5788
Molly.Weenink@vuw.ac.nz
Clare-Ann.Fortune@vuw.ac.nz

For Māori health support please contact:

Patrick Mendes, Cultural Advisor, Regional Youth Forensic Service,
Auckland District Health Board
Phone: 09 623 4646
Email: pmendes@adhb.govt.nz

OR

For support, talk to your whānau in the first instance. Alternatively you may contact the administrator for He Kamaka Waiora Māori Health Team on 09 486 8324 ext 2324. If you have any questions or complaints about the study, you may contact the Auckland and Waitematā District Health Boards' Māori Research Committee or Māori Research Advisor by phoning 09 486 8920 ext 3204.

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
Email: hdecs@moh.govt.nz

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Consent Form

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Please tick to indicate you consent to the following:

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.
I have been given sufficient time to consider whether or not to participate in this study.
I have had the opportunity to use a legal representative, whānau/ family support, residential staff or a friend to help me ask questions and understand the study.
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time up until two weeks after the end of the interview.
I understand that due to the small number of staff involved, my identity may become known to some people. I therefore understand that I will be given the chance to review (withdraw and/or change) all quotes used prior to the publication of this thesis.
I understand that quotes may be used in publications and presentations but that identifying information (e.g., names) will be removed as much as possible.
I know who to contact if I have any questions about the study in general.
I understand my responsibilities as a study participant.
I wish to receive a summary of the results from the study.   Yes ☐   No ☐

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Declaration by participant:

I hereby consent to take part in this study.

Participant's name: _____

Signature: _____ Date: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name: _____

Signature: _____ Date: _____

HWEN at Korowai
Manaaki: Process
Evaluation

Staff PIS/CF

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Dated: December 2018

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Appendix G: Interview Semi Structure (Facilitators)

Interview: Therapist Perceptions of the Programme (Post Programme)

Interviewer: _____Interviewee: _____Date: _____

Section 1: Background information

First of all, I would like to ask you some questions about yourself so that I get a few details about your background.

1. Can you tell me about your role in the He Waka Eke Noa group?

    _____

    _____

2. How long have you been working in this role for?

    _____

    _____

3. What kind of work experience do you bring to that role?

    _____

    _____

4. What are your qualifications?

    _____

    _____

5. What is your ethnicity?

    _____

    _____

6. What DBT training did you receive prior to the commencement of that role?

    _____

    _____

7. How well did this prepare you for your role?

    _____

    _____

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8. How was your work performance measured?

_____

_____

9. Did you receive any supervision/consultation? [Checklist: internal supervision, external professional supervision, group supervision]

_____

_____

10. How well did this supervision meet your needs?

_____

_____

11. Do you have any suggestions for improving training or supervision/consultation in relation to the He Waka Eke Noa group?

_____

_____

Section 2: Referral Process

1. Can you tell me about the way you received referrals?

_____

_____

2. Are there any ways you can think of that this process could be improved?

_____

_____

Section 3: Assessment Process

1. Tell me about the assessment process. Talk me through it.

_____

_____

_____

_____

2. How were the needs of the young person identified?

_____

_____

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3. What strengths/protective factors did you look for in the young people?

_____

_____

4. How did the assessment information feed into the treatment of the individual? [intensity, content]

_____

_____

5. What improvements do you think could be made to the assessment process?

_____

_____

Section 4: Treatment Programme

1. What are the goals of the He Waka Eke Noa group?

_____

_____

2. What are your thoughts on delivering this treatment to young people?

_____

_____

3. What do you think are the psychological kills these young people need to develop?/What do they need for psychological wellbeing?

_____

_____

4. How well do you think feel that the young people understood the concepts being taught? Why is that?

_____

_____

5. What do you think you could do to improve the understanding?

_____

_____

6. What skills used in the programme did you find most useful for the young people?

_____

_____

7. What skills did you find least useful for the young people? Why?

_____

_____

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8. Do you think the skills flowed well together?

    _____
    _____

9. How did you find the number of young people in the group?

    _____
    _____

10. What attitude to the young people usually present in group with? Are there things that you find influences this?

    _____
    _____

11. How did you find the length of the sessions?

    _____
    _____

12. How did you find the time the sessions took place?

    _____
    _____

13. Are there individual and group sessions?

    _____
    _____

    a. Did both types of delivery work well?

    _____
    _____

14. How did you cater to the criminogenic needs of an individual in a group format?

    _____
    _____

15. What do you think of the HWEN workbook?

    _____
    _____

16. How could it have been improved?

    _____
    _____

17. What contact did you have with family members? What restricted more access?

    _____
    _____

18. Was this sufficient? [Many criminogenic needs are systems related and emotion dysregulation often seen between parent and child]

_____

_____

19. What contact did you have with outside services other than MCOT?

_____

_____

20. Tell me about the rooms used to deliver therapy. How suitable was it?

_____

_____

21. Thinking about your time working in the programme, can you give an example of a young person who did particularly well?

_____

_____

22. What do you think were the contributing factors of this?

_____

_____

23. Can you give an example of someone that did not do so well on the programme?

_____

_____

24. What do you think were the contributing factors of this?

_____

_____

25. In general, what do you think are the factors that most contribute to successful treatment outcome?

_____

_____

26. What do you think are the factors that most contribute to poor outcome?

_____

_____

27. How well do you think the programme sets the young people up for reintegration? [Aftercare?]

_____

_____

28. How well do you think the unit environment integrated the teachings of the treatment programme? [Change in units?]

_____

_____

Section 5: Cultural Services

1. How well do you feel you are able to support the cultural needs of these young people:

   a. Their ethnicity

1	2	3	4	5	6	7
Not at all						Very well

   b. Their religious views/spirituality

1	2	3	4	5	6	7
Not at all						Very well

   c. Their age

1	2	3	4	5	6	7
Not at all						Very well

2. Did you receive any i) formal, ii) informal cultural supervision for working with Māori or Pasifika clients?

_____

_____

3. How well did this supervision support you to meet the needs of your clients?

1	2	3	4	5	6	7
Not at all						Very well

1. Do you have any suggestions for improving the way in which HWEN could meet the cultural needs of the young people in the group based on their i) ethnicity, ii) spirituality, iii) their age?

_____

_____

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_____

_____

2. Theoretically, how do you think DBT combines with cultural responsivity?

_____

_____

_____

_____

Section 6: Improvements and Outcomes

1. In your opinion, what are the three biggest strengths of the programme?

_____

_____

2. If you could change three things about the programme, what would they be?

_____

_____

3. What would you like to see for the future of the programme?

_____

_____

4. Theoretically, do you believe DBT meets the needs of these young people?

_____

_____

5. Is there anything else you would like to say about the programme?

_____

_____

Wrap Up

We are about to wrap up this interview and will be turning the audio recorder off. Before we do, is there anything that you would like to add about your thoughts of the programme; or change any of your answers to what we have discussed today?

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