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AN EVALUATION OF PUAWAITAHI:
NEW ZEALAND'S FIRST MULTI-AGENCY
FOR CHILD PROTECTION

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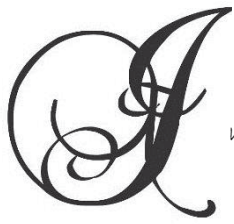
*I*n the beginning God created the heaven and the earth.

Then God stood back, viewed everything made, and proclaimed "Behold, it is very good." And the evening and the morning were the sixth day.

And on the seventh day God rested from all work.

God's archangel came then, asking, "God how do you know that what you have created is 'very good'? What are your criteria? On what data did you base your judgement? Just what results were you expecting to obtain? And aren't you a little close to the situation to make a fair an unbiased evaluation?"

God thought about these questions all that day and God's rest was greatly disturbed. On the eighth day God said, "Lucifer, go to hell."

Thus was evaluation born in a blaze of glory.

— From Halcolm's *The Real Story of Paradise Lost*

ABSTRACT

Puawaitahi is New Zealand's first multi-agency service for child protection. It incorporates health, child protection, Police, evidential interviewing, and therapy services at one centralised location. This research aimed to examine the processes and procedures within the multi-agency. Focus groups and interviews were conducted with staff, referrers and children and families who had been seen within the service. Transcripts were analysed to identify common themes in relation to the multi-agency processes and procedures, the organisation's culture, accessibility, coordination, timeliness, quality of care, and areas for programme improvement. The programme evaluation found that Puawaitahi meets the majority of its own vision and mission statement goals and performs well in relation to the standards described for Child Advocacy Centres as they are known elsewhere. In particular, the multi-agency processes and procedures provided effective case coordination, and the physical environment, child focused service delivery, staff cultural competence, and interactions with stakeholders were rated highly by most participants across staff, referrer and consumer groups. Desired improvements included better access to therapy, changes to client referral and case coordination processes to further reduce delay, better client follow up procedures, and provision of the multi-agency model across every region in Auckland. This evaluation shows that a model inspired by USA Child Advocacy Centres has been effectively implemented and Puawaitahi stands as a model for implementation elsewhere in New Zealand. Issues concerning the evaluation of such programmes are discussed.

— This thesis is dedicated to my family, for whom I would not be where I am without —

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have been looking forward to never having to say "I have to do my thesis" in response to nights out, weekends away and social events.

Finally, a massive thank you to my family, especially my mum and dad without your love and support I would not have had the opportunity to undertake, let alone finish this thesis (and finally walk across that stage in a maroon robe). Thank you for putting a roof over my head, food in my belly and being there to listen to all the highs and lows throughout this journey at any hour of the day or night. To my little brother and best friend, Kurty, you kept me sane! You always know how to put a smile on my face and make me laugh, thank you.

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CHAPTER ONE: INTRODUCTION

During my clinical psychology training I have taken specific interest in the structure, process and procedures of services and particularly child and adolescent mental health services. Given that children suffering from abuse are among the most vulnerable of clients presenting to services and that these experiences of abuse and neglect can have significant impact on the psychological well-being of children, I was particularly interested in the part agencies play in the management of child abuse. This interest has grown from the awareness of New Zealand's (NZ) shocking child abuse statistics and the media's negative depiction of child statutory services involved in the management of such cases. I have observed government initiated changes which have seen a funding focus shift from management to prevention in an apparent effort to decrease the number of children subjected to abuse and neglect.

The subject of this thesis is Puawaitahi, an Auckland based multi-agency service for child protection. The origins of Puawaitahi arose from the observation of professionals that effective coordination of child abuse service provision was lacking. This was subsequently confirmed in relation to child sexual abuse in a project that involved interviews with over one hundred non-offending parents and children in Auckland (Davies & Seymour, 2002). Their finding revealed gaps in service provision, long delays in investigation and access to treatment, lack of interagency coordination, conflicting messages to families from different professionals, and a lack of parent/family support. The efforts of a group of practitioners from across Health, Police, CYF and Auckland University researchers then sought to address these deficiencies through the development of a New Zealand adaptation of the USA Child Advocacy Centre model. As a result Puawaitahi, the first multi-agency of this kind in New Zealand, was established in 2002 with the aim of improving coordination, efficiency, and the experience of those who engage with social services. Puawaitahi aims to provide a one-stop-shop for those affected by child abuse and neglect. The multi-agency investigates alleged abuse of children and young people in the Auckland region and works with victims of abuse and their families to help them access additional therapy and support services.

At the 10th anniversary of Puawaitahi it was acknowledged that although the agency has received many anecdotal reports of better service and staff coordination and positive client satisfaction, there had been no formal evaluation of whether this multi-agency model of practice met its goals and provided an improvement in service delivery. Senior staff members

at Puawaitahi indicated the desirability of a systematic evaluation. This led to the present research.

This thesis provides Puawaitahi's first comprehensive programme evaluation. The research employed focus groups with staff members to investigate the multi-agency processes, evaluate these against their stated goals, and gather suggestions for improvements. Further, ideas were gathered from staff about what a comprehensive programme evaluation might entail. Evaluation ideas from the staff focus groups and consideration of programme evaluation literature were presented to the Puawaitahi management team. After a number of meetings a proposal was developed and agreed on by all key stakeholders to form the basis of this research. The study design included a mixture of focus groups and in-depth interviews with referrers to the service and consumers (both children and their caregivers) to explore their experiences of Puawaitahi.

The research was conducted over three phases. In the first phase information about the processes and procedures of the agency was gathered and focus groups were conducted with staff members. In the second phase, referrers' experiences of the multi-agency were examined. Finally, the third phase involved interviews with children and caregivers and a thematic analysis was conducted of their experiences of the services they received at Puawaitahi.

In setting the context for this research, this chapter starts with a brief overview of definitions of child abuse, estimates of prevalence and incidence, and impact of child abuse. There follows an overview of current and historical efforts, both overseas and in NZ, to coordinate the many statutory services involved in child protection. Then legislation, policies, and procedures that are pertinent to the management of child abuse in NZ are described. Finally, recent and current government initiatives, projects and promises regarding the management and prevention of child abuse are discussed.

Definitions of Child Abuse and Neglect

Child abuse is defined in NZ in s. 2(1) of the Children, Young Persons, and Their Families Act (CYFA) (1989) as "the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect, or deprivation of any child or young person". The different types of abuse are not defined in legislation, but are described elsewhere by the World Health Organisation (WHO) and the International Society for Prevention of Child Abuse and Neglect (ISPCAN) (WHO & ISPCAN, 2006); definitions that are commonly used in the

literature. These definitions are presented in the following, along with those of Child Youth and Family (CYF), NZ's child protection service, in order to give an NZ context.

Child physical abuse: Child physical abuse (CPA) is defined by WHO & ISPCAN (2006, p.10) as "the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating." Commonly physical violence against children in the home is inflicted with the purpose of punishing. In CYF's *An Interagency Guide to Breaking the Cycle* information brochure (Child Youth and Family, 2001, p.8), physical abuse is described as **"**any act or acts that result in inflicted injury to a child or young person. It may include, but is not restricted to: bruises and welts, cuts and abrasions, fractures or sprains, abdominal injuries, head injuries, injuries to internal organs, strangulation or suffocation, poisoning and burns or scalds. Such injury or injuries may be deliberately inflicted or the unintentional result of rage. Regardless of motivation, the result for the child is physical abuse."

Emotional and psychological abuse: "Emotional and psychological abuse involves both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment" (WHO & ISPCAN, 2006). Abuse of this type includes "the restriction of movement**,** patterns of belittling, blaming, threatening, frightening, discriminating against or ridiculing**,** and other non-physical forms of rejection or hostile treatment" (WHO & ISPCAN, 2006, p.10). In CYF's *An Interagency Guide to Breaking the Cycle* information brochure (Child Youth and Family, 2001, p.9), emotional abuse is described as "any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include, but is not restricted to: rejection, isolation or oppression, deprivation of affection or cognitive stimulation, inappropriate and continued criticism, threats, humiliation, accusations, expectations of, or towards, the child or young person, exposure to family violence, corruption of the child or young person through exposure to, or involvement in, illegal or antisocial activities, the negative impact of the mental or emotional condition of the parent or caregiver and the negative impact of substance abuse by anyone living in the same residence as the child or young person"**.**

Child sexual abuse: Child sexual abuse (CSA) is defined as any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It includes the involvement of a child in sexual activity that he or she does not fully understand, is unable to give informed consent to, or for which the child is not at a developmentally

appropriate stage for, or else that breaks the laws or social taboos of society (WHO & ISPCAN, 2006, p.10). Both adults and/or other children who are in a position of responsibility, trust or power can sexually abuse children. In CYF's *An Interagency Guide to Breaking the Cycle* information brochure (Child Youth and Family, 2001, p.8), sexual abuse is described as "any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to: non-contact abuse, exhibitionism, voyeurism, suggestive behaviours or comments, exposure to pornographic material, contact abuse, touching breasts, genital/anal fondling, masturbation, oral sex, object or finger penetration of the anus or vagina, penile penetration of the anus or vagina, encouraging the child or young person to perform such acts on the perpetrator and involvement of the child or young person in activities for the purposes of pornography or prostitution".

Child neglect: Neglect includes "both isolated incidents, as well as a pattern of failure over time on the part of a parent, caregiver or other family member to meet their child's developmental needs, protect them from harm, and ensure their well-being" (WHO & ISPCAN, 2006, p.10). This includes the areas of health, education, emotional development, nutrition, shelter and safe living conditions. In CYF's *An Interagency Guide to Breaking the Cycle* information brochure (Child Youth and Family, 2001, p.9) neglect is described as "any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It may include, but is not restricted to physical neglect (failure to provide the necessities to sustain the life or health of the child or young person), neglectful supervision (failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm), medical neglect (failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development), abandonment (leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning) and refusal to assume parental responsibility (unwillingness or inability to provide appropriate care or control for a child)".

Prevalence and Incidence of Child Abuse and Neglect

The scope of this problem is estimated from estimates of prevalence and incidence. Prevalence refers to the number of individuals in the population in question who have experienced child abuse and neglect, whereas incidence relates to the number of new cases reported to the relevant agencies – in this case child protection services and/or law

enforcement agencies - during a specified time period, such as a year (Fallon et al., 2010). Prevalence rates will inevitably be higher than those for incidence rates because many instances of abuse or neglect are not detected (Fallon et al., 2010; Finkelhor, 1994; MacMillan, Tanaka, Duku, Vaillancourt, & Boyle, 2013). Finkelhor (1994) concluded that if rates of CSA incidence were similar to those reported in the adult general population surveys, the North American incidence figures captured less than a third of all cases of child abuse. Child abuse prevalence rates are typically studied by way of population surveys, where adults are asked to report whether they experienced child abuse (e.g., Finkelhor, 1994; Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014). It is accepted that this method may not obtain accurate prevalence rates due to memory distortion and the data being reflective of rates of abuse when the sample was young, rather than current child abuse prevalence (Briere & Elliott, 2003).

It is also important to consider that children who have one type of abuse are often subjected to other forms of abuse (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Finkelhor et al., 2014; Gilbert et al., 2009). In New Zealand, an analysis of file information collected for 307 children who presented at Auckland's Puawaitahi multi-agency service for child abuse and neglect over a 4-month period revealed that approximately one fifth presented with more than one type of maltreatment, with the most commonly co-occurring types being sexual and physical abuse (Wolstenholme, 2013). These results are similar to those found elsewhere (e.g., Ackerman et al., 1998; Briere & Elliot, 2003; Stoltenborgh, Bakermans-Kranenburg, Alink, & van Ijzendoorn, 2015).

Prevalence of Child Abuse and Neglect

Stoltenborgh et al. (2015) conducted meta-analyses on the prevalence of child sexual, physical and emotional abuse and physical and emotional neglect, including 244 publications and 551 prevalence rates from all over the world for the various types of maltreatment. The overall global estimated prevalence rates for self-report studies (mainly assessing maltreatment ever during childhood) were 127/1000 for sexual abuse (76/1000 among boys and 180/1000 among girls; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), 226/1000 for physical abuse (Stoltenborgh, Bakermans-Kranenburg, IJzendoorn, & Alink, 2013a; 363/1000 for emotional abuse (Stoltenborgh, Bakermans-Kranenburg, Alink & van IJzendoorn, 2012), 163/1000 for physical neglect and 184/1000 for emotional neglect (Stoltenborgh, Bakermans-Kranenburg, & van IJzendoorn, 2013b).

CHAPTER ONE: INTRODUCTION

In New Zealand, research with the Christchurch Child Development Study cohort of 1265 individuals found that at age 18 years 7.6% reported they were often physically punished by their parents, and 3.9% indicated they were physically punished "too often or too severely", or were treated "in a harsh and abusive way" (Fergusson & Lynskey, 1997). At age 25, 4.5% of the sample indicated that they had experienced "frequent or severe punishment" or had been treated in a "harsh or abusive manner" (Fergusson, Boden, & Horwood, 2008).

Prevalence rates of CSA in NZ appear to be similar to those found internationally: 1 in 3 and 1 in 5 women and 1 in 10 men report having experienced CSA (Fanslow, Robinson, Crengle, & Perese, 2007; Flett et al., 2012; Van Roode, Dickson, Herbison, & Paul, 2009). In a large national survey of NZ secondary school students, 20% of female and 9% of male secondary school students reported they had at some point in their life been touched in an unwanted sexual way or been made to do unwanted sexual acts (Clark et al., 2013). Fergusson and colleagues (Fergusson, Horwood & Woodward, 2000; Fergusson et al., 2008) reported findings from the Christchurch Health and Developmental Study from retrospective reports at ages 18, 21, and 25. Combined results at age 18 and 21 indicated 14% of the cohort had experienced some form of CSA, within which 11.1% reported contact sexual abuse and 6% attempted or actual intercourse. At age 25, 14.1% of the cohort said they had been sexually abused as a child; 2.7% reported non-contact sexual abuse, 5.1% contact sexual abuse that did not consist of sexual penetration and 6.3% sexual abuse that involved actual or attempted sexual penetration of any type.

Stoltenborgh, Bakermans-Kranenburg, & van Ijzendoorn (2013b) noted that only a small number of prevalence studies focused solely on neglect. In an international comparative study, 9% of New Zealand adults reported experiencing three or more neglectful behaviours by their parents (Straus & Savage, 2005). In another NZ study, by Mullen, Martin, Anderson, Romans and Herbison (1996) involving a random survey of 497 women identified from the electoral role, 11.5% of the women reported emotional abuse during childhood at the hands of parents or primary caregivers.

Although the finding reported above confirm that child abuse overall is a global problem of considerable extent, there are methodological issues that influence and limit the conclusions that can be drawn from these studies, including procedural factors, measurement differences, sample characteristics and definitional issues (Stoltenborgh et al., 2011, 2012, 2013a, 2013b, 2015). For example, differences definitions of maltreatment types occur as there is no identical clearly operationalised criteria for each type. Moreover, it was reported that 'low-resource' countries were conspicuously absent or underrepresented in the child

abuse literature, and in particular in relation to child neglect research. Despite the identified issues, authors agree and commonly conclude that child abuse is a widespread, global problem of considerable extent, affecting the lives of millions of children all over the world (Stoltenborgh et al., 2013, 2015).

Incidence of Child Abuse and Neglect

Child abuse and neglect incidence in NZ is higher than in most comparable countries. Unicef's Child Maltreatment Deaths in Rich Nations (UNICEF, 2003) report was the first ever attempt to catalogue physical abuse of children in the 27 richest nations of the world. NZ was found to have the third-highest child-homicide rate (1.2. per 1000000) of children aged up to 14 years during a five year period in the 1990's – exceeded only by Mexico and the United States. Of OECD countries, the death rate per 100,000 children aged 0-19 due to negligence, maltreatment or physical assault over the period 2005-10 shows the rate for NZ to be 1.1, roughly three times the OECD median of 0.4 (OECD, 2013). Furthermore, Australia (intentional child death rate 0.3) share a number of demographic similarities to NZ but, per capita, for every three Australians aged 0-19 who die due to negligence, maltreatment or abuse, 11 NZ children die (OECD, 2013).

CYF is the government agency charged with the statutory responsibility for investigating notifications of suspected child abuse and neglect. In 2016, CYF received 142,249 notifications (84,228 care and protection reports of concern [ROC] and 58,021 Police family violence referrals). Notifications comprise "reports of concern" from people concerned enough about a child's safety to notify child protection authorities (which may require action by CYF) and 'Police family violence referrals' (which do not require action by CYF). Of the 84,228 ROC's 44,689 (53%) were deemed to require further action. When CYF receives a ROC, a social worker determines if further action is required and what needs to happen to keep the child or young person safe. Findings of abuse or neglect were made for 13,598 children (total distinct children and young people, counted once in the period). For many of these individuals there were findings of more than one abuse type: 3,073 had been physically abused, 1,167 had been sexually abused, 3,664 had been subjected to neglect, and 8,490 had been emotionally abused (Child, Youth and Family, 2016). The incidence of child abuse and neglect of Māori children is higher than for non-Māori children across all types of abuse (Child Youth & Family, 2016).

In 2015, NZ Police recorded 10 homicides of children and young people under 20 by a family member (New Zealand Police, 2016). In 2015, there were 1,982 reported sexual

victimisations against a child aged 16 years or under. Police apprehensions for assault against a child under the age of 16 years totalled 1720 (New Zealand Police, 2016). In 2014, 64 children aged 16 years or under were hospitalised for an assault perpetrated by a family member (Injury Prevention Research Unit, Ministry of Health, 2016). Furthermore, children are present at about half of all family violence callouts by police in New Zealand. In approximately 70% of families where interpersonal violence (IPV) occurs the children are also victims of violence directed at them (Murphy, Paton, Gulliver, & Fanslow, 2013). CYF's statistics reveal that the number of Police family violence referrals for 2016 was 58,021: these referrals describe Police call outs to IPV where children were present as either as witnesses or victims (Child, Youth and Family, 2016).

Infometrics (2010), in a report for "Every Child Counts", estimated that child abuse and neglect costs NZ around $NZ2 billion or over 1% of Gross Domestic Product each year. This figure includes the direct costs of health care and child welfare services, ongoing costs related to long run health and crime impacts and also the indirect cost of lost productivity. However, the real cost in terms of the psychological effects on children and their families that lasts a lifetime is incalculable.

Consequences and Impact of Child Abuse and Neglect

The consequences of child abuse and neglect can be devastating. Physical consequences range from physical health distorters (cardiovascular diseases, diabetes, asthma and others) to physical injuries (minor injuries to severe brain damage) and even death (Anda et al., 2006; Cicchetti, 2016; Cicchetti & Valentino, 2006; Perry, 2008; Trickett & McBride-Chang, 1995). Mental health, psychological and psychiatric consequences range from chronic low self-esteem to severe dissociative states (Anda et al., 2006; Green et al., 2010; Fergusson et al., 2008; Scott, Smith & Ellis, 2010). The cognitive effects of abuse range from poor educational achievement, attentional problems and learning disorders to severe organic brain syndromes (Boden, Horwood & Fergusson, 2007; Jonson-Reid, Drake, Kim, Porterfield & Han, 2004; Lansford, Dodge, Pettit, Bates, Crozier & Kaplow, 2002; Perez & Widom, 1994). Behaviourally, the consequences of abuse range from social and interpersonal relationship difficulties to extraordinarily violent behaviours (Gilbert et al., 2009; Kaplan, Pelcovitz, & Labruna, 1999; Tarren-Sweeney, 2013; Trickett & McBride-Chang, 1995). Familial consequences include children being placed in state care or being adopted from such care, fractured families and a loss of family relationships and contact (Andersson, 2005; Tarren-

Sweeney, 2008b). Thus, the consequences of abuse and neglect affect the victims themselves and the wider society in which they live.

Furthermore, the consequences of child abuse and neglect cannot be considered independently as they impact, precipitate and/or perpetuate one another. For example, the consequences of abuse in young children have been shown to damage their growing brain, with associated ongoing consequences of cognitive delays and emotional difficulties (Cicchetti, 2016; Cicchetti & Valentino, 2006; Perry, 2008; Trickett, & McBride-Chang, 1995). Psychological problems often manifest as high-risk behaviours (Atwool, 2011; Fergusson, Horwood & Lynskey, 1997). Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or drugs, or overeat (Fergusson et al., 2008). High-risk behaviours, in turn, can lead to long-term physical health problems, such as sexually transmitted diseases, cancer, and obesity (Child Welfare Information Gateway, 2013).

Children and young people who have contact with CYF go on to experience dramatically worse outcomes as young adults than the rest of the population. Analysis of children born in 1990/91 shows that, by age 22, those who had any type of contact with CYF were more likely to have left school with few qualifications, been in receipt of a main benefit, been in receipt of a main benefit with a child, been referred to CYF for youth justice reasons, and received a community or custodial sentence in the adult corrections system. Compared to the rest of the population, children currently in care have higher rates of stand downs, suspensions, exclusions and expulsions from school, lower levels of NCEA achievement, and lower levels of public health organisation enrolment and high rates of use of mental health services (Insights MSD, 2014). In addition

Both short and long term impacts of abuse and neglect are mediated and moderated by multiple variables, including abuse characteristics and responses to disclosure (Briere & Elliot, 2003), and individual differences in resilience and coping styles (Putnam, 2003). Several reviews have identified that severity, frequency, duration and number of perpetrators of abuse influence whether a person develops psychological symptoms following CPA or CSA (Beitchman et al., 1992; Briere & Jordan, 2009; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). Moreover, the concurrent experience of more than one type of maltreatment has also been associated with poorer psychological outcomes (Barker-Collo & Read, 2003; Beitchman et al., 1992). Factors that relate to the individual child such as age (Barker-Collo & Read, 2003; Briere & Elliot, 2003; Ogloff et al., 2012), coping and attachment style (Barker-Collo & Read, 2003; Briere & Elliot, 2003), and personality can

moderate and mediate the effects of child abuse (Barker-Collo & Read, 2003; Collishaw et al., 2007). Child characteristics shown to promote resilience in relation to exposure to adults' interpersonal violence include intelligence, self-concept, and level of commitment to education (Herrenkohl et al., 2008). Attribution of blame to the offender rather than one's self is another mediating factor shown to influence mental health outcomes following abuse and neglect (Barker-Collo & Read, 2003; Lev-wiesel, 2000; McGee, Wolfe, & Olson, 2001). Furthermore, for children in care, a lack of placement security and/or permanency predicted poorer mental health problems (Tarren-Sweeney, 2008a).

The child's relationship with the perpetrator is also significant as intrafamilial CSA has been found to have a greater impact on psychological functioning than extrafamilial abuse (Barker-Collo & Read, 2003; Beitchman et al., 1992). The reaction of caregivers to child disclosure and identification of child abuse and neglect is an important mediator of future wellbeing. Level of caregiver support following CSA disclosure, in its various forms, has been found to be strongly associated with children's adjustment (Barker-Collo & Read, 2003; Elliot & Carnes, 2001; van Toledo & Seymour, 2013). Delays in access to police and child protection services, lack of support to the victim and family members, and inadequate interagency collaboration are also associated with negative child outcomes (Barker-Collo & Read, 2003; Davies, Seymour, & Read, 2001). Further, there is a need for a more specialised, knowledgeable and multidisciplinary workforce that understands this population (children who have experiences abuse and neglect and are often in state care). Research has suggested that an effective response to child abuse and neglect would need to promote a "whole of government" responsibility which would translate in professionals with specialised knowledge and skills, a focus on psychosocial-development and a strong advocacy role (Tarren-Sweeney, 2010).

Children from families that are socially isolated and below the poverty line are at greater risk of being maltreated in the first place, and may also be more vulnerable to poorer outcomes following abuse since they may not have the environmental and personal resources that can buffer the effects of abuse (Alisic, Jongmans, van Wesel, & Kleber, 2011; Briere & Jordan, 2009). Secure parent-child attachments and strong relationships to a caring adult appear to be protective against poor psychological outcomes following abuse and neglect (Barker-Collo & Read, 2003; Holt, Buckley & Whelan, 2008; Collishaw et al., 2007). Further emotional support, social support, social contact, friendships and stable romantic relationships have been identified as protective factors from the experiences of childhood

abuse and neglect (Lee, Kotch, & Cox, 2004; Owen et al., 2008; Lambie, Seymour, Lee, & Adams, 2002).

Protective and resilience factors for Māori and indigenous culture have been attributed to cohesion, achievements, and success of the collective; that is, whānau, hapū, iwi and the indigenous population as a whole. It is commonly proposed that a strong, positive and "secure cultural identity" is a fundamentally protective factor in promoting healthy well-being (Durie, 2001; 2007; Kruger et al., 2004; Lawson-Te Aho & Liu, 2010; Moeke-Pickering, 1996; Pere, 2006; Quince, 2007; Tapsell, 2007; Te Puni Kōkiri, 2010).

In conclusion, NZ has a high rate of child abuse and neglect in comparison with similar countries. This carries a heavy burden on those affected and results in a high costs for the individual and society as a whole. Not all of those children affected suffer long-term consequences from their negative experiences, but nevertheless the service response to child abuse and neglect and prevention efforts are important.

Collaboration and Coordination of Service Provision

Child abuse and neglect typically involves the participation of more than one service for appropriate management. These services include the police, child protection services, medical services, mental health services, courts, non-government organisations (NGO) and advocacy services. In common with other developing countries NZ has three core agencies involved with the management of child abuse: CYF (statutory child protection agency), the NZ Police, including their Child Protection Teams (investigation and prosecution), District Health Board child protection teams (medical services) and Video Units (forensic interviewing). These services will be described in more detail later in the chapter.

Collaboration is commonly described as a process where two or more groups or individuals work together and coordinate to complete a task and achieve shared goals (Feng, Fetzer, Chen, Yeh, & Huang, 2010; Horwath & Morrison, 2007). In addition, coordination is a process of communication, or exchange of information, between two or more groups or individuals (Boulton & Hindle, 2000; Pietrantonio et al., 2013). Child abuse is multidimensional in nature, and thus requires responses by more than one professional or agency for appropriate management. Collaboration and coordination of these services is required for effective service delivery. An uncoordinated process has its greatest impact on those presenting for help.

In NZ, serious child abuse continues to have a high profile and a series of reports have pointed to poor inter-agency collaboration as a potential contributing factor (Bennett, 2012a,

2012b; Office of the Commissioner for Children, 2003, 2000). The review carried out by the Office of the Commissioner for Children into the death of six-year-old James Whakaruru in 1999 from physical assaults perpetrated by his mother's partner is a case in point. The Commissioner's investigation found that:

> Poor interagency communication characterised the professional work with James and his family. Agencies worked without reference to each other, and ended their involvement assuming that other parts of the system would protect James (Office of the Commissioner for Children, 2000, p.1).

Another investigation carried out by the Office of the Commissioner for Children a few years later into the deaths of sisters Saliel and Olympia Aplin (aged 12 and 11 years respectively) in 2001 at the hands of their stepfather also found that lack of interagency collaboration contributed to the tragic outcome. The Commissioner's investigation identified:

> Poor practice similar to that found in the June 2000 investigation… Policies and procedures were in place to protect these children but poor practice within and between agencies contributed to increased risks to the girls' safety. Many opportunities for appropriate interventions were lost because no single agency had the whole picture or a complete understanding of the risks present in their lives… Agencies did not meet to discuss their concerns and only dealt with the issues confronting their own agency at the time (Office of the Commissioner for Children 2003, p.1).

In both the Whakaruru and Aplin cases, interagency coordination and cooperation was absent (Office of the Commissioner for Children, 2003, 2000). Had an interagency meeting taken place with wider whānau members and professionals, then all the information held by the respective agencies and whānau members could have been shared and acted upon in a planned and collaborative way.

While it is evident that poor inter-agency collaboration has been a key contributor to bad outcomes in cases of physical abuse, neglect and other types of child abuse in NZ and internationally (Laming, 2003), the same conclusion has been reached in relation to family violence in general (Family Violence Death Review Committee, 2014; Office of the Commissioner for Children, 2000; 2003). Furthermore, Davies and Seymour (2002) found both investigators and primary carers of sexually abused children in NZ perceived interagency collaboration as poor despite the existence of interagency policies advocating collaboration. It seems likely this was also the case for other types of abuse in NZ – physical abuse and neglect. Non-offending parents of allegedly abused children reported

dissatisfaction with service provision, including delays, poor interagency collaboration, inadequate provision of information and inadequate access to support and therapeutic services (Davies et al., 2001). This research was significant for highlighting the lack of collaboration and coordination of services in Auckland and led directly to consideration of a different model for provision of child abuse services based on models for interagency practice in other countries (Davies et al., 2001).

Child Advocacy Centres and the Multi-agency Model

Overseas similar problems of coordination and collaboration exist when it comes to child protection. Efforts to improve the collaboration of child abuse services have led to co-location of services, with closely coordinated management structures. The most influential of these efforts has been Child Advocacy Centres (CACs), first implemented in USA. Typically, in such centres a range of assessment and investigation services, law enforcement, advocacy and treatment services are provided within the same building (Horwath & Morrison, 2007). Such multi-agency services (as they have been more commonly called in this part of the world) have reputedly revolutionised the response to child abuse to ensure a holistic service approach (Walsh, Jones, & Cross, 2003). Since the establishment of the first CAC in 1985 over 800 such centres have been established in the USA and in at least 10 other countries around the world (Faller & Palusci, 2007; Kuehnle & Connell, 2008).

The CAC model aims to "ensure that children are not further victimized by the intervention systems designed to protect them" (National Children's Alliance, 2014). Despite differences between centres, they have elements in common. The co-location of services is central, but there are a number of other elements also. Staff recruited into teams need the right experience, knowledge and commitment to drive change forward including a 'joined-up attitude' which includes a willingness to be self-reflective and enthusiastic about collaborative working, and willingness to take on new roles in liaison, bridging and coordination (Boddy, Cameron & Petrieet, 2006). Other elements to successful multi-agency operation are reflected in the criteria for CAC accreditation in USA where a CAC is required to demonstrate the presence of 10 essential programme components (Kuehnle & Connell, 2008; National Children's Alliance, 2017). The 10 programme components are listed below with a short explanation:

1. *Child-appropriate/child-friendly facility:* The setting must be both physical and psychologically safe for a child and their non-offending family members by providing a comfortable, private, child friendly setting.

2. *Multidisciplinary team (MDT):* Interagency coordination should be reflected by participation on the MDT of representatives from law enforcement, prosecution, child protective services, mental health, medical, victim advocacy and the CAC. An essential component required for accreditation is that all members of the MDT, including appropriate CAC staff as defined by the needs of the case, are routinely involved in investigations and/or team intervention.

3. *Child investigative/forensic interviews:* Standards require interviews to be conducted in a manner that is legally sound, or a neutral, fact-finding nature and are coordinated to avoid duplicative interviewing. Further, there should be a mechanism in place for collaborative case planning.

4. *Medical examinations:* Medical evaluation is to be for the purpose of forensic documentation and collection and preservation of evidence. The findings of medical examinations are to be shared with other members of the MDT in a routine and timely manner.

5. *Mental health services and therapeutic intervention:* Specialised trauma-focused mental health services designed to meet the unique needs of children and non-offending family members must be made available as part of the team response either at the CAC or through coordination with other treatment providers. It is assumed that all families seen at the CAC will be screened for their need for mental health services and that appropriate mental health services are provided for all CAC clients. If the therapeutic service is provided outside of the CAC written protocols and agreements must be established with mental health service providers.

6. *Victim support/advocacy:* Victim support and advocacy services should be routinely made available to clients and non-offending caregivers as part of the MDT response. This role includes, preparing a child for and accompanying the child to court, arranging crime victim compensation, providing the non-offending parent with ongoing information about civil and criminal legal proceedings and a number of other support services.

7. *Case review:* Team meetings are organized on a routine basis for information sharing about investigations, current cases and services need by the child and family.

8. *Case tracking:* A system should be in place for monitoring case progress and tracking case outcomes.

9. *Organisational capacity:* Both fiscal and problematic organisational efficacy must be demonstrated, which implements basic sounds administrative policies and procedures.

10. *Cultural competency and diversity:* Cultural competency is reflected in the agency's demonstrated ability to appreciate, understand, and interact with members of diverse populations.

Meeting the CAC's accreditation criteria alone does not ensure successful outcomes. In order for a CAC's to be effective they must meet the criteria and services must work together to ensure effective communication and collaboration. The extent or progression on the 'journey towards multi-agency working' has been explained in a hierarchical manner with simple communication (interactions are confined to the exchange of information) being on the lower end of the hierarchy and coordination (individuals remain in separate organisations and locations but develop formal ways of working across boundaries) and co-location (members of different professions are physically located alongside each other) being in the middle, and commissioning (professional with a commissioning remit to develop a shared approach to the activity) being the highest inter-professional benchmark (Leathard 2003; Hudson & Hardy 2002). "Commissioning" can include not only the three previous elements but also a higher level of collaboration where an overall service manager or coordinator is appointed to oversee the operations of the multi-agency and it is governed by one body of policies and procedures (e.g., in relation to costs and benefits, employment, accountability and decision making). Highlighting that although services can be co-located it is the extent in which they work together and share a common vision and goals that yields successful outcomes (Crockett et al., 2013; Jones, Cross, Walsh & Simone, 2005).

History of Child Welfare and Legislation in New Zealand

A number of reports outline and detail the history of child welfare and the development of child welfare legislation in New Zealand (e.g., Barrington, 2004; Watt, 2003). This section will summarise the history, legislation and developments relevant to the coordination of services, information sharing and the potential provision of multi-agency's in New Zealand. Through legislation New Zealand has made a number of attempts over many years to facilitate collaboration and coordination of the key agencies and professionals in the interests of child protection. These initiatives are outlined in the following.

Before the 1980s New Zealand child protection legislation was heavily influenced by British law (Seymour, 1976). The Children and Young Persons Act 1974 had a strong emphasis on child protection, with the prevailing consideration being whether or not to remove the child from their existing home. Gordon McFadyen, a previous Executive Manager with CYF and senior advisor to the Children's Commissioner's Office, described

this as a "child rescue" model of social work intervention (Barrington, 2004, p.13). Fundamental was the 'paramountcy principle', which held that 'the best interests of the child' should be the first and main consideration when decisions about a child's safety or well-being were involved in contrast to broader consideration of family or whānau involvement in decision making, and the role of extended family in provision of alternative care. The policies arising from this legislation gave rise to the creation of 'Child Protection Teams' in each CYF area office. These were interagency multidisciplinary teams made up of social workers, police and with strong legal and medical presence, and usually led by a paediatrician. They took what is these days considered to be a conservative approach to child protection, erring on the side of caution in recommending that children be removed from what were seen as dysfunctional families when difficulties arose.

This approach to child protection impacted particularly on the Māori population. Rates of child abuse and neglect amongst Māori have historically been significantly higher than for the general population – and remain so. However, this 'Child Protection Team' approach led to many Māori homes and parents being assessed as incapable of providing the nurture and the conditions for social and emotional growth needed for children to develop as a functioning member of society. The result was the removal and uplift of many Māori children from their whānau. Children were sent to institutions and group homes and in some cases were significantly disadvantaged in these environments as they were surrounded by anti-social peers, gangs and crime. Tags like "universities of crime" were used to describe living situations, and behaviours learnt often hindered settlement back into the community (Barrington, 2004, p.13).

The economic, social and political climate in New Zealand in the 1980s was one of flux: increasing importance was being placed on the place of the Treaty of Waitangi as the foundation agreement for how the relationship between the indigenous Māori people and the Crown should be conducted, and rangatiratanga, meaning self-determination for Māori, was emphasised. Furthermore, an economic slump was generating a new economic order and leading to government pressure for greater efficiency and accountability, and there was a questioning of the welfare state ethos and a move towards less government intervention in society (Duncan & Worrall, 2000). Accordingly, the Minister of Social Welfare at the time, Anne Hercus, established a Ministerial Advisory Committee in 1985 chaired by the late John Rangihau to report on the most appropriate means to 'meet the needs of Māori in policy, planning and service delivery in the Department of Social Welfare'. The Committee held 65 meetings on marae and in Department offices and institutions around the country and

produced a report, Puao-te-Ata-Tu (daybreak) in 1985 (Rangihau, 1986). The report outlined Māori experience of the social welfare system and in summary Māori were alarmed at the number of their children taken into State care under the Child Protection Team strategy and strongly opposed the 'Child Protection Team' model which they feared would perpetuate or worsen this problem as they were entrusting decisions to professional groups. Māori and Pacifica families in particular felt deeply hurt by these practices, especially when decisions relating to the child and whānau were being made by non-Māori and non-Pacifica social workers who they believed had inadequate understanding of the cultural or social implications of their attitudes and decisions.

The economic and political pressures, compounded by criticisms of the existing child protection legislation, provided sufficient impetus for legislative review and change. On 1st November 1989 the Children Young Persons and their Families Act (CYPF) became law. The CYPF Act emphasised empowering families to safe guard children, keeping children in their own families where possible and using the minimal intervention necessary to achieve safety. A central feature was the Family Group Conference (FGC), a formal process in which care and protection concerns are presented to the extended family, which then has the opportunity to devise and implement a plan for the child's welfare. Thus the Child Protection Team model was dismantled and the relative power shifted from professionals to a stronger voice from the families concerned.

The 1989 Act also introduced 'Care and Protection Resource Panels'. When social workers are notified of or suspected child abuse they are required to investigate after consulting with a local care and protection resource panel. These were community advisory groups created by the Act as another check and balance or accountability mechanism. Panel members are intended to include lay as well as professional members and members from different ethnic and community groups. Beth Wood's 1992 report investigating the effectiveness of Care and Protection Resource Panels concluded that panels varied considerably in most aspects of their organisation and functioning, and the degree to which they have been able to become an effective part of the care and protection processes. Some panels were strong and active and a positive part of the care and protection process, others, however, continued to struggle. Most panels fell between these two extremes (Wood, 1992).

The changes were not however without criticism. Opposition and criticism of the Act was made on the grounds that it went too far in favouring families as opposed to protecting children. Accordingly the Act was amended in 1994 to reintroduce the 'paramountcy

principle' stating clearly that the child's welfare should be the paramount consideration in decisions affecting children.

During the 2000s the focus of child protection shifted towards improving the coordination and collaboration of key agencies involved in the management of child abuse – CYF, Police, health services and the many NGOs that provided alternative child care, family support, and counselling - and this moved to the forefront of the policy agenda. As a result there were two main documents developed towards formalizing and improving interagency collaboration. Firstly, the Child Protection Protocol (CPP) came into effect in 2010, which is an agreement between CYF and the Police (Child, Youth and Family & New Zealand Police, 2010). The protocol sets out the way CYF and Police should work alongside each other in situations of serious child abuse. The CPP focused on clarifying the roles and responsibilities of each organisation, and the process to be followed, to ensure a prompt and effective response (Child, Youth and Family & New Zealand Police, 2012). Secondly, a Memorandum of Understanding (MoU) was developed collaboratively between CYF, the Paediatric Society of New Zealand, District Health Boards (DHB), the Ministry of Health's Violence Intervention Programme and the Police, which came into effect in 2011. The purpose of the MoU was to set out the mutual commitment of the parties to a collaborative working relationship, to ensure health and safety outcomes for children and young people are met within each party's legislative and funding responsibilities (Child, Youth and Family, New Zealand Police & District Health Board, 2011).

Due to the continuing high occurrence of child abuse there has been increasing awareness and publicity in the media and government considerations. This has sparked the prioritization of protecting children from ongoing or future harm and accompanying legislation, policy and practice reform. The Government released the White Paper for Vulnerable Children on 11 October 2012 with the Children's Action Plan. The Children's Action Plan was a response to the White Paper that was in turn based on nearly 10,000 submissions to the earlier Green Paper for Vulnerable Children (Bennett, 2012b), as well as consultation with key experts in health, justice, education and social services, and examination of international best practice. Subsequently new legislation was introduced. The Vulnerable Children Act 2014 made sweeping changes with the stated aim to protect vulnerable children and help them thrive, achieve and belong.

The Children's Action Plan and the Vulnerable Children Act 2014 rests on the belief that no single agency alone can protect vulnerable children. Therefore the heads of six government departments are now accountable for protecting and improving the lives of

vulnerable children. Police, the Ministries of Health, Education, Justice, and Social Development and the Department of Corrections have new, legislated responsibilities. With regards to interagency collaboration 'Children's Teams' have been introduced consisting of practitioners and professionals from the iwi/Māori, health, education and social services sector who are charged with the task of developing a single plan to help and support each vulnerable child. The professionals provide intensive, early intervention and wrap around services for vulnerable children and their families with the aim being to prevent further notifications to child protection services and promote safety and well-being.

The 2014 Act also recognises that the sharing of information between appropriate practitioners and agencies about a vulnerable child is essential in order for the early identification of risks and the needs of a child. This saw changes in 2015 to the CYPF 1989 and Privacy Act 1993 and introduced the Vulnerable Children's Approved Information Sharing Agreement (AISA) authorising agencies to share information with each other lawfully, outside of a specific notification of concern to CYF. Previously information was only to be shared when 'serious threat' was identified but due to this highly subjective term many professionals and agencies defaulted to not sharing information to manage their organisational and professional risk from prosecution for breaches of privacy; caution that was often to the detriment of children and young people (Adams & Tolley, 2016).

In conclusion, the current NZ Government initiatives focus on the ultimate goal of prevention by addressing family violence (e.g., mandatory screening of all adult women for family violence, advertising, prevention and monitoring programmes) and promoting early detection of child abuse and neglect terming it 'everyone's responsibility' (e.g., the continuation of FGC's, mandatory vetting and screening for those working with children, early intervention and children's teams and child protection protocols for all agencies working with children). The government's focus is on prevention and early intervention and little has been done in recent years to address society's response to child abuse and neglect. Although as of late, there has been a greater emphasis on coordination and collaboration of services this has not translated into overarching structural or operational changes. Instead the regional managers of the key teams involved in child protection (CYF, police and health) have taken on the responsibility themselves of improving the crisis response to child abuse and neglect by forming multi-agency services for child protection around NZ. Puawaitahi, the first multi-agency for child protection, can be seen in this context as being ahead of its time – not so in relation to international, especially USA developments – but certainly so in relation to prevailing practice in NZ up until recent times.

CHAPTER ONE: INTRODUCTION

Puawaitahi: Multi-agency for Child Protection

Child abuse requires responses by more than one agency for appropriate management. In central Auckland there are three core agencies involved with the management of child abuse. CYF, includes area offices staffed by social workers and the Specialist Services Unit (SSU) which includes psychologist and therapists who provide psychological and therapeutic services to children and young people who are in CYF care and have experienced abuse and/or neglect. The Child Protection Team (CPT) of the Police is a specialist service of the Police who are responsible for the investigation and resolution of child abuse. Te Puaruruhau of the Auckland District Health Board (ADHB) provides diagnostic and medical services for acute abuse cases, and carries out nursing and social work assessments for alleged physical or sexual abuse or neglect. Further, the Central Auckland Video Unit (CAVU), which is staffed by specialist interviewers from Police and CYF also plays a significant role in the management of child abuse allegations in providing forensic interviewing of children and adults with special needs.

Professionals' working in these three core agencies identified that coordination of child abuse service provision was lacking. As previously discussed, this had been identified in relation to CSA in a project that involved interviews with 124 non-offending parents and 51 children in Auckland (Davies and Seymour, 2002; Davies et al., 2001). The efforts of a group of frontline practitioners from across Health, Police, CYF and Auckland University researchers then sought to address these deficiencies through the development of an adaptation of the CAC model. As a result Puawaitahi was established in 2002 (Kelly & Webb, 2010). In the following a description of this service is presented.

Puawaitahi, which literally means "blossoming in unity" or "as one", reflects the bringing together of the three statutory agencies involved in specialist child abuse investigation with the common aim to enhance the recovery and care of those affected by child abuse. The key agencies involved in the child abuse processes in New Zealand are co-located at Puawaitahi on 99 Grafton Road, Auckland opposite Auckland's Starship Children's Hospital. These services include Te Puaruruhau (health), Special Services Unit (psychological), Police Child Protection Team and Central Auckland Video Unit (crime investigation and forensic interviewing).

Te Puaruruhau ADHB

Te Puaruruhau is the ADHB health service for children and young people who have experienced abuse or neglect. The name literally means "the sheltering of the bud". The

health team consists of nurse specialists, administration staff, paediatricians, social workers and a CYF liaison person. The team offers a 24 hour urgent medical service for acute abuse cases, and carries out nursing and social work assessments for alleged physical or sexual abuse or neglect.

Te Puaruruhau coordinates 'Gateway' health assessments for children in the care of CYF's in the Central and North Auckland regions. Referrals are accepted from health professionals, Police, CYF and the public, for children and young people aged 0 to 19 years with disclosed or suspected physical or sexual abuse, or neglect. Gateway Assessments are available to all children and young people entering CYF care, children and young people already in care, and children and young people who have high needs identified by the family, a social worker or a Family Group Conference Coordinator at, or in preparation for, a FGC. A Gateway Assessment is initiated when a CYF social worker makes a referral to the Gateway clinic for a child or young person who they believe will benefit from a gateway assessment. The overall objective of the Gateway Assessment is to enhance the physical, mental, educational and social wellbeing of children and young people who come to the attention of CYF. A Gateway Assessment will identify the health, education and care and protection needs of the child or young person, identify any health needs of the child's parents or caregivers that will impact on the child, create a plan to address these needs, facilitate access to appropriate services for health, education and wellbeing, help children and young people develop the knowledge, skills and confidence they need to adopt healthy behaviours, identify the skills and training that the caregiver may require to address the needs of the child or young person and collate a health and education history for the child or young person to assist them in their future interactions with the health and education systems. Gateway Assessments form a part of the 2011 Children's Action Plan (described above; Bennett, 2012c), the government's framework for protecting vulnerable children.

Te Puaruruhau also offers the Shaken Baby Prevention programme and the Family Violence Intervention Programme (VIP). The Shaken Baby Prevention programme team at Puawaitahi is responsible for the roll out of this initiative and includes training DHB staff and other health practitioners to provide brief advice to parents and those expecting their first child on how to cope with a crying baby (Kelly, Wilson, Mowjood, Friedman, & Reed, 2016). The information is also included in an ADHB/CYF pamphlet and the patients are told of the Starship Foundation 'Never, ever shake a baby' video, available on YouTube.

The ADHB VIP at Puawaitahi seeks to reduce and prevent the health impacts of family violence (partner and child abuse and neglect) through early identification, assessment

and referral of victims presenting to health services. The team's role is to train ADHB staff in brief intervention aligned with ADHB policy and procedure. The team equips frontline staff to recognise and give the appropriate support to victims of family violence. The VIP team also promotes networking and information sharing among domestic violence agencies, ensuring an effective multi-agency response to the matter of family violence. VIP is delivered in partnership with Shine a community service that provides help for victims of domestic abuse to get safe and stay safe. Shine offers a number of services including a free national helpline, crisis advocacy (safety planning and advocacy with victims referred by Police, Child Youth & Family, hospitals, etc.), women's refuges and transition housing and a number of programmes and interventions for adults and young people (Shine, 2017).

Special Services Unit CYF

The Specialist Services Unit (SSU) consists of psychologists and therapists who provide psychological and therapeutic services to children and young people who are in CYF care and have experienced abuse and/or neglect. Specialist Services staff are also available for CYF social workers to consult with or provide professional opinions about complex cases. These include those that might be in need of psychological assessment or intervention, as well as other cases which may need clarification regarding appropriate clinical pathways or most suitable services to access. SSU offers psychological assessments (individual, therapeutic needs and extended forensic assessments) and parenting capacity assessments to help social workers plan an intervention, an FGC, or for Family Court hearings. Therapy or therapeutic interventions are generally offered for children and young people not eligible for Accident Compensation Corporation (ACC) funded therapy, those already in the care of the CYF, those who are at high risk of being placed in CYF's care, and those presenting with a range of complex issues arising from abuse/neglect, multiple placements, developmental difficulties etc. Certain types of therapy/intervention may be provided also for caregivers/parents. Wherever possible, SSU recommend children and young people should be referred to appropriate services in their own communities. The therapies and interventions offered by SSU include individual therapy (cognitive behavioural therapy; Feather & Ronan, 2009), art therapy and psychodynamic play therapy), Parent-Child Interaction Therapy (PCIT; Eyberg & Funderburk, 2011), caregiver support and keep safe (develop self-protective skills and strategies to reduce their vulnerability to sexual or other exploitation). Finally, SSU also have a duty roster so that a psychologist or therapist is always available during business hours to see clients presenting to the multi-agency in need of psychological

first aid (most commonly post-interview 'debriefing' provided to the Central Auckland Video Unit, this includes internal staff, external referrers and children and their families).

Police Child Protection Team

The Police Child Protection Team (CPT) and the Child Exploitation Team is a group of detectives whose role is the investigation and resolution of child abuse (both online and in person) and neglect. Their roles are to determine the validity of the complaint, pursue investigation should the child recant and interview of the offender (off site), and ultimately deciding whether to lay charges and pursue prosecution of the offender.

Central Auckland Video Unit

The Central Auckland Video Unit (CAVU) is comprised of both CYF social workers and Police personnel trained in the forensic interviewing of children and adults with special needs. The service conducts forensic interviews with children who have experienced abuse and/or neglect and forensic interviewing of child witnesses to serious crime. The service also provides liaison and consultation with CYF social workers and provides reports for Court, Social Work Plans and Family Group Conferences. In collaboration with SSU, CAVU also provides diagnostic assessment and first aid for children and caregivers presenting with distress or in need of support and education.

Puawaitahi has been in operation for 15 years, and other multi-agency centres have since been established elsewhere in New Zealand, albeit not as comprehensive in scope as Puawaitahi. Although there are many anecdotal reports of better service and staff coordination and client satisfaction, there has been no formal evaluation of whether this model of practice meets its goals and actually leads to an improvement in service delivery.

Evaluating CAC's and Multi-agency Models

The term "evaluation" means different things to different people (Gunn 1987). This thesis will use the definition proposed by Rossi and Freeman (1993, p.5): "The systemic application of social science research procedures for assessing the conceptualization, design, implementation, and utility to answer basic questions about a program". Patton (2003) defined programme evaluation as "the systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgements about the program, improve programme effectiveness and/or inform decisions about future programming" (p.224). Evaluation is essential to ensure that a programme is benefiting, not harming, the clients it is designed to help (Holzer, Higgins, Bromfield, Richardson, &

Higgins, 2006; Thompson & McClintock 1998). Without an evaluation, interventions are not able to measure their effectiveness (Lamont, 2009). Evaluations may analyse a number of things; for example, how a service is used, profile service consumers, aid the ongoing improvement and refinement of a programme and provide informed cost-benefit analyses (Tomison, 2000). Evaluation findings are valuable for those planning a new service, practitioners providing services and policy-makers making decisions about public policy and programme funding (Lamont, 2009).

There are a number of evaluation types and methods and this section will focus on describing the most common methodologies for evaluating pre-existing programmes, including process evaluation, impact evaluation and outcome evaluation. It should be noted that different types of programme evaluations are fundamentally linked and can be used either independently or together (Tomison, 2000). Process evaluation is widely recognised as fundamental to most evaluations being the first step for understanding and interpreting both outcome and impact evaluation results (Ashcroft, Daniels, & Hart, 2004; United States Department of Health and Human Services, 1996). Without the information gathered from a process evaluation and understanding how a programme works, there is no way of knowing which aspects of the programme were fully and properly implemented and what processes and procedures within the programme the findings can be attributed to.

Programme Description

A programme description is a summary of the intervention being evaluated. It should explain what the programme is trying to accomplish and how it tries to bring about those changes. The description will also illustrate the programme's core components and elements, its ability to make changes, its stage of development, and how the programme fits into the larger organisational and community environment. Also, the description allows members of the group to compare the programme to other similar efforts, and it makes it easier to figure out what parts of the programme brought about what effects. Moreover, different stakeholders may have different ideas about what the programme is supposed to achieve and why. A shared understanding of the programme and what the evaluation can and cannot deliver is essential to the successful implementation of evaluation activities and use of evaluation results (National Center for Chronic Disease Prevention and Health Problems, 2011). Evaluations done without agreement on the programme definition are not likely to be very useful. In many cases, the process of interviewing and working with stakeholders to

develop a clear and logical programme description will bring benefits long before data are available to measure programme effectiveness.

Process Evaluation

Process evaluation, also known as programme monitoring evaluation, is concerned with how a service is delivered (Lamont, 2009). It encourages examination of the operations of a programme, including which activities take place, who conducts the activities, and who is reached as a result (Center for Advancement of Community Based Public Health, 2000). Tomison (2000) explained that process evaluations essentially investigate a programme's 'integrity'. The purpose of a process evaluation is to identify whether activities are implemented as planned, areas that are working well and areas that may require or benefit from change or improvement in order to enhance service delivery (Hall, 2009). It involves the systematic documentation of key aspects of programme performance that indicate whether the programme is functioning as intended or according to some appropriate standards, for example, the service's operational guidelines (Ashcroft et al., 2004).

Impact and Outcome Evaluation

Impact evaluation measures whether an intervention has an effect on participants in accordance with the intervention's aims and objectives (Holzer et al., 2006; Tomison & Richardson 2004). Any change in participants is assumed to result from participating in the programme. For example, an impact evaluation on a multi-agency centre would assess the number of times participating children were forensically interviewed, as multi-agency centres aim to reduce the number of times a child is interviewed and has to 'tell their story' (Jones et al., 2005).

Outcome evaluation assesses the long-term effectiveness of an intervention programme. The difference between an impact and an outcome evaluation is that an impact evaluation looks at direct aims, such as reducing the number of forensic interviews or increasing the number of referrals to trauma intervention services, whereas an outcome evaluation considers underlying goals, such as reducing trauma symptoms or improving client and family satisfaction. Outcome evaluations may investigate whether the direct aims of a programme are accurate. For example, outcome evaluations may assess whether reducing the number of forensic interviews a child has to endure resulted in the reduction of further traumatisation (the overarching goal or purpose of the multi-agency; Berliner & Conte, 1995; Bruck, Ceci, & Hembrooke, 1998; Tedesco & Schnell, 1987). Impact and outcome

evaluations are often described interchangeably; however, only outcome evaluations consider the underlying and long-term goal of an intervention.

As the main goal of an evaluation is to indicate whether a programme is effective or not, it is important that an evaluation is conducted appropriately. There are three elements that represent the gold standard for a rigorous evaluation and these include pre- and post-designs, a comparison group and follow-up testing, these are explained in more detail below (Lamont, 2009; Richardson & Tomison, 2004).

Pre- and post-test designs. Pre- and post-test designs assess participants "before" and "after" a programme in order to ascertain whether participants have changed according to programme goals (Chalk & King, 1998).

Comparison group. A comparison group is a group of people who are not involved in the intervention programme being evaluated. Comparison groups are used to compare the outcomes of service participants with nonparticipants. Using a pre- and post-test design on its own is insufficient for determining programme impact, as other variables or factors that cannot be ruled out may have influenced the result. A programme is considered effective if the outcomes for the programme group were significantly better than those for the comparison group. The most effective method for obtaining a comparison group is to randomly allocate people into the programme being evaluated and the comparison group, which is commonly known as an experimental design or a randomised control trial (Chalk & King, 1998; Lamont, 2009; Nixon, 1997). However, as discussed below, this model of research has not been applied to CAC evaluations, and presents perhaps insurmountable barriers from practical and ethical considerations.

Follow-up testing. Follow-up testing is needed for assessing whether successful outcomes of an intervention extend beyond the short-term. To determine whether an intervention has a lasting effect, an evaluation will need to conduct follow-up assessments on the same outcome measures. This can be referred to as a longitudinal research design (Lamont, 2009).

In conclusion, process, impact and outcome evaluation have a number of purposes including providing feedback to staff mainly in order to check progress toward stated aims, and promoting appropriate development in areas where the programme is not functioning as originally intended (Houshmand & O'Byrne, 1996; Rapaport, 1970; Seymour & Davies, 2002). It is important that any evaluation is concerned with how real people in the real world can apply the evaluation findings, implement the recommendations and experience the evaluation process (Patton, 2003).

CHAPTER ONE: INTRODUCTION

Programme Evaluations of CACs

Although interagency collaboration is favoured by both professionals and families in the child protection system, there has been little research to date that seeks to provide evidence that such efforts are effective in terms of improved outcomes for children because such evaluations have yet to be conducted. The field has lacked data about the actual impact and outcomes of CACs (Dowling, Powell, & Glendinning, 2004). A formal interview of 117 CAC directors and an extensive literature search completed by the U.S. Department of Justice in 2004 found only one published CAC outcome evaluation at that time (Jenson, Jacobson, Unrau, & Robinson, 1996). Since this finding, the National Children's Alliance (NCA), who is responsible for coordinating efforts among the CACs, providing resources, and producing national guidelines for the centres, has published 'a resource for evaluating CACs (Ashcroft et al., 2004).

Following on from this, the USA Department of Justice employed an independent researcher to conduct a multi-site comparison evaluation of four CAC's (the most experienced and long-standing) in the country comparing them to communities without CACs (Cross et al., 2008). The research used mixed methods and employed both a process evaluation and impact evaluation, and both qualitative and quantitative methodology. It included analysis of case file data (e.g., information about the victim, the alleged perpetrator, the victim's family, the alleged abuse, whether the victim disclosed the abuse, investigation, interviewing, services provided, whether the child was removed from the home, and whether the offender was charged and prosecuted), interview data (e.g., research interviews with children and non-abusive caregivers about their experiences and satisfaction with the investigation, on services their families received as a result of the investigation, and on their child's emotional well-being) and descriptive, site level data (e.g., detailed information about a site's policy, protocols, and day-to-day operations). In this study, CAC cases demonstrated several apparent advantages over comparison communities (Cross et al., 2008). Multi-agency investigations of child sexual abuse were more likely to be coordinated and more likely to involve police. Children were more likely to receive referrals for forensic medical evaluations and mental health services. Non-abusive caregivers reported a higher average level of satisfaction, both with child interviewing and with the investigation as a whole. Children tended to report feeling less scared during CAC interviews. However, no evidence suggested that children were subjected to multiple forensic interviews in either CACs or comparison communities.

Similar evaluation efforts also occurred in Europe at five of London's Multi Agency Safeguarding Hubs (MASH). A mixed methods approach was also used in this evaluation and included pre implementation MASH site visits, a pre and post implementation snapshot audit of referrals to MASH, a pre and post implementation qualitative interview study of MASH professionals and a post implementation qualitative interview study of referrers to MASH (Crockett et al., 2013). The findings from this review showed that MASH appears to facilitate more effective multi-agency working, for example improvement in partnership communication and information sharing. One of the most significant findings was the reduction in turnaround time of referrals to safeguarding services at all levels of risk. There was evidence that more children were receiving services appropriate to their needs following referral. The main areas of concern arose from heavy workloads, poor staffing levels and frustrations with inadequate information technology resources. Further, referrers to MASH complained about the failure to communicate feedback about the outcome of referrals (Crockett et al., 2013).

Organisations cannot learn from partnership working unless evaluation takes place and the results are fed back, however, there is no distinctive multi-agency 'success criteria' (best practice guidelines) against which to compare results (Rummery, Clarke, & Glendinning, 2002; Glendinning, Powell & Rummery, 2002). To achieve the intended results, individuals would need to understand the required ingredients for a successful partnership in terms of the concept of success; no-one in the research has managed to achieve this feat (Dowling et al., 2004). This highlights the limitations and difficulties in evaluating CAC's and multi-agency models. What measureable indicators determine success? And are those indicators the same for every multi-agency service in every region? At the very least such services need to have an adequate programme description and process evaluation that is then linked to outcome and/or impact evaluation.

Most of the research to date has concentrated on criminal justice outcomes and the number of sexual abuse examinations perhaps because of the fact that such measures are readily accessible. However, such measures may not be adequate indications of the wider success of a multi-agency. Furthermore, it may be unreasonable to assume that changes made within the multi-agency to investigative processes and medical examinations can impact common, broader multi-agency goals (e.g., the reduction of additional trauma associated with inappropriate responses to abuse, and the reduction of child trauma symptoms). For instance, by measuring criminal justice outcomes we are indirectly assuming that higher conviction rates result in a successful multi-agency service. These measures do not directly address the

goals of the multi-agency which are often much broader and focused on client outcomes/well-being. It raises the question, are criminal justice outcomes and the number of medical examinations relevant measures of success if a multi-agency's primary focus is the reduction of systemic trauma and client well-being?

Outcomes of CAC and Multi-Agency Evaluations

Herbert and Bromfield (2017; 2016) have published two systematic reviews of the multi-disciplinary team (MDT) evaluation literature which included 63 studies. The scope of this review includes what was termed multidisciplinary child abuse teams. These include a variety of cross-agency and cross-disciplinary partnerships between agencies responsible for elements of the response to child abuse. Typically, these teams are assembled in order to improve information sharing and coordination between agencies, recognizing the serious consequences poor cross-agency communication can have (e.g., Child Protection Systems Royal Commission, 2016). This review examined the evidence for all types of cross-agency teams (including CACs) in order to evaluate the existing quality of the evidence base of multi-disciplinary responses to child abuse broadly. Not all MDTs included in this review operated within CACs but the research is nevertheless relevant as MDTs are an essential feature of CACs.

The findings conclude that overall there is reasonable evidence to support the idea that MDTs are effective in improving criminal justice and mental health responses compared to standard agency practices (Herbert & Bromfield, 2017; 2016). Much of the research focused on criminal justice outcomes, with studies generally finding significant differences (i.e., more police substantiations) earlier in the criminal justice process (e.g., Bradford, 2005; Joa & Eldelson, 2004; Miller & Rubin, 2009; Smith, Witte, & Fricker-Elhai, 2006; Wolfteich & Loggins, 2007), but some finding differences in terms of the rates of convictions (e.g., Bradford, 2005; Jaudes & Martone, 1992; Joa & Eldelson, 2004; Turner; 1997). Many of the earlier studies (e.g., Jaudes & Martone, 1992; Turner, 1997) found significant differences compared to more recent studies, suggesting, many of the practices of MDTs and CACs have diffused into practice-as-usual in some jurisdictions, which may result in a higher baseline for MDTs in later studies.

The research on mental health and support services overwhelmingly found that the presence of MDTs were more likely to result in increased receipt of services (e.g., Bai, Wells, & Heillemeier, 2009; Chuang & Lucio, 2011; Cross, Finklehor, & Omrod, 2005; Edinburgh,

Sawyc, & Levitt, 2008; Hurlburt et al., 2004; Smith et al., 2006; Turner, 1997), although there were some exceptions (e.g., Glisson & Hemmelgarn, 1998).

Among a small number of studies, MDTs fairly consistently were more likely to have significantly higher rates of child protection substantiations (e.g., Jaudes & Martone, 1992; Ruggieri, 2011; Smith et al., 2006; Wolfteich & Loggins, 2007) and were more likely to result in referral to medical services (e.g., Edinburghet al., 2008; Smithet al., 2006; Walsh, Cross, Jones, Simone, & Kolko, 2007). Findings were mixed in terms of caregiver satisfaction and staff satisfaction (Goldbeck, Laib-Koehnemund, & Fegert, 2007; Jones et al., 2005; Lalayants, Epstein, & Adamy, 2011; Walsh et al., 2007).

Limitations of Evaluation Attempts

Despite a number of evaluation studies no research has yet been able to conduct a conclusive outcome evaluation of the multi-agency child protection practice that shows measurable differences in the incidence of child abuse and neglect, reductions in the recurrence of child abuse and neglect or other objectively-measurable changes in the long-term outcomes for children and families. This reflects the complexity of the issue, and the ethical and practical difficulties in trying to randomise families to different models of intervention or account for the multiple variables involved. Some centres in USA have published data using quazi-experimental designs comparing rates before and after the establishment of a CAC on specific outcomes, such as numbers of medical examinations for sexual abuse (Cross et al., 2008; Walsh et al., 2007), or rates of criminal convictions (Cross et al., 2008; Walsh, Lippert, Cross, Maurice, & Davison, 2008). Others have made comparisons between regions with a CAC to communities that did not have a CAC (Campbell, Greeson, Bybee, & Fehler-Cabral, 2012; Lippert, Cross, Jones, & Walsh, 2009; Miller & Rubin, 2009; Shao, 2006; Walsh et al., 2008). The criteria used to compare CACs with other communities included prosecution characteristics (Miller & Rubin, 2009; Walsh et al., 2008), disclosure in forensic interviews (Lippert et al., 2009), abuse and neglect rates (Miller & Rubin, 2009; Shao, 2006), case resolution time (Walsh et al., 2008). Moreover, as noted previously, there is a lack of systematic research on the effect of the model on child and family outcomes (Herbert & Bromfield, 2016; 2017). More research is needed in terms of child and family outcomes, both in terms of the effect of more child-friendly practices and of supported referrals to therapeutic services.

A further problem identified in research to date is that many studies lack detail on the nature of the intervention being evaluated, details of the particular programme and details

about the comparison condition the intervention is compared with. Further, there may also be numerous other factors affecting families deemed to be at risk of child maltreatment that may not be readily controlled within an evaluation study (Tomison, 2000). For example, a particular intervention service may not be able to 'control' or 'contain' the influence of participant circumstances beyond the programme (such as changes in employment or home environment). Some CAC directors and evaluators have argued that because of the significant variation between CACs, and the nature of related services in that community, an evaluation result from one programme may not be relevant to another: each centre is unique (Ashcroft et al., 2004; Rossi, Lipsey, & Freeman, 2003).

Ethical Issues in Conducting Evaluations

In terms of ethical issues, consideration has been given to whether it is ethical for a comparison or control group to be used when they would otherwise have access to the CAC or multi-agency service. That is, when targeting a specific group of disadvantaged families, it could be considered unethical to provide services through a coordinated, collaborative service to some families but not to others simply to gain a more scientifically rigorous comparison group. This would be the case in random allocation within a single population. Comparisons across different communities where one has a CAC and another does not, avoids this ethical problem, but has the problem of not being able to control for differences in the relative populations.

Other ethical issues that evaluation researchers confront, particularly when seeking data about or from individuals and their families include confidentiality issues and gaining informed consent (Holzer et al., 2006). Studies on sensitive research topics (e.g., child abuse and neglect) require confidentiality and privacy protection for participant (e.g., Langhinrichsen-Rohling, Arata, O'Brien, Bowers, & Klibert, 2006; Valentine, Butler, & Skelton, 2001). Confidentiality and privacy are imperative in research with participants who have experienced abuse and violence, in order to protect them from potential stigma and/or reprisals from an abusive parent or other adult (Baker, 2005). One particularly contentious issue in the literature is the dilemma around the limits of confidentiality in the light of a participant's disclosure of abuse or risk of harm during the research process itself during interviews. There are divergent opinions and practices about breaching confidentiality to report suspected abuse in these circumstances (Cashmore, 2006). Some researchers would breach confidentiality even if the participant did not agree to further disclosure, and specify this clearly before the interview (Lynch, Glaser, Prior, & Inwood, 1999). Others believe that

disclosure of abuse should not occur until the participant consents, following a discussion (Hill, 2006).

In addition, gaining informed consent is possibly the largest and most complicated issues for researchers hoping to involve children in a study. It is best practice to ensure that all research participants fully understand the research so that they can give truly informed consent (Chawla, 2001; Dockett & Perry, 2011). If a child is under 16 a parent or guardian's consent may be necessary (National Health and Medical Research Council, 2007). Wherever possible, assent should also be sought from any children involved in the research. Assent is defined as a child's affirmative agreement to participate in research (Alderson & Morrow, 2004; Ford, Sankey, & Crisp, 2007). The assent procedure should reflect a reasonable effort to enable the child to understand, to the degree they are capable, what their participation in research would involve (Vitiello, 2003). This is part of engaging children so they have opportunities to make their own decisions as well as ensuring they are willing participants (Skanfors, 2009).

In conclusion, process evaluation appears to be the most relevant evaluation methodology and a critical first step in checking whether a particular programme is being implemented as intended. It represents an essential part of a comprehensive evaluation that might later include impact and outcome evaluation. Impact and outcome evaluations are valuable when the multi-agency has clear and measureable aims and been shown to be performing according to these aims. Impact and outcome can be measured against the particular aims and objectives of the service in question. It is unrealistic to regard evaluations of a particular as proof of the success of all and any multi-agency service because of variations in programme design and intentions. Ethical issues present a challenge to conducting research in the child abuse and neglect field because of the vulnerability of this population.

Aims of the Current Evaluation

Before commencing this research I reviewed the international literature on evaluating CAC's and multi-agency models, and communicated directly with some international experts. This informed me of current practice, and of the limitations of what is possible and likely to provide meaningful information. I also considered the Puawaitahi staff members' goals and priorities for an evaluation: what would be meaningful and useful for them. Finally, I was aware of the practical restrictions in terms of time and resources available to me within the constraints of a DClinPsy thesis.

CHAPTER ONE: INTRODUCTION

The evaluation of Puawaitahi eventually came to focus on achieving a clear and comprehensive description of the programme, a process evaluation to examine implementation procedures and processes within Puawaitahi, and a limited impact evaluation in relation to goals related to people external to the service, notably referrers and consumers. Across all evaluation activity, interviews and qualitative analysis of the resulting transcripts was employed. In these respects the evaluation is similar to the studies conducted by Crockett et al. (2013), and Cross et al. (2008). Process evaluation was chosen over an impact and/or outcome evaluation as the literature has widely recognised and agrees that understanding how a programme works is the essential first step in any programme evaluation. Further, process evaluations can shed light on the required ingredients for a successful multi-agency and in turn provide insight into key performance indicators and measures for conducting impact and outcome evaluations.

The broader contribution and implications of this thesis beyond the Puawaitahi context are, (1) to examine the feasibility and effects of bringing together the three agencies needed to address child protection concerns in NZ and (2) to develop an evaluation methodology that can be used to evaluate multiagency services in NZ and Australia.

CHAPTER TWO: METHODOLOGY

The research consisted of three population groups and was broken into three stages namely: (1) internal staff working at Puawaitahi, (2) external referrers who work within the community and have referred clients to Puawaitahi and (3) clients both children and families that have had contact with two or more services within Puawaitahi. This chapter will give an overview and rationale for the methodology used in the evaluation, including ethical considerations, describe the three participant populations, explain the interview schedules used, define the research procedure and described how the data was analysed.

Overview of Methodology

As a first step to developing this research I conducted a literature search. Firstly I searched online databases. There was a dearth of research or evaluations with multi-agency programmes for child abuse. I therefore went on to consult with overseas professionals involved in multi-agencies and evaluation research, but again found there to be a dearth of relevant publications. However, this is when I was provided with a copy of the Multi Agency Safeguarding Hub review (Crockett et al., 2013). I also presented my research proposal to the Australasian Conference of Child Abuse and Neglect (ACCAN) for feedback and peer review. I then proceeded to consult with Puawaitahi staff members.

Evaluator's Involvement with Staff Members

Process evaluation is concerned with how a service is delivered and measures if a programme or intervention meets its stated objectives (Hall, 2009). The purpose of process evaluation is to identify areas that are working well and areas that may require or benefit from change in order to enhance service delivery. Preceding, during and following the evaluation there were a number of steps taken to ensure goal attainment, internal staff engagement and buy-in. Nobody knows a programme better than the people who implement it. Internal staff have a unique perspective on Puawaitahi, including about what works, what doesn't, and what should really be measured. Their involvement was considered important not only in the design of the subsequent evaluation activity with the other groups (referrers and consumers) but also as a means of ensuring the information obtained would be seen as relevant to them thereby increasing the probability that any recommendations arising would be implemented.

It was also considered essential that senior managers were part of the research design and involved in engaging internal staff. This created a sense of responsibility for and ownership of the research. I involved senior managers and internal staff in workshops/kick-off meetings that familiarised staff with the evaluation, its purposes, methods and the role they would play in the recruitment of participants in other phases of the research. Staff were also provided with written information about the evaluation process as this emerged and specific step-by-step instructions about their role in recruiting participants (see Appendix D1 & D2). These meetings were also an opportunity for staff to express their concerns, problem-solve and make changes the recruitment process was appropriate.

Throughout the period during which the research was conducted I visited Puawaitahi regularly to brief new staff, collect completed permission to contact forms in the later stages of the evaluation, ensure paper work was refreshed and to answer any questions or clarify processes. These weekly visits were important to not only ensure the recruitment process was going smoothly but my presence also reminded staff about the evaluation and provided an indirect motivation to encourage recruitment.

Once each stage of the evaluation was completed internal staff were provided with feedback about the findings of each participant population and were provided with a short written summary. This meant that at least once a year staff were kept updated about the process. Feedback meetings were also an opportunity for staff to provide feedback to me about the evaluation process and to maintain staff buy-in and motivation.

Focus Groups and Individual Interviews

Semi-structured interviews rather than more formal interview schedules were favoured for both focus groups and individual interviews. Semi-structured interviews were considered appropriate in this evaluation for the following reasons. This approach provides high credibility and face validity; results "ring true" to participants and make intuitive sense (Swell, 2008). Direct face-to face contact in data collection allows the evaluator to probe for more details and ensures that participants are interpreting questions the way they were intended. The interviewer has the flexibility to use their knowledge, expertise, and interpersonal skills to explore interesting or unexpected ideas or themes raised by participants, allowing the participant to describe what is meaningful or important to him or her using his or her own words rather than being restricted to predetermined categories (Patton, 2005). Thus participants may feel more relaxed and candid. Qualitative methods have the advantage of being able to elicit unanticipated information, suggested solutions

and/or innovations that address programme needs. Hutchinson, Wilson, and Wilson (1994) describe catharsis, self-acknowledgment, sense of purpose, self-awareness, empowerment, healing, and providing a voice for the disenfranchised as the sometimes unanticipated benefits reported by interview participants.

Focus groups were used with internal staff members and most referrers. The aim of the focus group is to get quality data within a social setting so that participants can reflect on their own views in the context of the views of others (Carey & Asbury, 2016). Focus groups provide researchers with a number of advantages over individual interviews. They enable a greater range, breath and amount of information to be gathered in a smaller time period thus significantly increase sample size (Berg & Lune, 2004). Furthermore, those who participate in focus groups have the opportunity to be exposed to issues raised by the group and to respond to those issues accordingly. Participants' interactions enhance data quality as participants get to hear each other's responses, make additional comments and provide checks and balances on each other. Furthermore, the degree to which there is a consistent, shared view or diversity of views can be quickly assessed (Carey & Asbury, 2016). During focus groups there is also a possibility that there may be differing views within organisations but strong incentives to adhere to an organisational view therefore it is the researcher and focus group facilitator's responsibility to provide space for contradictory views or disagreements between participants (Carey & Asbury, 2016).

Individual interviews rather than focus groups were used with consumers for practical and ethical reasons. The use of a semi-structured interview format was also employed here in order to allow a focused yet conversational communication. Semi-structured interviews consist of several key questions that help to define the areas to be explored, but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail (Gill, Stewart, Treasure, & Chadwick, 2008). Individual interviews are particularly useful to develop rapport and encourage open and honest conversation. This approach, compared with focus groups, also allows privacy and may alleviate fear of reprisal for disclosing negative or personal experiences. They are useful for collecting details of historical events, opinions, interpretations, and meanings. Individual interviews allow participants to articulate their 'story' in their own words, interviewers can be reactive to participants' reactions and guide interviews in order to avoid undue psychological distress. Individual interviews allow the evaluator to ask sensitive questions as the participant is more willing and comfortable to provide detailed answers in a one-to-one setting (Curry, Nembhard, & Bradley, 2009).

CHAPTER TWO: METHODOLOGY

Qualitative Research

Qualitative research methods continue to become increasingly popular within psychology, particularly for projects which investigate complex issues or phenomena (Morrow, 2007; Ponterotto, 2010). Qualitative approaches aim to gather experiences rather than facts, and attempt to report the meaning of an experience within its context. Larkin, Watts and Clifton (2006) state that qualitative research enables the investigation of complex and dynamic experiences. Through its flexibility, a qualitative approach allows for a broad and rich survey of phenomena (Parry & Watts, 1996). Furthermore, it allows for the individual's voice to be heard (Ahearn, 2000), which contributes to new levels of understanding, especially of phenomena that is under-represented in the research such as, in this evaluation, the experience of Puawaitahi, multi-agency for child protection.

Furthermore, qualitative methodology is not confined by the limitations of pre-set questionnaires or standardised measures. Such measures tend to be constructed from western concepts and use western terminology. These may not be relevant to, or may not adequately capture the experiences of people from non-western cultures. Qualitative approaches are able to adapt to cultural and individual needs, increasing their potential to be culturally sensitive.

Finally, a qualitative approach allows the participant to identify aspects of their experience which are of importance to them. This facilitates expansion of the literature and understanding of the phenomenon. It also increases the likelihood that the study will be relevant to the participants and will address factors of social validity.

The interpretive aspects of the analysis in this evaluation were primarily from a critical realist perspective. A critical realist perspective has been described as acknowledging "the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (Braun & Clarke, 2006, p.5). The critical realist stance aims to capture the lived 'reality' of participants' everyday experiences as much as possible and also aims to give voice to participants and their opinions, whilst acknowledging that it can never really be fully understood or cannot represent what participants say absolutely (Denzin & Lincoln, 2000; Willig, 1999). In a critical realist framework the researcher must interpret what is being said and thus it is acknowledged that they have an influence over what is reported. In this thesis I had the most significant influence in these areas; the questions asked, and the analysis of information, or what is reported from transcripts and how it is represented. Generally, in qualitative research it is recognised that the researcher plays a central role and the resultant themes may be influenced by their particular interpretations, biases and agendas (Potter &

Hepburn, 2005). It is therefore important that the researcher be transparent and clear about any theoretical position they may have, as well as any personal or professional interests in the research or its outcome by including a reflexivity statement (see below).

Reflexivity Statement

I had no prior experience working with individuals at Puawaitahi, nor with child protection and/or abuse services. I have taken a psychotherapeutic assessment and formulation course prior to commencing the present evaluation which covered child maltreatment and its implications for assessment and formulation, which gave a grounding of knowledge and increased my interest in the area.

It is also important that the researcher's role is considered when undertaking research with different cultures, as ideas may be misinterpreted by those who are not familiar with the culture, customs or world views. All interviews and analysis for this evaluation were carried out by the researcher. I identify as New Zealand Samoan.

My supervisor, Fred Seymour, has had extensive experience as a clinical psychologist practitioner and researcher in child abuse and neglect. He has had some ongoing contact with staff within the multi-agency, but has not been employed by any of the services. His background was potentially useful as he was able to draw on a basic understanding of the agency and current government policy relevant to the multiservice agency.

Ethical Considerations

Research Access

The design of the evaluation was developed in collaboration with Puawaitahi staff and the senior management team. Additionally, discussions were held with a Māori research team member and the Waitemata and Auckland District Health Board Māori Research Review Committee to ensure the suitability of the intended research procedures across cultures in accordance with the Treaty of Waitangi.

Ethical approval was sought and granted from the three key agencies operating in the building for the study. This included the Health and Disability Ethics Committee (reference number: 14/NTB/169, see appendix F1), Waitemata and Auckland District Health Board Māori Research Review Committee (reference number: 14/NTB/169), Auckland District Health Board Research Review Committee (ethics number: NZ/1/3196010), Ministry of Social Development Research Access Committee (see appendix F2) and the New Zealand

Police Research and Evaluation Steering Committee (file number: EV-12-356, see appendix F3). All ethical procedures outlined by the committees were followed as agreed.

Cultural Considerations

Research suggests that in New Zealand, Māori and Pacific children are socio-economically disadvantaged compared to Pākehā and face greater family adversity, both of which are linked to child maltreatment. Results of a longitudinal study showed that, Māori and Pacific adults reported significantly higher rates of childhood exposure to severe types of physical punishment and regular physical punishment and significantly higher rates of childhood exposure to domestic violence than Pākehā. Further, previous research conducted on the population who presented at Puawaitahi over a four-month period showed with regard to ethnicity, there were a disproportionately high (to population) number of children who were identified as Māori or Pacific in their file information (Wolstenholm, 2013). With this in mind one must consider the population and therefore, cultural issues that may be faced in the present research when interviewing clients and families who have presented at Puawaitahi.

The Health Research Council of New Zealand (2005) recognises when undertaking research with Pacific Island participants, one must ensure qualitative research procedures are conducted in accordance with Pacific Island worldviews. They recommend the best way to do this by having a "Pacific researcher... doing the Pacific analysis" (p.58). In addition, The Health Research Council of New Zealand (2010) suggests that any research involving Māori participants needs initial consultation and conversations with a variety or Māori and Māori groups before putting the proposal together. They recommend that where appropriate Māori researchers are included as a part of the research team. The researchers were in ongoing consultation with a number of key Māori stakeholders throughout the research project including, Māori staff members at Puawaitahi, Erana Cooper a Māori cultural consultant and the Māori Research Review Committee. Ongoing consultation with Māori advisors helped prevent problems from arising in the research process that may have been unforeseen by the researchers working alone. In addition to minimise this risk, participants were provided with a culturally matched interviewers where necessary. As a Pacific Island researcher I conducted interviews with Pacific Island caregivers and children that participated in the research and a Māori interviewer (Simon Waigth, a fellow DClinPsych student) conducted interviews with Māori caregivers and children.

Vulnerable Participants

When conducting child abuse research with those who have experienced abuse, the ethics of the research process are of paramount importance. Families and children were initially approached by someone they already knew (e.g., an evidential interviewer, social worker, nurse specialist or police officer). Families were invited to participate in the research (an 'opt-in' method), rather than assuming they would participate unless stated otherwise (an 'opt-out' method). This is because I had some discomfort with 'opting-out' for fear that it can be coercive. Explanations of the research process were done carefully with both children and families. The formalities of consent forms were not pursued with children (under 13 years of age), relying instead on parental or guardian consent. However, assent was gained from the children involved. Children and primary carers were interviewed separately where appropriate as it gave the children more opportunities to speak about their perceptions of the process without feeling the need to protect their primary carers in their statements and vice versa. Having said that, children always had the option to have their primary carers or another support person or object (e.g., dog, sibling, teddy bear) with them if they wished.

Children as young as 6 years were included in the range of potential participants. Researchers have previously argued for children as young as this to be included on the grounds of younger children's right to be heard (Davies et al., 2001; Davies & Seymour, 2002). The involvement of children and young people in research needs to be placed within the context of an international rights-based framework within which children and young people were granted a right to have a say. Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) states that all children and young people who are capable of forming their own views, have a right to express those views freely in all matters affecting them, with the views of the child being given due weight in accordance with their age and maturity (UNICEF, 1989). Including children in research gives them the opportunity to access their right to have a say in decisions that affect their lives, make an active contribution to their communities and to improve services used by children, access broader personal development, for example increased confidence, knowledge, self-esteem, and the confirmation that their views matter and can effect change and gain acknowledgement of their contribution by receiving a payment, reward or other recognition (Shaw, Brady & Davey, 2011). Wider benefits of including children and young people in research include, if the research is used to inform decision-making or policy formation, it is likely to lead to policies and services that reflect children and young people's priorities and concerns, the research can offer practitioners new ways of engaging with children, highlighting existing or

newly acquired skills and competencies, and leading to greater mutual understanding and respect and in organisations where this is not already developed, involving children in research can help to promote a more participative culture (Shaw et al., 2011).

Asking children about their experiences of the service provided by Puawaitahi multi-agency raised the possibility of disclosure of previously unreported abuse, thus producing a potential conflict between maintaining confidentiality and protecting the safety of the child. This research placed the safety of the child as paramount and research issues of secondary importance. Children or their primary carers were not asked about the original abuse that lead to their engagement with social services but it was explained to all potential participants (verbally and in writing), prior to their participation, that the researcher was obliged to report any incidental disclosure of abuse that had not already been reported to a statutory organisation (see Appendix A1 for the protocol for reporting of incidental disclosure).

There was a potential for re-traumatisation of the participants involved but previous research of populations of children who have experienced abuse indicates the likelihood of distress is minimal and that the research process is rarely experienced as distressing and is frequently experienced as empowering or therapeutic (Bergen, 1993, 1996; Campbell, Adams, Wasco, Ahrens, & Sefl, 2010; Draucker, 1999; Johnson & Benight, 2003; Newman & Kaloupek, 2004). Careful consideration was given to whether benefits of including young people in the research outweighed risks. Additionally, there was a clear plan to deal with potential psychological distress (see Appendix A2, participant distress protocol). Young people were not asked any detail of the original abuse, although it was acknowledged that young people can find it difficult to draw a clear distinction between talking about the services received at Puawaitahi and talking about the abuse events. Therefore, I received training and had supervision in respect of interviewing children, I monitored mood during interview, and steered conversation back to other topics when I observed discomfort. These precautions along with those outlined below (e.g., caregiver consent, both caregiver and child being fully informed about the study, voluntary participation, support person option and access to counselling and support) ensured that the research was undergone in an ethically appropriate manner. In addition, a resource and information file of local counselling and support services within the region was developed and given to participants where appropriate (see Appendix A3, information and resource booklet).

CHAPTER TWO: METHODOLOGY

Participants

Internal Staff

All internal staff participants were either current staff members with greater than six months experience or experienced staff members that had recently left Puawaitahi and returned for the focus groups. In total there were 25 internal staff members who participated in the study. The following five focus groups were conducted; *Specialist Services Unit (SSU)* (5 participants including psychologists, therapists and administration staff), *Te Puaruruhau,* the health service of the Auckland District Health Board (16 participants, including paediatricians, registrar, research fellow, nurse specialists, social workers, administration staff and the Family Violence Intervention team), *Police* (4 participants), *CAVU,* which includes staff from both CYF's and Police forensic interviewers (3 participants), and finally the *Management Team* (the 3 senior managers at Puawaitahi and 4 previous senior staff members, that were invited back for this focus group).

External Referrers

Previous research (Wolstenholm, 2013) identified Puawaitahi's key external referrers as CYF social workers, General Medical Practitioners (GP's), District Health Board staff, Police, community health services and counsellors. For the purpose of this study, referrer information from the Puawaitahi database was collated and the senior management team agreed that staff members from the following external referrer groups would be recruited: (1) CYF social workers from seven sites (Grey Lynn, Panmure, Takapuna, Westgate, Waitakere, Orewa and Onehunga) serviced by Puawaitahi, (2) police officers, (3) health staff, both hospital and community services, (4) mental health services (e.g., Kari Centre and Marinoto), (5) GP's and (6) school staff (including school nurses, social workers, counsellors and teachers).

The contact information of all external referrers from the previous 12 months were extracted from the database by a Puawaitahi staff member and provided to me. CYF social workers were contacted by their practice leaders and invited to a focus group which was organised by the site. Police officers that had referred to Puawaitahi were invited to participate via email and staff members of the Waitakere Police Child Protection Team was contacted about participating in the study through their manager and the focus group was organised at time that best suited the team. Fifteen key health professionals who had referred to Puawaitahi were identified by the senior management team and approached via email to participate in the research, focus groups or interviews were organised at their place of work.

The lead psychologist at the mental health services (Kari Centre and Marinoto) in the geographical area were contacted by Fred Seymour about their participation in the research. The services advised that they did not meet the inclusion criteria as they did not directly refer clients to Puawaitahi, if they had any care and protection concerns they would refer to the local CYF site or make a CYF report of concern. Thirty randomly selected General Practitioners (60% of the total General Practitioners who had referred to Puawaitahi in the time period) were contacted via email (see Appendix C1, for example correspondence) inviting them to participate in the study with the information sheet attached. They were followed up with a reminder email 10 days following the initial email but no responses were received and therefore they were not included in the research project.

From the recruitment strategies outlined above 65 external referrers participated in the study. The study included 47 CYF staff from five local CYF sites (social workers, supervisors, co-ordinators, practice leaders and management), six Police personnel (including constables, sergeants and senior sergeants), seven health care professionals (including both staff from the hospital and community services) and five school staff employees (including school counsellors, social workers and nurses).

Clients

In NZ the classification of "child" and/or "young person" changes depending on the organisation, service, legislation or law in question. One example of this discrepancy is within child protection services where CYF are responsible for the care and protection of children up to the age of 17 years old (Child, Youth and Family, 2001) but Te Puaruruhau the Auckland District Health Board (ADHB) health service for children and young people who have experienced abuse or neglect will see patients from 0 to 19 years (Starship Children's Health, 2016). This varying definition reflects one of the many challenges in NZ with regard to inconsistency of services for children who have experienced child abuse.

For the purposes of this study the inclusion criteria were: (1) clients had to have filled in a permission to contact form (see Appendix D6), (2) clients (children and families) had to have had contact with at least two of the services within Puawaitahi to ensure they had a multi-agency experience, (3) children could only be interviewed if they were between the ages of six years and 19 years of age and (4) if they were under 16 years of age they had to have parental consent.

Participants were recruited by the Puawaitahi staff member who was most familiar with the family. When and if it was appropriate, while receiving a service from Puawaitahi,

staff informed clients and families of the study (using information provided on cue cards see D3), offered for them to be contacted by the researchers, provided them with information sheets and (if they consented) obtained written consent for contact from the researcher via a "Permission to Contact" form (see Appendix D6). Contact was then made 3-6 months after their initial visit with families and clients who had given permission to be contacted and meet the inclusion criteria (outlined above). The evaluation was also advertised to clients using brochures (see Appendix D4) that were inserted into the standard Puawaitahi information brochure given to families when they first presented to the multi-agency, and posters (see Appendix D5) which were displayed in the waiting rooms.

There were 42 permission to contact forms filled in by clients and families during a 3 month period (1st May 2015 to 31st July 2015). There were 23 participants who did not meet the inclusion criteria and 19 participants who did. Of those 19 participants who did meet the inclusion criteria four were not contactable (e.g., phone numbers changed or disconnected, contact details not complete), five declined to participate and ten completed the interviews and participated in the study.

Of the 10 participants that participated in the study, four were children and six were adults (see table 1). Of the four children one (25%) was male and three (75%) were female with an average age of 12.75 years. Of these one identified as European (25%), one as Māori (24%) and two as Pacific (50%). Three of the children presented at Puawaitahi due to alleged sexual abuse and one due to alleged neglect.

Of the six adults, one was a caregiver (17%) and five were parents (83%), there were two males (33%) and four females (67%). Of the adults one identified as European (17%), three as Māori (50%) and two as Pacific (33%). Of the adults that participated in the study three presented at Pauwaitahi because of alleged child sexual abuse (50%), two because of alleged child physical abuse and one because of alleged child neglect (17%).

Table 1

Demographic information on children and parents/caregivers who participated in the evaluation

		Number (n = 10)	Percentage
Children (n = 4)			
Gender	Male	1	25%
	Female	3	75%
Ethnicity	European	1	25%
	Māori	1	25%
	Pacific	2	50%
Age	6-13	2	50%
	13-19	2	50%
Type of abuse allegedly experienced	Sexual	3	75%
	Physical	-	-
	Neglect	1	25%
Adults (n = 6)			
Relationship to child	Parent	5	83%
	Caregiver	1	17%
Gender	Male	2	33%
	Female	4	67%
Ethnicity	European	1	17%
	Māori	3	50%
	Pacific	2	33%
Type of abuse their child allegedly experienced	Sexual	3	50%
	Physical	2	33%
	Neglect	1	17%

CHAPTER TWO: METHODOLOGY

Interview schedule

Internal Staff

There were three key objectives of interviews with internal staff: (1) gather ideas about what a full evaluation of the multi-agency might look like, (2) to understand how Puawaitahi was currently operating, processes, procedures and day-to-day operations and (3) explore opinions (positive and negative) about how the multi-agency was operating and its outcomes. A semi-structured interview schedule was developed (see Appendix B1) covering five broad topics: how the system at Puawaitahi operates (internally and externally), what is working well, what is not working well, improvements that could be made, and finally, what should be included in a more detailed evaluation of Puawaitahi. Questions were open-ended such as "What improvements would you like to see?" followed by specific probes. This allowed practitioners freedom in their responses but enabled answers to be followed for more detail. In addition, in later focus groups, specific questions/probes were added with regard to comments brought up in earlier focus groups, to gain more information and/or gain another perspectives on the information provided earlier. In other words, probes were adapted and added as more information was gathered and the researchers' knowledge base broadened.

External Referrers

The internal staff comments and suggestions about what a full evaluation of the multi-agency might look like assisted in the designing of the external referrers interview schedule and was also informed by previous research that lead to the inception of Puawaitahi (Davies & Seymour, 2002; Davies et al., 2001).

A semi-structured interview schedule was developed (see Appendix B2) covering six broad topics: knowledge and experiences of Puawaitahi, making a referral, interpersonal working, information sharing, children and families feedback and suggestions for improvement. Questions were open-ended such as "What has your experience been like when making a referral to Puawaitahi?" followed by specific probes. This allowed practitioners freedom in their responses but enabled answers to be followed for more detail. In addition, in later focus groups and interviews, specific questions/probes were added with regard to comments brought up in earlier focus groups and interviews, to gain more information and/or gain another perspectives on the information provided earlier. In other words, probes were adapted and added as more information was gathered and the researchers' knowledge base broadened.

Clients

As per above, the internal staff comments and suggestions about what a full evaluation of the multi-agency might look like assisted in the designing of the clients interview schedule and was also informed by previous research that lead to the inception of Puawaitahi (Davies & Seymour, 2002; Davies et al., 2001).

A semi-structured interview schedule was developed for both parents and children (see Appendix E1) covering four broad topics: series of events leading up to and during the initial consultation, what is working well, what is not working well, improvements that could be made, and finally, what happened after their appointment (referrals and follow-up). Questions were open-ended such as "What were your first impressions of Puawaitahi?" followed by specific probes. This allowed participants freedom in their responses but enabled answers to be followed for more detail. In addition, in later interviews, specific questions/probes were added with regard to comments brought up in earlier focus groups, to gain more information and/or gain another perspectives on the information provided earlier. In other words, probes were adapted and added as more information was gathered and the researchers' knowledge base broadened.

Procedure

Raw research data, recordings and transcripts were only accessed by the independent researchers from the University of Auckland (Fred Seymour and Rachel Stevenson). This was to eliminate the possibility that information gathered from the research may influence an individual's care or professional relationship with the service. This also provided reassurance to the participants as they are able to speak more freely about their opinions and experiences knowing their feedback will be received anonymously.

Internal Staff

Contact was made with staff members of the respective services through the management team and team leaders at Puawaitahi. This included an email outlining the present study, with the Information Sheet attached (see Appendix B2) which invited them to participate in the study. The respective managers organised timing of the focus groups and booking of the rooms at Puawaitahi. Staff members met with the researchers at the arranged time and place, and gave written consent for the recording of the focus groups and the use of anonymous quotes throughout the report (see Consent Form, Appendix B3).

CHAPTER TWO: METHODOLOGY

Five focus groups were conducted at Puawaitahi; one for each of the respective agencies, and one for the Puawaitahi Senior Management Team. In order to ensure that staff felt entirely free to express their opinions on the way in which Puawaitahi operates, senior managers were not included in the four distinct service focus groups. All focus groups were conducted by Fred Seymour and the writer. Each session began with introductions, followed by, each participant introducing themselves and briefly describing their role. This general introduction focused on gaining context and background, and enabled the researchers and participants to establish rapport. One of the focus groups was of 30 minutes only because of scheduling constraints; the others were from 50 minutes to 1.5 hours in duration.

External Referrers

Ten focus groups and one individual interview were conducted. The format depended on the practicality and availability of participants. For example, CYF social workers who work at a community sites were interviewed using focus groups as they are located on the same site but healthcare professionals working in a community service were interviewed individually at a time, location and method (in person or via telephone) that suited them. Each session began with the researchers providing Information Sheets (see Appendix C3) to all participants and also explaining verbally about the details of the study and answering any questions. Participants gave written consent for the recording of the focus groups and the use of anonymous quotes throughout the report (Appendix C4). Participant's then took turns and went around introducing themselves and briefly describing their role and the contact they have had with Puawaitahi. This general introduction focused on gaining context and background, and enabled the researchers and participants to establish rapport. Each interview lasted between 45 to 60 minutes and each focus group were between 1 hour and 1.5 hours in duration.

Clients

Eleven interviews were conducted in person. Interviews were between 20 and 60 minutes in duration. Participants were culturally matched with interviewers to ensure cultural processes were adhered to and recognized (e.g., prayer, karakia and tapu) during the data collection process (Edwards, McManus, & McCreanor, 2005; Jones, Crengle, & McCreanor, 2006). Participants were provided with the appropriate information sheets (see Appendices E3, E4 & E5). Explanations of the research process were carried out carefully with both children and families. Participants over the age of 13 years were asked for written consent for the interviews and for access to their health data (outlined above; e.g., age, gender, ethnicity

and type of abuse) (see Appendix E6). The formalities of consent forms were not perused with children (under 13 years of age), relying instead on parental or guardian consent (see Appendix E7). However, written assent was gained from the children involved (see Appendix E8). Participants were reimbursed for expenses such as their time, travel and parking, via $30 petrol/supermarket/gift vouchers (depending on the participant's preference) and presenting with a Certificate of Participation (see Appendix E9).

Data Analysis

The internal staff data was divided into these three topics. The first topic was data where staff talked about what a full evaluation might look like and what they would like to achieve and this contributed to the methodology and designing of the evaluation. The second topic was where staff made statements that described Puawaitahi's process and procedures and day-to-day running of the multi-agency and this contributed to describing the programme (see "Chapter Three: Programme Description"). The third topic was when staff talked about their opinions providing either positive or negative statements about the multi-agency's processes, procedures and outcomes and this contributed to the process evaluation (see "Chapter Two: Process Evaluation").

The data analysis methodology for the processes evaluation was common for all three population groups (internal staff, external referrers and clients). The key objective of the process evaluation analysis was to identify key themes in the participants' opinions about how Puawaitahi was currently operating and any ideas about how the multi-agency could improve their service. I analysed the data based on the principles of Theoretical Thematic Analysis, according to Braun and Clarke (2006). Thematic Analysis is a method for identifying, analysing, and reporting patterns (themes) within data. Advantages to Thematic Analysis include, flexibility, accessibility of results to the educated general public, a thick/rich description of the data set, the potential to generate unanticipated insights, allowance for social as well as psychological interpretations, and being useful for producing qualitative analyses to inform policy development (Braun & Clarke, 2006).

All focus groups were recorded on a digital recorder. Focus groups and interviews were transcribed by me or by a University of Auckland approved transcriber who had signed a confidentiality agreement. The initial analysis was conducted independently. The audiotapes were listened to initially in order to identify common statements, areas of agreement and opinions that appeared to represent significant exceptions. This process provided an opportunity to reflect on participants' comments and the strength of their

opinions and responses. The entire data set was then listened to again for a second time, with brief notes made toward the identification of codes and ultimately, themes.

Recordings were replayed in their entirety three times. On the third listening, key quotes were coded manually. "Codes" are identified features of the data that referred to the most basic segment, or element, of the raw data that could be assessed in a meaningful way regarding the topic (Braun & Clarke, 2006). Once all the key quotes had been initially coded and collated, codes were organised into tentative working themes according to common patterns or variations. Themes were different from the coded data in that they were often broader and involved grouping/combining the codes to make up a theme. These themes were then reviewed and collapsed or expanded as appropriate throughout the process of data analysis. By the end of this process themes were clearly identified and titles were assigned to each theme.

To help promote validity of the analysis (Morrow, 2005), which can be compromised by the researcher's own perspective and opinions, the process of reviewing and refining themes was carried out in conjunction with my supervisor in order to assist with validity. In addition, the themes are supported by extensive use of quotations, so others can assess their relationship to practitioners' own words, and divergent comments and perspectives are also recorded and explored.

Specific details about participants were not provided in order to preserve anonymity of the speaker. Further, agencies or job titles were not associated with the illustrative quotes due to small numbers of staff in some of the clinical positions. Therefore, quotes were only credited to internal staff (I), external referrers (R) and clients (C). A range of illustrative quotes used from all the interviews and focus groups are included in the findings in order to highlight the opinions present in the three populations that participated.

Finally, once the findings section was written up and the report was completed the evaluation was reviewed by both Ministry of Social Development Research Access Committee and the New Zealand Police Research and Evaluation Steering Committee. Feedback was provided by the respective groups, all of the participants' quotes were preserved, and the integrity of the findings were not compromised or changed in any way.

CHAPTER THREE: PROGRAMME DESCRIPTION FINDINGS

The programme that was evaluated is Puawaitahi, a multi-agency for child protection. Chapter Three will describe this programme I detail as the first step in this evaluation. The Puawaitahi Operations Manual (Puawaitahi, 2009) outlines the interagency processes that help ensure effective service delivery and the smooth day-to-day operations of the coordinated multi-agency response (Puawaitahi, 2009). The processes and procedures also strive to help the multi-agency meet its programmes visions, mission statement and goals. Each of the agencies will have their own operational policies and procedures for their work within the multi-agency. The matters covered in the Operations Manual provide clarification for areas where a co-ordinated effort is required to ensure the smooth running of the multi-agency. As the Operations Manual was created in 2009 and some of the information may be out of date the Programme Description will comprise information from the Operations Manual document and also feedback and quotes from the qualitative interviews with internal staff, external referrers, clients and family.

Vision and Mission Statement

Puawaitahi is a tertiary treatment provider which aims to provide a one-stop-shop for those affected by child abuse through co-location of services, coordinated case management, improved inter-agency cooperation, reduced inefficiencies, duplications and omissions, improved linkages to community providers. Puawaitahi's vision is "working together with families affected by child abuse" (Puawaitahi, 2009, p.5). Their mission statement is the following:

Puawaitahi is an interagency, multidisciplinary partnership, committed to providing a coordinated and effective response to the abuse and neglect of children and young people, by:

- Providing access to specialized medical, forensic and mental health services in a safe and child and youth friendly environment;
- Coordinating and streamlining the investigation;
- Empowering children, young people and their families in the intervention and healing process;
- Striving to provide quality, culturally safe services
- Facilitating timely referral to appropriate community services
- Education, training and research

Operations, Interagency Processes and Service Delivery

Visitors

All persons visiting Puawaitahi, including clients, must register at reception on arrival and departure, and wear an identification label in the form of a visitors lanyard pass. The responsibility for registering these persons rests with individual staff members.

In order to provide a safe environment for clients and visitors accessing Puawaitahi's facilities best endeavours are made to ensure that no perpetrator (offender) is permitted within the premises. Particular care must be taken regarding perpetrators who feature in active (current) agency investigation.

Centre Communication

A newsletter for all centre staff is published and distributed regularly. A Puawaitahi staff contact list for all staff working within the building will be updated and distributed regularly by reception staff.

Library

Puawaitahi will maintain a shared library on Level 3. The principle is that resources available to any one professional discipline in Puawaitahi, should be available to all. The Endnote database of these resources will be supervised by the Puawaitahi co-ordinator.

Relationships with Other Providers

Improving communication and relationships with all referral and linked services is an important goal for the Centre. All internal and external liaison or education will, where possible, involve all agencies based at Puawaitahi. All staff are expected to use best endeavour in all communication with other organisations.

Complaints

Complaints will be treated sensitively and in accordance with each agency's policy. If a complaint involves more than one agency the relevant managers will agree upon an appropriate process and if necessary seek advice.

Senior Management Meetings

The Puawaitahi Senior Management Meetings are attended by the Management Team, which consists of: The Officer in Charge, Auckland City District Police Child Abuse Team, The Manager, Auckland Specialist Services Child Youth and Family, and the Clinical Director and Team Leader, Te Puaruruhau, ADHB. The Senior Management Meeting was

established to discuss the general operation of the building and basic management tasks. This includes, discussing issues around cleaning and maintaining the building (i.e., painting the building). Further, funding, office space sharing, rental ratios (shared building operating costs are proportioned according to the space allocation ratio, or other agreed arrangement), landlord problems, OSH requirements and fire regulations are also discussed. Lastly, issues and employment of shared staff members are also discussed (i.e., receptionists and building coordinator). In addition, once a year a planning meeting is held to review the operational guidelines and discuss the big picture (i.e., Puawaitahi's goals, objectives, vision and mission statement). Their respective manager communicates to each agency and to relevant staff key issues from these meetings.

This system has been in operation since 2008. Meetings were intended to occur fortnightly but this proved unrealistic so was reduced to monthly. Currently the Senior Management Team Meeting occurs sporadically, due to time availability of managers and the lack of someone who takes charge of the organisation of meetings (Coordinator role).

Internal Referrals

Processes for referral between the agencies is different for each government service. All agencies within the building can directly refer to the health team. Although agency staff within the building cannot directly refer clients to SSU, CAVU or Police CPT because of Police and CYF policies. Referrals instead must go through the individual CYFs area social workers or the Police at their local station and then from there back to Puawaitahi. Further, Puawaitahi staff members can only make recommendations to area social workers or local police officers regarding client referrals, there is no guarantee that these will be followed through.

Puawaitahi Interagency Referral Meeting (PIRM)

The purpose of PRIM is to facilitate best interagency practice in the interests of the client. It is current practice in Puawaitahi and has been in operation since 2008. This meeting takes place at Puawaitahi four mornings a week (Monday, Tuesday, Thursday and Friday) at 8.30am for half an hour. The attendees at the meeting include representatives from each of the four agencies within Puawaitahi: Te Puaruruhau team rostered for that day (a nurse, social worker and doctor), normally the detective sergeant for the Police unless they are unavailable someone else will attend, one CAVU representative and one SSU representative. Each staff member will bring along with them a laptop with which they are able to access their own agency's database of clients/history.

The purpose of the PIRM is to discuss all referrals received into the Police, CYF and Te Puaruruhau the previous day/night/weekend. It is a forum to share information between the agencies. This is done by the individual agency representative, looking up the client in question in their individual agency database and talking to past/current information held about the client and family. The agency representative is free to share as little or as much information as they see appropriate. Other agency representatives at the meeting will not sight another agency's database; information sharing is verbal only. However, a written record of meeting proceedings is kept in a Puawaitahi shared database on the secure L-drive of the Te Puaruruhau team. The database is maintained by the Health representative (see below for further information).

PIRM was described by internal staff as an important meeting facilitating coordination within Puawaitahi. It ensures the agencies are working together, all of the client's needs are met and that nothing slips through the cracks.

> The advantage to that is that if a client was referred to say the Police or something and from a health perspective it would be helpful to have input from the health service, we would then suggest that the Police arrange for us to see the child... I find that quite a valuable meeting. I4

In particular, working as a team and building a common identity was something internal staff members liked about the PIRM:

> PIRM was not only about information sharing but making us into a much more genuine team. I2

When sharing client information national interagency policies and procedures will apply in the first instance. The exchange of information pertaining to common clients will occur through PIRM when the information is deemed necessary and in the best interests of the client. In a circumstance where sharing of information by different services at the meeting prompts concern, actions are considered, discussed and agreed on within the meeting by all agencies involved. If any formal action is required, requests need to be made for disclosure of information from formal records, information disclosed at the meeting is for the purposes of collaboration and information sharing (flagging risks) it cannot be formally used without going through the appropriate processes and procedures. Thus, during the meeting the privacy act is abided by a common understanding regarding the sharing of information:

> There's a basic understanding, which is set down in the operational guidelines about what you do with that information. That is that no one will walk out of a PIRM meeting and take any action on the basis of the information they have obtained from

another agency without consent of those agencies. I5

If you want to use it [information given at the PIRM] officially, then you apply for it officially. I3

Puawaitahi Shared Database

The shared database is current practice at Puawaitahi and has been in operation since 2008. Every referral/client that comes through Puawaitahi is captured on the shared database. The database consists of excel spreadsheet forms with dropdown, tick and text boxes. Each entry contains documentation on the referral, type of abuse reported, demographics, which services were involved and action points regarding the referral. A child can have more than one entry if they have been through the building more than once. This information is used to look at basic client and family history of anyone that has been through the multi-agency and can also be used to generate client statistics about Puawaitahi as a whole or the individual agencies (e.g., How many children have come through the service and how many were seen by which service).

The fact that everything is captured on the one database, so you could have one client enter the database through three services, at different points in time. I4

The Health representative updates the shared database four times a week at the PIRM meeting. The shared database is hosted on the ADHB computers and can only be accessed through the Health computers situated on the first floor of Puawaitahi. Although access is only via Health computers, other staff can access the database with the help of a Health staff member.

Case Management Meetings

Case conferences are obligatory for; Starship inpatients with non-accidental injury (NAI); sexually transmitted infections in children; extended forensic assessments of young children; forensic interviews of clients with special needs. These conferences will involve staff from all agencies based at Puawaitahi, and other appropriate professionals. Case conferences can be held in person, or by teleconference or videoconference depending on the case requirements. Other case conferences will be held between agencies as necessary in the best interests of the client. Puawaitahi Protocol's for the Management of Children admitted to ADHB with Suspected / Alleged NAI and the Interagency Guidelines for the Management of Sexually Transmitted Infections in Children and Adolescents have been developed and can be found in the Puawaitahi Operational Guidelines (Puawaitahi, 2009).

The NAI conference is a formalized process where a case conference is held within 24

hours of an NAI client coming through the hospital. The purpose of this meeting is to share and gather information. It is a forum to discuss an immediate action plan for the client and family, along with discussing the involvement of each agency and the role each professional will have with the case. By the conclusion of the conference there will be an agreed action plan. The Case conference is chaired by a representative from Puawaitahi and minutes are taken at the conference, where action points for each agency are recorded and are disseminated to attending parties, as soon as practical, thus, ensuring a timely and coordinated response. This is current practice at Puawaitahi and has been in operation since the opening of the building in November 2002. The frequency of these meetings is undefined as they are arranged as the situation/case arises. In 2013 there were 28 NAI Case Conferences held, so one ever couple of weeks. The agencies that are represented at the case conference are largely dependent on the needs of the specific case.

> This is the point of recognition that there is even a child and protection issue for this child. I3

Internal staff and external referrers reported case conferencing as positive step resulting in a timely, coordinated and informed response. One staff member reflected on the differences to how things operated before the inception of Puawaitahi:

> We didn't case conference before we came here [Puawaitahi]... that came in after we moved here, that was a Puawaitahi thing actually... we might have had an informal kind of thing but we didn't have a formalized process of, and sort of a structure around that and time frames and things, we would expect a case conference to happen within 24 hours of the child hitting the hospital and these are the people involved and this is who gets invited and this is the process around it. I4

Many internal staff and many external referrers identified NAI conferences as a truly coordinated response from all three agencies working together as a team to provide immediate case management to imminent cases. For case conferences to be effective teams must communicate and work together to ensure the safety of the child and to maximize the chance of a successful investigation:

> All three agencies get together within the first 24 hours and collaboratively decide how the case will be managed. We are working together in real time to work out what the best thing is to do about this child. I1

Informal Consultations

The Operations Manual states that "staff working at Puawaitahi will make themselves available for case consultations as required". Many internal staff commented on how informal communication occurred on a daily basis. Staff members from each of the services had fostered an "open door policy". This meant that they walk up or down the stairs to talk to the others and get advice, often without an appointment or prior arrangement:

> All our different services in the building have got a real open door policy so that means, that even if people come to us we are available to them to talk to at that time.... I know I can go and talk to anybody about anything. I2

> Having the accessibility of each of the agencies and being able to go to them straight away to talk through any issues or get advice around certain things. I1

> Consults.... if anything comes through that we are worried about we will go and talk to them [other agencies in the building]. I4

> A general chit chat, catching up, about building relationships, our office is open they just walk in and talk... if we need something answered. I3

Most internal staff identified the benefits of co-location and a team culture on positive outcomes for clients and families that go through Puawaitahi as they are provided with a more efficient, accurate and coordinated response:

> I think it works well... it's because we are all in the same building it makes it much easier to resolve some of the families issues very quickly... we can get hold of someone straight away, it's about meeting the needs of our families... more of a team response. I2

> I just go down the stairs or up the stairs and talk to people. I3

Often this communication would involve accessing a staff member from another service to talk with a client. An example given was where a staff member from Te Puaruruhau has a client who is unsure about reporting the incident to the Police so one of the Police officers informally came down to talk to the child and family about the process, what to expect and what is involved. The child and family understood that this discussion did not commit them to making a formal complaint; it helped the family understand the process so that they could make an informed decision.

Gateway Health and Education Assessments (Gateway Meetings).

Gateway meetings are a joint Ministry of Health and Ministry of Education initiative and are held every fortnight. They pull together any service within or outside Puawaitahi with

a stake holding in the case are invited to the meeting (Police are commonly not a part of these meetings), commonly attendees include, SSU, Ministry of Education, the Social Worker, Health representatives, a child and adolescent mental health representative and other key community service representatives (these services will hold a CYF contract or be funded through government funding). The Gateway meetings most commonly deal with children who are in care or have just come into care and are generally regarded as already safe. The focus of this meeting is planning for the future of the child (addressing education, social/leisure, physical health and mental health needs). In other words the purpose of these meetings is long-term management of children in care. These meetings deal with about 5-10 families each fortnight.

Such meetings are regularly held at Puawaitahi for children in the central Auckland region. Although Gateway Meetings are not explicitly a form of internal coordination within Puawaitahi, there is large involvement from staff that work within the multi-agency and they contribute strongly to the coordination effort.

Training and Education

Puawaitahi internal staff identified three organised meetings and forums to ensure continued training and education for staff in the building; the clinical liaison meeting, journal club and joint training sessions. Further, some internal staff recognised that being collocated meant that there was also a lot of informal education that occurred from working with different agencies and professionals in the building, resulting in improved coordination.

Clinical liaison meetings. Clinical Liaison Meetings are an education and learning exercise where a past Puawaitahi case is reviewed for the purpose of promoting the continuous improvement in the quality of interagency management of child abuse cases and protocol development, as distinct from the current planning of specific actions for that particular client. The case selected is commonly one where all agencies were involved with the client and family. Discussion at the meeting includes how the case went, what went well, any problems that occurred and what could be improved. Thus it serves as a means to review clinical case management systems and processes at Puawaitahi. The Puawaitahi Clinical Liaison Meeting terms of reference has been developed and is outlined in the Operational Guidelines (Puawaitahi, 2009).Clinical Liaison Meetings were intended to be a regular meeting every 6 weeks but are currently held infrequently. In the past Police have taken the organising and guiding role in these meetings (e.g., organizing the PowerPoint presentation and creating awareness about the meeting). All staff members within Puawaitahi are invited

to attend. Many internal staff members described the advantages of these training and education opportunities to include, education purposes, team building, increasing morale and forming relationships:

Learning from our mistakes. I5

>The learning was just invaluable, everyone left this room having learnt a lot... brilliant, very useful. I4

>[Clinical liaison meetings are a] …really good way to meet everyone in the building... present a case from start to finish. I3

A few internal staff commented that this has fallen away due to a number of reasons including the loss of the building coordinator role.:

>It's sort of fallen off the bandwagon a bit... would be nice to see that up and running again. I3

It was the building coordinator's responsibility to plan, organize and disseminate information about these meetings.

Journal club. A weekly Journal Club is a current practice at Puawaitahi and has been in operation since 2007. The Journal Club Meetings are a Health initiative and are open to anyone in the building and even outside agencies can be invited if it is felt the topic is relevant and may be helpful. Although it was acknowledged that they are almost entirely attended by health staff only. The purpose is to share information and education around topics relevant to the work done at Puawaitahi. The meeting is run very informally, and is a forum and education exercise to discuss an article, news piece, journal, book and/or topic, although more commonly, relevant literature published in scientific journals are reviewed.:

>Journal Club... is open to anyone in the building and that gets circulated to everyone they are welcome to join us if there is a topic they feel is of relevance to them. It's initiated through Health and others are welcome… so far we have not been successful in making this a truly inter-disciplinary forum. I4

All professional staff working at Puawaitahi are encouraged to present on different topics, but as indicated in the quote above some professional groups are not well represented at the Journal Club. The reasons for this were not explored.

Joint training. Puawaitahi holds six weekly interagency "joint training sessions". Responsibility for organising and delivering these sessions are held by each agency in turn. These sessions take priority over all non-urgent commitments. The purpose of these sessions was to share professional knowledge and skills between disciplines, to improve our

understanding of the roles performed by other services and agencies, and to keep up to date with developments in knowledge and practice as they relate to abuse and neglect.

Informal learning. Some internal staff identified that working together daily with the different agencies at Puawaitahi improve their expertise in the field of child abuse and neglect. Colocation and working together in a multi-agency meant staff are being exposed to different ways of thinking and doing things, this further develops expertise and systems within the building:

Working with all the different agencies and getting their views on a case, and you know, there's different angles, interpreted in a different way. I3

As a result processes, systems and coordination have improved as they are more aware of the requirements and restrictions of the other agencies and as a result cases are handled and coordinated more efficiently and effectively:

Our expertise grows working within a multi-agency compared to being a psychologist in a private practice doing contract work for CYFs. You are exposed to other agencies which develops expertise in certain areas that which perhaps you wouldn't get anywhere else. Yeah I think that is a benefit. I5

We have learnt a lot about one another.... about the way [other agencies] processes work, their language and what they need to do and how they do things… I think that it is really highlighted when we are dealing with Police teams outside of this building because you notice a big difference in their approach and how they do things. I4

Few internal staff identified an advantage of this being that they have learnt about the other agencies' processes, strengths and limitations and as a result by understanding the difficulties each other face they now have more realistic expectations of one another resulting in a more coordinated, comprehensive and efficient service for clients:

We start to learn each other's' limitations... you don't have as unrealistic expectations and as a result you can respect each other more. I4

Social Events

Social events are another way informal coordination, team culture and relationship building occurred within the building. Many internal staff reported that organised events for all staff members at Puawaitahi helps foster relationships, build support networks and collaboration between staff members and agencies. These events included but are not limited to Christmas partiers and mid-year event:

We have had some quite fun social events. I1

Although not strictly speaking a "social event", interaction is also encouraged through sharing a staff tea room. Puawaitahi has one main shared staff room on the third floor, for all staff working within the building. This has been in operation since the opening of Puawaitahi in November 2002. Some internal staff reported that the shared staff room fostered the forming and maintaining of relationships between staff members. Moreover, a few internal staff members reported commonly discussing current clients and cases they are dealing with, further contributing to coordination and cohesiveness between the services:

> I know it's only minor, go upstairs for lunch, mingling with other people in the building. I3
>
> We try not to talk about cases but it tends to happen anyway, it is a connection thing anyway. I1

Conclusion

Overall it appears Puawaitahi has a number of interagency processes that help ensure effective service delivery and the smooth day-to-day operations of a coordinated multi-agency response. This includes multi-disciplinary practices and meetings (e.g., PIRM, Gateway, case management meetings, shared database, senior management meetings, etc.), multi-agency training and education for internal staff and external referrers (e.g., joint training, journal club, clinical liaison meetings, etc.) and events and initiatives to promote collaboration and relationship building (e.g., social events, newsletter, etc.).

CHAPTER FOUR: EVALUATION FINDINGS

A number of focus groups and individual interviews were conducted with internal staff, external referrers and clients. The external referrers included nurses, social workers, supervisors, managers, counsellors and police personnel. The aim was to identify what is currently working well and improvements that should occur.

Focus groups and interviews were analysed under four topics (specific services, collaboration and multi-agency environment) for themes and sub-themes. Overall participants were generally positive about Puawaitahi and the multi-agency model and felt that this was the result of co-location and the close collaboration of services. The themes and findings are outlined below.

Overall Impressions of Puawaitahi

The majority of participants (internal staff, external referrers and clients) in this study were positive in their reports of experiences at Puawaitahi. Internal staff and external referrers were in general, pleased and enthusiastic about the multi-agency model, the team environment, the child-focused service, the culture and the process and procedures in place at Puawaitahi. They described Puawaitahi as a "standout service" and a "therapeutic process" which promotes well-being for children and families. More specific comments will be provided in what follows.

I think it's a standout service and environment for children. R2

I think Puawaitahi is good, in the old days you had to start at this building and try and get the police involved, but it's a lot better now where you can go to one place and that family and that child is seen and they become familiar with the building also, they don't have to go from building to building. R4

It's a very therapeutic process. I think just seeing kids come in they're quite anxious, they're really nervous about what's going to happen but mostly by the end of it they're relieved having got it out. It is really supported, well organised. It's great. R5

This is such a fantastic place, I mean it's a really privileged situation... just amazing. We are able - although we have protocols and processes there is some flexibility around working effectively… it's about relationships. I1

Helpful, I like talking about stuff. C1

Everything was pretty great… The atmosphere that was built around everything that was in there made you feel pretty good. C3

Despite the majority of participants speaking positively about Puawaitahi, participants (internal staff, external referrers and clients) also identified improvements that could be made. For some these comments were made in the context of an overall positive regard for the programme, such as reflected in the following statement.

> There shouldn't be any other model. It's just that we can make this one works better. I5

These suggestions for improvement were made mostly in response to a question asked specifically about improvements: "What are some of the improvements you would like to see at Puawaitahi?" Whereas many of the positive comments were made spontaneously, suggested improvements mostly arose from this question being asked. The improvements proposed are presented later in in Chapter Five.

A few internal staff, some external referrers and many clients commented on the overall positive long-term outcomes for children that were attributed to Puawaitahi. In particular, referring to children that had been through all the services at the multi-agency, they felt their wellbeing and self-confidence had significantly improved and as a result they had ended up being successful and positive members of society.

> The child appears to have a better long term outcome. Whether it's because it's outside school or whether because they're still seeing them outside, but they do seem to have a better, more self-confidence. R7
>
> I'm thinking of a couple from a few years ago and one of the girls still comes back to see me now and she has that to remind her how good she is and she's a fantastic person. She's actually training to be a [occupation] now but if you'd seen her in the beginning there's no way you could have expected her to be as confident and self-assertive and just totally together. R8

Specific Services

During the interviews and focus groups participants were asked about their experiences of the specific services within Puawaitahi and what they thought of the referral process, service and feedback and reporting. Not all of the participants had visited or used all of the services therefore some services received more feedback than others. This topic analyses participants comments about the four individual services within Puawaitahi and the themes and subthemes have been identified below.

Central Auckland Police, Child Protection Team

Very few external referrers and clients had contact with the Central Auckland Child Protection Team therefore not many could specifically comment on this service. This service does not receive referrals from the public and often does not have a lot of contact (often none) with the client during their time at Puawaitahi. The police's responsibility lies with collating the evidence, dealing with the perpetrator and managing the case in court.

However, a few external referrers commented on how police personnel engaged with the children and found their interactions appropriate and friendly. A few external referrers reporting that the police were "really, really helpful" (R3) when the referrer is trying to gather information or are seeking advice.

> Oh they're pretty cool, they're alright… They're pretty good and they're pretty cool with the kids and stuff. R8

Many of the external referrers that had experience with the Police at Puawaitahi spoke very highly of the service they provided. They commented on how they were professional, skilled in the area of child abuse and had a coordinated and streamlined process that reduced delays and repetition. This was most prominent when comparing the service Puawaitahi provides to other police officers from different offices.

> We occasionally get the police come down and get involved and I'd just say they are awesome to the other police we get and so clearly they just have the training and they just know because out of ours we get the guys coming from the different stations and stuff. I had a case once, I had three different cops from different areas. There was one from the local area and I told him everything and then the next one came and he was from another area and then a third person came and each of them was surprised that someone had already been and in the end I wrote out this thing and I said here it is, hand it round each other because it was just like it was too complicated. The different police stations don't seem to communicate whereas the guys over at Puawaitahi have the whole thing, they're just so smooth and they've just got it running perfectly and they just seem a little bit more professional with the families. Obviously they've had the training. R8

In contrast a few external referrers and a few clients commented on how the Police were poor at communicating with families and keeping them informed about the process and investigation. One client also spoke about feeling like the Police "didn't believe" (C1) her disclosure and that the Police's questions were made her feel uncomfortable:

> The Police are fairly average with the way they handled it … they were fairly average about keeping in touch. C7

Some internal staff, many external referrers and a few clients commented on the delays within the Police CPT processes. Specifically the delay with cases needing a second or third interview due to missing evidence or gaps in the EVI that needs to be explored. Internal staff put this delay down to two possible reasons, either a delay in reading the CAVU report to check for gaps or a delay in assigning a Police officer to the case.

> Police asking for additional interviews and their process is so slow that they often don't read the blinking CAVU report for a number of weeks and then they picked up somebody else and somebody else and then they come back to us six/eight weeks later and say we need little Mary to go off and have another interview and it's like you should have been bloody there at the time or have read the thing the day after. We can keep dragging kids back for intervention interviews, it's not, well heavens what the material is like anyway so that's a problem, there's not a good, it's not the relationship but it's not a good fit between the CAVU work and the Police reviewing the results and deciding whether or not they need something more. R2

> Once the EVI or medical, that information has been collected it can be quite a long delay for Police to really become involved. And that is, it's more for the families and I guess for us as well. Like for the families there's that anxiety around what's going to happen with the Police side of things but for us we need to work with Police and kind of know what they're doing and often that makes it a bit difficult. R5

The many of internal staff and some of the external referrers commented on the Police rotations being only 2-3 years and how this can be problematic when trying to build relationships and develop efficient processes and procedures with staff. Participants felt staff turnover made coordination difficult as it can be disruptive and cause collaboration issues and delays:

> You also think that the change in CP team that once upon a time you had quite a strong [Police Officer] that was quite stable but now we're seeing every two years, or three years they're turning them round because I think what it is you start to get to know and they get to have a good understanding of where social workers are coming from and then they do a two or three year stint and then it's roll round time again. It's like starting again to do negotiations because you get different people coming and different views. R5

> One of the disadvantages is the Police, who are part of the Police team CPT team only stay 2-3 years... it kind of often takes a winter and summer to almost you know introduce them to what working with psychologist or therapist or nurse specialist is like, so you only just getting these detectives who are familiar with the system and work alongside and then they are off... it's a short time, it takes time to familiarize yourself. I1

Overall, participants spoke highly of the Police CPT team at Puawaitahi, although participants reported process delays and staff rotations as impacting negatively on service provision.

Central Auckland Video Unit (CAVU)

Overall most internal staff and external referrers commented that the staff in CAVU were doing the best job possible with their limited resources. It seemed widely understood amongst internal staff and external referrers, especially CYF social workers, that CAVU were under-resourced in terms of staff and the number of interview rooms available. It was understood that they could complete approximately a maximum of 4-5 interviews a day with the resources they had. The demand for forensic interviews often outweighed CAVU's capacity resulting in delays for clients, families and external referrers and (as a few internal staff reported) over worked and stressed forensic interviewers.

Specifically a few participants commented on how they liked the mixture of having Police and CYF staff in the team.

> I do like the mix of CYFs and police. I think it's really helpful. Because in another area where we had a kid interviewed it was two police officers and it didn't work as well, so the mixture of police and social worker is really good, works well. R9

Appointment delays. Almost all referrers and some clients raised the issue around the length of time between the first disclosure being made which lead to the referral and the child actually being seen for an EVI at CAVU. There was a range of experiences with wait times that were anywhere from a couple of days to a few weeks.

> Sometimes we're waiting two plus weeks. I think once we've prepped a child for video I think that's a long time. R9

> I think it was about a 3 month wait from when the Police knew to doing the interview. C9

Most external referrers were unclear about how CAVU prioritised cases and how appointments were assigned to families.

> No-one is really too clear on how they prioritise their cases because sometimes it goes through really fast, a couple of days, sometimes it's weeks, you're not quite sure. R2

> I don't know how they prioritise that but we know they've got lots of work. R1

External referrers found they had little influence on prioritising of cases or timing of appointments. As mentioned above, this was put this down to high demand of the service and staffing shortages.

> We have in the past couple of months had some discussion about having our clients pushed up the list and you know they do try and accommodate us but it just seems like they can't do anything if they don't have the staff. R5

> [CAVU] Hasn't grown to reflect the population… I'm sure their workload has grown, in fact our workload has grown and we are bringing in extra staff. R9

All external referrers and clients that had experienced significant delays at CAVU commented on how these delays impact negatively on clients and families "it was really hard and stressful" C6 and "creates potential problems" R10. The delay appeared to have the biggest impact on cases where social workers had to enforce 'safety planning' around the child and remove the child/children or accused perpetrator/s from the family home. This caused a lot of disruption to the family and could not be resolved until the outcome of the EVI was known.

> You want to remove the child and you remove the parent until they have the interview done and then you will come back and out of the outcome that is a deciding factor for you if the child is safe or bring back mum or that child back. R1

> And that is problematic for us because we have to have the kids away from the perpetrators obviously and that's difficult, if we can't find safe family we've got virtually no caregivers available within the Child Youth and Family system it's broken beyond repair, and yeah so it's quite complicated for us to maintain kids outside of their own home if we can't get rid of the perpetrator and if mum and dad are both perpetrators well you're up the creek. R2

The delay can have a huge impact on the children as routines are disrupted, they might be removed from the home to be kept safe which might result in travelling long distances to get to school or significant adults in their lives (accused perpetrator) may have had to move out/stop all contact with the child. These changes can affect a child's well-being, mental health and relationships. External referrers and clients reported that the delays cause significant disruption to the child's living situation and routine which as a result causes

internal tension, anxiety and stress for the child but also places tension and stress on their relationships with those affected.

> So that's a huge impact on that child who's moved out of the home, then having to face this travel into school, because of the wait time for the EVI... you've got to keep them [the child/victim] separate from an alleged perpetrator, it could be a mum and dad and that period of time is quite stressful. R5

One of the clients interviewed recalled their experiences of the CAVU delay. They reported that the delay had significant impacts on the child's relationships with family and well-being, it was very hard for the child to be away from her family for such a significant period of time.

> We waited a couple of weeks, maybe two or maybe it was three, to go to Puawaitahi … [the child] was only supposed to stay with me for a couple of days but it ended up a lot longer. We were waiting to do the interview because they were unsure what was happening until interview was finished. [The child] ran away, tried to return home to her family. C8

A further impact of the delay was how this was perceived to in some cases be responsible for the child retracting their statement. This is commonly because they start to realise the impact their disclosure is going to have on them and their family situation and therefore retract their statement so things can go back to normal. They may also feel pressured by family members and others to retract their statements/s. Further, with teenagers, one external referrer commented on how social pressure from their peers can result in poor reporting of incidents. Some external referrers reported that the longer you keep a child away from their family and out of their routine the less likely they are to give a complete disclosure or retract their statement.

> He or she finally realises staying with another whānau is not the same as with the parent. R3

> Often we have to keep them outside of the home, keep them from their family for that time, so we're bouncing between families and what have you so often that's quite a tense period for the child. We find that the longer the time, the more likely they are to not talk or retract. R9

> And particularly with teenagers they think through what are the consequences for me and there's this whole social suicide thing, people might find out and not like me and seems more important than the sexual assault on them. Those things in a teenager's life are much more important. R10

If they don't retract their statements and decide to continue with the EVI the delay can also have an impact on how much they disclose and they keep some of the detail to themselves in fear of the impact on the perpetrator and their family.

> They under disclose in the EVI. R10

Some referrers and a few clients had a different experience to most and commented on the prompt appointment times and that they had not experienced such delays at CAVU. It appeared that this may have been due to the urgency and level of risk to the child determined by the presence of imminent danger but may have also been due to the variability in CAVU's appointment availability.

> I have never had this issue because whenever I refer, immediately within a day I got a response from them and it is flexible with my availability that I have always taken children there. R1
>
> My interview was done the same day as reporting it to the Police … maybe hour and a half later … I didn't have to wait long we went straight from the Police station to the place [Puawaitahi]. C3
>
> It's what worked logistically [interview was held a couple of days after the disclosure]… you can interview them straight away but then a lot of time you get bad information because there is a lot of emotion stuck in there… you need a bit of time to clear the rubbish out of your head and get it straight. C7

Referral. Few participants commented that referral form was not a "hard one to fill in" and several noted that there were "always open conversations" with the staff at CAVU regarding the referral.

Appointment length. Some of the referrers and clients commented on the length of time children were at Puawaitahi. Specifically, the length of time families were present to complete the EVI process. A few internal staff, many clients and some external referrers described that although the lengthy CAVU process was expected, they may have been reduced if children were better prepared for the EVI before coming to Puawiatahi. Often children and families found the EVI frustrating, tiring, long and exhausting.

> EVI can take quite some time, two to three hours and then you bring down the psychologist and talk to the child, talk to the parent, whoever is there to support them and then he talks to the social worker and then goes back to the child or young person. It can take quite a long time and the young people that I've worked with that have experienced that have been quite frustrated and not liked the whole process because it's just been too lengthy. R5

This was also commented on by some clients.

> It was a bit long… I was tired. C1

Doing social work. In one focus group a few external referrers expressed the view that CAVU staff would sometimes cross a line into the roles and responsibilities of referrers. That they would make "quick judgement calls" (R1), blame the social worker and give instructions regarding social work decisions when CAVU's role is only to offer suggestions.

> CAVU are there for a specific purpose, like it's to gather forensic evidence by way of an interview, but I think sometimes and it has happened is that they go beyond that. So then they start getting into social work. Social work decision making, social work plans, and actually what we are saying is you do your part and let us do what we are qualified to do. R1
>
> CAVU start to dabble in social work and social work decision making because they are suggesting and almost saying this is what you should be doing as a next step as a social worker. R1

SSU screening post EVI. Many of the external referrers commented on how they felt that having a psychologist on call and available to come down to assess children after the EVI as a very helpful service. This provided the expert reassurance needed when making decisions and recommendations about the child's mental health, well-being and care needed post the EVI experience.

> It has been really good having when we take in a person for evidential interview and for the last year or so they're doing the psychologists from SSU are coming to do the screening which has been really, really helpful after the evidential interview and then we get feedback around that quite promptly and that's been fantastic that process, really helpful. R9

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is used as a screening tool for CAVU clients to measure their level of distress. In one focus group of external referrers comments were made on the SDQ being an inaccurate measure of how the child is feeling. The score is reflecting the impact of the EVI process they thought and is not a true reflection of how the child is actually coping day to day.

> SSU who will be a psychologist who will come from downstairs and they'll talk to the children and they'll do a Strengths and Difficulties Questionnaire and of course the child, their emotions are up here and they are responding to the Strengths and Difficulties Questionnaire. Well really if you did it two days later or even two hours later or the next day the reading would be completely different. R3

Feedback and reports. Many external referrers spoke positively about the debrief both families and referrers were given after the EVI. These are conducted by CAVU staff that completed the forensic interview with the young person.

> Well they give a brief about it, verbal to the social worker so when you leave you've got a really clear idea about the seriousness of what's happened through the child's disclosure which l gives you a much better idea of what you're dealing with. R5
>
> I've had straight after the interview a phone call to give me a summary of what had happened, the report is followed up. We have a very good relationship. R10

Further, many external referrers commented that the written reports are commonly received "within a couple of days" (R2) or in a timely manner.

> They come through pretty quick. We usually get those within about three or four days. R9
>
> CAVU reports I think are pretty timely. You'll generally get them within a couple of days. They'll quite often ring you up, perhaps email you too. R10

Overall, the delay to accessing forensic interviews was seen as a resource issue by some, and was accepted despite the consequences for clients and their families; yet others reported they received prompt access. External referrers reported being unclear about CAVU's criteria for prioritising appointments and lengthy appointments had the biggest impact on clients and families. CAVU screening post-EVI and the timeliness of feedback and reports were process that appeared to be helpful and operating well.

Health, Starship Paediatric Te Puaruruhau

Many participants, both referrers and clients, spoke very highly of the service that Te Puaruruhau provided within Puawaitahi. Most commonly they made positive comments about the staff, the accessibility of the service and staff competence.

> And the doctors are really approachable. You can email them, you can send photos… and then the doctor would go off and take it to the group and they had a look. They were just really easy to talk to. You know that old medical model of doctors are Gods seem to be not evident there. R2
>
> Everything was really good and the nurses they were brilliant, they were absolutely amazing those nurses, so well trained. But I think since then you've got the old people that have been there for many years, they're fabulous if you get one of them. R11

And the majority of them have been there since the day dot. They've been there since the door opened and that shows their commitment as well to the children and young people that they advocate and work for. R9

Referral. All external referrers commented on how easy it was to refer clients to health as it was just a phone call. Referrers felt it was more of a consult, than a formal referral. It was a discussion around how the case should be dealt with and what steps need to be taken. There was always someone on duty in charge of answering the phone and returning messages. So it was a prompt and efficient process, with referrers getting an outcome within the hour.

They're really clear on whether that's suitable or not and if it's not suitable, how I would manage it. That sounds like I don't know what I'm doing, but there's sometimes grey areas. You're just like do I need to refer this or not and you run it through and they go yeah you should be referring that to us or no I don't think you need to but this is what you need to watch out for or you know, so they're pretty good with their advice. R4

Usually when you ring through on the line they're pretty swift at answering it. If you ring through on the mobile number it's always answered and if I leave a message they do get back usually within the hour… if you can just pick up the phone and talk the referral through it's so much more straight forward. I certainly wouldn't want to go to paper. R7

I often phone the advice line, you know that mobile number they have at the advice line and they're fantastic. They always answer it, they always give really good advice, they tell you exactly what you need to do. R5

I would say it would be very unusual even for non-major urgent if they were coming to see them, I would say they usually see them within an hour. They're pretty impressive they really are and I don't think I've ever had them refuse to see someone. R8

Most external referrers and most clients also commented on how quickly they received appointments with the health team. Wait times ranged from children coming in straight after the referral had been made to a maximum of one or two days after. Often the prioritisation of the appointment is part of the discussion that was had with the individual making the referral so everyone was clear about what was going to happen and why.

I think I had to wait hour and a half [from the time the Police were informed to the time I was seen at Puawaitahi]. C3

> I think they're really accommodating too like in some of our emergencies we've got a young person with a child that needs to be seen that day, we can, we ring them and negotiate that and nine times out of ten we would get an appointment for someone to see that child straight away which is really, really helpful. R5

Service. Most external referrers and some clients commented positively about the service they received within the health team at Puawaitahi. As noted already, all external referrers commented on how easily contactable they were on phone or email. Many external referrers and clients felt the staff were friendly, helpful and went the extra mile to make children feel as comfortable as they can. External referrers also often commented positively about the different services offered in the health service, for example therapeutic medicals were often seen as extremely helpful to children and their families.

> They also offer therapeutic medicals which are really good ... So for girls then to kind of explore just so they have a more therapeutic healing side. Yeah it's kind of informative and educative and sometimes it brings in family members as well so it is therapeutic. R2

> I think they've just got such a lovely sensitivity. They do slightly overstep the mark sometimes to help these kids and it's really, really appreciated. R8

Appointment length. Some external referrers commented on the length of health appointments with some appointments taking as long as four hours. These long appointments not only negatively impacted the child (e.g., fatigue) but also put the family and social worker out for a significant part of their day:

> These appointments are fairly lengthy appointments and they all require social workers to be sat there while these appointments occur. R2

In contrast one client felt that although it was a long appointment it "went quite fast".

NAI process. Some external referrers commented on the NAI process and how this was a very slick, efficient and coordinated process that works well for both referrers and families. They felt that the professionals worked well together, it was a team effort that was completed in a timely manner.

> The whole NAI protocol is really spot on, it works really, really well. They're having the meeting within the first 24 hours getting everyone together, police, CYFs, health, it works really, really well so that's really good and the acute work we do which we seem to have ironed out, that is working good. R9

Feedback and reports. A few external referrers commented that they would receive immediate feedback from staff after the medical exams. "They give you a general picture of,

if there was something really pressing from the medical side, they'd let you know straight away" (R2). However, some external referrers and clients commented that the reports that they receive following the appointment are not so prompt. External referrers found the written reports can take a while to get back, weeks and often months "I know they are busy and they usually come back quite quickly but there have been some that have taken quite some time" (R4). Further, one external referrer commented on the knock on effect that this delay can have on the case.

> If we take the child just for a standard medical sometimes we can be waiting three plus weeks for that report and again the police might be waiting before they go and speak with an offender because they want to have that piece of paper that identifies that the bruises inflicted or whatever, so again there's that timeframe where we're sitting. It would be nice if we could get those quicker. R9

In addition, some external referrers felt that there was a lack of communication about the delay of reporting. Health staff were not communicating with referrers about what was holding up the report or they did not give them timeframes for when it would be completed. This meant that referrers had to follow up on missing reports.

> But it would be good to have an understanding of what is going on, if there was a bit of a problem and why we are not getting it, so for example if someone is sick there can be a delay, but we didn't necessarily have that feedback... And then we are phoning up saying gosh where is this report? So the communication I guess because everyone has issues, it would be good to know if there's going to be delays. R3

Some external referrers reported feeling the written health reports were "very detailed" (R2) which often made them difficult to read with all the jargon. "I feel some of the medical terms are very hard for some families to actually understand." (R3). In contrast a few external referrers commented on the NAI or acute reports being completed in a much timelier manner.

> The reports from Te Pua in terms of the acute stuff, so if we're doing an NAI and we'll say okay we need to take orders, can we have a report, they will come on the same day which is really good. R9

Overall, participant's spoke positively of the health service provided at Puawiatahi specifically the internal staff communication and interaction style, processes (including referrals and NAI case conferences) and accessibility. Participants described the process around written health reports possibly benefiting from change specifically focusing on improving, report timeliness and readability for clients and families.

Specialist Services Unit (SSU), Child, Youth and Family

In general many external referrers made positive comments about the therapy rooms, the staff at SSU and their interactions with referrers and families.

I was up at SSU yesterday and yeah everyone was just lovely and welcoming and yeah I went into an initial meeting with a parent and with the psychologist and yeah he valued my knowledge and um looked at what the plan was going to be, it was good. R2

And I've always found working with the staff there to be, lines of communication, to be open and for them to be I suppose supportive of me and my role and trying to provide a service quickly in terms of if a child needs to be seen and getting back to you within a relative acceptable time span. R9

This was consistent with the comments made by clients with all clients that had contact with SSU reporting positive experiences. Clients spoke positively about the staff and therapy rooms being welcoming which meant children were happy to come to therapy and often had a lot of fun during sessions. Clients reported that the staff at SSU were great at communicating and kept parents and caregivers informed:

My child could go away and play and she was happy to do that… If there was anything that was a concern or something like that she would ring me on the phone and say this is, can you work on this or something or this is what [my child] kind of mentioned, just be pre-warned or you know that something that might happen at home. C6

Many positive comments were also made by external referrers and clients about the therapy provided by SSU, children found it enjoyable and parents found it a helpful service:

They were fun… we did some colouring picture, paintings and sandpit. C2

Once she got to know the person… cause it was all art stuff and stuff she actually enjoys, she really enjoyed it … I think she liked the idea of going out of school. C6

Colocation. Many external referrers and a few clients commented on how they really liked how clients could continue therapy at Puawaitahi. They felt this was beneficial for the client and family as they were already familiar with the building and some of the staff. It made it an easier and smoother transition into therapy. Further, having therapy at Puawaitahi meant that the incident and associated experiences could be contained and associated with one building and away from the school environment and their peers.

A lot of the students I refer stay in their care, they don't tend to go to places like Sexual Abuse Helpline or something. It's a sense of taking it out of school, so for me

that's a really way of dealing with it, particularly if it's associated with a social event that there's been a lot of the school at or a lot of their school friends at so it's really good to have that external resource. R7

Site liaison person. Many CYF social workers within the external referrer focus groups made positive comments about the site liaison person from SSU that comes and visits fortnightly. They felt that this was an important in building relationships between social workers and Puawaitahi. Further, this process allowed a space to consult face-to-face with psychologists about cases and possible referrals.

So we have a lady [from SSU that come and visits] on Thursdays so usually we consult the case with her first and see is it alright to refer to SSU or what else that we need to fill into the referral, so it's a help. R1

I think they like to have a clear question, like why do you want to use this service and that's what the consult, the liaison person that comes here is that we have a discussion and it's like trying to narrow down, what do you see us doing which is quite helpful so the social worker should go away with the questions and then you can make that referral. R5

Referral. Many of external referrers that spoke about using the service found having to fill in the referral form to be time consuming, with one participant saying, "it's a lot of detail and a lot of information" (R1). At times social workers reported that they wouldn't have all the information and incomplete forms would just get pushed back with little conversation or exceptions.

Many external referrers disclosed either not knowing a lot about the service SSU provided or commented on the strict criteria their client had to meet to get seen within the service. Further many of the external referrers were not clear about what the criteria to get a child and family into SSU was and therefore didn't want to waste their time filling in the referral form.

Over the years I've never, I don't think I've ever got one case to SSU where I thought it might have fitted into a criteria. I don't know anything about it and I don't use them. R3

I think sometimes it's a bit of a grey area as to the threshold is and what their rationale is for why they wouldn't pick it up because we rely on them in terms of their professional opinion… I suppose if we don't get that buy in or don't get them on board it sort of leaves us in a sort of quandary at times. R9

A few external referrers and some clients experienced significant delays with the services provided by SSU following a referral. It took months for a psychologist or therapist to make contact with the family and start the assessment process:

> [Waited] ages, almost 7-8 months, [I was] always touching base with social worker... hey any word on this [therapeutic assessment]? ... It's annoying, it's frustrating… you get irritated with the lack of service. C5

Service. Some external referrers reported that SSU was really helpful when they were seeking advice and guidance around cases. They found having a professional opinion on the case gave them confidence in the decisions they were making about the child and family.

> The other thing just very quickly is that we do use SSU for is professional opinions, particularly for court stuff and I'm just thinking about a case with a caregiver. It was helpful to have that professional opinion about how the, and it can happen with parents as well. You've got one parent wanting this and the other parent wanting that and they give us a professional opinion that we can take to court on the impact of that on the child. R9

Many external referrers and clients felt that they service that SSU provide was extremely limited. "SSU have limited to the diagnostic work they can do… quite confined in what it will give us" (R2). Further, many internal staff and a few external referrers even felt that SSU was under staffed and under resourced to handle the demand for specialist therapy within CYF. They felt that this resulting in children and families slipping through the cracks and not receiving a complete service and only the most serious cases being supported.

> The threshold is getting higher and higher. R3

> I tend to think that SSU kind of try to edge away from some of the therapy and push it to other people where they can. R5

External referrers and clients reported that due to the lack of therapy provided by Puawaitahi the majority of clients were provided with recommendations and referrals for community services. A few external referrers commented about the extra costs incurred when seeking therapy outside of Puawaitahi, they felt that this may mean that only the 'serious' cases receive therapy and a large number of clients that may benefit from an intervention are missing out.

> Cost can be an issue like specialist services if they can provide that service, I mean obviously yeah that's not a cost to the site but like community support could be a cost to the site and that can be a struggle sometimes. R2

A few clients felt that the service that SSU provided did not meet the needs of the children and families presenting at Puawaitahi. For example, a few family members reported needing more than just individual therapy for their children, and that services and interventions needed to cater to the needs and support the family as a whole:

> There would have been a good chance to do a family one [therapy session], because it doesn't just affect my child. I think it would have been really good if the other children also go some support… because they are struggling C6

Some referrers agreed that the service SSU provided did not meet the needs of the children and families presenting at Puawaitahi as families found it difficult traveling into the city every week for therapy:

> My personal feeling is that a lot of our services don't fit our clients, like just even the fact that families have to go to a centre to have some therapeutic input when we look at some of our probably more successful programmes, it's the ones that go into the homes. I know that we have lots of challenges don't we, with parents that are referred to SSU and just getting there and all of that sort of thing can be a majorly a big huge challenge. R5

Appointment length. A few clients commented on the length of assessment appointments being "a bit long" (C1). These long appointments not only negatively impacted the child (e.g., "tired" C2) but also meant the family and social worker was waiting in the waiting room:

> Long assessment … short attention spans especially for children ... over an hour and a half, maybe close to two hours. C5

Feedback and reports. Many external referrers commented positively about the written report they receive from SSU following the assessment. They felt that they were a good source and reference to work from when making intervention plans for the families and children. They also felt that the psychologists report provided professional psychological support and gave the social worker confidence in their recommendations.

> They are a good kind of source to feed off from in terms of intervention plans and what might need to be done for, or with this family. R1

> It's more credited, they are professionals, they are psychologists, they are experts in their fields whereas we are sitting on a social work field level, so we are getting an opinion from someone that can really back up your findings and give families options that are going to be substantial to their wellbeing and development. R2

Despite the reports being helpful to referrer's one external referrer raised the concern about whether the reports are useful to parents and caregivers. They worried that the reports are not reader friendly because of their length, jargon, etc and wondered if they were even read by the families.

> I mean they get the piece of paper at the end, whether or not any of it is comprehensible to them who would know. R1

Some of the external referrers and a few of the clients thought that the verbal feedback SSU staff give the family was helpful in their understanding of the report. During this meeting a SSU staff member would run through the report and recommendations with the family. External referrers felt this was delivered in a way that was respectful to the family and so that understand.

> Usually once the SSU report has been completed they then make a meeting time for the family, the social worker and SSU to go through the report and recommendations. R1

A few external referrers and a few clients commented on delays in receiving reports and feedback. External referrers felt that they were often chasing up the clinician to get the results and recommendations from the assessment. The delay in receiving written reports was generally understood by social workers as a workload and capacity issue for SSU staff:

> Feedback from it was a long time coming as well, you know the outcome of the actual assessment… properly about three months… lots of me trying to initiate [meetings and conversations] … I had to chase them. C5

A few external referrers felt that the more experienced the SSU psychologists were more efficient and timely with reports. When handling a critical and urgent case, the faster the report was received the better and it took pressure off the referrer when having to make critical decisions for the family and client and did not stall the case.

> A number of psychologists from SSU you can see the really skilled workers for that kind of acute and critical work able to quickly get case notes on and get those reflections back to you and then other workers that are kind of less able to manage that in an acute way and for us that's a real hindrance. R9

Overall, participants were positive about the SSU therapy rooms, staff, co-location, therapy, site liaison person and consultation. SSU was described as limited in the interventions, assessments and service provided to clients although that was generally understood by external referrers as a resourcing issue resulting in referrals to community services. The SSU referral form, criteria and process were identified as areas for improvement; this also

appeared to impact the timeliness of clients accessing interventions resulting in delays in service uptake.

In conclusion, participants generally spoke highly of all of the services within Puawaitahi. Common areas of strength included staff interactions with clients, client-focused environment and collaborative efforts. Common areas for concern included delays (e.g., Police delay's in requesting subsequent EVI's and CAVU appointment delays), limited resources (e.g., staffing and service provision constraints) and timeliness (e.g., Health written reports and SSU access to therapy).

Collaboration

During the interviews and focus groups internal staff, external referrers and clients were asked about interpersonal working (e.g., external referrers were asked "does the multi-agency model change the way you work with other professionals when protecting children?") and a number of the participants commented on Puawaithai's ability to collaborate and coordinate internally with the services in the building, with referrers to the multi-agency and other outside services and lastly with service users including clients and families. This topic analyses comments about how services within the building collaborate and coordinate internally, with referrers and with clients and families. The themes and subthemes have been identified below.

Internal Collaboration

All of the internal staff and external referrers spoke positively about the multi-agency model and felt that colocation contributed to the coordination and collaboration of services within the building. Participants felt there was a real team approach to each case and colocation contributed to the ease of multi-disciplinary case management.

Communication is always better where groups are co-located, that's the bottom line. R10

That's the good thing about it that they're all working in together. R11

I really like the fact that they always say they're going to go consult with their team and get back to you so they're actually not making their own decisions by themselves, they're actually going to the wider team and consulting. R8

Many internal staff and a few external referrers commented on the benefits of having a "one-stop-shop" and felt that this model was benefiting both the referrer and the family. The referrer felt safe referring the client to a place with specialist care and the family had one

familiar place with all the services they needed collocated. This is not only helpful to coordinate services but also eases the process for the children visiting, as the building and staff become familiar and this can reduce anxiety for the child and family:

> We just feel safe that they will be communicating with all different groups and going through the right paths. R8

> Having that one place makes it very easy for social workers because they're very connected, so they meet and discuss cases so the police know, the health workers know, the doctors know so you just find that it's much more joined up and the same for the families I think when we take young people up there for an evidential interview like you've got the psychologist who can see them and also the health check can be booked in and they can take them down, show them around, introduce them to who's going to do it and it's seamless and it kind of feels like it's a real true kind of wrap around that the client goes in there and it's really connected. R5

Also one external referrer commented on how they felt the multi-agency model helped with difficult families that would usually get lost through the cracks. A consistent professional team dealing with the family and also continuous communication between the agencies increased the chances of ensuring clients received the care they need following a disclosure.

> Some of the families can be quite difficult. Often it's the educated middle class who've had an unfortunate accident or something's happened that's involved Te Pua so I think the less people you have involved, the easier it is because otherwise you end up playing off and then you end up running around so it is really important to keep it quite tight. It quite tight so there's good communication and they're getting the right message from the right people otherwise you have this tendency to play everybody off and everything just gets messy. R8

A few external referrers commented on how colocation meant that the different professionals were always on hand to offer advice or see a family and professionals worked collaboratively by moved freely between the three levels when needed.

> It helps with the multi-agency, we've got all the assistance and they come down when they are available, more quickly. R1

> There are doctors downstairs that are available, like that's what I've noticed, if they need them they pull them in, they're more readily there. R5

Many internal staff and external referrers felt like the multi-agency model promoted team work and collaboration of cases. Puawaitahi is a specialist service equipped to deal with child abuse. Many external referrers felt that in other Auckland areas where there was not a multi-

agency model the environment and processes were not equipped to deal with these cases resulting in a lack of communication and collaboration. Families would bounce from service to service and professional to professional where each of the agencies was working independently, not as a team which at times had a negative impact on the family and the case, resulting in delays, miscommunication and repetition.

> It's much nicer for the families just to have one group as well rather than this doctor and that doctor and everybody. R8

> It just made me feel really safe with Te Pua because you had a group of supportive people from different disciplines working together as opposed to this kind of not working together at the other place. R5

Despite all being in the same building many clients reported that they or their child had to repeat their 'story' (sequence of events in which the incident occurred or historic CYF involvement) a number of times (3-5 times), despite the professionals all working in one building:

> In the same day, I had to tell the story three or four times... a couple of weeks later I had to do it again. I was just annoying to having to tell it first to another person and asked to tell it again and asked to tell it again, just being asked to repeatedly tell it. C3

> I thought because she asked so many questions about previous things that I know CYFs already have on record, that was annoying, having to repeat, rehash. Urks the life out of me… Information hasn't been passed on, breakdown… I know they asked for background but they should have just read the notes. C5

> It's horrible because it's like why can't you just go read up on it or something… its frustrating cause you know they all work together, they should be able to find stuff out but you are having to repeat the same stuff all the time. C6

Some internal staff and external referrers speculated that a possible barrier to clients coming to Puawaitahi is fear about visiting an agency where all the services are seen as a team as they are worried they might lose control over who they see. For example, they may fear if they visit Te Puaruruhau that they may automatically, and without choice, be referred on to Police:

> The one negative of this building is because we are co-located with Police and CYFs there are for example, schools that are reluctant to refer to us because we are going to refer it on. I4

Referrals within the building. A few internal staff and some external referrers commented on the process in which referrals are dealt with in the multi-agency. They felt that currently the referral path was such that Puawaitahi seemed as though it was operating as four

separate services collocating in one building. Participants pointed out that you had to go through a separate referral process to access each of the services and that a child did not simple flow through the building in a coordinated manner. This had a negative impact on clients and families as it resulted in delays, multiple visits and was more work and repetition for the referrer.

> It's one process that should effectively follow on to each other, so the initial contact with Puawaitahi is really a complete, potentially take a child right through those services. But what is currently happening it's almost like you are dealing with the police and it ends, health and it ends, SSU and it ends type of thing because after EVI there's quite possibly conversations with a psychologist etc. to say that there could potentially be this, this is the recommendation that comes from me. So it's should be one process. R3

Furthermore, many internal staff reported this process can result in clients "getting lost in the system" (I1) as a result of the relevant referrals not being followed through and also creates time delays in the child seeing the respective agency.

> We can recommend to the CYF social worker that they should refer to Specialist Services... but we can't make a direct referral ourselves, it has to go through the CYF social worker. I3

> The other major barriers... we can't actually refer directly to the other services, so Police CPT, it has to go to your general Police station and then to Police, CAVU. It's got to go to Child Youth and Family and then CAVU and same for SSU, so we are always having to do it backwards... [Health] is the only services you can directly refer into. I4

Multidisciplinary meetings. Many of the external referrers reported finding the multidisciplinary meetings that are held at Puawaitahi with all the professionals involved in the case (also referred to as "case conferences") as very helpful. It brings all the different professionals into the room that are involved in the case and it brings together a range of knowledge and experience to ensure the best outcome for that case/family. They found that being able to have everyone in a room to discuss the case and make an action plan helpful as it contributed to efficient coordination of cases. It meant professionals were more informed and able to delegate jobs, reduce overlap and delays.

> So that has been really useful and talking about those really high serious physical abuse cases where we've had those case conferences with everybody in Te Pua and

CYF staff around. Okay these are the injuries to this child, what is each agency going to do. R1

MDT meeting with the family explaining the rationale for the issues and going through the x-rays and going through all those sorts of things, having the OTs and physios explaining the hip spiker and what specific cares they will have. That's a really useful forum for everybody, the doctors, the social workers, CYFs social workers and the family to all be on the same page and to have that, those are really, really useful meetings and they're really good for discharge planning and they're really useful. They work really well. R8

I think having the multi-agency approach thing I think when there's cases, it's been quite good at pulling us into professional meetings if there's information that needs to be shared or planning needs to happen, then you have that meeting with the medical staff, they bring in a psychologist from SSU. You've got us there and you've got the Police. So I think that's really good. I like that. R5

A few external referrers commented on how at times it can be difficult to coordinate feedback meetings or FGCs with everyone from the MDT and the family. Professionals are all very busy and trying to find a time that everyone is available can be very difficult. One external referrer described that they have gotten around that by having professional meetings where the social worker would meet beforehand with the professional that couldn't make the meeting so that the social worker could relay the information they were supposed to be presenting at the meeting. Although this appeared to work, the referrers felt that it was not as impactful, efficient and effective as having the professional present at the MDT.

But we've gotten around that in the past by having professionals meetings before, so if they have told us in advance that they can't make a conference what they have given us instead of is the report. It's not as like an impact, it's not as impacting as someone being there in present, but I've had an experience where we've had a professionals meeting before the conference and then that information was shared at the FGC on behalf of the person that wasn't there. R1

Three individual agency databases and privacy laws limiting efficient sharing of information. Puawaitahi addressed the privacy laws some time ago and information is now shared between agencies in the building during the morning PIRM. If more information is needed or the information shared in that meeting needs to be acted on, then it is obtained officially through the formal process/avenues (which is different depending on the agency providing the information). Information obtained in the PIRM cannot be used when

assessing/interacting with the client and family. Some internal staff reported, separate agency databases and privacy laws as being a barrier to effective and efficient service for clients and families.

Some internal staff commented on the limitations of the privacy laws and what this means for them when they are working with clients. A few internal staff expressed that if this barrier was removed and the conversation was initiated in a sensitive way, it might really help when interacting with clients and establishing the facts and would help avoid clients having to repeat conversations and their history with each agency within the building:

> We can't let them [the client/family] know what information we know, so if we are seeing a patient like a parent or a child and we know there is extensive family violence we can't tell them that... we are allowing them to lie to us without being open and honest and saying look we know there's a history of this. We might actually get more information if we can provide information to them... because we can't give that information people say no there's not a history of family violence, we're all fine the kids have been great, we knows there's a whole shit load of family violence but we can't tell them that, therefore they don't have that opportunity to open up to us. I4
>
> Could be embarrassing for someone to initiate that kind of conversation to us, you know, ooh yea there is family violence, my husband does beat me up or my children are being abused. That's an embarrassing situation to be in but if they know that we know that information it might make it a little bit easier for them to talk to us. I1

One of the solutions offered by the internal staff was a shared database between agencies which would help facilitate coordination and make important information more immediately accessible.

> One of the barriers, we all have separate computer systems. I4

In contrast, many other internal staff members disagreed as it was suggested that a shared database would create more problems (e.g., misinterpreting other professional's notes and having to learn the lingo of different professions) and they felt that the PIRM is a "perfect compromise" with flexibility, autonomy, human interaction, and relationship building:

> I don't know that it is necessary for everyone to share the same information system. I4
>
> The real strength of PIRM is that it respects peoples' privacy and autonomy as an organisation and that it's not X looking into Y's database, it is Y looking into Y's database, familiar with it, understanding how it works, what it means and what it doesn't mean and interpreting it and that giving information that in Y's view is relevant to X. If X in real time thinks, you know, I need to know more about this or

what do you mean or, you can have that conversation... I think personally it is quite a nice balance between sharing information but retaining control over information. I5

If you take away the human element and just have this huge database that we are all going into and we meeting brick walls cause I can't go any further in the section because I don't understand it. I think it would be less effective. I3

Collaboration with External Services

External referrers. When asked about interpersonal working and the contact referrers has with Puawaitahi the majority of external referrers commented positively about the relationship they had with Puawaitahi. They expressed that having a good relationship with the staff and services in the building helped them do their job more effectively. This was a result of referrers regularly going to the building with clients and forming effective working relationships with the staff there. This relationship appeared to result in more effective coordination and collaboration.

But you feel part of, well respected. R2

At most, I don't know about you guys, but when I go there I don't see them anymore as Puawaitahi. I just go and do, okay, you just go to the kitchen, you go to this and you go to that, because we are there so regularly. We are the main users of the service. R3

A few external referrers talked about how their relationships with the Puawaitahi staff not only made their job easier but also had a positive impact on clients and families. They felt that the families seeing the referrer (whom they have already built a relationship with) positively interacting with the staff at Puawaitahi would put them at ease and would facilitate a trusting relationship with the professionals at Puawaitahi.

Because particularly with adolescents there's that trust issue. From that perspective the relationship I've built up with the staff at Puawaitahi is fantastic and the trust issues are a very much smaller part of establishing that working relationship so the girls will go back and they will go back for follow up and the boys. R7

In contrast, in one of the external referrer focus groups a few participants felt quite differently about going to Puawaitahi. They reported a negative experience, of not feeling welcome, despite having visited the multi-agency a number of times with clients.

I have been there more than ten times, but still I feel some strange place for me there. It is not like a friendly atmosphere happening there. R1

> Yeah and I just think there's a coldness sometimes down there. But again like I said over the years I've seen that get a little bit better. R1

Many internal staff and external referrers found staff turnover to be a disruption to effective coordination and collaboration. When staff leave or are rotated onto another position it can disrupt collaboration both internally and externally. When staff build working alliances with each other, they each start to understand how each other work, how the multi-agency works and establish an effective process that works for both parties. When that alliance is disrupted by a staff member leaving that relationship building has to start all over again with the new staff member and that can take some time.

> Well you build up those relationships with really good ones and you have them for a period of time and then for some reason they've shifted to another area so you lose that relationship that you've built up and I suppose that knowledge that they share with you in terms of the cases you work with which can be hard when you're transitioning to test someone that's new because you're starting the whole process again. R9

Community therapy referrals and recommendations. Many external referrers felt that there was insufficient follow up or follow through when community referrals and recommendations were made. External referrers felt that while a report or letter would get written by the staff at Puawaitahi containing recommendations for support or therapy no one at Puawaitahi took the responsibility of following up and ensuring recommendations were implemented or followed through. It was up to either the family or social worker to contact the support service or counselling, and this did not always happen. Therefore a number of families and clients that would benefit from therapy have slipped through the cracks and never received support.

> It's just maybe making other agencies in particular more obliged or more accountable to following through their recommendations. R4

> Reports are incredibly well written and extremely thorough and give a whole lot of information and their recommendations are awesome. I think the problem is that there's not enough weight put on them and that a lot of the recommendations it's up to CYFs to put in place those recommendations and they don't. R4

Most clients also reported a lack of follow up and support to ensure that recommendations were followed. Clients felt that it was often left up to them to contact the community services and this created a number of problems including financial barriers to engaging with services (e.g., the cost of making a phone call) and being unsure about how to approach the topic and

how to have a conversation with their children about therapy. This resulted in most of the families not receiving any support following their engagement with Puawaitahi:

> There was a part of me that didn't [want to go to counselling] but everyone said it would help so I went … It was my choice if I wanted to go or not. They gave my family some phone numbers and left it up to us to ring the lady [counsellor] and make it happen. C3

> I didn't know whether [my child] wanted [counselling] or not, cause yeah even to this day we haven't really talked about what actually went on … yeah it was just hard, I didn't know how to talk to my [child] about it, [my child] didn't come to me and talk to me about it … I wasn't sure how to even approach about counselling. C9

A few internal staff, some external referrers and a few clients spoke positively about community therapy referrals offered to clients and families from Puawaitahi staff and felt this was a good option. They felt that the client was matched with the service to meet specific requirements (e.g., culture) and also felt that they could find a service provider that was practically appropriate for example a service close to the clients home or one that comes to the home in order to minimise transport difficulties.

> Sometimes we need to culturally match, if we can't provide a cultural match in this setting [Puawaitahi] ... we know that this child needs to go out [in the community] to a Māori psychologist or therapist. I1

> Yeah also I think there's also some community service where they offer cultural respect and everything and they can work really well. R1

> Gave her different places for counselling, they don't say you have to go to this one, there are a few different services available… local is good. C7

Many external referrers discussed their frustrations with community services. One of these frustrations was that despite their best efforts to reduce travel time there were not many community services that were locally available who had a good reputation. The external referrers expressed a need to be confident in the service provider's ability to provide a competent and specialised service to an abused or neglected child and/or family. Transportation became even more difficult if the young person decided to not inform their parents of the incident.

> Guess probably the most difficult thing afterwards was contracting an ACC counsellor that the young people could get to, that was probably the biggest barrier to ongoing care was how do we get them there? These are young people that don't have

access to transport. Their parents might not know and the counsellors won't come to school. R6

I think that's a barrier to young people accessing any sort of service, not just counselling but any sort of service is their ability to get there, particularly if it's something that they're trying to keep from their parents. It's virtually impossible to maintain regular contact with somebody if you're trying to keep it a secret. R6

This was reiterated by some clients who reported attending therapy at a community service often required travel time and money:

If there was a counsellor closer it would have been better… I could have walked … I paid for the bus to get there [counselling] out of my pocket money. C3

Another frustration of community services that a few external referrers expressed was the delay from the client being seen at Puawaitahi and beginning therapy. This appeared to not be a smooth process and was not completed in a timely manner. The child was left to cope alone without professional support.

Sometimes when a young person has gone through the process and they're still waiting for (sexual abuse counselling service) to pick up, still waiting and they're clearly traumatised. R11

Collaboration with Clients and Families

Internal staff, external referrers and clients were asked about children and family's feedback/ their own feedback about their experiences of Puawaitahi and most external referrers and clients spoke positively about the interactions between staff at Puawaitahi and the clients and families. They felt that the staff treated the families and clients with respect. Further Puawaitahi staff listened and empathised with the clients and families, they appeared to understand that this was a very stressful time for families and tried everything in their power to make an uncomfortable process more bearable. This approach from staff helped ease some of the family's anxiety at an extremely stressful time.

And the staff's really respectful even if you've got parents in there with like NIA or like there's no blame. They're just very respectful and they just do what they need to do and they're very good with our parents. I think they need to be told that as well. R2

I spoke to mum yesterday and she thought it was awesome because she was there for four hours and finally someone listened to her and heard her out on what all her anxieties and concerns were and someone she could vent to. R4

> I think all of the clinicians come from that place, come from a place where yeah we know whatever happened is real shit but your experience is as good as I can make under the circumstances. R6

Further, many external referrers reported that on arrival at Puawaitahi, staff made a real effort to ensure families and clients were communicated with and that they had opportunities to ask questions so that they understood what was going on and could make informed choices about what was going to happen.

> Making sure that they're well informed, that their consent is really informed consent. R7

> Able to talk to the children on their level. R3

> They're all really clear with experience and communication with young people and children so I think their biggest skill is probably their relationship building and communication. R6

This was consistent with most of the client comments as they reported that Puawaitahi staff informed clients verbally about the process (e.g., what was going to happen and what to expect) and also provided families with written information (e.g., brochure) about the multi-agency service:

> They introduced themselves and told me what was happening. C3

> They sat in the room and then kind of went through what was going to happen… [staff were] good, nice, basically told me what the procedure was, how the interview was going to go … so I felt good that they would be okay and I would be there for support and stuff. C9

> I think they gave me a pamphlet or something. C6

> We were given some pamphlets and that where I understand more. C8

Despite the effort made by the staff to educate the clients about how the building worked and the process a some of the external referrers and clients reported how that initial visit to Puawaitahi was overwhelming and anxiety provoking for families therefore they couldn't really remember or recall the information they were given:

> I think they explained the building but it might have been too much at the time. C6

There were no formal processes for preparation of clients before coming into the building. Some clients commented on the lack of or inconsistent preparation provided to the clients and families before presenting at Puawaitahi. The type of preparation and information provided appeared to significantly differ between clients. The professionals who provided this preparation to the clients and families also differed for example some clients reported getting

information about Puawaitahi from their social worker, a Police officer on the case, a forensic interviewer and/or a community health professional. Often families would present to the multi-agency uninformed and unaware of the process or expectations which often resulted in misinformation, confusion, anxiety, fear and apprehension for clients:

> I was slightly apprehensive, you know just have nerves, thinking how's this going to go, what's going to happen … [not knowing what to expect made it] hard waiting in the waiting room. C5

> [First visit to Puawaitahi] kind of nerve racking, I didn't know the people… we didn't really know what was involved… not sure about their expectations of us… it was just the unknown. C6

> We turned up not really know what was going on or what to expect. C9

Most clients reported that it wasn't until they got to Puawaitahi and met the Puawaitahi staff that they were fully informed about the processes and what was going to happen.

> I thought it was a little bit scary and then it was fine [once I knew what was happening]. C2

In contrast, one client commented on having really good preparation before coming to Puawaitahi. Having a clear and accurate understanding of what would happen and what to expect, reduced anxiety:

> Before I entered the building I was told what was going to happen… I found that it was better, than going in there and getting told. I would have enough time to think about it… They told me everything that was going to happen and everything they said was going to happen, happened. C3

A few external referrers reported that having the professionals in their field on hand to communicate and collaborate directly with families made a real impact. It helped families realise the seriousness of the incident and contributed to forming a relationship where collaboratively the family and staff could work together to get the best possible outcome for the client.

> It's really hard for sometimes I think people to hear information from a social worker, particularly with the stigma that is attached to Child Youth and Family, so when you've got someone like [leading specialist] who is very well known in general but as good at what he does and he's showing x-rays and he's pointing out where the bones are broken and how that affects the child and vice versa, yeah it's a heck of a lot more of an impact. It stops families in their tracks and makes them realise that this is serious stuff. R1

> Like we give that information as well to families but when you've got a detective sergeant and you've got a paediatrician giving that information like with those hats on families seem to take that on just a little bit more. Like Suzy said that's their profession, that is the expert fields, so when they hear it from those professionals it kind of really hits for them. R1

A few external referrers commented on the difficulties of making appointments and felt that this was not a collaborative process between the family and Puawaitahi. Instead the client just had to fit into an available time slot they were given as the professionals were so tight for time. They felt that this did not promote a collaborative alliance and instead was a one sided start to the relationship, especially if the family found it difficult to make the assigned appointment time.

> When the police make an appointment often I don't know if there is negotiation, I always encourage for me negotiation to happen because we don't work the same hours. Similarly also doctors, because doctors, they are not always on either. I am not quite sure, I don't really think that we have had any difficulty with getting our children seen by Puawaitahi in terms of medicals, but equally they also too have an expectation that we get families to these appointments and sometimes the times that are set don't take into account that we have to come into work to get a car, to go and get the family. So there's all these little things that make the workings of it a little bit frustrating at times, but we have managed so far as best we can to get our families there and sometimes we have the assistance from health because they do have the capacity of getting taxis out to some of the families and getting them to some of these appointments. R3

> Whereas we don't have that luxury because it's around supply and demand. Here is an appointment time, we need to then get our kids to that appointment. R3

Overall, participants spoke positively about the coordination at Puawaitahi, internally and externally with both referrers and clients. Specifically, Puawaitahi's team approach, co-location, communication, multidisciplinary meetings, professional relationships/partnerships, and welcoming environment. Some areas that participants identified that would benefit from change included clients having to repeat their story, lack of client preparation, multiple referral processes within the building, staff turnover and lack of follow up and support accessing community referrals and recommendations.

Multi-Agency Environment

During the interviews and focus groups participants were asked about what they thought of the environment and service at Puawaitahi for example clients were asked "what were you first impressions of the Puawaitahi building?" This topic analyses participant's comments about the physical building, the internal staff, the service ethos and cultural considerations. Themes and subthemes have been identified below.

Physical Building

Many of the external referrers commented positively about the appearance of the building from the outside. They liked that it was not a Police station, CYF site or hospital. It provided privacy for the family seeking support for such a sensitive incident and removed some of the anxiety attached to the stigma of child abuse.

> I love the way it's an anonymous building. The fact that it's away from the main hospital site but still near is probably the winner for me. R7

> It's a disarming building when you rock on up it's kind of like oh yeah it's a building, nothing intimidating about it. R7

> I know that the clients I've taken there have normally been a little bit older and appreciated the anonymity of the building with it not being hugely signposted of what services it includes. They just see it as a great big office building with number 99 on the side, that's huge. R2

Most clients agreed that the building being inconspicuous and unidentifiable reduced the stigma for families presenting for support:

> Good how it was pretty plain. C3

> It is better than coming out of there with a big sign on your head saying this has happened, that would destroy some people… it was better for [my child]… other people [the public] seeing her [walk in to Puawaitahi] didn't know what it was for. C7

> It doesn't stand out… that's good. C9

However, the outside of the building was described by some clients as plain and formal and not matching the child friendly ethos that was so prominent inside the building:

> The outside didn't look very inviting… it's kinda like walking into a Police station, the vibe of it is like walking into a Police station or court office. C4

> Not to judge a book by its cover. The building really got to me, the outside, and so some kids might double think not wanting to go in, so just wanting them to go in and see what the inside looks like and how comfortable it is. C3

> It's not really anything exciting…. Nothing flash or anything. C6

Further, some external referrers and a few clients liked the paint colours, murals and artwork on the walls once you were inside the building this made it feel like a welcoming, inviting and a friendly environment and "brightened up things" (C9):

> The younger kids like the big murals on the wall as you go in. R2

> When you went in it was like bright colours and artwork all over the walls and that was pretty good. It made me feel better when I walked in. C3

A few external referrers commented on how the building needed a tidy up and how it hadn't changed much since it first opened. Specifically, the demand for the service had grown since it first opened and the building size has not expanded with this demand.

> The tools are all there but it's just a bit old and a bit tired really. R7

> I think they've outgrown, when it was initially set up they've probably outgrown that building. They're probably bursting at the seams but no, it's pleasant. R10

Location. Many of the clients from outside of central Auckland commented on the location of the building being a long distance from their home and/or workplace. Further a number of logistical issues made getting to Puawaitahi difficult. These difficulties included having no access to personal transport or the cost of public transport.

> Cause we live [elsewhere in] Auckland, I did ask if we could do it somewhere close to home but that wasn't an option… this made getting there, it was expensive. C5

> Sometimes it was a pain [travelling to Puawaitahi]… I had a friend that would take me... I knew that this was the best solution for [my child]. C6

Many referrers that had clients outside of the central Auckland region agreed that the location made the multi-agency less accessible as families and clients have to travel a long way to get there. This was specifically problematic because of the financial cost, logistics, difficulty and hassle for families having to travel long distances.

> I think because I was out South it's a difficulty coming all the way here to Grafton Road isn't it. R1

> The reality is for us, five bucks petrol into town is no big deal even if it's our own personal cars but not that we use them but for them, they either don't have a car, they don't have a license, they don't have petrol. R10

Parking. There are nine allocated visitor car parks at the entrance of Puawaitahi. There was a mixture of both positive and negative reviews about the availability of visitor car parking spaces at Puawaitahi. Only a few external referrers and clients reported not having any issues with parking.

There usually seems to be enough space in the carpark. R2

Parking was easy, surprised tho cause they only have a small carpark. C5

In contrast the majority of external referrers reported major issues with parking at Puawaitahi. They reported that the car park is too small and often all of the parking spaces are taken. It appears that the staff at Puawaitahi are aware of this problem as they are extremely vigilant with visitors checking in and ensuring the parking spaces are used by the service users and not neighbouring businesses.

There is a problem with the parking. R3

Parking is a problem. Parking is actually atrocious. R7

Parking is a major. They get ferociously protective about their parking. R5

Many external referrers felt that this was a major issue which caused a lot of problems due to there not being many other options in close proximity. This resulted in visitors having to pay for parking, clients and referrers being late to appointments and it increasing anxiety levels due to poor accessibility.

If you can't get those parks, you're screwed. R11

You rock on up and then you've got to pay for frigging parking if the free ones out the front aren't available. R7

The anxieties around parking space. I would normally park metres away and the client when they arrive at the building they are already stressed because there is not enough space. R3

Waiting and consult rooms. Many of the external referrers reported that the waiting rooms and consultation rooms were suitable for young children with a lot of toys and activities to keep them occupied. Further the consultation rooms even had animal shaped beds that were described as "kid friendly" (R5).

I think the downstairs is really nice with the kids play area, so that helps. R1

They have got ample toys and resources there for them to keep them occupied. R3

They have a beautiful room don't they with all the toys. R4

There is space for kids to go and play with toys. R5

And the medical rooms are set up really well with the hippo table. R5

One external referrer even commented on how the waiting and consultation rooms have improved in their appearance and toy/activities significantly since its opening.

There's comfortable chairs in there so it has improved over the years tremendously compared to what it used to be. R7

Many clients agreed and thought the waiting rooms were designed for families, had enough toys/activities to keep children entertained and were informative:

> Waiting room… looked like it was based for families, there were toys and books, everything was really colourful. C3

> Yeah you know standard. There magazines there to burn and lots of chairs. Lots of things to read on the wall about safety and drugs. C5

> Good they had lots of toys for the kids. C6

> There was a lot there to keep him occupied. C9

Despite the waiting rooms being child friendly many of the external referrers and most clients felt that they were not appropriate for older children and teenagers. There were no age appropriate activities or toys to keep them occupied and artwork was for younger children.

> They were alright [artwork on the walls], it was just like drawings and that, little kids drawings. Kind of like scribbly. C1

> It was pretty, there was a big picture thing… toys, playhouse… but the toys were for younger kids. C2

> Entertainment. More like activities, drawing and stuff… kinda gets a bit boring. C1

> It's very good for small children, for youngsters because there's lots to do for youngsters and the big playroom it's really good but increasingly the clients, there's an increase in the number of teenagers that I'm taking there and there's nothing, not really. R7

This was also the case with some of the consultation rooms. For example, some of the medical beds are shaped like animals and although this is appropriate for young children, it might not be as suitable for teenagers.

> And it's just when with our young people it might just be a bit childish. Because you know the beds in the medical rooms are like… It's not just children accessing it. R5

A few external referrers and some of the clients discussed how some of the waiting rooms could get overcrowded when there are too many families there at once. This reduced the amount of privacy the family had and also the increased noise levels meant that the waiting room was not a pleasant or relaxing place to be.

> Sometimes it's overcrowded and you get how many families in and kids in and it's just the whole place, there is not enough space there and sometimes there is a whole lot of families there in the play room and the noise that is going on in the thing and the mums are getting impatient because if you are bringing four children or bringing three children and that is the waiting to queue in to go and the other families are being

seen as well. I just wait for someone to smack the kids in front of me. They throw the toy on the floor and I just say let's cool off, why don't we do something and you find yourself engaging them in activities just to keep them engaged. Sometimes it can be quite crowded. R1

A lot of people coming and going. C9

Amenities. Many of the external referrers positively about the tea, coffee and MILO available to the visitors, families and clients while they are waiting. They felt that this was essential as often families could be waiting for hours while their child is seen by a number of the services at the multi-agency.

There's tea and coffee there. You just have to make it yourself. There's cold water there. R3

They're always very accommodating with drinks and stuff like that for the kids. R9

Yeah and then you go through to that little waiting room. There's a place to make tea and coffee. R11

All of the clients reported positively about being offered and making use of the tea, coffee and MILO available to visitors:

Offered me some yummy hot chocolate. C2

We got milo and a cookie. C3

There were hot drinks and stuff on offer and I could go out and have a cigarette… they [the children] had milo, they had biscuits, they were all good and happy. C9

A couple of the referrers and clients commented on the lack of food available to visitors. Often visitors can be waiting a long time, three plus hours and because of the location of the building, there is not a lot of shops within a reasonable walking distance if they get hungry.

I think it's just like a small with sandwich or something because sometimes when we go in as social workers sometimes you expect maybe like an hour, and it can go three hours with staff and it's quite a distance to walk and get something and we can't leave the children so it's continually having a coffee milo, coffee, milo. Yeah something for the children things that we can buy and munch there. R2

Maybe something to eat. Might be hungry. C3

Overall, participants spoke positively about the physical building, specifically the anonymity of the building, child-friendly facilities and amenities. Areas identified for improvement included the visitor parking and waiting rooms and consult rooms being for young children and not targeted at adolescents.

Puawaitahi Staff

When asked about the internal staff at Puawaitahi (e.g., clients were asked "when you first met the staff at Puawaitahi what did you think?), most external referrers and clients commented more specifically about the overall culture of all internal staff working at Puawaitahi. Clients described the culture and staff as "friendly" (C2), "helpful", "supportive" (C9), "caring", "receptive", "accommodating" and "warm" towards referrers, clients and their families.

The staff seemed like friendly, like they were always nice and said hello… what you would hope. C6

Welcoming [staff] and the fact we could just help ourselves [tea, coffee and milo]. C9

External referrers agreed and spoke positively about internal staff at Puawaitahi and felt that these positive interactions facilitated engagement of families and put them at ease.

Everyone is helpful and warm and the clients like it. R11

And that helps with our families. I've never seen any of them [families] show fear or non-willingness to engage. And that's partly because right at the very beginning that feeling of caring and sharing is there. It's right there. R6

In addition many of the external referrers commented on how experienced and knowledgeable the professionals were in the field of child abuse and neglect. This made them feel safe referring clients to the multi-agency as they would get skilled and expert care.

I just think they're clearly really experienced clinicians that are able to, and they all acknowledge that this is a really unpleasant thing to have to do and so let's just put that out there. Nobody wants to be here, whatever has happened is not okay but while you're here with us we'll make it as okay as it can possibly be. R6

I've felt very comfortable handing over, you are secure in the knowledge that they're getting expert care which is important. R7

A few external referrers commented on the staff being passionate about their jobs and caring about the outcome of all clients and families that go through the service. They often went that extra mile for families and that really made a positive difference to the service they provided.

You can see they've really got a passion for the work they do and they really care about providing the service. R9

Reception staff. Most of the external referrers spoke positively about the reception staff and the initial contact they received at Puawaitahi. Puawaitahi had processes where visitors would check in at the reception desk on the ground floor, this was so that they could manage the flow of visitors coming and going but also monitor the parking spaces in the

carpark. Most of the external referrers spoke positively about the initial interaction and commented on how reception staff were "responsive", attentive, "welcoming" and helpful.

> From when you walk into reception and deal with the receptionist there, very obliging. Never ever had an issue with working with them. R9

> I've never had a problem with reception but I love the way they're very strict at reception. When you go in you have to have your ID and you have to put your car parking number. R7

These positive comments were reiterated by most of the clients reporting they felt welcomed by the reception staff and their friendly manner put the family at ease and helped them to relax and feel comfortable:

> There was a lady that took us, introduced herself and just took us into the building, she told us where the toilets are, sat us down in reception and asked if we wanted coffee or something… She was great had a smile on her face all the time… felt a bit more at ease. C3

> The receptionist that welcomed us with a cup of tea and coffee… yeah she was friendly, she was engaging, chatted to [my child]. C5

> They were quite good when you turn up, the welcome was good. C7

Overall, participants commented positively about the internal staff at Puawaitahi specifically about the way they interacted with clients, their experience and expertise and the welcome they received from reception staff.

Client Focused Ethos

> The majority of participants spontaneously commented on the positive and client-focused ethos of the multi-agency. Many external referrers experienced the multi-agency as extremely client focused this was evidenced by the staff interactions with clients and the physical environment. Staff were described as extremely attentive towards the clients and that they would prioritise the clients' wellbeing and experience above their own professional agenda.

> For what children experience and lots of different things, how we work with them and things like that, I think it really does stand out as being so focused on about them. I've always felt really comfortable taking children into that space and explaining to parents what it's going to look like or be like. Like it really does walk with the talk of what it says it's going to be for children and families. R2

> Yeah I've had great feedback from children or kids and they don't mind, you know they can go along and doing a visit. They don't mind going back there and doing an EVI. I think that says a lot. They're really holistic how they approach children if they're nervous and that type of thing. They're really clear on no pressure and you don't have to do it. It's just very open for them to have their experience with what an EVI is and the medical requirements so I think that needs to be acknowledge really more clearly.R2

> I think the thing about Puawaitahi they really make the young person feel that they are the most important person in the room... they are the absolute focus of any conversation and I really respect that. I think that's fantastic so they do feel that they're being listened to, they're being respected. R7

All of the clients reported experiences were consistent with the external referrers, in that Puawaitahi internal staff prioritised the well-being of the child and family and professionals were very accommodating:

> Their thing [focus] was about the kids head [psychological well-being] not about the legal stuff [Police investigation]. C7

> It was nice because they made sure they were comfortable and there was no pressure. C9

A few external referrers and many clients reported that Puawaitahi staff ensured clients and families were well supported and they were invited to bring along a support person if they wished:

> I was able to bring a support person… previously I have always been by myself so I haven't been too, maybe, confident to express what I want to say or think… it was good. C5

> [Support person] doesn't have to be mum or dad either can be someone who knows the system, which is usually more beneficial. C7

In all internal staff focus groups participants reported how having a child friendly, client focused ethos contributed to Puawaitahi working well. One aspect of this was that Police are not in uniform:

> Soon as people mention the Police, all of support they think Police Station, but obviously, it is not a police station but it's actually a child friendly place... takes away a lot of the stress initially, kids don't want to go to a Police station obviously, which is why this works really well here. I3

Overall, participants spoke positively about the client focused ethos at Puawaitahi and this was a combination of a number of factors including the staff interactions and physical environment.

Cultural Considerations

Many of the participants during the focus groups and interviews spontaneously commented on Puawaitahi's responsiveness to culture and so as focus groups and interviews went on if culture was not touched on the interviewer would ask for the participant's opinion regarding this topic. For example when talking with external referrers, "I noticed we haven't touched on cultural responsiveness of the multi-agency, what has been your experience with clients at Puawiatahi who were not the dominant Pākehā culture (Māori and Pacific)?" Many external refers and many clients spoke positively about how Puawaitahi and the internal staff were overall culturally aware and proactive about issues that may arise when it comes to a client's culture. Participants used words like "culturally sensitive", "culturally aware", "respectful", "appropriate" and "understanding" to describe the internals staff's interactions with clients and families of different cultures. They felt that staff not only took the time to consider cultural issues but were also aware of potential social and economic barriers this clientele may be facing.

> Well they're there with cultural support, they kind of ask what the ethnicity is the young person so they're aware of that and respectful of it… Puawaitahi culturally they're very good. R7
>
> That's not just talking Māori families, other nationality families as well, they have always felt comfortable there. R3
>
> I think it's the people in the building that is really bringing that through. In terms of culture, the people that I have been dealing with have been very nice, you know, they greet appropriately, sometimes, other times in any language, that is all appropriate. R2
>
> I personally feel now the staff that I've come across I deal with, understand so much more culturally for these young people and because these young people are brought up in a cultural society the fact that these staff understand their dilemma because when they're in school they're in a very much European whatever, they go home they're in the island community but in their own cultural identity. R7

Despite these positive comments a few internal staff and external referrers also felt that there could be more Puawaitahi could do to meet the needs of different cultures. The language, building and processes are based on a very western model and can be very foreign to clients

and families of different cultures. This unfamiliarity and lack of understanding can cause anxiety, fear and confusion for clients.

> Over the years I've seen them get a lot better, so I do think that they are coming and talking to parents a lot more, that they are explaining things more in a way that parents are able to understand, but I still think it's a huge area that is lacking. R1

> One of the things that I think too is lacking down there is some cultural sensitivity, not just in terms of language. R1

Physical Building. A few external referrers and clients commented positively about the physical appearance of the building. They felt that the artwork and wall hangings made it a culturally inviting environment. Further the name of the building being in Māori also contributes to the diversity of the service.

> I think that there is some stuff that indicates that culturally. There is some hangings, there are some paintings, there are some things and words and stuff. R3

Staff diversity. Some of the internal staff and a few of the external referrers commented on the cultural diversity of the staff at Puawaitahi. They identified that very few (if none) the professionals in the multi-agency were Māori or Pacific Island. Some participants felt this created a barrier to understanding and communication with clients and families:

> We don't have Pacific Island faces in the team as well and even though there are professionals out there you have to understand also that you need someone that can actually correspond or communicate with the families as well. I1

A few clients agreed about the lack of cultural diversity among the internal staff and felt this may be a possible barrier to client participation and/or comfort and it was noted that the ideal would be to culturally match staff and clientele:

> For those who are really into it, it would have helped having a Māori clinician or liaison person… a lot of people don't trust 'the system' anyway… [trust] might come down to having a liaison person from a similar cultural background… so they feel at ease as well, cause sometimes the Pākehā looking at all these brown faces, she doesn't know where to tread, she may not be aware… [Māori and Pacific clients] don't want to make a fuss, but they will for their own [culture] but outside they won't, that's something mainstream needs to understand… especially [Pākehā] people part of 'the system'… The biggest thing is that cultural communication, getting that part right, if they can get that right you should get better uptake. C7

> For a family that is a bit iffy on the process and that, like if they are Samoans, it would help if there was a Samoan lady there because they will talk to her, they won't talk to anyone else. C9

In contrast some of the external referrers and many of the clients felt there was enough cultural diversity within that staff at Puawaitahi and if it was needed they could call on these individuals within the multi-agency and culturally match families so that they received the support they need.

> I think the staff there are really aware [of culture] and sometimes they also ask for someone where they can look into or there's a person from the same culture who might help to come in or just to look for interpreter when children are not, so all those things, I think it's quite neat. R2

> The staff are aware of those and communicate to the students and they offer somebody to come in and because they've got a diversity of people working in there. There's usually somebody from within that can come in and be the support. R7

> Mixed culture around the building from the ones that I saw, it was good… Might put the person at ease if there is someone from the same culture or similar upbringing. C3

Despite this some external referrers and many clients reported that this was not an issue as staff were culturally aware and appropriate. Staff formed working relationships with clients and this was facilitated by the ethos of staff to work together with clients and families no matter their culture.

> None of the clinicians that I had come across were Māori, 99% of the clientele, because one of the communities I worked in was Māori, most of my clients were Māori and so that's not to say that the clinicians there were culturally appropriate. R6

> And they just want something that's non-judgemental, they don't care, they're not exactly going to be friends with that person and I mean they're just wanting somebody that's going to help them and those nurses just give them that connection and that's what they want. It's that connection, that trust and they come with that genuine wanting to help, what the young person is wanting. They're not oh well you're not the right colour. We don't have that problem here. R11

One external referrer even made the comment that it is unrealistic to expect the culture of the internal staff to reflect the population as there as a huge lack of cultural diversity within health professionals in general. Therefore, with the current cultural diversity of qualified professionals this is an unrealistic goal and expectation.

> I'm just looking and thinking whether people who were accessing the health service expect to see their own, I don't know, it could be nice, it's just not the reality. R6

English is not their primary language. Many external referrers commented on how for a number of their clients English was not their first language. Despite this a few external referrers commented on how well staff at Puawaitahi could take complex concepts and break them down into simple English so that a family could understand what was happening. External referrers felt that this skill came with experience and that the longer the staff member had been at Puawaitahi the better they were with communicating on a level families could understand.

> I think staff that have been there for a while like I've gone down there and had [a Paediatrician] come down and talk to a family and he was amazing, just really like language that family understood, there wasn't any sort of high fluting medical terms and things and people understood it. We are talking about a Samoan family, mum New Zealand born, dad not, but they understood, like they got what he was talking about. And so I just think it's different. I guess that's a skill and experience. R1

> The longer the people have been in their roles the more skilled they are at wording things in a way to pitch at the level of the audience, like of the families. I have had the same experience with Neil heaps of times going into case consults and case conferences and family meetings talking about CPP stuff and yeah like he just explains things in a way that is just easy to understand. There is no sugar coating, but there is no jargon as well. R2

Some of the external referrers and a few of the clients commented on how there were interpreters available to families if it was needed. Some of the services asked if an interpreter was required during the referral process but it was the referrer's responsibility to let Puawaitahi know if this service was required.

> They did ask something about an interpreter or something like that. C5

> They will use a phone interpreter if necessary to really ensure that the parents understand, or they'll bring an interpreter in to do the interviews. R2

> I've been offered a translator and also requested a translator because I guess they don't know what their English skills are like, so I think the onus potentially might on us [referrer] for that as well. R3

In contrast one external referrer reported a lack of interpreters being utilised at Puawaitahi with families where English is their second language and they are not understanding the concepts being explained to them:

> I don't know that I have ever had an interpreter down there for some of our families that just don't understand a process… So parents are having to manage language issues and process issues and all these other things and there is just very little. [Interpreters services] that is not a strength down there. R1

Also a few of the participants found that the majority of the written hand-outs, brochures, forms and questionnaires were only in English. This can be problematic as they are designed to both provide information to the family and collect information for the professionals and this may lead to misunderstandings and inaccurate sharing of information.

> You can't expect every family to have good English and so it would be good if they can look into how that can be managed, like even the strengths and difficulties questionnaire, even that is in English. R3

> The EVI information sheets are just in English aren't they that explain the evidential process, it's only in English. R3

> **Cultural support.** Many of the external referrers reported either scarce or an absence of cultural support workers within the service. There were very mixed experiences about whether this was a service that was lacking within the multi-agency. A few external referrers commented on a pervious poor experience when working with cultural advisors, they felt that in the presence of cultural support workers clients would withhold information and would be less inclined to talk to the professionals. They felt this might be because these communities are very small and clients might worry that they might know the perpetrator or that word might get out about the incident.

> The staff are very culturally aware but sometimes if they've used the support workers from the hospital, the cultural support workers from the hospital my experience has been that the young persons have clammed up because the support worker that's come out from the hospital talks to them in their own language, Samoan, Tongan whatever and I don't know what's said but the young person suddenly becomes very stiff and doesn't want to talk at all. R7

> Yes particularly in the Samoan culture and in the Samoan community here in Auckland particularly everybody knows everybody else. Pacific communities everybody knows everybody else and somebody knows somebody else and that caused me a bit of concern. R7

These comments were supported by one of the clients interviewed, "I feel more comfortable with outsiders. I don't like talking to my people sometimes …. It's a small community and we all do things together". C8

In contrast a few external referrers and clients felt that it was really poor not having a cultural support service available to clients and families. They felt cultural support workers were a key part of understanding the clients and making appropriate recommendations to the client and family and at least having that option available for families was important.

> I guess it's also about making sure that as we do here, we access cultural advisors around … an ethnic minority or that sort of cultural stuff that they were accessing that because obviously behaviours and communications vary across the board because they get a snapshot of a family or a child and then obviously then they make recommendations with us on that snapshot and sometimes they can be in conflict. R3

> I think that there could be a bit more input like when we think about a lot of the children that we do take in, there's a high percentage of tangata whenua. I think it would be very good to have something that was or someone, if they just had somebody who came and spoke to them, it would be in that nurturing supportive role because you know, it just makes them, it just gives that whole dimension of being not singled out. I think there's a stereotype that all is bad but I think when you've got somebody who engages from you as a parent, I think in this family you see somebody who can, it just takes a couple of sentences in their languages and they engage and it takes a lot of the anxieties down in regards to the process, even though we've explained, experiences are different and I know I've sent a lot of forgotten, even the reception woman who was Māori at one time, just saying kia ora and a family's face and demeanour would change. Just that acknowledgement and I just think if there was a bit more that that was available round just helps with acknowledging families and families feeling comfortable in the spaces. R5

> Defiantly having that option [cultural practices] for families is good. C9

Gender of staff. Two male clients commented on how there was mainly female staff in the building and that Puawaitahi lacked gender diversity, specifically male professionals. To the males it was important to have both males and females present throughout the process:

> There were heaps of females in the room… I guess it would have been nice to have some more guys so I wasn't, you know, like, outnumbered. C1

In comparison one of the female clients commented on how she appreciated that there were only females as it made her feel more comfortable:

> The hospitality, since I was female, they had all females around, having the same gender around was pretty comforting. C3

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Overall, participants spoke positively about Puawaitahi's cultural responsiveness to clients and families specifically in regards to cultural competence, communication and physical building. Despite Puawaitahi's efforts some participants felt that there was more Puawaitahi could do to be culturally responsive including having a more culturally diverse team, provide information in other languages and have cultural support workers available.

In conclusion, participants spoke positively about Puawaitahi's multi-agency environment and specifically about the internal staff, physical building, client-focused ethos and cultural responsiveness. Areas identified for improvement included accessibility to the multi-agency, adolescent focused service and formal cultural processes and support for clients and families.

CHAPTER FIVE: SUGGESTED IMPROVEMENTS

During the interviews and focus groups all of the participants were asked "what are some of the improvements you would like to see at Puawaitahi?" Internal staff, external referrers and clients suggested a wide range of suggestions for improvement to the service, although in most cases this was from a general base of satisfaction with the current service, as reflected in this comment: "It's a service that's needed but maybe they need some tweaking on how they provide the service" (C5). This topic analyses comments about improving the service experience from internal staff, external referrers and clients. Suggestions included, duplicating the model elsewhere in Auckland, introducing a standardised building induction process, reinstating the multi-agency coordinator role, reducing delays, strengthening relationships with referrers, refining the referral process, enhancing the multi-agency environment and service provision and ensuring long term outcomes of clients. The themes and subthemes are described in the following.

Multi-agency for each Auckland Region

Many external referrers that were located outside of the central Auckland area commented on the comparative inadequacies of the local Police stations and hospitals when dealing with child abuse. The issues that arose were they are not equipped to deal with child abuse, staff re not specialised and experienced in the area and coordination is poor and services are not collaborating on cases.

> We've got an emergency department just down the road here, at [X] Hospital and we do occasionally run into a shit fight between Puawaitahi and them about well why don't you just take the child down to [X] Hospital, they've got paediatricians they can do whatever. That's really difficult. I have managed to orchestrate one multi-agency review of a child with a non-accidental injury down there but they're not set up for it. R2
>
> They say they are, they've got paediatricians and Starship or Puawaitahi says or Te Pua says they've got a specialist down there, you take them down there, but it's not the same service by such a long chalk. R6
>
> Or the environment because the purpose kind of design and set up and everything that they've done for the environment around children and young people there compared

to at the hospital is just a mainstream hospital environment and I think the setup of the environment is a lot more holistic children to be in, in relation to abuse. R2

I mean [DHB] basically do not have any NHIs, they have two or three a year. What rubbish, we don't have such friendly parents out here and that's exactly what was happening before, it was like the services were all disparate and not connected and there was an awful lot of fighting about who did what to who and that's exactly what we've got out here as opposed to this incredibly streamlined services, not just friendly to the kids and families but to us well. Like actually values that we have a role in the whole thing. R2

Most external referrers agreed that having only one specialist child abuse multi-agency service in Auckland caused a lot of problems and that a great solution to this problem would be to have a multi-agency located in each of the Auckland regions. Duplicating the Puawaitahi model so that child protection services are in collocated for each region would solve a lot of problems.

Te Pua is fabulous but it would be good if we could have that in people's own areas and make them feel a little bit more engaged in their own DHBs. R8

I would be great if we had a child service at [X] Hospital then we'd be going yeah bring it over. R9

We would ideally in this district like our own multi-agency centre based on the same sort of structure and we've been pushing for that for a while because we obviously use their services but we would like to have our own services in our own district. R2

We would dearly love one in our district and certainly our workload would justify one. R10

We would like a MAC [Multi-agency Centre] and even if there was a shorter distance to a medical facility but good communication then that would be a step in the right direction. Obviously we'd like all the bells and whistles, it's like reinventing the wheel isn't it, if you've got a medical facility at [X] Hospital, why not take advantage of that and have a MAC on site there or something like that. R6

Most external referrers felt that despite Puawaitahi being in the most logical and centralised location it caused problems with travel. Having one in each region would reduce travel time significantly for clients and referrers coming from other regions. Participants felt that this would improve client engagement especially with difficult clients and adolescents.

It makes sense to be where it is, but a bigger offering is, the population is growing, Auckland is spread out, then obviously sometimes the services don't expand to meet the needs. R9

Especially if you've got adolescents who are hard to engage anyway, they're really hard to follow up so if you could improve that in any way, shape or form would be fabulous because then you're setting them up to succeed and not setting them up to fail. R8

This concern was echoed by some clients, particularly those who had transport problems:

If it [Puawaitahi] was closer to home… I wouldn't have had to rely on someone else to take me and it could have been something that [my child] and I could have done together. C6

Overall external referrers felt strongly that improving access for clients would be achieved by duplicating the multi-agency model throughout other Auckland regions. This would result in more clients accessing specialist child protection services following allegations of abuse and neglect.

Programme: Operations and Interagency Processes

All of the programme improvement suggestions for operations and interagency processes were given by internal staff. External referrers and clients would have little understanding of these issues as they are outside the organisation, visitors so to speak.

Some internal staff felt that there needed to be improvements to the internal operations and interagency processes. These included having clearer and more collaborative processes and procedures, setting up a prevention initiative, reinstating the multi-agency coordinator role and standardising staff inductions, setting up a system for ongoing evaluation and feedback and including a Shine representative at PIRM.

Clearer and More Collaborative Process and Procedures

Many internal staff commented on some processes between agencies within Puawaitahi and how actions could be executed in a timelier manner. Internal staff commented that a clearer process for notifying different agencies at the optimal time may result in a better outcome for the client and family. An example given was the timing of evidential interviews following forensic medical examinations:

If a NAI comes into the hospital Police are notified early... [but] Police really need to be with that first doctor... it's about locking mum or dad, or about locking the person,

into stories; into their version of events first. We seem to miss that after 48 hours, or even less. …. The hospital has a different agenda, which is about treating the patient and I guess we [Police] are secondary to that at that time. I3

The Responsibility of Primary Prevention

Although, Puawaitahi was not originally set up with the aim of primary prevention and is instead a tertiary service provider, some internal referrers reported feeling like the "ambulance at the bottom of the cliff" where their role was the management of the child abuse response. Some internal staff wanted to add primary prevention and education of the community into their everyday roles and responsibilities at Puawaitahi. Internal staff reported that there was so much knowledge and experience within Puawaitahi and suggested that their knowledge could be shared with the community through education and assisting community primary prevention efforts. These efforts would aim to help prevent first episode child abuse and to stop repeat clients through the building:

> Service specifications cover management of clients when they come into this building but they don't cover prevention and we do need prevention in our service specifications. I think in this building there is a huge combined knowledge of what could be implemented to prevent people coming to our front door. I4

> Something in the service specifications that states that part of the purpose of this building is for the prevention of abuse not just the management. I5

Multi-Agency Coordinator Role

Most internal staff members commented on a number of previous elements within Puawaitahi that were once in operation and were an effective means of coordination, and in particular, the building coordinator role. Internal staff commented that the result of some elements falling away has been less coordination between internal agencies, roles and responsibilities becoming less clear as staff have left, and a diminishing of team culture within the building.

> There were systems and they worked well. I think a lot - about a third of everything - has slipped away, and I think it needs to be re packaged. I1

An explanation for the drop off in these activities was explained thus:

> When any of the teams in the building are under stress then the pressure is always to go back to your basic bread and butter work, the work you're paid to do. The things that tend to go are anything that is slightly away from your core business and that includes team meetings, joint education. So the moment the pressure levels go up

paradoxically but almost inevitably the pressure to stop doing those things happens. Then of course they're actually the lifeblood of this building, if we don't do them you notice after six months or a year that, hey we're not, we don't actually feel, as much like a team as we did. I5

A key reason for the drop off was given as the lack of the coordinator role:

There was specific tasks, now it's like who's going to do it? Maybe sometimes it's an admin person from Te Pua... tends to be a lot more haphazard. I1

Each agency, within their teams has a coordinator usually the receptionist. Although, this person is responsible for coordination within the individual agency and its staff members, they also assist in the coordination of the whole building. Internal staff suggested in addition to the individual coordinators within each agency there is a need for an overall multi-agency coordinator.

A Puawaitahi Co-ordinator position was always identified as a need for the Centre, even before it opened. However, it was not until 2005 that a part-time co-ordinator position was funded, with support from the Starship Foundation. A key focus was on building the relationships between Puawaitahi and community therapy services. Unfortunately, this part-time position proved to be insufficient because the limited hours did not allow the flexibility required to serve the wide variety of functions of the role. In 2008 this half-time position was added to with a half-time ADHB-funded administrative position in Te Puaruruhau, allowing the Puawaitahi co-ordinator to be available very flexibly throughout a full working week. For the first time, the Co-ordinator position functioned effectively, although now the focus was on supporting the function of Puawaitahi as a true multi-agency and inter-disciplinary facility. This person took the responsibility of many coordination tasks across all services within Puawaitahi; for example, ensuring systems and procedures were maintained and functioning effectively. Their responsibilities included, organizing meetings (Clinical Liaison Meetings, Journal Club, Senior Management Meetings), booking rooms, coordinating people, looking after visitors to the building, organizing outside staff training, networking, conferences, organizing/ reminding/ informing staff about activities in the building, taking meeting minutes, distributing those minutes and following up external enquires. Further, they also ran inductions and orientations for new staff and visitors to the building. This role ceased in 2011 due to the staff member leaving and this position not being reinstated because of funding unavailability.

In general the coordinator contributed in a significant way to the cohesiveness of the multi-agency. The personality of the person in that role was also acknowledged as

contributing to its success

> The coordinator role was most effective when the individual employee was a bubbly, social, proactive, confident and self-motivated staff member, as they drove and took responsibility for ensuring the systems within Puawaitahi were operating as intended. I5

In all internal staff focus groups participants identified many benefits of having a coordinator. Benefits included having someone solely in charge of driving the multi-agency processes, accountability and more effective meetings:

> It makes you accountable to be there [at meetings] because you are getting a proper invitation, you know there is going to be a formal meeting and there is an expectation you do turn up prepared. I5

> She also did things like she took minutes at the NAI meetings... she would then disseminate it so that people who were there could focus on the content matter. I4

The importance of this role within Puawaitahi is represented in the following internal staff quotes, "it was an essential role" (I5), "probably the most important role in the building" (I1). The building coordinator role was repeatedly brought to light in all internal staff focus groups in relation to the topic of improvements. In all focus groups internal staff expressed the desirability of reinstating this role at Puawaitahi.

Introduce a Standardised Building Orientation and Induction for New Staff Members

In all focus groups internal staff reported there being in recent times inadequate orientation for new staff members when starting work at Puawaitahi. Internal staff suggested that not having an induction meant that there was a lack of education of some staff members (especially the newer ones) around what services are provided by each agency and how each of the agencies work together. For example, in one focus group participants reported it took a while for new staff members to learn the value of therapy for victims and establish relationships in the building. Further, internal staff commented that not having an orientation meant that there was no formal process to meet new staff in the building hindering/slowing the process of developing effective working relationships and coordination:

> Often there is a new person in the staff room, it' like 'ooh hi who are you?' Yeah I have been down here for two weeks. I1

Ongoing Evaluations and Feedback

Many internal staff commented on the need for ongoing evaluation and feedback about Puawaitahi's service as a whole and the individual staff members providing the service

within the agency. This ensures that the agency and staff members are providing an effective, useful, timely and quality service to their clients and can also guide on-going changes and improvements:

> Evaluation from the clients, on how they feel about, not just the service they got from Puawaitahi but the individuals who were involved in providing that service, I think as within any service the standard varies a lot depending on who you see and I do think that we should be getting feedback from clients on how we can provide better services. I4

Shine Representative at PIRM

In two internal staff focus groups internal staff reported that Shine would be a good resource to have at the morning PIRM. Ideally, a Shine representative could attend the PIRM, with access to the Shine database. This would provide access to further information about family abuse history. As a result this would improve coordination with an agency that have some very important information that would help with improving service and enhancing child protection:

> When we first set up the PIRM we have discuss from time to time and thought about the whole idea of having a Shine representative present at that meeting... The logical fourth party with access to their family violence, community information would be Shine, but because of the privacy issues and the fact that we don't really have an established clinical relationship with Shine we have never really gone anywhere with that. I5

Overall internal staff suggested a number of improvements to internal operations and interagency processes. The suggestions included clearer and more collaborative processes and procedures within the building, adding primary prevention efforts to the internal staff roles and responsibilities, reinstating the multi-agency coordinator role, introducing a standardised building orientation and induction for new staff members, establishing an ongoing evaluation and feedback programme and including a Shine representative and information sharing at PIRM. Of these suggestions the availability of a full time coordinator was uppermost.

Specific Services

Some internal staff and external referrers suggested improvements to service delivery within individual services within the building and to processes outside of the building (e.g.,

delay in cases being heard in court). These included improving appointment delays at CAVU, Health expanding supervision to include all staff and reducing the time cases took to get to prosecution.

CAVU: Appointment Delays

Most external referrers reported their frustrations with the delays to scheduling EVI's at CAVU and felt that this service was unable to meet the demand in a timely manner. All participants that reported this concern felt that the delay needed to be reduced. Ideally, participants considered the delay should be no longer than a couple of days, with some suggesting within a week.

> It's almost like a medical isn't it. You wouldn't do a medical a week later. Next day. Within a couple of days is more appropriate. R10

> Well within a week. Like about seven working days but kind of rolled around something like that would be more ideal. R2

External referrers made a number of suggestions to improve this delay that included increasing resources (e.g., employing more evidential interviewers and having more rooms) and duplicating the multi-agency model in other Auckland regions (e.g., North Shore and West) so that case load could be spread across other community multi-agency services.

Health: Staff Supervision

Many of the internal staff were aware of the absence of supervision provided to nurses working within child protection and suggested this needed to be rectified. All the internal staff we spoke with, except nurses, either had regular supervision or had funding provided to access supervision. Some internal staff suggested the lack of supervision and support for specialist nurses may explain the reasons for burn out and fluctuations in staffing levels.

> I would like to see more supervision available to staff, supervision and support because I think the work we do is often very stressful. We're at the cutting edge of some of these cases. Out there people only hear the ones that hit the media but we are dealing with this day to day... We have talked about fluctuations in staffing levels and things and I think that actually if people felt that support or supervision was there then maybe the staff base would be more stable. I don't know, it's just a theory, but certainly I think it would help people's ability to work better and more effectively. I4

In summary, some suggestions were made for specific services in the multi-agency as to what they could do to improve the service they are providing. These suggestions included, reducing the delay to court trials in case where prosecutions has been taken, by permitting

pre-recorded evidence and cross examination for the court. Suggestions for reducing CAVU appointment delays included increasing resources at Puawaitahi and duplicating the multi-agency model in other Auckland regions to share the work load. Finally, providing regular supervision to nursing staff at Puawaitahi was suggested to improve well-being and retain staff.

Court: Delay in Getting to Court

Some internal staff commented on the delays form prosecution to getting to court. Although outside the control of staff at Puawaitahi, this was recognised as one of the biggest frustrations as it can take up to two years to get to court. This can produce many problems for both the agency and especially the clients:

> Prosecution is the hugest problem that we have, in relation to any of the work that we do... huge frustration. I3

> Courts have always been an issue... they always take forever. I1

> You get a six or eight year old, mum and dad have broken their leg or something, and it's hard enough for them to come in and do their EVI and then you are going to say now we are going to go to court and you are going to have to tell that story again... and you are going to be giving evidence against mum or dad now. When they are that age, doesn't matter what's happened, there's still that love there. If I tell my story, mum could be going to jail or dad could be going away and it's bloody tough. I3

Possible remedies for this for children were suggesting to be permitting pre-recorded evidence and cross examination for the court, but this is not possible in NZ at this time. Another suggestion made was a court solely dedicated to child abuse cases, thus reducing the wait time and prioritizing children's needs.

Collaboration and Coordination

In respect of managing referrals, some participants felt that there needed to be improvements to both internal process within the building and Puawaitahi's relationship with referrers and outside agencies. Suggestions included streamlining the referral process to increase efficiency, building stronger relationships with referrers, regular orientation, education and training for referrers and formal processes around preparation, information and support for clients and families before coming to Puawaitahi.

Referral Process

Many of the internal staff and some external referrers reported frustration with the referral process at Puawaitahi. At times referrers reported having to make a number of different referrals to each separate agency within Puawaitahi for the same child, and then having to duplicate that process over and over if there was more than one child that was affected in the same incident or circumstances. External referrers felt that this process was very time consuming and inefficent.

> And if you've got a family with five or more children a lot of that information is the same, you know, the parents are the same, the home address, that doesn't automatically populate, so that's time consuming of doing five or more separate. R3
>
> Especially when you are working in a critical situation, when there is a critical you have to answer very quickly to go and take the kids to EVI and after that get a date and time. Time is very precious. R1

These internal staff and external referrers felt that this process needed improving. Suggestions included having a single referral to the whole multi-agency, rather than separate referrals being necessary to access particular services. Participants felt then clients could move through the services in the building smoothly and efficiently without delay.

> It would be nice to have one referral for services, say for example, somebody that is doing an EVI may well also be needing services from SSU at one time. I guess if there was one referral that was populated you could just almost tick a box to say we are looking at an EVI right now and possibly looking at an SSU therapeutic needs. I think that would work better for us in terms of not duplicating information. R3
>
> So if the police says that okay we want more information and potentially there is an EVI needed or potentially there is a medical needed then at that point a referral could be made which then covers all three services instead of such a separate process through it. R10

One external referrer noted that having three different referral processes actually contradicts that claim that Puawaitahi is a one-stop-shop as it highlights that it is actually three distinct services located in one building.

> There's somebody from SSU, there's somebody from health and somebody from CYF. So they are all sat around the table. If they are all deciding that this particular pathway is in the best interests of the child it surely would make sense for that just to be a natural process rather than having to come back, and then there will be delay because that particular day might not be our priority for filling in a referral form for

another service, so we might have lots of other demands on our time, so something could be happening a lot quicker and a lot more seamlessly for our clients if we could do things like a one stop shop that came through the door, there was an agreement that those services were all talking, yes we can get consent, yes we can you know say we give an approval for that pathway to be considered over the phone and it is automatically done. I think that would probably save a great deal of time for our families. R9

Build Stronger Relationships with Referrers

Some of the external referrers felt that it was important to improve the relationships between Puawaitahi and the external stakeholders (e.g., external referrers, schools, non-government organisations, etc). External referrers felt that these relationships were essential in the effective collaboration and coordination of cases. Building a stronger relationship with external referrers also helps referrers feel more comfortable and confident taking families who might be referred to the multi-agency to seek help.

I think it's that interpersonal stuff, like that interpersonal relationship building that like you say they are just getting to terms with what each of their neighbours up or below them are doing then the next step should be what are sites doing and likewise for sites, sites needing to know what each of those agencies in the building are doing. R2

One external referrer also commented that it is not just about meeting each other but it is about forming a working relationship with each other and maintaining continuous contact. This requires both parties to want to make it work.

I guess it's about people, it's about their relationships, the way that they interact with you, whether you build that relationship or not is so determined on who that person is right, not just someone turning up every week. R1

Many external referrers suggested that there could be more site visits from the internal staff at Puawaitahi to see how the referrers were operating and to introduce any new staff members. Forming new relationships with staff and continuing contact is important for the multi-agency to collaborate and coordinate with the right services to ensure positive outcomes for their clients.

One more suggestion for the team to at least visit us maybe once every so often, just for us to put a face on their names. R3

> It would be really good when they get new members if they could come over and meet us or we could meet them because then we know who we're talking to face to face. That to me would make a big difference from here. R4

Orientation, Education and Training

A few external referrers commented on the issues that arise when there is not a good working alliance between referrers and Puawaitahi. These issues included not understanding each other's roles, processes and responsibilities, which resulted in services crossing over each other's boundaries and "stepping on toes".

> It's us and them, we are the clinicians and they are the social workers and they don't know our eight page job description. Our job is very complex, very broad and wide. R1

> It would help, well they would then understand some of the drivers that we've got going on for us so the court stuff and the other thing too is around the types of cases we've got and the urgency around those cases. The interface with mental health and some of the difficulties around that, particularly adult mental health. Drug and alcohol, adult again and the impact that has on the safety of children. It's around that kind of, I don't know. R9

A few external referrers commented that the solution to this could be training and education of referrers and internal staff about each other's roles and what helps and hinders their ability to perform their job. This could improve collaboration and coordination of cases and over all improve outcomes for the children and families being seen at Puawaitahi.

> No at medical centres, so how much training are Puawaitahi giving to other doctors about not to do genital swabs and stuff like that. The generic doctors swabbing a six year old girl... Thinking they're doing the right thing but… so whether they need to train outside their own agency a bit more not to do that. R10

> So it's bigger picture stuff I guess but it would be really good if they had some understanding, education or could pick up quite quickly around what our core business is. R9

In addition to training and education some external referrers referred to "professional development", "orientation days", "open days" or "study days" organised and organised by a Puawaitahi coordinator. These were events where referrers could come along to the multi-agency, were given a tour, orientation and learnt about the services provided. It was a way of meeting the staff, learning about what the service could offer and sharing knowledge. Many

external referrers that had attended these days when they were offered in the past felt they were extremely helpful and that it would be good if they were more available and occurred regularly. This would also contribute to building relationships with the internal staff which in turn would promote coordination and collaboration between Puawaitahi and referrers.

> For new employees, as part of their induction, to go and visit and see where it is and what they do and talk to people there. R3

> So like an open day or part of your orientation is probably the way to go because you don't need to sit through the whole case review. Actually probably what would be more useful is to go and have a tour of the building and to get a talk from somebody, like this is what health sees and does, this is who we do, this is who we don't see and the same for each floor, for the public health nurses would probably be much more interesting. R4

> I went to a study day they had there, it was the most fabulous professional development I've ever done, so it was a whole day, it must have been in [year] … They took us right through, a person from each department spoke to us, so I think that was really worthwhile, really important and there's another one coming up for the first time in five years. So I think those things are really important in terms of letting users of that service to know about. R7

Internal staff and external referrers felt the "open-days" were important as it was a way of building relationships, promoting the service, upskilling referrers and making the right people aware of the service they provide.

> It was useful, very helpful yeah. Because you network, you meet the people, you know what service they can provide because they did tell us what they can provide and what they couldn't. I mean you learn more as you go along as well. R4

> I would like to see them make more people outside more aware of what they do. Give more skills for us outside to use. R7

It was reported by some internal staff that new Puawaitahi internal staff were sometimes also invited to this orientation and that it was an efficient way to give them an overview of how the multi-agency worked.

> Training for the building... the Puawaitahi training, it's for the social workers but people here go to it as well. That is a good training. That's almost a piggy back rather than an arranged situation though. I4

Preparation, Information and Support

Many of the external referrers and clients talked about clients and families needing more preparation and information before coming into the building. Also, ongoing support and being kept informed throughout process was really important but wasn't something that was consistently happening. Most clients suggested having someone from Puawaitahi come to their home before the initial appointment to tell them all about the building and what to expect.

> Get them to tell you all the facts before you go so you know what is really expected instead of just walking in there not totally sure. C6

> Understand what it is you are walking into… call the parents in first this is what is going to happen, your child is going to be really upset possibly or may be not bothered at all, and it's going to be like this and its properly good if your child has what went on in their hand beforehand … what to expect before you get to the building, so you are not walking in going "ooh my god". C7

A few of the clients suggested having a single consistent contact person that they could talk to and ask questions about the Puawaitahi process and services, like an advocate for the family.

> That would help the families, to have someone there that has been through the process and knows what it's like. C4

In summary, participants made a number of suggestions to improve collaboration and coordination both within Puawaitahi and externally with external referrers and clients and families. These suggestions included improving the referral process by having one referral for the whole multi-agency. Suggestions to improve Puawaitahi's relationships with referrers included having internal staff at the multi-agency visit referrer's workplaces and providing orientation, education and training for external referrers about the services in the multi-agency. Finally, suggestions to improve collaboration with client and families included establishing formal processes for preparing, informing and supporting children when they present at Puawaitahi.

Multi-agency Environment

Many of the external referrers and clients when commenting on the environment at Puawaitahi suggested some improvements to both the physical building and environment. These included additional parking spaces, making the building more teen friendly, having

free WIFI available, providing work stations for referrers while they are waiting, and having child minding available in the waiting rooms.

Outside of the Building

Some clients felt that the outside of the building could be more inviting, colourful and match the child-friendly aesthetic of the inside of the building:

More colour in the building… it just looks really boring… [colour] makes you feel more welcome and changes everything. C6

Waiting Rooms and Consult Rooms

Many of the external referrers and many of the clients commented on improvements for the waiting rooms and consult rooms and how the building needs to also be targeted at the adolescent age group and not just young children. A few clients suggested, reading material for parents while they are waiting (e.g., "todays newspaper") and having "music playing" in the waiting rooms:

Too quiet in the waiting room, they could play some jams, like music. C4

Many clients also suggested different waiting rooms and consult rooms for different ages which have more age appropriate toys and activities for middle schoolers and teenagers.

Computer or something like that, for the older kids to play with, or something. C3

[It would be] more fun playing on a tablet. C4

This was congruent with the external referrers' comments as they also felt the waiting rooms were aimed at younger children and did not cater to the needs of adolescents:

The waiting room could be a bit more adolescent, there's a couch and a couple of chairs. R8

External referrers made a number of suggestions including separate waiting rooms for adolescents, iPads to play with, gaming machines and games and activates targeted at older children:

Yeah I've been to the one in South Auckland and its set up so they've got rooms for teenagers and really nicely set up and age appropriate. So it's not too childish. They've got for the different age groups. R5

Probably if they had iPads too they could sit and play. R8

Or even a gaming machine in the room so they can do something like that because they need distractions. R7

Wireless Internet (WIFI)

The majority of external referrers and most clients suggested Puawaitahi should provide free WIFI to visitors. This comment was often made in conjunction with the discussion about improving the service to be more adolescent friendly so that they could play on their phones. It was also pointed out that it would be convenient for referrers and families having to wait long periods of time while there client/child is being seen.

> They need Wi-Fi. R3

> Free wi-fi so they can use their own phones. R7

Despite supporting this idea one external referrer did point out that one of the dangers of having free WIFI is a parent may sit on their phone and not attend to their child.

> Mind you don't want them sitting there playing on free wifi when they're supposed to be minding their children and they're possibly not looking after them. R8

Parking

A majority of external referrers and clients commented on the lack of parking at Puawaitahi and suggested that there needs to be more parking spaces available for visitors.

> It would be good if they had more parks. R5

> It could do with some more carparks. R10

One external referrer suggested that it would be great if there were a couple of reserved parking spaces for emergencies.

Work Stations for Visitors

A couple of external referrers commented on how having 'hot desks' or work stations available to referrers to use while they are visiting Puawaitahi. They did comment that they could use an empty desk of an existing internal staff member but that these were not always available and that they also felt uncomfortable using someone's private desk.

> There is an expectation, a real expectation that social workers will be present. So for example some assessments can take several hours. EVIs can take several hours. I mean I know that we have our laptops and our I-phones now which is relatively new, so you can't access CYRAS, so there could be a smarter way of managing that so that our social workers are able to do work that they still need to do. R3

> There is no extra computer. You just have to use any available computer, especially the computer of the interviewers, when they go to interview the children, that's when you can get into the computer. R3

Childcare

Despite supporting this 'hot desk' solution one external referrer commented on how they felt this might not work logistically as external referrers are sometimes expected to look after children while they are waiting and therefore have to be present in the waiting room.

> So you then locate yourself where you could possibly access CYRAS, which is on a different floor, but if you have to look after children and have to be there for when the interview finishes etc. then that could be a little bit problematic. R3

Some external referrers suggested a solution to this issue could be that there are designated child minders in the waiting rooms. This could mean that the referrer is then free to get on with their work at the temporary work stations and can use the waiting time efficiently.

> In an ideal world wouldn't it be nice if they had somebody like a child care person…
>
> They do that overseas. They have volunteers that come in and sit in the waiting rooms. R3

in summary, external referrers and clients made a number of suggestions about improving Puawiatahi's environment and these included painting the outside of the building, enhancing the waiting rooms and consult rooms, providing access to free wireless internet (WIFI) for visitors, additional parking, providing work stations for visitors and employing childcare staff for the waiting rooms.

Multi-agency Service

Many of the external referrers and clients when commenting on the service provided by Puawaitahi identified some gaps in service provision and provided some suggestions for improvements. These included improving access to therapy and establishing formalised feedback and follow up processes.

Access to Therapy

Many of the external referrers and some of the clients commented on the difficulties with accessing therapy both at Puawaitahi and in the community. External referrers made a number of suggestions for improvement to solve these issues and these included growing the resources at SSU to increase therapy provision, going into the home to provide interventions, having specialist therapy available at schools and having culturally specific service providers available.

A few external referrers commented on expanding therapy provision within Puawaitahi. Some stated that the 'one stop shop' model was not complete without this and

that by increasing access to therapy, on site, a more complete, therapeutic and holistic service would be provided. Clients would then receive all the services they needed in one building.

> More resourced SSU… good child specialist psychologists. R9

> They tend to keep the really complicated ones because they are so loaded. I would love to see every case go through them but money and time, an ideal world. So it gives them one place to be for everything. R7

This was congruent with suggestions from the internal staff supporting the idea of expanding therapy provision within the multi-agency:

> What would be absolutely wonderful if we had the capacity within the building, having a service that can deal with acute crisis but also a service that could have some ongoing therapeutic work to be done... because that is sadly lacking in the building. I4

On the other hand, a few external referrers commented on how interventions would be more helpful if they were provided in the client's homes and in their environment. Therefore skills would be more easily transferable and applied to a real environment and situation.

> I think for when we've got families where there's reunification happening, having somebody going into the home, doing that modelling for them, giving them that support and giving them that feedback is invaluable. R5

A couple of external referrers commented on how it would be great if the community services could come into schools to provide therapy. External referrers felt that the school is a safe place for the child and it would improve access to therapy by minimising travel concerns and fears about having to go back to the multi-agency.

> Yeah counsellors should be coming into schools. R6

> Kind of helps with that situation where kids can access or have some therapeutic input in that very safe environment at school. R5

One external referrer suggested that it would be great to have more culturally specific services available to clients. They felt that this need could not be met by SSU and instead having a trusted community agency they could referrer to would be helpful.

> We have a lot of Samoan children coming in and I'd like something that's culturally appropriate for them and their families. And have people that have got skills to talk them through and its education really. If you know that they have the ability and they have capacity then those are the people you'd want to help without feeling as a social worker that you've got to fight battles to get that service provided and SSU doesn't really meet that next step for our families and children. R5

Feedback

Many clients discussed the lack of feedback, follow up and communication following appointments at Puawaitahi. It resulted in anxiety and frustration as they were not informed about the outcome of the appointment or if they were contacted there was a significant delay.

> I just thought that if they don't get back to me, that mean it's finished, everything's finished … Maybe my parents could have gotten a phone call … Couple of months after it, I had that feeling, just wondering if they were going to call again or not. But later on in the year I just forgot and thought it must be done. C3

> All this time and all that time and there was nothing [no follow up, no answers], deflating… oooh that was a waste of time. C5

> We left the building still not knowing where it was going to go from there… [I was anxious] waiting, every time the phone rings … a month later we had a meeting. C6

> They didn't give me any feedback. C8

Most clients suggested that someone from Puawaitahi should provide immediate feedback to the family following the appointment and also provide information about where to from here. Some clients felt this was best done in person and in a feedback meeting and others felt a phone call was sufficient.

> I properly would have liked a phone call I think, from [the professional who did the assessment] or someone from Puawaitahi, someone to be able to voice what they thought. C5

> Knowing when and where it was going to go from there…even if they said at the end of the meeting "we think it might be 2 or 3 weeks and then we will make a decision" at least then I would have known… I would have liked some feedback… even if it didn't happen straight away just knowing, okay, on this date we have got someone who is going to work with her. C6

> Most Polynesian and Māori's you don't do that on the phone, you actually go over and see them… you can't just ring them up… making it a personal contact rather than a thing on the phone. C7

Follow Up

A couple of external referrers reported not getting any follow up or feedback about clients they have referred to Puawaitahi and felt that more information about the outcome of the referral would be helpful. This would provide referrers with closure about cases but would also inform them about what referrals are appropriate.

> No it would be nice to get the feedback just to say that this person attended a couple of times, we closed the file… so that in the future if that person comes through any of the sexual health clinics they can see. R4

> It would be really nice to get a feedback at the end when they close a case just to say oh gosh this one was referred to us, we'll just give you a really quick feedback. It doesn't have to be much you know. R4

Many clients reported they did not receive any follow-up from Puawaitahi regarding the recommendations made following their initial presentation to the multi-agency. Clients felt if this had happened they have received some support to access community services:

> It might be better if they make contact with the family again, say months down the track, you know, just as a backup, just in case it's all fallen through. C7

Many internal staff identified that there is a need for a role within Puawaitahi where a staff member is actively making the links between Puawaitahi clients and the external services (CYF sites, local Police stations, health services, support services, therapy, etc.) they are later referred to, and in particular follows up on the implementation of recommendations for clients and families progress:

> A lot of the time we make recommendations for services and I believe you know most of the time they are the right ones but there is a gap between the services, so unless we have the ability to go out and assist in that case managing and things then we have just created another gap... so we still need to work on those gaps that are outside of the building... every kid needs primary medical care and everyone needs someone at school who knows, so we've got a lot of work to do in that sort of case management gaps and mental health as well. I4

> What happens after for these kids.... making sure there is support for the families to get them [children] to counselling... a lot of it is getting kids to services because often the families maybe not that motivated to do it. I1

A number of suggestions were made to improve access to therapy and these included growing resources at SSU to increase therapy provision, going into the home to provide interventions, having specialist therapy available at schools and having culturally specific service providers available. Providing timely feedback to clients and their families was identified as lacking at Puawaitahi and suggestions to improve this service gap included proving feedback in person or making a phone call. Participants suggested that Puawaitahi lacked a formal follow up for both referrals and clients following contact. Follow up improvements included improvements to information provided to referrers about the outcome of the referral, informing referrers

about what referrals are appropriate, supporting clients and families to access community services, actively making links between Puawaitahi clients and the external services and following up on the implementation of recommendations.

Conclusion

Participants made a number of suggestions to improve the response to child abuse and neglect both Auckland wide and at Puawaitahi multi-agency centre. Some improvements had resource implications and are therefore dependent on additional funding (e.g., reinstating the multi-agency coordinator role, reducing CAVU delays by employing more evidential interviewers and employing staff to provide a preparation and support programme to clients, and formal follow up following contact with Puawaitahi), some would require changes in external agencies' procedures (e.g., to implement a single referral process into the multi-agency), some had external government level restructure implications (e.g., reducing delays to Court, establishing additional multi-agencies in the Auckland region) and some suggestions were for improvements that could be implemented within Puawaitahi's discretion and resources (e.g. introducing a standardised building induction process, providing timely feedback to clients and outlining clearer, updated and more collaborative process and procedures).

CHAPTER SIX: DISCUSSION

The purpose of this thesis was to evaluate Puawaitahi, New Zealand's first multi-agency for child protection and provide recommendations for future programme development. During the evaluation 25 internal staff members, 65 external referrers and 10 clients (children and caregivers/parents) participated in the evaluation via either individual interviews or focus groups. The opportunity to obtain a wide range of opinions and advice about how Puawaitahi was operating was thus obtained.

Overall this evaluation shows that a model inspired by USA Child Advocacy Centres appears to have been effectively implemented in the opinion of internal staff and external referrers, although improvements were called for across a range of areas by all three participant groups. Internal staff and external referrers in general reported Puawaitahi as bring a model for implementation elsewhere in New Zealand. A small group of clients expressed overall satisfaction with the service they received.

This chapter will compare Puawiatahi's operational guidelines to the findings, compare CAC accreditation criteria to Puawaitahi's current operation, comment on the key findings of the evaluation and compare it to the current literature, explore general implications of the evaluation on child protection and finally discuss the limitations of the current evaluation.

Operational Guidelines

Puawaitahi's vision and mission statements are contained in the first section of Puawatitahi's Operational Manual and are used to provide purpose and direction for the multi-agency. It is important that current evaluation establishes if the multi-agency's current processes and procedures support and are in line with these statements.

Puawaitahi's vision statement is "working together with families affected by child abuse" (Puawaitahi, 2009, p.5). The evaluation identified a number of initiatives, processes and procedures that support Puawaitahi staff working collaboratively with clients and families and this is highlighted in the theme 'collaboration with clients and families'. For example, staff interactions with clients and families were described positively, staff made a real effort to ensure families were kept informed and families were empowered throughout the processes by being given choices about their treatment.

CHAPTER SIX: DISCUSSION

Puawaitahi's mission statement outlines eight key areas which contribute to providing a coordinated and effective response to the abuse and neglect of children and young people. These eight areas will be outlined in relation to the findings to establish if Puaiwaitahi is achieving its mission and where the multi-agency might be falling short.

"Providing access to specialized medical, forensic and mental health services in a safe and child and youth friendly environment". Findings suggested that medical and forensic services were not only specialised in regards to being for children and youth but were also child protection services specialised in child abuse and neglect. Participants across the three groups strongly agreed that Puawaitahi was a child-centred service and this was reflected in the physical building through to the staff interactions with the clients. However, a number of participants felt the physical environment was less targeted to youth and adolescents than to younger children; for example, the toys in the waiting rooms and physical appeared of the consult rooms were aimed at younger children. Participants also commented on how Puawaitahi did not provide adequate access to therapy/ therapeutic interventions and that their resources and service were limited. Participants described limited therapy access and that the majority of the work was weighted towards professional consultation, the assessment of complex cases and psychological 'first aid'. Further, the 'mental health' arm of Puawaitahi only involved a small team of psychologists and therapists and fell short of a comprehensive multidisciplinary mental health service.

"Coordinating and streamlining the investigation". In general being co-located and having collaborative Puawaitahi Operational Guidelines resulted in coordination and streamlined investigations but some disruptions and delays were identified. Participants spoke positively about NAI case conferences, multidisciplinary meetings, gateway health and education assessments and PIRM. They felt that these processes and procedures contributed strongly to coordinating and streamlining the investigation. Coordination was also achieved via positive informal practices that resulted due to co-location, including informal consultation between services and increased understanding about other agencies' processes, strengths and limitations resulting in a more streamlined investigation. Areas for improvement included that forensic interviews and the assignment of cases to CPT Police detectives often had significant delays. CAVU is one of only two services in Auckland who employ specialist child interviewers to conduct forensic interviews of children and youth. CAVU covers central, west and east Auckland and the huge demand for forensic interviews results in delays for some clients with potential consequences for coordination and streamlining of the investigation. Delay in assigning a Police detective to a case also has an

impact on the children and young people involved as this can mean they are asked to come back, sometimes, months later to do a second interview as not all of the information was covered in the first interview. It is not until a Police detective has thoroughly looked through the evidence, once the case is assigned, that this is picked up. Further, participants felt that the limitations and restrictions on referrals to and between the separate agencies within Puawaitahi resulted in a less streamlined and coordinated response.

"Empowering children, young people and their families in the intervention and healing process". There are a number of positive ways in which Puawaitahi appears to meet this mission statement. All children and families that Puawaitahi serve are provided with appropriate and accurate information to make informed choices about interventions and their care. Young people and their families are provided with psychological first aid and education, when deemed appropriate, about the effects of trauma on children and simple ways as a family that can start the healing process. Parents are empowered to support their children and also seek support themselves if needed. External referrers and clients reported that Puawaitahi staff listened to clients and families and treated them with respect, dignity and understanding. Participants spoke about limited intervention and therapeutic service provision within Puawaitahi but what was provided was spoken of very highly by both referrers and clients.

"Striving to provide quality, culturally safe services". External referrers and clients commented on internal staff being culturally sensitive and culturally aware and that this made clients and their families feel comfortable and put them at ease. In addition, participants commented on the physical building incorporating features relevant to different cultures, provision of interpreters if necessary, and staff ensuring complex concepts were broken down so that everyone could understand especially if English was the family's second language. Some participants commented that there was a lack of cultural diversity in the staffing group, and ideally culturally matching clients with professionals would be best practice. It was recognised that cultural support workers were a scarce or non-existent resource.

"Facilitating timely referral to appropriate community services". Participants spoke of clients and families receiving appropriate community referrals and recommendations as common practice at Puawaitahi following an assessment (medical, forensic interview and/or therapeutic). Nonetheless, participants also spoke of a number of difficulties with these referrals and recommendations, including a lack of follow-up by staff and/or follow through by clients and families, a lack of competent and specialised community referral options, and delays and waitlists for beginning therapy. It appears that some clients and their families are

not receiving support in a timely fashion, resulting in delays in professional help and clients slipping through the cracks and never receiving support.

"Education, training and research". Puawaitahi staff commented on a number of initiatives to promote education, training and best practice within the internal staff including weekly journal club, Puawaitahi joint training and clinical liaison meetings. Participants commented on previous orientation/open days at Puawaitahi for referrers and felt these were extremely helpful to teach external referrers about the services Puawaitahi provides. It was noted that this provision has fallen away. Research was not commented on by any of the participants but a literature search indicated that individual agencies within Puawaitahi were conducting research on different areas of interest (e.g., Trauma Focused Cognitive Behavioural Therapy, by Feather & Ronan, 2009; the Shaken Baby Prevention Programme, by Kelly et al., 2016).

In conclusion, it appears Puawaitahi meets its vision statement and a larger number of its mission statements in most respects. Participants identified Puawaitahi's strengths as their co-located specialist services, child-friendly and family ethos, cultural responsiveness and continued commitment to education and best practice. Some of the areas identified for improvement to better meet the mission statements included widening counselling service provision within Puawaitahi, increasing CAVU's capacity therefore reducing delays, reinstating the coordinator role, employing cultural advisors and support people for clients and families and improving links between Puawaitahi and community referrers.

CAC Accreditation Criteria

In general Puawaitahi's current practice performs well in relation to the accreditation standards described for CAC's elsewhere. According to the findings Puawaitahi meets CAC accreditation criteria in the following areas, *child-appropriate/child-friendly facility*, *child investigative/ forensic interviews*, *medical examinations*, *case review*, *organisational capacity* and *cultural competency and diversity*. However, Puawaitahi falls short of the comprehensive CAC criteria for the following areas: *mental health services and therapeutic intervention* and *case tracking*.

Provision of m*ental health services and therapeutic intervention* is provided at Puawaitahi although it is a limited capacity (as explained above). When intervention cannot be provided at the multi-agency recommendations are made to community services although this is not done in coordination or communication with the treatment providers. For example, recommendations are made by Puawaitahi staff and it is up to the original referrer and/or the

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client to contact that service. CAC accreditation assumes that all families coming into the building will be screened for their need for mental health services. At Puawaitahi, the client (child or young person) is screened using a range of psychometric measures if they are being seen by SSU psychologists or therapists, the SDQ is used to screen patients coming through CAVU and Gateway assessments involve a few mental health screens (including the SDQ). Despite this there does not appear to be one common mental health screen across services and Te Puaruruhau only use screens when completing Gateway assessments and not in their general child protection work. In addition, therapeutic interventions and mental health screens are provided for the child but no services are targeted at the non-offending parents and caregivers accompanying the child. CAC accreditation suggests that if appropriate services are provided outside of the CAC written protocols and agreements must be established with mental health service providers; this does not appear to be the case at Puawaitahi.

CAC accreditation suggests that a system should be in place for *case tracking* that is monitoring case progress and tracking case outcomes. Puawaitahi currently has a shared database in which referrals are entered at regular PRIM meetings but no further information is recorded about a case on a shared system. Each agency has their own database to record their role and progress made with the case but this ongoing work is is never collated into one shared case tracking system. Participants commented that often professionals are unclear about the outcomes of the multidisciplinary response and that there is no systematic follow up or tracking system to ensure recommendations are implemented.

Puawaitahi does not meet the accreditation criteria of *victim support and advocacy* and therefore due to this does not meet the ultimate criteria for the *multidisciplinary team*. In NZ, an independent service that works closely with the Police called Victim Support, Manaaki Tangata provides 24 hour, seven day a week access to a support service to all victims of crime and trauma and advocacy for the rights and interests of these victims (e.g., arranging financial assistance or compensation, legal assistance, information and education and advocating for victims' rights; Victim Support, 2014). The New Zealand Ministry of Justice also provides 'court victim advisors' and offers a Court Education for Young Witnesses programme where child witnesses are prepared for court. Although these services are not provided at Puawaitahi they are accessible and often families and/or clients are informed about these services by the Police detective in charge of the case.

CHAPTER SIX: DISCUSSION

Key Findings

Overall it appeared that both external referrers and clients were generally positive in their recollections of the experiences at Puawaitahi. Internal staff and external referrers were in general, pleased and enthusiastic about the multi-agency model and the processes and procedures in place at Puawaitahi. Participants who had been in NZ child protection for greater the 15 years felt that the multi-agency model and Puawaitahi was a significant improvement in NZ's response to child abuse and neglect with better outcomes for children and families.

Within the specific services participants identified a number of strengths and also areas for improvement. Participants spoke positively about SSU screening client's post EVI, the ease of referring clients to the health team and SSU's CYF site consults. Some of the areas for improvement included the Police rotations and staff turn-over disrupting professional relationships and coordination, limited intervention and therapy provision at Puawaitahi and an unclear threshold and referral criteria for SSU (therapy intervention). Delays within the Police CPT processes and appointment delays at CAVU were key areas for improvement. Participants identified that these delays had the most significant impact on the families and young people and on the investigation and evidence gathering process which was often compromised.

In relation to the collaboration theme participants felt that the multidisciplinary meetings were an effective way of sharing information, collaborating and ensuring a streamlined process to establish roles and ensure clients safety. Some of the areas that were identified that may benefit from change included clients having retell the incident and there history a number of times to difference professionals in the building, sharing information and the limitations of the Privacy Laws, Puawaitahi having four referral paths one for each of the services and community therapy referrals and recommendations not being followed through or coordinated effectively.

In relation to the multi-agency environment participants spoke positively about the inconspicuous appearance of the outside physical building, Puawaitahi's client focused ethos and child- and family-friendly service culturally appropriate and culturally competent internal staff. Some area identified that could benefit from change were having areas (waiting and consult rooms) within the multi-agency targeted at an older age group (teenagers and adolescents) and limited cultural support (e.g., cultural support workers and clinicians cultural diversity).

CHAPTER SIX: DISCUSSION

Overall the current evaluation suggests significant improvements in the professional response to child abuse and neglect compared with findings from Davies and Seymour (2002) which lead to the inception of Puawaitahi. Davies and Seymour's research revealed gaps and inadequacies between agencies, long delays in investigation and access to treatment, lack of coordination, conflicting messages from different professionals, and a lack of parent/family support. It appears that all of these areas have been resolved or significantly improved since the opening of Puawaitahi in 2002. Participants spoke positively about the coordination and communication of the three key agency's involved in child abuse investigation (health, Police, and child protection services) and there was no mention of conflicting messages from professionals by caregivers or clients. Puawaitahi has been a huge step in the right direction in improving the response to child protection although some areas could still benefit from improvement; as noted, in particular, CAVU delays and limited access to interventions for the child and their family. It appears Puawaitahi lacks objective measurements of these matters via a tracking system, for example, the tracking of delay measured in days, number of community referrals made effectively and followed through by families and so on.

In terms of the broader aims of this thesis, this evaluation showed that bringing together the three agencies involved in child protection is feasible and effective in NZ. The evaluation found that Puawaitahi performs well in relation to the CAC accreditation standards and generally participants spoke positively about the service that was being offered. Most participants spoke about expanding the model so that there is a multiagency for each region in Auckland and throughout NZ. Further, health services were identified as a key part of a multiagency service. In other multiagency services developed elsewhere in NZ, a comprehensive specialised health child protection team is missing.

In respect to the broad aim of developing an appropriate model of evaluation, the approach adopted in this thesis appeared to be an effective methodology for describing the programme and its processes (process evaluation) and evaluating its impact on service users (impact evaluation). It is considered essential to have staff buy-in and for the implementation of the evaluation methodology to be tailored so that it is practical and feasible for the multi-agency being evaluated. This buy-in was achieved as there was an overwhelming response to invitations to participate, both from internal Puawaitahi staff and external referrers. Furthermore, engaging with participants face to face, rather than via questionnaires, provided them with the opportunity to tell their story and gave them a direct voice. Finally, the evaluation method employed was acceptable to research access and ethics committees thus paving the way for future evaluation research at Puawaitahi and/or at other sites within NZ.

Implications for Child Protection

The CAC and multi-agency model is a common sense approach to addressing the multidisciplinary response to child abuse and neglect (National Children's Alliance, 2014). Generally the evaluation supported the multi-agency model of practice and there were a few key findings that may be generalised to child protection practice across NZ. Firstly, the evaluation supported other international research that concludes that the multi-agency model improves coordination, collaboration and service provision for clients and families as well as professionals; improvements that should lead to improved outcomes (Crockett et al., 2013; Cross et al., 2008). Co-location and working within a MDT also leads to improved job satisfaction and further education and learning opportunities for those staff working within the multi-agency (Boddy et al., 2006; Crockett et al., 2013; National Children's Alliance, 2017). The findings of the evaluation suggest that when current child protection process are compared to previous practice, prior to Puawaitahi's opening, that the response to child abuse has improved in central Auckland. This supports international findings that CAC or multi-agencies provide the best model of response for allegations of child abuse and neglect (Herbert & Bromfield, 2017; 2016).

The evaluation showed there were a number of key processes and procedures outlined in the operations manual that promoted collaboration and information sharing between agencies. These processes (e.g., PIRM, case review, etc.) were in line with those outlined by the CAC accreditation criteria and were seen by participants as important to ensuring Puawaitahi operated as a multi-agency and not just three services sharing the lease of a building. This finding was supported by other research suggesting that key MDT processes are essential to ensure multi-agencies are operating as intended and producing positive outcomes for their clients and families (Kuehnle & Connell, 2008; National Children's Alliance, 2017).

Lastly it was also highlighted that even if all the right process and procedures are in place the staff and people employed in the service need to be willing to work together and learn from each other. This also supports other research that suggests multi-disciplinary responses are an extraordinarily complex intervention, reliant on relationships between staff, attitudes about the approach, and accepted and routine work practices (Crockett et al., 2013; Jones et al., 2005). A poorly implemented or potentially dysfunctional MDT is unlikely to produce a better outcome than standard practice. Therefore it is Puawaitahi's positive relationships between services, 'open door policy' and multi-agency culture that influence its successful outcomes. The evaluation stresses the importance of child abuse not being one

services responsibility but the responsibility of a well-coordinated team, of child-focused professionals providing a streamlined response, no matter whether you are collocated or not.

Strengths and Limitations of the Evaluation

Although there has been some previous research in evaluating CAC's and multi-agencies, the majority of the evaluations have focused on impact or outcome evaluations. Implementation fidelity is critical to the success of all kinds of social programs (Carroll et al., 2007) therefore this process evaluation focused on the implementation of the programme at Puawaitahi which is essential to understanding the impact and outcome of these processes on its clients and participants. A wide range of participants were interviewed including, internal staff, external referrers and clients and families to get a broad range of perspectives on the programme. Qualitative methods were used to conduct a systematic evaluation which allowed for a broad range of topics and issues to be explored.

Participants in general reported that the evaluation was done appropriately and, as suggested in previous literature, evaluation participants appeared to enjoy providing their opinion about the programme (Sapsford & Jupp, 2006). It was important that all participants especially children were fully informed about what information was collected and for what purpose, for interviews to be conducted at a time and location of convenience, and seeing the benefits of participation, particularly with sensitive research (Renzetti & Lee, 1993). All participants were seen face-to-face and all of them agreed that this worked well for them. However, children, parents and caregivers felt that it would have been better if the interviews were closer to their final appointment at Puawaitahi to help them remember more detail about their experiences and to help prevent them having to revisit a difficult time for their family much later. However, several participants spoke about the usefulness for themselves of looking back to see how far they had come over this time period and prompted some of them to seek help for unresolved difficulties.

A concern could arise that by consulting staff members in the design of the evaluation there was a risk they may have influenced the evaluation so as to prevent examination of things they regarded as not functioning well, or to avoid examination of aspects of the programme that mattered to the research team and/or other stakeholders. This was not the case. Staff were consulted about the implementation of the evaluation to ensure it was practical for the Puawaitahi setting and population, and to ensure that issues important to them were included. They did not influence the overall methodology as this was determined by the process and impact evaluation literature. Consulting with staff and ensuring the

evaluation methodology fitted with their current processes and procedures was a strength of the evaluation. Consultation allowed space for adaptions (e.g., creating the staff information prompting cue cards, see Appendix D3) and discussion and problem solving around implementation (e.g., when/ is it appropriate to ask a young person/ family presenting for a critical assessment to participate in the research?) to ensure the methodology was suitable, feasible and practical for staff and would seamlessly fit into the current processes. Ensuring the evaluation methodology was practical for staff at Puawaitahi was critical to enhance recruitment efforts and buy-in.

Limitations include that NZ, and specifically Auckland, has a very unique multi-cultural population with very diverse needs which may limit the generalizability of the findings even to other NZ regions and/or Western countries that may have different sociological make-ups and traditions. Additionally, the evaluation was conducted on the Puawaitahi programme, processes and procedures, therefore cannot be generalised to other multi-agency efforts elsewhere in Auckland or NZ.

The evaluation of Puawaitahi could have been strengthened with quantitative data regarding programme implementation and impact. The evaluation was based on participants' opinions, experiences and perspectives on Puawaitahi. Qualitative data obtained could have been supplemented with quantitative data confirming operations were being implemented as intended (e.g., case file records, meeting minutes, real time observations, etc.). Due to the time and resource restrictions of the evaluation this was not feasible.

Only a small number of clients and families were interviewed for the evaluation and the ethnic diversity, age and type of abuse did not reflect the population seen at Puawaitahi. This was because there was only a very small pool of clients that met the criteria for inclusion in the three month period in which permission to contact forms were collected. Additionally, despite significant efforts not all referrer groups participated in the evaluation as GP's and mental health professional's perspectives were not obtained. This was due to a limited response to volunteering to participate in the research.

Future Research

Due to there being very limited research on the evaluation of CAC's and multi-agencies worldwide it is important more research is done in the area. Future research should aim to address the limitations in the current research by expanding research efforts and methodology. More could be done examining the impact of Puawaithai's approach as a whole in terms of important outcomes such as client satisfaction, recovery from trauma, the reduced

infliction of systemic trauma and improved referral and take-up of support services. Further, conducting outcome research about the long term outcomes of clients who present to Puawaitahi using a comparison region in which a multi-agency doesn't exist would assist in substantiating the argument for more multi-agencies across NZ. Also using a comparison region would mean that potential clients don't miss out on a potentially helpful MDT response to allegations (when using a comparison group or waitlist type design). Additionally, other multi-agencies that have been established around NZ since the opening of Puawaitahi could be included in a larger scale evaluation to assess their implementation of the multi-agency model and the impact and outcomes of similar efforts compared with Puawaitahi. It would also be important to include significant cultural conclusions in a larger scale evaluation therefore including Māori models of research and/or appropriate programme evaluation for minority groups, ensuring Puawaitahi and the multi-agency model is responsive to Māori and other cultural minorities.

Future research may also consider how to implement and duplicate a similar multi-agency model in a variety of regions across the country. Additionally, there is a need to produce a set of standards and/or accreditation criteria for multi-agency centres in NZ that could be used to evaluate individual programmes and to ensure best practice standards.

CHAPTER SEVEN: RECOMMENDATIONS

Wider Auckland and New Zealand

1. Implementation of the multi-agency model across other Auckland regions and New Zealand

   - West Auckland at Waitakere Hospital and North Shore at North Shore Hospital.

Puawaitahi

1. Re-establish the multi-agency Puawaitahi coordinator role

   - Reinstate the multi-agency coordinator role
   - Promote multi-agency systems within the building

2. Update the Operations Manual

   - Include roles, responsibilities and timeliness of each process/service

3. Standardise and update the building orientation and induction processes

   - Create an induction video of the Operations Manual

4. Establish a single referral system for referrals into Puawaitahi

   - Negotiate and remove the barriers to referral between agencies within the building

5. Have a Shine representative at PIRM

   - Information sharing

6. Build stronger relationships with external referrers

   - Hold orientation open days, provide education and training.
   - Include referrers in the development of protocols for referrals

7. Provide further evaluation – impact and outcome, cost-benefit analysis

   - Establish an ongoing evaluation and client feedback process

8. Improve waiting rooms and consult rooms

   - Establish more adolescent-friendly areas
   - Play music in the waiting rooms and daily new paper available
   - Provide free WIFI for visitors

9. Provide more visitor parking

10. Provide hot desks for external referrers to use when they are waiting

11. Improve and streamline case monitoring systems for feedback and follow-up

    - Establish a case monitoring system for the multi-agency

- Improve policies around feedback and follow-up
- Provide routine follow-up phone calls to all families that present at the building 1 month following their final appointment

12. Establish volunteer participation

- Provide this in particular for the waiting rooms helping to calm, entertain and answer questions children might have

13. Establish a victim advocacy programme

- Preparation for multi-agency visit
- Provide information about the multi-agency
- Video of walk around and introduction to the service
- Contact and support person availability

14. Prevention efforts

- Include prevention activity to staff roles
- Promote community efforts around prevention

15. Expand therapeutic services

- ACC sexual abuse counsellors also included in the building

Specific Services

1. Central Auckland Video Unit

- Reduce appointment delays for evidential interviewing by increasing interviewing staff and expanding the number of interviewing rooms

2. Police Child Protection Team

- Reduce the delay in assigning a CPT detective to a case

3. Te Puaruruhu

- Improve access to supervision for nurses

4. Specialist Services Unit

- Increasing therapy provision at Puawaitahi
- Establishing preferred referral agencies and establishing working relationships and mandates that facilitate referrals and engagement

5. Ministry of Justice Courts

- Timing of prosecution extremely delayed
- Specialised courts in Auckland

APPENDICES

APPENDIX A: General Documents for Interviews and Focus Groups

A1: Procedure for Reporting of Incidental Disclosure

A2: Participant Distress Protocol

A3: Information and Resource Booklet

REPORTING OF INCIDENTAL DISCLOSURE

The Protocol for reporting incidental disclosure of child abuse during the individual interviews with children: Assessment and response guidelines

[1] Identify incidental disclosure

- Disclosure of alleged abuse or neglect of a child or partner abuse.
- Physical abuse, sexual abuse, emotional/psychological abuse (e.g., family violence, exposure to illegal activities, rejection, etc.) and/or neglect (e.g., medical neglect, abandonment, neglectful supervision, etc).
- Write down what the child, young person or parent says. Check that comments and events surrounding the concern are also recorded.
- Do not formally interview the child or young person. Obtain only necessary relevant facts for when clarification is needed.

[2] Provide emotional support for identified or suspected victims

- Listen to the child and reassure them they did the right thing in disclosing.
- Acknowledge what they tell you and validate their experience.
- Tell the child that no one deserves to be hurt or neglected, and that is was not their fault.
- Tell them that you will seek help for them and their family/caregivers.

[3] Assess risk

Immediate protection of children is required if:

- the child has been severely abused
- there is immediate danger of death or harm
- abuse has occurred and is likely to escalate or recur
- there is immediate risk to the child, or the environment to which the child is returning is unsafe.

Refer to Child, Youth and Family if:

- the child has injuries which seem suspicious, or are clearly the result of physical abuse
- interaction between the child and parent or caregiver seems angry, threatening, or aggressive
- the child states that they are fearful of parent/s caregivers, or have been hurt by parent/s or caregiver/s
- multiple risk indicators exist, for example, partner abuse in the relationship, alcohol/drug use by caregivers, caregivers avoidant of health agency contact.

Consider risk of self-harm or suicide.

Assess for co-occurrence of partner abuse.

Review and consult with the research team

Ensure that during the next stages of the protocol you are continuously consulting with the research either by phone or in person.

[4] Informing the parents or guardians

Communicate with the victim's parents/caregivers. *Do not* discuss concerns or child protective action to be taken with a victim's parents or caregivers under the following conditions:

- If it will place either the child or you, the interviewer, in danger
- Where the family may close ranks and reduce the possibility of being able to help a child
- If the family seek to avoid child protective agency staff.

If you have any doubts about discussing concerns about child abuse with the suspected victim's parents or caregivers, you should first consult with a senior member of the research team, and with the duty Social Worker at Child, Youth, and Family.

If circumstances permit discussing concerns or child protective actions to be taken with a victim's parents or caregivers, broach the topic sensitively.

[5] Safety planning and referral

If there are concerns about immediate safety (including your own) contact the Police.
If there are no concerns about immediate safety contact Child, Youth and Family.

When child abuse is a possibility, but you are uncertain about what to do, consult:

- A senior member of the research team
- Child, Youth and Family

Take advice from the person you consult.

Decide if you are going to file a report.

When you are concerned about the child's care, but not about abuse, refer to an agency for:

- social support
- parenting skills
- well child services.

[6] Document your concerns

- Date/time/location of the interview
- Name of child
- Date of birth
- Ethnicity
- Name of parents and/or caregivers and other family members and current living situation
- Reasons why it is believed that the child is at risk
- Any other signification information

[7] Refer

- The child and/or family to a specialist social service agency, legal agency or Child, Youth and Family if required.
- Provide the child and/or family with the information and resource booklet.

PARTICIPANT DISTRESS PROTOCOL

An evaluation of Puawaitahi: Australasia's first multi-agency for child protection
The Protocol for managing distress in the participant individual interviews and focus groups

Detection of Distress

- A participant indicates they are experiencing a high level of stress or emotional distress AND/OR
- A participant exhibits behaviours suggestive that the focus group/interview is too stressful such as becoming quiet, looking distracted, uncontrolled crying, incoherent speech, indications of flashbacks, shaking, etc.

Stage 1 Response

- Either stop the individual interview recording or remove the participant from the focus group and accompany them to a quiet area
- One of the researchers (who are all training clinical psychologists) will offer immediate support and allow time for the participant to regroup
- Assess mental status:
  - Tell me what thoughts you are having?
  - Tell me what you are feeling right now?
  - Do you feel you are able to go on about your day?
  - Do you feel safe?

Review

- If the participant is unable to carry on;
  - Go to stage 2
- If the participant feels able and wants to carry on;
  - Resume the individual interview or let the participant return to the focus group

Stage 2 Response

- Discontinue their participation in the research
- Provide the participant with the information and resource booklet
  - Encourage the participant to contact their GP, mental health provider or a support service listed in the information and resource booklet OR
  - Offer, with participant consent, for a member of the research team to contact a support service/person on their behalf OR
  - With participant consent contact a staff member at Puawaitahi that is involved with their case for further advice/support (e.g., key worker, social worker, psychologist, etc.)

Follow up

- Follow the participant up with a courtesy call (if the participant consents) OR
- Encourage the participant to call one of the researchers or a support person if he/she experiences increased distress in the hours/days following the individual interview or focus group.

INFORMATION & RESOURCE BOOKLET

ACC (Accident Compensation Corporation)

www.acc.co.nz

ACC provides ACC-approved counsellors for children who have been sexually abused. ACC can help with some of the costs of counselling. You can find registered counsellors by region, including ACC-approved sexual abuse counsellors, at the ACC website. You can also phone your local ACC office to ask about counsellors. See the ACC website for ACC contact details or check the government phone listings in the front of the white pages of your phone book.

Aiga Atia'e Pasefika Family Trust

http://www.aigaatiaepftrust.org.nz

Aiga Atia'e Pasefika Family Trust provide, parenting programmes for Pasefika Matua, social work and family support, family violence and life skills, couple and family counselling, interpretation, family therapy and do work with all form of abuses and neglect. They also provide resources, information, advice and intervention, additional social resources and support and have a number of support groups. They cover Auckland City, Manukau City and Papakura. Contact (09) 262 3725 or staulapapa.n.wulf@aigaatiaepftrust.org.nz.

Alcohol and Drug Helpline

www.alcoholdrughelp.org.nz

The Alcohol Drug Helpline provides friendly, non-judgmental, professional help and advice. If you are concerned about your own drinking or drug taking we can assist with information, insight and support. 0800 787 797 – 10.00am-10.00pm, 7 days a week.

Barnardos

www.barnardos.org.nz

Barnardos works within the community with programmes developed specifically for New Zealand children and families. The services they provide reflect their commitment to ensuring that all children are able to receive the very best start to life. Services include home-based care and education services, as well as family support and early learning centres. Barnardos also runs supervised access programmes. Call 0800 BARNARDOS (0800 227627367).

Betty Siō: The Pacific Island Safety and Prevention Project

http://bettysio.com

Providing, counselling, Language specific counsellors (Samoan & Tongan), Family Violence Men's Programme (delivered in the English, Tongan & Samoan language), Whānau/family support, Parenting programmes/skills, Prevention of child abuse, Anger management support services and Sexual abuse support services for Pacific people by Pacific people. Offices in Massey, Manukau, Otara and Grey Lynn. 0800 PASEFIKA or info@theproject.org.nz.

CAB (Citizen's Advice Bureau)

www.cab.org.nz

Citizens Advice Bureau provides free, confidential information and advice to anyone about any query or problem. You can contact your local CAB for details of local crisis counselling services, as these differ from centre to centre. There is also a CAB Multi-lingual Information Service. Call free on 0800 FOR CAB (0800 367 222).

Child, Youth and Family Services

www.cyf.govt.nz

Child, Youth and Family is the government agency that has legal powers to intervene to protect and help children who are being abused or neglected or who have problem behaviour. Child, Youth and Family works with families to protect children and young people, promote the wellbeing of children, young people, their families and family groups, ensure that children in need are secure and cared for and help families maintain and strengthen their child-rearing role. To discuss concerns about a child or young person's safety or wellbeing ring Child Youth and Family on 0508 FAMILY (0508 326 459). See also the Child, Youth and Family website for brochures for parents, for children and young people, and for families and the community.

Family Action

http://www.familyaction.org.nz

Counselling, therapy, family therapy, art therapy and domestic violence groups for women, children and families who have experienced domestic violence, abuse or trauma, who reside in the West Auckland region. Call (09) 836 1987 or (09) 837 2491 or email counselling@familyaction.org.nz.

Family Services Directory

www.familyservices.govt.nz/directory

The Family Services Directory lists organisations in your area that can provide families with help and support.

Family Violence - It's not OK

www.areyouok.org.nz

This Ministry of Social Development website has information about family violence, what it is and where to get help. They also have an 0800 Family Violence Information Line (0800 456 450) which provides self-help information and connects people to services where appropriate. It is available seven days a week, from 9am to 11pm, with an after-hours message redirecting callers in the case of an emergency.

Family Works

www.familyworks.org.nz

Family Works delivers a full range of social work and counselling services in communities throughout New Zealand. Family Works supports families/whānau to become resilient, connected to their communities, and independent of social services long term.

They offer services such as
- support and counselling for children and their families
- Early Years programmes to give kids a great start
- parenting programmes for when the going gets tough
- budgeting advice and foodbanks
- They can be contacted on 64 4 473 5025.

Glen Innes Family Centre

http://www.gifc.co.nz

Provide Social Work Support, Counselling (Individual/Family), Budgeting, Parenting Programmes, Domestic Violence Programmes, Senior Recreational Programmes. Call (09) 570 6250 or email admin@gifc.co.nz.

Healthline
www.kidshealth.org.nz
Call Healthline on 0800 611 116 if you need advice about a child of any age who is unwell or hurt, or has any symptoms of sickness. Healthline nurses are specialists in assessing and advising over the phone. Healthline is available 24 hours and is free to callers throughout New Zealand, including from a mobile phone. If you need to talk to someone in your own language, Healthline can usually arrange this using an interpreting service.

Jigsaw Family Services
www.jigsaw.org.nz
Jigsaw is a national organisation focused on the wellbeing of all New Zealand children and their families. The diverse group of independent, community-based social service agencies that make up the Jigsaw network, advocate against all forms of child abuse, neglect, and family violence and provide support to families so they can raise their children in safe and nurturing ways.

KidsLine
www.kidsline.org.nz
KidsLine is New Zealand's only 24-hour helpline for New Zealand children (five to 18 years). KidsLine is part of the LifeLine family of services. Children and young people can ring any hour of the day on an 0800 number and talk to a trained counsellor about anything that might be worrying them. These counsellors are caring, understanding adults who will listen. Children can also talk on weekdays between 4-6pm to a Kidsline Buddy. KidsLine Buddies are specially trained year 12 and 13 students. Call free on 0800 KIDSLINE (0800 543 754) any time.

Lifeline
http://www.lifeline.org.nz/
(09) 5222 999 or 0800 543 354. Provides professional and confidential support and information through a 24/7 phone counselling service.

New Zealand Police
www.police.govt.nz/advice/family-violence/help
There are various ways you can report a crime. Always call 111 in an emergency. For non-emergencies you contact your local police station or you can report crimes anonymously to Crimestoppers, free phone 0800 555 111. See the New Zealand Police website for a list of local police contact details or to find out how to get help for family violence (domestic violence) and learn about Protection Orders and Police Safety Orders.

North Harbour Living Without Violence Inc.
http://www.livingwithoutviolence.org.nz
Education programmes for male perpetrators of violence; support and education programmes for women and children victims of violence and abuse; anger management. Contact (09) 489 3770 or email nhlwv@xtra.co.nz.

NZAC (New Zealand Association of Counsellors)
www.nzac.org.nz
The professional organisation for counsellors in New Zealand. NZAC offers ACC (Accident Compensation Corporation)-approved counsellors and, if the correct procedures are followed, costs are met by ACC. You can check whether a counsellor is a member of NZAC by asking the individual counsellor to show you their certificate, by emailing membership@nzac.org.nz (link sends e-mail) or by phoning 64 7 834 0220. Remember, if your child has been the victim of abuse, they should only see an approved counsellor who has experience in this area. Check with ACC for approved counsellors.

Open Home Foundation
www.ohf.org.nz
The Open Home Foundation of NZ has been helping families since 1977, providing social services for children, young people and their families throughout New Zealand. In each service centre they provide:
- home based social work
- parenting education
- foster care

Also available in some centers are mentoring, youth services, care and support for families who have a child with a disability and supervised access. You can get assistance from Open Home Foundation by phoning or visiting one of their service centres.

Parentline
www.parentline.org.nz
Parentline works with children who have been sexually, physically or emotionally abused or who are at risk of abuse. Their core business is to work with children who have been traumatised by abuse and domestic violence. At the same time, parents are encouraged to support the healing process of their children and often siblings will require the same level of support. They can be contacted on 64 7 839 4536 or parentline@parentline.org.nz.

Relationship Services
www.relationships.org.nz
Relationships Aotearoa is New Zealand's largest professional counselling and family therapy provider. They are a not-for-profit organisation delivering professional and affordable services which effectively meet the needs of the people they see. Each year they work with many thousands of people helping them make positive changes in their lives by dealing with issues such as: parenting, family conflict, rocky relationships, separation, domestic violence, trauma, anxiety, grief and loss, depression, and alcohol and substance abuse. Call them on 0800 735 283.

SAFE
www.safenetwork.org.nz
SAFE are a specialist treatment service working with adults and youth who have harmful sexual behaviour and with children who have problematic sexual behaviours, assisting them to learn to express themselves in healthier ways.
Looking for further information on how you might access help for you or someone you know? Visit: The Harbour www.theharbour.org.nz

Salvation Army
www.salvationarmy.org.nz
The Salvation Army helps people in need through a wide range of community programmes. These include food assistance, budgeting advice, life skills training, counselling, crisis and supportive accommodation, addiction services (drug, alcohol and problem gambling), chaplaincy support, employment training, chaplaincy, emergency services, and youth work.

Shakti New Zealand
www.shakti-international.org/shakti-nz/
Shakti New Zealand is a specialist provider of culturally competent support services for women, children and families of Asian, African and Middle Eastern origin. Their website has information on how they can help if you or someone you know in a situation of domestic violence. They encourage you to reach out to them if you are living a life of fear and violence or if you are unsure that you are affected by domestic violence. They offer a 24-hour national crisis call service, supporting ethnic women experiencing domestic violence. 0800SHAKTI (0800742584)

Shine

www.2shine.org.nz

Shine provides a range of services, including a comprehensive web site on family violence. Although the organisation is Auckland based, the information on the website is nationally relevant. The organisation provides a national helpline 0508 744 633. The helpline operates 9.00am -11:00pm every day.

Te Tai Awa o Te Ora

http://www.taiawa.org.nz

To provide culturally appropriate services to whānau incorporating key values of Tika, Pono and Aroha. All staff have qualifications in social work and/or counselling and offer a range of services, information and assistance to individuals, couples and whānau. These include * help and advocacy with budgeting and financial matters, social circumstances, e.g. housing, benefits. * the facilitation of programmes (Parenting, Stopping Violence, support for people with alcohol and other drug related issues * counselling for personal, relationship and whānau concerns. Call (09) 274 4220 or (027) 274 4220 or email admin@taiawa.co.nz.

Victim Support

www.victimsupport.org.nz

Victim Support provides 24-hour emotional support, personal advocacy and information to all people affected by crime and trauma throughout New Zealand. Call free on 0800 VICTIM (0800 842846).

Victims of Crime Information Line

www.victimsinfo.govt.nz

0800 650 654 provides information for people affected by crime about support services and the justice system. This free phone line is available from 9am – 6pm on normal working days. Outside of these hours there is continued support available as callers can connect to the line's partner agency Victim Support.

What's Up

www.whatsup.co.nz

What's Up is a free, national telephone counselling service for New Zealanders aged five to 18 years. The service operates seven days a week from noon to midnight. Paid, trained and closely supervised professional counsellors answer the telephones. What's Up aims to provide early help to children and teach them skills that will help prevent the development of major problems later in their lives. What's Up is provided by The Kid's Help Foundation Trust in association with Barnardos New Zealand. Call free on 0800 WHATSUP (0800 942 8787).

Women's Refuge

www.womensrefuge.org.nz

Women's Refuge is an independent community organisation, run by women, for women and children. It provides support and information when you are dealing with violence in your life. Support includes a 24-hour helpline, 24-hour access to a safe house, counselling, support with financial and legal matters, childcare programmes and information and education. Services are confidential and free. For crisis, support and advocacy please contact a local Women's Refuge. See the Women's Refuge website for:

- how to get help when you're dealing with violence in your life
- a practical guide for women wanting to be free from abuse
- safety plan - choosing to stay for now
- safety plan - leaving the relationship
- safety plan - after you've left
- Helpline: 0800 REFUGE (0800 733 843).

Young New Zealanders' Foundation

www.youngnz.org.nz

The Young New Zealanders' Foundation aims to create safer communities by supporting, educating and empowering young people in their families and in the wider community. The Foundation supplies a range of educational resources.

Youthlaw

www.youthlaw.co.nz

Youthlaw is a law agency set up just for young people. They have a huge range of brochures and booklets on most things that involve young people and the law. Give them a call if you need some legal advice, or want to know your rights in a particular situation. They are friendly and helpful and their information is free to young people. The website has a section about domestic violence and young people. Phone: 64 9 309 6967. If you are outside of Auckland, collect calls are accepted.

Youthline

www.youthline.co.nz

A free telephone counselling service. Need support or want to talk? Get in touch with this help line via phone, text, web or e-mail it is for everyone of all ages. Call free on 0800 376 633. Or free text 234. Email: talk@youthline.co.nz.

APPENDIX B: Documents for Internal Staff Focus Groups

B1: Interview Schedule for Internal Staff

B2: Participant Information Sheet for Internal Staff

B3: Consent Form for Internal Staff

A stepping stone in evaluating Puawaitahi,

New Zealand's first multi-agency service for child protection

Semi-Structured Focus Groups with Internal Staff

Topics for Discussion

1. Can you tell us how your service coordinates with other agencies within Puawaitahi?
   - Who are the key parties that are needed in the coordination process?
   - What are some of the systems for doing that?
   - How do clients needs influence coordination?

2. What services/professionals do you work with outside of Puawaitahi?
   - How does coordination work with these services/people?

3. What's working well for Puawaitahi with regards to collaboration?

4. What are some of the barriers to effective coordination?

5. What improvements would you like to see?

Puawaitahi has been in operation for over 10 years and there has been no formal evaluation of the multi-agency. Although there are many anecdotal reports of better service and staff coordination and client satisfaction, there has been no formal evaluation of whether this model of practice meets its goals and actually leads to an improvement in service delivery.

6. What would a full-scale evaluation need to involve for Puawaitahi?
   - Key stakeholders? – Internally and externally to Puawaitahi
   - What information would be needed to indicate how it is working?

PARTICIPANT INFORMATION SHEET
For internal staff

Project Title: A stepping stone in evaluating Puawaitahi, New Zealand's first multi-agency service for child protection.

The aims of this study are to investigate Puawaitahi's processes, evaluate these against their stated goals, and gather suggestions for improvements. Puawaitahi has been in operation for 10-years, and other multi-agency centres have also been established since, elsewhere in New Zealand. Although there are anecdotal reports of better service and staff coordination and client satisfaction, there has been no formal evaluation of whether this model of practice meets its goals and actually leads to an improvement in service delivery. Further the study aims to develop a proposal for a more comprehensive programme evaluation with the input of key stakeholders. This project was initiated by Patrick Kelly, who then supported Rachel Stevenson's successful application for a summer scholarship from the Child Injury Prevention Foundation of New Zealand. Rachel is a first year student in the Clinical Psychology Program at the University of Auckland.

YOU'RE INVITED TO PARTICIPATE IN THIS STUDY
You are invited to participate in this research. Taking part in this study is entirely voluntary and you are under no obligation or pressure to participate. However, in order to participate, you must meet the following selection criteria:
- Must be currently involved with Puawaitahi
- Have worked within Puawaitahi for greater than 6 months

WHAT DOES THE STUDY INVOLVE?
The research will involve confidential focus groups with staff that volunteer to participate. Focus groups will be conducted with staff members from the four agencies operating within Puawaitahi (*Te Puaruruhau,* the *Police Child Protection,* the *Central Auckland Video Unit* and the *Specialists Services Unit).* The focus groups will include talking about processes and coordination within Puawaitahi as well as discussing a future full-scale evaluation. Focus groups may take from one hour and a half to possibly two hours at the most. The interview will take place at Puawaitahi. The focus group will be set at a time that is most convenient for everyone involved. You can say as much or as little as you like. At any time during the focus group you do not have to answer any questions you do not want to. You also can decide to change your mind about participating and leave the focus group at any time, without any questions being asked. The focus group will be recorded with a digital voice recorder and then transcribed by the researcher or a professional transcriber who has signed a confidentiality contract. You can ask for the recorder to be turned off (and turned back on) at any time during the focus group. In order to ensure that staff feel entirely free to express their opinions on the way in which Puawaitahi operates, the senior management team of Puawaitahi will form a separate focus group.

WHAT WILL HAPPEN TO THE INFORMATION I SHARE?
All identifiable information that is provided by you, such as your name, will not be seen by anyone, for any reason, other than the researchers Rachel Stevenson, Dr. Patrick Kelly and Professor Fred Seymour. Dr Kelly will not listen to the audio recordings, or extracts from them, in order to ensure the anonymity of staff. Extracts from the information you provide may be quoted in the report for this research, and in possible publications or presentations about the research. This will always be done in a way which preserves your anonymity (no one will be able to identify you). This is done by assigning a number to your speech extracts,

and excluding any other possible identifiable information such as where you come from, your gender, and your age in the final report. A summary of the final research report will be available for you if you wish. Your interview data and consent forms will be stored securely and separately at The University of Auckland, and destroyed six years after the research is finished.

ARE THERE ANY RISKS INVOLVED?
No

WHO WILL BENEFIT FROM THIS STUDY?
The key benefits of this process evaluation of Puawaitahi will be: providing the agency with an insight into its current practice and procedures, recommendations for improvement and a proposal for a more comprehensive evaluation, informed in part by the ideas and wishes of staff members. It is intended that this will form the basis for a future application for research funding. This proposal will be dynamic – transferable to any multi-agency, not only Puawaitahi.
Thank you very much for taking the time to consider being involved in this research.

WHERE CAN I GET MORE INFORMATION ABOUT THIS STUDY?
If you have any questions or would like to discuss participation, please contact one of the researchers who will be conducting the focus groups/interviews.

Rachel Stevenson
0211 655 967
rste152@aucklanduni.ac.nz
The University of Auckland
School of Psychology
Private Bag 92019,
Auckland 1142

Professor Fred Seymour,
(09) 923-8414
f.seymour@auckland.ac.nz
University of Auckland
School of Psychology
Private Bag 92019
Auckland 1142

For any other queries you may contact
Dr Patrick Kelly, *Pediatrician*
(09) 307 2860
patrickk@adhb.govt.nz
Clinical Director,
Te Puaruruhau
Starship Children's Hospital
Private Bag 92024, Auckland

If you have any questions or complaints about the study you may contact:

Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by telephoning 09 4868920 ext 3204

OR

Health and Disability Ethics Committee on 0800 4 ETHICS (438 442) **or** hdecs@moh.govt.nz

CONSENT FORM
For internal staff
(This consent form will be stored for a period of 10 years)

Project: A stepping stone in evaluating Puawaitahi, New Zealand's first multi-agency service for child protection.

Profession: _____

Position: _____

I have read and I understand the Participant Information Sheet. I understand the study, and have had the opportunity to ask questions and had them answered to my satisfaction. I have had time to consider whether to take part. I understand that taking part in this study is voluntary.

I agree to take part in this research.

- I have been given, and have understood, the explanation of this research project. I have read the Participant Information Sheet and I have also had an opportunity to ask questions about this research and have them answered.
- I understand that my participation in this research is entirely voluntary.
- I understand that I will be taking part in a focus group evaluating the processes and coordination within Puawaitahi
- I understand that this focus group may take up to a maximum of two hours of my time.
- I understand that I may withdraw from the focus group at any point I choose, and that I am under no obligation to answer any particular questions that I may not want to.
- I agree that the focus group can be digitally recorded and transcribed by the researchers, and that this will be stored in a secure electronic location on a computer at The University of Auckland and/or a locked filing cabinet at The University of Auckland.
- I understand that I may ask for the digital recorder to be turned off (even just temporarily and then turned back on) at any time during the focus group.
- I agree that extracts from the information I provide may be quoted in the report which will be written about this research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.
- I agree that Dr. Patrick Kelly, Professor Fred Seymour and Rachel Stevenson may use the data from this research for up to 6 years, after which time it will be destroyed.
- I understand that I will receive a summary of the findings of this research should I wish to, and I must provide my contact details below so that I may receive this.

Participants Contact Details:

Email: _____

Name: _____

Date: _____

Signed: _____

APPENDIX C: Documents for External Referrers Interviews and Focus Groups

C1: Example Correspondence for Recruitment

C2: Interview Schedule for External Referrers

C3: Participant Information Sheet for External Referrers

C4: Consent Form for External Referrers

C1: Example Correspondence for Recruitment

Dear Dr. [Insert external referrers Name],

Puawaitahi is currently conducting an evaluation.

According to our records you have referred a client to Puawaitahi (Starship Paediatric Te Puaruruhau) within the past year and we have chosen YOU to take part in this evaluation.

We are talking to a number of different external referrers to the multiagency including Police, Child, Youth and Family staff, schools, General Practitioners, ADHB staff and mental health services.

We want to find out what YOU think of Puawaitahi. The evaluation looks at the experiences and perceptions external referrers have of the service and the referral process.

Interviews will be about 45-60 minutes long and at a time and place that suits you.

The information collected from the evaluation will make an important contribution in making recommendations to improve the experience and processes for future referrers like yourself and for parents and families who present to the service.

For more information please see the "Research Information Sheet.doc" attached.

If you have any questions or would like to take part in the evaluation, please contact Rachel Stevenson the University of Auckland researcher on, 021 446 114 or rste152@aucklanduni.ac.nz

Thank you for making the time to read about, and consider taking part in this study.

Kind regards,
Rachel Stevenson

Clinical Psychology Department
The University of Auckland,
Tamaki Campus
MOBILE: 021 446 114
EMAIL: rste152@aucklanduni.ac.nz

An evaluation of Puawaitahi New Zealand's first multiagency service for child protection

Semi-Structured Focus Groups and Interviews with External Referrers

Topics for Discussion

1. *Referrers contact with Puawaitahi* (e.g., How does your role bring you into contact with Puawaitahi? How many times have you used/referred to Puawaitahi? How often do you use Puawaitahi? What changes (if any) have there been to your work following the introduction of Puawaitahi in November 2002?).

2. *Knowledge of Puawaitahi.* (e.g., What do you know about Puawaitahi? How do you know this? What do you think are the main aims of Puawaitahi? Why do you think Puawaitahi was set up? What do you see as some of the benefits and challenges with the multi-agency model?)

3. *Making a referral.* (e.g., What is your process for making a referral to Puawaitahi? What has your experience been like when making a referral to Puawaitahi [responsiveness, delays, helpfulness, etc.)?, What happens If there is not agreement with other professional/agencies about the outcome of the referral?).

4. *Interpersonal working* (e.g., What challenges and benefits have you experienced when working with other professionals in the protection of children and young people from child abuse? Does the multi-agency model change the way you work with other professionals when protecting children?)

5. *Information sharing* (e.g., how do you share information with other professionals/agencies who are involved with child protection? What are the strengths and difficulties of this? Is there a difference in sharing the information with independent agencies versus Puawaitahi a multi-agency? How do you make decisions about what information to share/not share with other professionals/agencies? How do you feel about the way Puawaitahi records and responds to the information you have shared?)

6. *Children and families' feedback* (e.g., What feedback have you have received from families and young people about their interactions with Puawaitahi?)

7. *Improvements* (e.g., What are some of the improvements you would like to see at Puawaitahi?)

PARTICIPANT INFORMATION SHEET

For external referrers

Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.

Dear Referrer,

You are invited to take part in a programme evaluation of Puawaitahi. The evaluation looks at the experiences and perceptions external referrers have of the service. The results of this evaluation will make an important contribution in making recommendations to improve the experience and processes for future referrers like you and for parents and families who present to the service.

Taking part in this study is entirely voluntary and you are under no obligation or pressure to participate. However, in order to participate, you must meet the following selection criteria:

- You must have made at least one referral to Puawaitahi within the last 12 months
- You must be able to share your understanding and experiences about the multi-agency service

About the study
Puawaitahi has been in operation for 12 years, and other multi-agency services have been established in New Zealand over this period. Although there are anecdotal reports of better service, agency coordination and client satisfaction, there has been no formal evaluation of whether this model of practice meets its goals and actually leads to an improvement in service delivery.

The aims of this study are to investigate Puawaitahi's processes, evaluate these against their stated goals, and gather suggestions for improvements. For example, the topics that will be covered are, the challenges and benefits you see in the referral processes, any issues you have experienced in relation to working with other professionals, perceptions of information sharing, and your view on client's and families' experiences of passing through Puawaithai. In addition we are interested in your ideas about changes to the referral process and/or improvements to the service that you think would be useful for either yourself and/or others.

What will participation involve?
Focus groups will be about 1.5 hours long. We will conduct these at a time and place that suits you and your organisation. Each focus group will be audio recorded and the recordings will later be transcribed. You do not have to answer all the questions if you do not wish to.

At the conclusion of the study, a summary of the findings will be made available to you if you are interested. You can request this on your consent form.

Storage of information
Recordings, transcripts and any other information related to you will be kept in a locked filing cabinet for 10 years, and will then be securely destroyed.

Will information be confidential?
Yes. All identifiable information that is provided by you, such as your name, will not be seen by anyone, for any reason, other than the independent researchers (not Puawaitahi staff) who conduct the focus groups. All the information you provide and the focus group recording will remain confidential, and any information shared within the research team will be anonymous. In addition, a University approved transcriber will be

required to sign a confidentiality agreement. Parts of what you say may be quoted in research reports or presentations, however this will be done anonymously as no material that could personally identify you will be used in any reports of this study.

Are there any risks involved?
You will not be asked about any details to do with the children and/or families you have referred to Puawaitahi as this minimises the possibility of client information disclosures. Although if this was to occur the interviewer will make every effort to alert the professional to stop further disclosure and any details identifying the client and/or family will be cut from the interview recording and removed from the transcribed documents.

You will only be asked to talk about your experience of the referral process and your view of the family and/or young person's experience with Puawaitahi. However, you are welcome to leave the focus group at any time should you become upset in this process.

If you tell us about anything that makes us concerned about the safety of you, or anyone else, we would be obliged to report this to a relevant authority and/or service.

What are the benefits of participating?
We hope that this research will contribute to changes, which improve the experience of referrers, clients and families presenting to Puawaitahi, and that you will find participating to be a positive experience.

Thank you for making the time to read about, and consider taking part in this study.

If you have any questions or would like to discuss participation, please contact one of the researchers who will be conducting the focus groups/interviews.

Rachel Stevenson	**Professor Fred Seymour,**	For any other queries you may contact
0211 655 967	(09) 923-8414	**Dr Patrick Kelly**, *Pediatrician*
rste152@aucklanduni.ac.nz	f.seymour@auckland.ac.nz	(09) 307 2860
The University of Auckland	University of Auckland	patrickk@adhb.govt.nz
School of Psychology	School of Psychology	Clinical Director,
Private Bag 92019,	Private Bag 92019	Te Puaruruhau
Auckland 1142	Auckland 1142	Starship Children's Hospital
		Private Bag 92024, Auckland

If you have any questions or complaints about the study you may contact:

Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by telephoning 09 4868920 ext 3204

OR

Health and Disability Ethics Committee on 0800 4 ETHICS (438 442) **or** hdecs@moh.govt.nz

CONSENT FORM
For external referrers
(This consent form will be stored for a period of 10 years)

Project: An evaluation of Puawaitahi NZ's first multiagency service for child protection

Profession: _____

Position: _____

I have read and I understand the Participant Information Sheet. I understand the study, and have had the opportunity to ask questions and had them answered to my satisfaction. I have had time to consider whether to take part. I understand that taking part in this study is voluntary.

- **I agree to take part in this research.**
- I understand that I will be taking part in a focus group evaluating Puawaitahi.
- I understand that this focus group may take up to a maximum of one and a half hours of my time.
- I understand that I may leave the focus group at any point I choose, and that I am under no obligation to answer any particular questions that I may not want to.
- I agree that the focus group will be audio recorded. I understand that I can ask for the digital recorder to be turned off (even just temporarily and then turned back on) at any time during the focus group.
- I understand that a third party who has agreed to a confidentiality agreement will transcribe the audio recording the focus group.
- I understand that my participation in this study, any information about me and the audio recording is confidential and only participating researchers will have access to this information.
- I understand that any direct quotes used in the reports will be done so anonymously and that no material that could identify me will be used in any reports on this study.
- I understand that this consent form will be stored separately from my interview data in a locked filing cabinet for a period of 10 years and then destroyed.
- I understand that if I do accidently disclose any client information that any identifying information will be deleted from the audio recording and removed from the transcribed data.
- I wish/ do not wish to receive a summary of the findings [please cross out one option].

Participants Details:
Name: _____ (please print clearly)

Signed: _____ Date: _____

Contact details *(only required if you would like a summary of findings):*

Email or Postal Address: _____

Interviewers Details:
Name: _____ (please print clearly)

Signed: _____ Date: _____

APPENDIX D: Documents for Recruiting Children and Families

D1: Staff Instructions for Client Facing Clinicians

D2: Staff Instructions for Receptionists

D3: Staff Information Prompting Cue Cards

D4: Research Advertising Brochure

D5: Research Advertising Poster

D6: Permission to Contact

PUAWAITAHI EVALUATION
Recruitment Process Information for Staff Members

The Big Picture
The evaluation of Puawaitahi is made up from information obtained from interviews and focus groups with these three groups of people:
1. Internal Staff – Completed (Summer 2013/14)
2. External Referrers – In progress
3. Clients and family – We need your help to make this happen!!

Why do we need to talk to children and families?
• Important they have a voice and are valued
• "Straight from the horse's mouth"
• Puawaitahi staff expressed this population as being important to an evaluation of the multiagency.

Why we need your help?
• Families will be invited to participate in the research (an 'opt-in' method), rather than assume they will participate (an 'opt-out' method) – discomfort in 'opting-out'
• You are a familiar face at Puawaitahi and are providing the service or part of it
• It is important they are approached by someone they already know

What we would like you to do?
• Inform clients and families of the study as early as possible (preferably on their first visit)
• Provide the client and/or family with the Puawaitahi brochure which contains the research flier
• Direct them to the receptionist (sign out book) where they will be able to sign a form which gives the researchers permission to contact them about potentially participating in the research

What will the research require?
• Participants who have signed the "Permission to Contact" form will be contacted by the researchers 3 months after their initial visit to Puawaitahi.
• Researcher will organise a time and place that best suits the family for the interview.
• Individual interviews are 30 to 60 minutes in duration.
• Interviews will be recorded.
• Participants will be reimbursed for expenses such as travel and parking, via $30 petrol/ supermarket/ gift vouchers (participant's preference).

What we will be asking in the interviews?
• NOT asked about why they came to Puawaitahi
• We want to find out about the experiences they and/or their child had at Puawaitahi
• Their perceptions of the building, services and process
• What went well and what could be improved at Puawaitahi
• Their experiences after leaving Puawaitahi (e.g., possible follow-up contact, referral information and access to therapy if appropriate).

Common Questions and Answers

When will the researchers contact me?
Researchers 3-6 months after their initial visit will contact those families and clients who have given permission to be contacted.

Who will I be talking to?
Interviews will be conducted by properly trained and supervised psychologists at the University of Auckland an outside research team. Most of the interviews will be conducted by Rachel Stevenson. Interview questions and techniques will be adapted to suit the developmental level of the interviewee. Participants will be culturally matched with interviewers (where possible).

How old does the client have to be to participate?
Six years or older. Current research argues the lower age limit on the grounds of younger children's right to be heard.

Will my child be interviewed alone?
Children and primary carers will be interviewed separately where appropriate as this gives the children more opportunities to speak about their perceptions of the process without feeling the need to protect their primary carers in their statements and vice versa. Having said that, children will always have the option to have their primary carers or another support person if they wish.

Will my child or I be asked about the reason he/she came to Puawaitahi?
No, the alleged incident/s leading to you and/or your child coming to Puawaitahi will NOT be asked about. It will be explained to all potential participants (verbally and in writing), prior to their participation, that the researcher will be obliged to report any incidental disclosure of abuse that has not already been reported to a statutory organisation. This research will place the safety of the child as paramount and research issues of secondary importance.

Who will know if I participated in the study?
Only the outside researcher will know if you have decided to participate in the research. None of the staff at Puawaitahi will be informed of this.

Will my name and identity be protected?
All information will be anonymised by the use of a coding system, which will be applied to any quotes or commentary held by the researchers. The reports produced and published from this research will not contain any identify information.

Will my child's participation be voluntary?
Explanations of the research process will be done carefully with children, in language that they understand and no pressure will be placed on children to participate in the research. The formalities of consent forms will not be followed with children, relying instead on parental or guardian consent. However, verbal assent will be gained from the children involved before the interview.

Where and when will the interviews take place?
The interviews will take place at a time and location that best suits you. We can come to you (e.g. your home or work, etc.) or a neutral location can be organised (e.g. a meeting room at one of the Auckland University Campuses, etc).

PUAWAITAHI EVALUATION
Recruitment Process for Reception/ Administration Staff

The Big Picture

The evaluation of Puawaitahi is made up from information obtained from interviews and focus groups with these three groups of people:

1. Internal Staff – Completed (Summer 2013/14)
2. External Referrers – In progress
3. Clients and family – We need your help to make this happen!!

Why do we need to talk to children and families?

*   Important they have a voice and are valued
*   "Straight from the horse's mouth"
*   Puawaitahi staff expressed this population as being important to an evaluation of the multiagency.

Why we need your help?

*   Families will be invited to participate in the research (an 'opt-in' method), rather than assume they will participate (an 'opt-out' method) – discomfort in 'opting-out'
*   You are a familiar face at Puawaitahi and are providing the service or part of it
*   It is important they are approached by someone they already know
*   The reception is a single point of contact which all clients and families must sign in and out of the building and the best chance of catching the majority of clients.

What we would like you to do?

*   Inform clients and families of the study as early as possible (preferably on their first visit as they sign out at reception)
*   Provide the client and/or family with the appropriate "Participant Information Sheet" depending on the child (clients) age (i.e., 12 and under/ 13 and over).
*   If they would like to be contacted and potentially participate in the research provide them with the "Permission to Contact" form to sign

What will we do?

*   Weekly visits to refresh hand-outs and collect completed forms – **Thursday mornings**
*   We will be available to answer any questions you or participants might have
    *   Rachel Stevenson: 0211 655 967 or rste152@aucklanduni.ac.nz
    *   Fred Seymour: (09) 923 8414 or f.seymour@auckland.ac.nz

What will the research require?

*   Participants who have signed the "Permission to Contact" form will be contacted by the researchers 3 months after their initial visit to Puawaitahi.
*   Researcher will organise a time and place that best suits the family for the interview.
*   Individual interviews are 30 to 60 minutes in duration.
*   Interviews will be recorded.
*   Participants will be reimbursed for expenses such as travel and parking, via $30 petrol/supermarket/gift vouchers (participant's preference).

What we will be asking in the interviews?

*   NOT asked about why they came to Puawaitahi
*   We want to find out about the experiences they and/or their child had at Puawaitahi
*   Their perceptions of the building, services and process
*   What went well and what could be improved at Puawaitahi

- Their experiences after leaving Puawaitahi (e.g., possible follow-up contact, referral information and access to therapy if appropriate).

Common Questions and Answers

When will the researchers contact me?
Researchers 3-6 months after their initial visit will contact those families and clients who have given permission to be contacted.

Who will I be talking to?
Interviews will be conducted by properly trained and supervised psychologists at the University of Auckland an outside research team. Most of the interviews will be conducted by Rachel Stevenson. Interview questions and techniques will be adapted to suit the developmental level of the interviewee. Participants will be culturally matched with interviewers (where possible).

How old does the client have to be to participate?
Six years or older. Current research argues the lower age limit on the grounds of younger children's right to be heard.

Will my child be interviewed alone?
Children and primary carers will be interviewed separately where appropriate as this gives the children more opportunities to speak about their perceptions of the process without feeling the need to protect their primary carers in their statements and vice versa. Having said that, children will always have the option to have their primary carers or another support person if they wish.

Will my child or I be asked about the reason he/she came to Puawaitahi?
No, the alleged incident/s leading to you and/or your child coming to Puawaitahi will NOT be asked about. It will be explained to all potential participants (verbally and in writing), prior to their participation, that the researcher will be obliged to report any incidental disclosure of abuse that has not already been reported to a statutory organisation. This research will place the safety of the child as paramount and research issues of secondary importance.

Who will know if I participated in the study?
Only the outside researcher will know if you have decided to participate in the research. None of the staff at Puawaitahi will be informed of this.

Will my name and identity be protected?
All information will be anonymised by the use of a coding system, which will be applied to any quotes or commentary held by the researchers. The reports produced and published from this research will not contain any identify information.

Will my child's participation be voluntary?
Explanations of the research process will be done carefully with children, in language that they understand and no pressure will be placed on children to participate in the research. The formalities of consent forms will not be followed with children, relying instead on parental or guardian consent. However, verbal assent will be gained from the children involved before the interview.

Where and when will the interviews take place?
The interviews will take place at a time and location that best suits you. We can come to you (e.g. your home or work, etc.) or a neutral location can be organised (e.g. a meeting room at one of the Auckland University Campuses, etc).

Cue Card Front:

PUAWAITAHI EVALUATION
INTRODUCTION

The staff at Puawaitahi value what you and your family think of the service. Therefore, we routinely ask all children and their families if they would like to take part in an evaluation.

1. The researcher will <u>NOT</u> ask you about why you or your child came to Puawaitahi.
2. We would just like to know what has been helpful and what could be better.
3. If you would like to take part you can sign a **permission to contact form**. This does not mean you have to take part it just means that one of our research team will contact you three months after your initial visit to see if you would like to take part.

Cue Card Back:

PUAWAITAHI EVALUATION
THE FACTS

4. It is your choice if you want to take part.
5. Participants must be 6 or older.
6. Participants under 16y/o will need their parent or caregivers consent.
7. Interviews will be between 30 minutes (children) and 1 hour long (> 16 y/o).
8. Arranged at a time/ location that suits you.
9. University of Auckland psychologists will be conducting the interviews and staff at Puawaitahi will not have access to any information you provide the researchers.
10. All information you provide is confidential, your name and identity will be protected.
11. Each participant in the research will receive a $30 voucher and a certificate of participation to thank you for your time.

Brochure Front:

WHAT DO YOU THINK OF PUAWAITAHI?

We want to find out what you think of Puawaitahi.

We are talking to children, teenagers, parents and caregivers like you who have been to Puawaitahi.

We would like to talk with you about what you think has been helpful and what you think could be better.

By talking with you and others we can make improvements to Puawaitahi for the benefit of future children & families that go to the service.

If you want to out find more, please ask a staff member at Puawaitahi or contact *Rachel Stevenson* on:

0211 655 967
rste152@aucklanduni.ac.nz

Brochure Back:

COMMON QUESTIONS & ANSWERS

When will the researchers contact me?
3 months after your initial visit if you have signed the "Permission to Contact" form at reception.

Who will I be talking to?
Properly trained and supervised psychologists at the University of Auckland. Participants will be culturally matched with interviewers (where possible).

How old does my child have to be to participate?
Six years or older. Children have a right to be heard.

Will my child be interviewed alone?
Children will always have the option to have a support person of their choice if they wish.

Will my child or I be asked about the reason he/she came to Puawaitahi?
No, the alleged incident/s leading to you and/or your child coming to Puawaitahi will NOT be asked about.

Who will know if I participated in the study?
Only the Auckland University researchers will know if you have decided to participate in the research. Staff at Puawaitahi will not be informed.

Will my name and identity be protected?
Yes, all information will be anonymized.

Will my child's participation be voluntary?
Yes, no pressure will be placed on anyone to participate in the research.

Where and when will the interviews take place?
At a time and location that best suits you.

Will I receive something to acknowledge my participation and time?
Yes, a $30 voucher and a certificate of participation will be awarded to participants.

WHAT DO YOU THINK OF PUAWAITAHI?

Multi
Agency
One
Service

Puawaitahi

HAVE YOUR SAY!

We want to find out what YOU think of Puawaitahi.

We are talking to lots of children, teenagers, parents and caregivers like you who have been to Puawaitahi.

We would like to talk with you about what you think has been helpful and what you think could be better.

By talking with you and others we can make improvements to Puawaitahi for the benefit of future children & families that go to the service.

If you want to out find more,
please ask a Puawaitahi staff member, take a flier and/or contact one of the Auckland University researchers:
Rachel Stevenson: 021 165 5967 or rste152@aucklanduni.ac.nz
Fred Seymour: (09) 923 8414 or f.seymour@auckland.ac.nz

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

PERMISSION TO CONTACT FORM
For children and families

Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.

We want to find out what you think of Puawaitahi.

We are talking to children, teenagers, parents and caregivers like you who have been to Puawaitahi.

We would like to talk with you about what you think has been helpful and what you think could be better.

By talking with you and others we can make improvements to Puawaitahi for the benefit of future children & families that go to the service.

The research team would like your permission to contact you and/or your child 3 months after your first visit.

At that time, we will explain the research further and see whether you would like to take part. The interviews will take place at a time and place that suits you.

If you agree to be contacted now, you can still say "No" when they contact you.

If you are happy to be contacted please provide the following details:

Name:	
Home Phone:	
Mobile Phone:	
E-mail:	
Address:	
I prefer to be contacted by (please tick):	☐ Phone ☐ Email
I am (please tick):	☐ a child and client of Puawaitahi (aged 15 years or younger) ☐ a young person and client of Puawaitahi (aged 16 years or older) ☐ a parent or caregiver of a client at Puawaitahi

Signed: _____ Date: _____

Name: _____ (please print clearly)

APPENDIX E: Documents for Children and Family Interviews

E1: Interview Schedule for Clients

E2: Participant Information Sheet for Children 12-years and under

E3: Participant Information Sheet for Children 13-years and over

E4: Participant Information Sheet for Consenting Parents

E5: Participant Information Sheet for Parents and Caregivers

E6: Consent Form for Participants Aged 16 or Older

E7: Consenting Parents Form for Children 15-years and under

E8: Assent Form for Children 15-years and under

E9: Certificate of Participation

An evaluation of Puawaitahi New Zealand's first multiagency service for child protection

Semi-Structured Interviews with Clients

<u>Topics for Discussion</u>

1. *How the situation came about of referral to Puawaitahi:*
   - Who was the first professional you told?
   - How long after you told did you see that professional?
   - Who and how were you referred?

2. *Puawaitahi initial consultation*
   - What were your first impressions of the Puawaitahi building?
   - When you first met the staff at Puawaitahi what did you think?
   - Did the staff member tell you what would happen?
   - How did you feel after the first consultation at Puawaitahi?
   - What worked/ what didn't work?
   - Improvements that would make the process better?

3. S*pecific questions about each service*: Evidential Video Interview – Central Auckland Video Unit, medical examination – health team/ Te Puaruruhau, police – Child Protection Team, psychologists – CYF Specialist Services Unit.
   - What worked/ what didn't work?
   - Improvements that would make the process better?

4. *Outside referrals/recommendations after Puawaitahi*
   - Were there any referrals?
   - Recommendations made from professionals working at Puawaitahi for therapy or support services in the community? What were they?
   - What was the process in contacting those agencies (responsibility of professional or family)?
   - Have you had any contact from the social worker or case manager following up how the referral/recommendation is going?
   - Have you found the referral/recommendation to be beneficial?

5. *Whole process*
   - How many times did you have to tell professionals about all the details about what happened?
   - Who did you have to tell?
   - What do you think about how much time it has taken?
   - If you could improve anything at Puawaitahi what would it be?
   - If you had a message for other children and families going through it all what would it be?

PARTICIPANT INFORMATION SHEET
For Children (aged 12 and under)

Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.
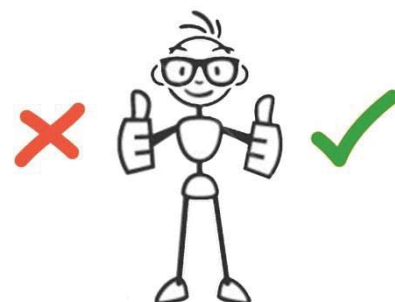
We want to help children like you by finding out what YOU think about Puawaitahi.

A member of our team would like to talk to you.

It is your choice if you want to talk to us.

If you want to talk to us, we will ask you:
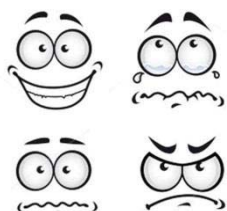
How you felt about going to Puawaitahi

What and who was helpful or supportive of you at Puawaitahi

Was there anything hard or worrying about coming to Puawaitahi

What you think would have made coming to Puawaitahi better for you

We will NOT ask you about why you came to Puawaitahi.

The interview will be about 30 minutes long and we will audio record our talk.
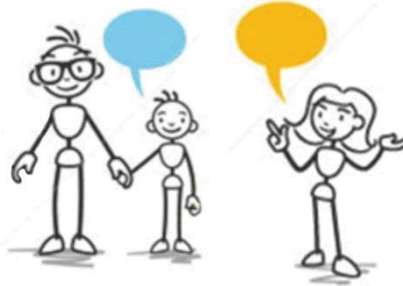
You can choose to have someone with you if you want.

You can stop the talk any time, or stop the recording. You can decide not to take part at any time, and you don't have to give a reason.

We will not use your real name in our report. Instead you can choose a made-up name.

If you told us anything that made us worry about your safety (or the safety of someone else), we would have to tell someone who could help.

You will be given a $30 voucher and certificate to thank you for talking with me today.

You can talk to an adult to help you understand the study more and think about it together.

If you have any questions or would like to discuss participation, please contact:

Rachel Stevenson
0211 655 967
rste152@aucklanduni.ac.nz
The University of Auckland
School of Psychology
Private Bag 92019,
Auckland 1142

Professor Fred Seymour,
(09) 923-8414
f.seymour@auckland.ac.nz
University of Auckland
School of Psychology
Private Bag 92019
Auckland 1142

For any other queries please contact
Dr Patrick Kelly, *Pediatrician*
(09) 307 2860
patrickk@adhb.govt.nz
Clinical Director,
Te Puaruruhau, Puawaitahi
Starship Children's Hospital
Private Bag 92024, Auckland

If you have any questions or complaints about the study you may contact:

Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by telephoning 09 4868920 ext 3204
OR
Health and Disability Ethics Committee
0800 4 ETHICS (438 442)
hdecs@moh.govt.nz
Ministry of Health, No 1 The Terrace, PO Box 5013, Wellington

PARTICIPANT INFORMATION SHEET
For adolescents (aged 13 and older)

Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.

We are currently carrying out an evaluation of Puawaitahi.

We want to help young people like yourself in the future by finding out what YOU think about Puawaitahi. A member of our team would like to talk to you.

In order to take part, you must:
- Have had contact with at least two services within Puawaitahi (e.g., Child Youth and Family Specialist Services, the health team and/or the Police).
- Have had at least 3 months pass by since your initial visit to Puawaitahi.

About the study
Puawaitahi has been going for 12 years. We know that going to a place like Puawaitahi can often be a good experience but sometimes can be upsetting and stressful. Lots of changes have been made, but there may be more things we can do better.

We want to understand your experience at Puwaitahi, and the experiences of your family.

We would like to know about:
- How you felt about going to Puawaitahi
- What and who was helpful or supportive of you
- What was difficult or stressful
- What would have made the experience better for you

What will taking part involve?
If you want to take part, it will involve talking with a researcher. You do not have to take part, it is your choice.

You may have friend or family/whānau support to help you understand this study. We are happy to explain the research and answer any questions you have. If you want to take part you need to sign a consent form. Your parent needs to sign a consent form too if you are under 16.

We will interview you at a time and place that suits you. It is up to you whether you want to be interviewed by yourself or whether you want to have a support person sit in on the interview.

Interviews will be about 1 hour long. They will be audio recorded. You can stop the interview or turn off the recording at any time and you do not have to answer all the questions.

You will be given a $30 voucher and certificate of participation acknowledging and thanking you for your participation.
If you would like to know what we found out from talking to you and other participants, we can send you a summary when we have finished. You can ask for this on your consent form.

Storage of information
Your recording and any other information will be kept in a locked filing cabinet for 10 years, and will then be destroyed.

Will information be confidential?
Yes. All the information you provide, including the interview recording will remain confidential and only the researchers will be able to see it. Parts of what you say in the interview may be quoted in research reports or presentations, however this will be done anonymously as we will make sure that there is nothing in any reports that could identify you. For example, we will use no names of people or places. If you do not wish to have your direct quotes used in the reports please let the person interviewing you know before the interview starts.

Right to Withdraw from Participation
You can decide not to be part of the project at any time without giving reasons, up until two weeks after the interview.

Will I find talking about the experience at Puawaitahi upsetting?
You will not be asked about why you came to Puawaitahi. You will only be asked to talk about your experiences at Puawaitahi. Usually people find these interviews to be a positive and helpful experience. However, in the unlikely event that talking about the experience is really upsetting for you, we can stop the interview. We will give you information and referrals to services that will be able to offer support to you if needed.

If you told us about anything that made us worried about your safety, or the safety of someone else, we would have to report this to the appropriate service. More specifically, if during your interview there is a case of incidental disclosure which has not been reported to the appropriate authorities, the researchers have an ethical responsibility to report this through the statutory notification process. The researchers will make every effort to complete this process with you.

What are the benefits of participating?
We hope that this research will help improve the experience of children and families involved in Puawaitahi, and you will find taking part is OK.

Cultural support
If you require Māori cultural support talk to your whānau in the first instance. Alternatively you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324

Thank you for making the time to read about, and consider taking part in this study.

If you have any questions about the evaluation or would like to discuss participation, please contact one of the researchers:

Rachel Stevenson	**Professor Fred Seymour,**	For any other queries please contact
Researcher	*Researcher*	**Dr Patrick Kelly**, *Pediatrician*
0211 655 967	(09) 923-8414	(09) 307 2860
rste152@aucklanduni.ac.nz	f.seymour@auckland.ac.nz	patrickk@adhb.govt.nz
The University of Auckland	University of Auckland	Clinical Director,
School of Psychology	School of Psychology	Te Puaruruhau, Puawaitahi
Private Bag 92019,	Private Bag 92019	Starship Children's Hospital
Auckland 1142	Auckland 1142	Private Bag 92024, Auckland

If you have any questions or complaints about the study you may contact:
Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by telephoning 09 4868920 ext 3204

OR

Health and Disability Ethics Committee
0800 4 ETHICS (438 442)
hdecs@moh.govt.nz
Ministry of Health
No 1 The Terrace
PO Box 5013
Wellington

PARTICIPANT INFORMATION SHEET

For parents or caregivers giving consent for participants' aged 16 and under

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Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.

Dear Parent or Caregiver,

Your child is invited to take part in an evaluation of Puawaitahi. We want to learn from the experiences that young people and their caregivers have of the service. This will lead to recommendations to improve the service provided to other children and families.

Taking part in this study is entirely voluntary (your choice). However, in order to for your child to take part, they must meet the following criteria:

- Your child must have had contact with at least two services within Puawaitahi (e.g., Child Youth and Family Specialist Services, the health team and/or the Police).
- It must be at least 3 months since your child's initial visit to Puawaitahi.

About the study

Puawaitahi has been in operation for 12 years, and similar services have been established since, in other parts of New Zealand. There has been no formal evaluation of whether this model of practice (three agencies in one building) works well for children and families.

The aims of this study are to investigate Puawaitahi's processes, evaluate these against their stated goals, and gather suggestions for improvements. This includes, challenges and benefits of the service offered at Puawaitahi, your child's experiences with staff and different services within the building, what the process was like and the care and support your child received afterwards. In addition we are interested in your child's ideas about changes to Puawaitahi's service that would have helped them or might help others.

What will participation involve?

Because your child has recently been involved with Puawaitahi they are invited to take part in this research by being interviewed. They do not have to take part in this study, it is your choice, and you may withdraw your child at any time up until two weeks after being interviewed.

You may have support from friends or family/whānau to help you understand this study. We are happy to discuss the research with you and answer any questions you have. If you agree to your child's participation, we will ask you to sign a consent form, your child will be asked to sign an assent form and/or give verbal consent (this will be recorded) and your child would be interviewed in person about their experiences at Puawaitahi.

We ask that children be given the opportunity to choose where they want the interview to take place, so caregivers may need to provide a room at home that allows your child to speak confidentially. Alternatively, a confidential meeting room can be arranged in a location close to your home. Your child will be offered the opportunity to have a support person present in the interview with them. However, we ask that if young people wish to be interviewed alone then parents respect this choice.

Interviews will be about an hour long and we will do these at a time and place to suit you. Each interview will be audio recorded and the recordings will later be transcribed. Your child may stop the interview or ask

to have the audio recorder switched off at any time and do not have to answer all the questions.

Your child will be given a $30 voucher and certificate of participation acknowledging and thanking them for their participation. At the conclusion of the study, a summary of the findings will be made available to you if you are interested. You can request this on your consent form.

Storage of information
Recordings, transcripts and any other information related to you will be kept in a locked filing cabinet at Puawaitahi for 10 years, and will then be securely destroyed.

Will information be confidential?
Yes. All the information you child provides, including the interview recording will remain confidential and only participating researchers will have access to it. In addition, a University approved transcriber will be required to sign a confidentiality agreement. Parts of what your child says in the interview may be quoted in research reports or presentations, however this will be done anonymously as no material that could personally identify your child will be used in any reports of this study. If you do not wish to have your child's direct quotes used in the reports please let the researcher know when signing the consent form.

Right to Withdraw from Participation
You are free to withdraw your child from the project at any time without giving reasons, up until two weeks after the interview. In this case please contact a member of the research team, and any documents related to your child would be shredded.

Will my child find talking about the experience at Puawaitahi upsetting?
Your child will not be asked about the alleged incident/s leading to you and/or your child coming to Puawaitahi. They will only be asked to talk about their experiences of the service they received at Puawaitahi (before, during and after discharge).

Usually people find these interviews to be a positive and helpful experience. However, in the unlikely event that talking about the experience is upsetting for your child, we will stop the interview. We will also offer information and referral to services that will be able to offer support if needed.

If your child told us about anything that made us concerned about the safety of your child, or anyone else, we would be obliged to report this to a relevant authority or service. More specifically, if during your child's interview there is an incidental disclosure which has not been reported to the appropriate authorities, the researchers have an ethical responsibility to report this through the statutory notification process. The researchers will make every effort to contact you, the parents and/or guardians to complete this process collaboratively.

What are the benefits of participating?
We hope that this research will contribute to changes, which improve the experience of children and families presenting to Puawaitahi, and that you child will find participating to be a positive experience.

Cultural support
If you require Māori cultural support talk to your whānau in the first instance. Alternatively you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324

Thank you for making the time to read about, and consider taking part in this study.

If you have any questions about the evaluation or would like to discuss participation, please contact one of the researchers:

Rachel Stevenson
Researcher
0211 655 967
rste152@aucklanduni.ac.nz
The University of Auckland
School of Psychology
Private Bag 92019,
Auckland 1142

Professor Fred Seymour,
Researcher
(09) 923-8414
f.seymour@auckland.ac.nz
University of Auckland
School of Psychology
Private Bag 92019
Auckland 1142

For any other queries please contact
Dr Patrick Kelly, *Pediatrician*
(09) 307 2860
patrickk@adhb.govt.nz
Clinical Director,
Te Puaruruhau, Puawaitahi
Starship Children's Hospital
Private Bag 92024, Auckland

If you have any questions or complaints about the study you may contact:
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OR

Health and Disability Ethics Committee
0800 4 ETHICS (438 442)
hdecs@moh.govt.nz
Ministry of Health
No 1 The Terrace
PO Box 5013
Wellington

PARTICIPANT INFORMATION SHEET

For parents and caregivers

> **Project Title: An evaluation of Puawaitahi New Zealand's first multiagency service for child protection.**

Dear Parent or Caregiver,

You are invited to take part in an evaluation of Puawaitahi. We want to learn from the experiences that young people and their caregivers have of the service. This will lead to recommendations to improve the service provided to other children and families.

Taking part in this study is entirely voluntary (your choice). However, in order to for you to take part, you must meet the following criteria:

- Your child must have had contact with at least two services within Puawaitahi (e.g., Child Youth and Family Specialist Services, the health team and/or the Police).
- It must be at least 3 months since your child's initial visit to Puawaitahi.

About the study

Puawaitahi has been in operation for 12 years, and similar services have been established since, in other parts of New Zealand. There has been no formal evaluation of whether this model of practice (three agencies in one building) works well for children and families.

The aims of this study are to investigate Puawaitahi's processes, evaluate these against their stated goals, and gather suggestions for improvements. This includes, challenges and benefits of the service offered at Puawaitahi, you and your child's experiences with staff and different services within the building, what the process was like and the care and support you and your child received afterwards. In addition we are interested in your ideas about changes to Puawaitahi's service that would have helped you or might help others.

What will participation involve?

Because your child has recently been involved with Puawaitahi you are invited to take part in this research by being interviewed. You do not have to take part in this study, it is your choice, and you may withdraw at any time up until two weeks after being interviewed.

You may have support from friends or family/whānau to help you understand this study. We are happy to discuss the research with you and answer any questions you have. If you agree to take part, we will ask you to sign a consent form and you will be interviewed in person about your experiences at Puawaitahi.

You can choose to be interviewed at home, or a confidential meeting room can be arranged in a location convenient for you. You will be offered the opportunity to have a support person present in the interview.

Interviews will be about an hour long and we will do these at a time and place to suit you. Each interview will be audio recorded and the recordings will later be transcribed. You may stop the interview or ask to have the audio recorder switched off at any time and do not have to answer all the questions.

You will be given a $30 voucher and certificate of participation acknowledging and thanking you for your participation.

At the conclusion of the study, a summary of the findings will be made available to you if you are interested. You can request this on your consent form.

Storage of information
Recordings, transcripts and any other information related to you will be kept in a locked filing cabinet for 10 years, and will then be securely destroyed.

Will information be confidential?
Yes. All the information you provide, including the interview recording will remain confidential and only participating researchers will have access to it. In addition, a University approved transcriber will be required to sign a confidentiality agreement. Parts of what you say in the interview may be quoted in research reports or presentations, however this will be done anonymously as no material that could personally identify you will be used in any reports of this study. If you do not wish to have your direct quotes used in the reports please let the person interviewing you know before the interview starts.

Right to Withdraw from Participation
You are free to withdraw from the project at any time without giving reasons, up until two weeks after the interview. In this case please contact a member of the research team, and any documents related to you would be shredded.

Will I find talking about the experience at Puawaitahi upsetting?
You will not be asked about the alleged incident/s leading to you and/or your child coming to Puawaitahi. You will only be asked to talk about your experiences of the services you or your child received at Puawaitahi (before, during and after discharge).

Usually people find these interviews to be a positive and helpful experience. However, in the unlikely event that talking about the experience is upsetting, we will stop the interview. We will also offer information and referral to services that will be able to offer support if needed.

If you told us anything that made us concerned about the safety of your child, or anyone else, we would be obliged to report this to a relevant authority or service. More specifically, if during your interview there is an incidental disclosure which has not been reported to the appropriate authorities, the researchers have an ethical responsibility to report this through the statutory notification process. The researchers will make every effort to contact you to complete this process collaboratively.

What are the benefits of participating?
We hope that this research will contribute to changes, which improve the experience of children and families presenting to Puawaitahi, and that you will find participating to be a positive experience.

Cultural support
If you require Māori cultural support talk to your whānau in the first instance. Alternatively you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324

Thank you for making the time to read about, and consider taking part in this study.

If you have any questions about the evaluation or would like to discuss participation, please contact one of the researchers:

Rachel Stevenson	**Professor Fred Seymour,**	For any other queries please contact
Researcher	*Researcher*	**Dr Patrick Kelly**, *Pediatrician*
0211 655 967	(09) 923-8414	(09) 307 2860
rste152@aucklanduni.ac.nz	f.seymour@auckland.ac.nz	patrickk@adhb.govt.nz
The University of Auckland	University of Auckland	Clinical Director,
School of Psychology	School of Psychology	Te Puaruruhau, Puawaitahi
Private Bag 92019,	Private Bag 92019	Starship Children's Hospital
Auckland 1142	Auckland 1142	Private Bag 92024, Auckland

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Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by telephoning 09 4868920 ext 3204

OR

Health and Disability Ethics Committee
0800 4 ETHICS (438 442)
hdecs@moh.govt.nz
Ministry of Health
No 1 The Terrace
PO Box 5013
Wellington

CONSENT FORM

For participants aged 16 or older

(This consent form will be stored for a period of 10 years)

Project: An evaluation of Puawaitahi NZ's first multiagency service for child protection

Participant Code: _____

I have read and I understand the Participant Information Sheet. I understand the study, and have had the opportunity to ask questions and had them answered to my satisfaction. I have had time to consider whether to take part. I understand that taking part is voluntary (my choice).

- **I agree to take part in this research.**
- I understand that this means the researchers will be provided with some health information from my/ my child's file.
- I understand that I am free to withdraw my information at any time up to two weeks after participation, without giving a reason.
- I agree that my interview will be audio recorded. I understand that I can stop the interview, or have the audio recorder turned off at any point.
- I understand that a third party who has agreed to a confidentiality agreement will transcribe the audio recording of my interview.
- I understand that my participation in this study, any information about me and the audio recording is confidential and only participating researchers will have access to this information.
- I understand that any direct quotes used in the reports will be done so anonymously and that no material that could identify me will be used in any reports on this study.
- I understand that this consent form will be stored separately from my interview data in a locked filing cabinet for a period of 10 years and then destroyed.
- I understand that if I disclose any issues related to the safety of others, or myself the researchers are obligated to report this to the relevant authorities or services.
- I understand that I will be offered a $30 voucher and certificate of participation as an acknowledgement of my time.
- I agree that I have told the interviewer if I do not wish for my direct quotes to be used in the reports.
- I wish/do not wish to receive a summary of the findings [please cross out one option].

Participants Details:

Name: _____ (please print clearly)

Signed: _____ Date: _____

Contact details *(only required if you would like a summary of findings):*

Email or Postal Address: _____

Interviewers Details:

Name: _____ (please print clearly)

Signed: _____ Date: _____

CONSENT FORM

For parents or caregivers of participants aged under 16 years
(This consent form will be stored for a period of 10 years)

Project: An evaluation of Puawaitahi NZ's first multiagency service for child protection

Participant Code: _____

I have read and understand the Participant Information Sheet. I understand the study, and have had the opportunity to ask questions and had them answered to my satisfaction. I have had time to consider whether I agree to my child taking part. I understand that my child taking part in this study is voluntary (our choice).

- **I agree for my child to take part in this research.**
- I understand that researchers will be provided with some health information from my child's file.
- I understand that I am and/or my child is free to withdraw my child's information at any time up to two weeks after participation without giving a reason.
- I agree that my child's interview will be audio recorded. I understand that my child can stop the interview, or have the audio recorder turned off at any point.
- I understand that a third party who has agreed to a confidentiality agreement will transcribe the audio recording of my interview.
- I understand that my child's participation in this study, any information about them and the audio recording is confidential and only participating researchers will have access to this information.
- I understand that any direct quotes used in the report will be done so anonymously and that no material that could identify my child will be used in any reports on this study.
- I understand that this consent form will be stored separately from my child's interview data in a locked filing cabinet for a period of 10 years and then destroyed.
- I understand that if my child discloses any issues related to the safety of my child or any other people, the researchers are obligated to report this to the relevant authorities or services.
- I understand that my child will be offered a $30 voucher and certificate of participation as an acknowledgement of their time.
- I agree that I have told the interviewer if I do not wish for my child's direct quotes to be used in the reports.
- I wish/ do not wish to receive a summary of the findings [please cross out one option].

Participants Details:

Name: _____ (please print clearly)

Signed: _____   Date: _____

Contact details *(only required if you would like a summary of findings):*

Email or Postal Address: _____

Interviewers Details:

Name: _____ (please print clearly)

Signed: _____   Date: _____

ASSENT FORM
For participants aged under 16
(This consent form will be stored for a period of 10 years)

Project: An evaluation of Puawaitahi NZ's first multiagency service for child protection

Participant Code: _____

An adult has helped me read and understand the Information Sheet. I know that the study is about helping children and young people like me by finding out what I think about Puawaitahi. I have had all of my questions answered and I have had time to choose if I want to take part. I know that taking part in this study is my choice. I know that an adult who cares for me has said I can take part. An adult has helped me understand this form if I wanted help.

- **I want to take part in this research.**
- I know that this means the researchers will get some information from my file.
- I know I can choose to have someone with me in the room if I want.
- I agree that our talk with be audio recorded.
- I know I can stop the talk any time, or stop the audio recording.
- I know I can decide not to answer a question at any time without saying why.
- I know that my name will not be used on any documents and the name I choose will be used instead.
- I know that if I talk about anything that makes the interviewer worry about the safety of me or someone else they would have to report it to the right professional/s.
- I *want/ do not want* to get a summary of what is found [circle the one you want].

Participants Details:

Name: _____   (please print clearly)

Signed: _____   Date: _____

Contact details *(only required if you would like a summary of findings)*:

Email or Postal Address: _____

Interviewers Details:

Name: _____   (please print clearly)

Signed: _____   Date: _____

Multi Agency One Service
Puawaitahi

Certificate of Participation

To acknowledge and thank

_____

for taking part in this evaluation. Your experiences were very valuable to us. We know you are very busy and we very much appreciate the time you spent talking with us.

_____ _____
Senior Research Team Member   Interviewer

_____
Date

APPENDIX F: Evidence of Ethics Approval

F1: Auckland District Health Board

F2: Ministry of Social Development

F3: New Zealand Police

Health and Disability Ethics Committees

Ministry of Health
Freyberg House
20 Aitken Street
PO Box 5013
Wellington
6011

0800 4 ETHICS
hdecs@moh.govt.nz

07 January 2015

Dr. Patrick Kelly
Puawaitahi
99 Grafton Road
Auckland 1010

Dear Dr. Kelly

Re:	**Ethics ref:**	**14/NTB/169**
	Study title:	An evaluation of Puawaitahi New Zealand's first multi-agency service for child protection

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.

Conditions of HDEC approval

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 _a 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.

After HDEC review

Please refer to the _Standard Operating Procedures for Health and Disability Ethics Committees_ (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Your next progress report is due by 07 January 2016.

Participant access to ACC

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).

Research and Evaluation Steering Committee response to proposal

Application date:	6/11/2014
Principal Researcher:	**Rachel Stevenson**
Project name:	Evaluation of Puawaitahi, New Zealand's first multi-agency service for child protection
File number:	EV-12-356
Supervisor:	Dr Fred Seymour
Associated organisation:	University of Auckland
Ethics committee approval:	Required
Resources requested:	1. Specific data about the study participants will be extracted by Police staff from Police records, and provided to the student researcher on a standardized data form. The amount of staff time required is estimated at 10 hours (20 minutes per participant) 2. Interviews (or focus groups) with Police officers who referred participants to Puawaitahi. The number of and length of interviews with officers has not been estimated.
Publication plans	Presentations at conferences; submission to *NZ Medical Journal.*
Police subject matter expert / sponsor	Detective Sergeant Neil Hilton, Auckland CIB Child Protection Team
Committee decision:	**Approved in principle**
Comments and provisos:	1. An estimate is needed of the number of Police officers required for interviews or focus groups as referrers.
	2. The proposal needs to clarify the questions that the evaluation aims to answer and how the proposed research will provide these answers.
	3. Detective Sergeant Neil Hilton should act as the subject matter expert and sponsor, while Rachel Stevenson is the principal researcher.
	4. Security clearance is approved for all research team members.
	5. A research agreement is signed by the research team before evaluation work can start.
Decision date:	11 December 2014.

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