Cross-Sector Information-Sharing in Youth Justice Residences

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Abstract

Within a context of increased emphasis on interagency information-sharing and collaboration, this qualitative research project aims to explore the expectations of Oranga Tamariki case leaders and youth forensic service (YFS) clinicians about cross-sector information-sharing in youth justice residences. Eight focus groups were conducted around Aotearoa New Zealand. Four focus groups were with case leaders from each youth justice residence. The remaining four focus groups were with YFS clinicians who provide mental health services into each residence. Participants were asked about their information-sharing expectations of their cross-sector partner, and factors that contribute to effective information-sharing practices.

The findings showed positive cross-sector relationships, despite a lack of policy around information-sharing in this context. Themes from case leaders included the practicalities of the residential environment, and case leaders' brokerage role between competing frameworks in residence. Themes from YFS clinicians included the importance of cross-sector information-sharing for the assessment and discharge phases of mental health input. Overall themes from all eight focus groups included the impact of relationships on information-sharing, and the importance of including residential care team staff within information-sharing practices.

A model of information-sharing in youth justice residence is proposed, based on the feedback from research participants. Conclusions of the research include a number of practice recommendations to improve information-sharing, and suggestions for future research.

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Glossary

CAMHS

Child and adolescent mental health teams that provide mental health services to young people in the community under the age of 18 years.

Care team

A group of youth workers who work rotating shifts in a unit of a youth justice residence. Care teams spend their shift with the young people in the unit. Care team members do not need formal qualifications.

Case leader

Case leaders provide case oversight for a number of young people within a youth justice residence. They liaise with the professionals involved with a young person. They are part of the clinical team in residence.

Cross-sector partner

Within each region there is one youth justice residence and one youth forensic team. Those residence teams and YFS teams from the same region are cross-sector partners.

Kai

Māori term for food.

Karakia

Māori incantations or prayers used to start and begin meetings.

MAT

Multi-agency team (MAT) meetings are held at youth justice residences. They involve residential case leaders, youth forensic clinicians, and other professionals such as those from health and education services. MAT meetings encourage information-sharing and are mandated through an Approved Information Sharing Agreement.

Mihimihi

Māori form of greeting.

Oranga Tamariki

Oranga Tamariki – Ministry for Children is the statutory child protection and youth justice agency in Aotearoa New Zealand. It has recently gone through a name change, and was previously known as Child Youth and Family.

Pepeha

Māori process of reciting geneaology and geographical roots.

Remand

A young person may be remanded to a youth justice residence. This can occur at an early stage of their Youth Court process, when it is deemed that there is no safe community placement available, and the young person is considered to be at risk of re-offending. When remanded, a young person will not necessarily have a clear discharge date from residence.

Residence

Youth justice residences provide residential services for young people whose offending poses a risk to themselves or others. There are four youth justice residences in Aotearoa New Zealand, which are managed by Oranga Tamariki. Korowai Manaaki in Auckland, Te Maioha o Parekarangi in Rotorua, Te Au rere a te Tonga in Palmerston North, and Te Puna Wai ō Tuhinapo in Christchurch.

Section 333

Section 333 reports are psychological or psychiatric court reports about young people. They are ordered under section 333 of the Oranga Tamariki Act 1989. These reports can only be ordered by a Youth Court Judge, and remain the property of the Youth Court. Judges usually release these reports to a select number of professionals working with a young person, which may include Police, Oranga Tamariki and a young person's lawyer. These reports are written by youth forensic staff, or are completed by psychologists or psychiatrists in private practice. Reports may include, but are not limited to: comprehensive family background, mental health history and current presentation, risk issues including risk of re-offending, cognitive assessment, formulation of issues, and recommendations for a young person's care.

TWB

Towards Wellbeing (TWB) is the suicide monitoring service provided by Clinical Advisory Services Aotearoa, an external provider who consults with Oranga Tamariki staff about suicide risk assessment and safety planning for young people.

Whakawhānaungatanga

A Māori process of identifying interconnectedness in relationships.

Whānau

The Māori term for family, including extended family and kinship groups.

YFS

Youth forensic services (YFS) provide mental health assessment and intervention for young people in the youth justice system. One aspect of this role is the provision of mental health services within each youth justice residence. Other tasks include consultation and liaison within each Youth Court, and provision of formal and informal mental health assessments for young people before the Youth Court.

Chapter One
INTRODUCTION

This research project explores professionals' expectations of cross-sector information-sharing in youth justice residences. In particular, the two sectors explored are Oranga Tamariki - Ministry for Children (referred to as Oranga Tamariki) and youth forensic services (YFS). These two sectors share information with each other about the mental health needs of young people in youth justice residences. The research questions are:

> *What are the expectations of Oranga Tamariki case leaders about the function, form and content of information-sharing with YFS?*
>
> *What are the expectations of YFS about the function, form and content of information-sharing with Oranga Tamariki case leaders?*
>
> *What factors contribute to effective information-sharing in youth justice residences?*
>
> *What is a model of information-sharing in youth justice residence that meets the needs of both sectors?*

Thesis structure

This first chapter provides an introduction to the context of this research project, looking at the youth justice population, their mental health needs, the establishment of youth justice residences, youth forensic services, and the legislative framework that allows information-sharing in this context. Following this introductory chapter, there is an exploration of the literature regarding cross-sector information-sharing generally, and the workplace factors impacting on information-sharing in this specific context, as well as factors that impact on collaborative practice. The third chapter has a description of the methodology of this research project, providing a rationale for the participant selection and the procedural process of focus groups and the accompanying analysis. There is also a thorough examination of the ethical issues involved in this particular research project, especially in my role as a practitioner researcher. The fourth chapter provides a summary of the findings of the research, with themes identified from Oranga Tamariki focus groups, YFS focus groups, and overall themes from all focus groups. The fifth chapter contrasts the research findings with the relevant literature, and includes the limitations of this research project, along with scope for further research.

The sixth and final chapter answers the research questions, with a proposed model of information-sharing in youth justice residence. The chapter also contains practice recommendations for both Oranga Tamariki and YFS teams, and concluding remarks.

Language

In researching this area, there have been a number of decisions to make about the use of language. In writing about this country, 'Aotearoa New Zealand' has been used. As a social worker who is committed to upholding the principles of the Treaty of Waitangi, I have chosen to use the bicultural name for my country.

During the course of this research, Oranga Tamariki - Ministry for Children was established. At the time of writing, the Ministry was still in its infancy, with a number of different names used in the public sphere (including OT-MC, CYF, MCOT and MVCOT). The most common name used in social work practice is Oranga Tamariki, and so is the name I have chosen to use. When discussing research conducted before the establishment of the new Ministry, the organisation is referred to as Child Youth and Family (CYF).

Additionally, each youth forensic team has a different name. In order to preserve confidentiality, and to have one shared name, I have used the term 'youth forensic service' (YFS) when discussing these teams.

Finally, after much deliberation, I have used the term 'youth offender' to describe those young people who are before the Youth Court, including those who end up in a youth justice residence. It is acknowledged that there may be a negative impact from labelling a young person as a young offender. However, as this is the term commonly used in the literature, it has been adopted in this thesis.

Research context

In recent years there has been a movement in Aotearoa New Zealand, and internationally towards increased cross-sector information-sharing and improved interagency collaboration, with recognition of the benefits of information-sharing in order to protect vulnerable children. This has occurred alongside the change from Child Youth and Family (CYF) to the newly established Ministry, Oranga Tamariki, with a child-centred operating model (The Modernising Child, Youth and Family Panel,

2016). There are a range of policy documents that call for greater cross-sector information-sharing and cooperation for young offenders (Ministry of Health, 2011; The Werry Centre, 2009).

There are high rates of mental health issues among young offenders, particularly those who end up remanded or sentenced to a secure youth justice residence (McArdle & Lambie, 2018). Young offenders in residence often have high and complex needs, which necessitates a collaborative approach by agencies. Cross-sector cooperation is particularly important in youth justice residences, where young people are in the care of Oranga Tamariki while YFS teams, external to Oranga Tamariki, provide mental health services in the residence. YFS teams have developed their practice in localised ways, with few national guidelines about mental health service provision in residences. Despite the call for close information-sharing, there has been no model of what this should look like in practice between Oranga Tamariki and YFS.

Effective cross-sector communication is difficult to achieve in any context (Shepherd & Meehan, 2012). Having clear expectations of roles and responsibilities is important to enhance cross-sector information-sharing. The aim of this research is to explore the views of both Oranga Tamariki and YFS about effective information-sharing, to find out what information is most sought by each team, what information is most helpful for shared care, and ideas for improved communication and treatment, through alignment of expectations. It is hoped that improved collaboration and information-sharing will lead to better mental health service provision and outcomes for these young people.

I currently work in a YFS team, providing mental health services to the Auckland youth justice residence. My experience has included noting a degree of confusion among professionals about the extent to which information can be shared, observing different practices across individuals and services, and my own curiosity about what particular information is most useful across sectors. The aim of this research is for effective information-sharing to be better understood and utilised, in order to best serve the youth justice population.

Profile of youth justice population

Youth justice residences are filled with the country's most serious and persistent young offenders. Overall, this group of young people has a number of distinguishing features, including over representation of Māori males, and high levels of social deprivation, substance issues, and learning problems.

Current trends

Aotearoa New Zealand's previous Principal Youth Court Judge has claimed that there is a small group of youth offenders who are committing most of the crime (Becroft, 2009). This group is overwhelmingly male, and half of the group are Māori. Judge Becroft (2009) notes that 70-80% of these young people have substance abuse problems, and most are not attending school. The young people who are before the Youth Court most frequently have a long history of abuse, neglect and poverty (Becroft, 2009).

The current Principal Youth Court Judge has also spoken about current trends in youth justice, noting that many of those before the Youth Court have a history of care and protection concerns, and that 80% have been exposed to family violence (Walker, 2017). He explained what is currently being seen in the Youth Court:

> *In summary: increasing violent offending, particularly in area of high population density and high levels of deprivation, increase in young girls offending violently, increased identification of neuro disability, mental illness, dislocation from school, disconnection with culture, the effects of traumatic brain injury, the effects of the trauma of sexual abuse and being brought up in a climate of family violence, alcohol and other drug dependency. Often a young person will be affected by more than one of these serious issues.* (Walker, 2017, p. 2)

Recently there has been a focus from Oranga Tamariki on trauma-informed care for young people in youth justice residences, in recognition of the high levels of trauma experienced by this population (Lambie, Krynen & Best, 2016). The recently published discussion paper on preventing youth offending in Aotearoa New Zealand identified that most young offenders have been victims themselves, with high rates of experiences of abuse, neglect and violence (Office of the Prime Minister's Chief Science Advisor, 2018). That report also identified that victimisation is often intergenerational, with cumulative effects that are often most apparent in adolescence.

The most recent official statistics show that the number of young people charged in court has increased. Between 2015 and 2016, there was a 9% increase in the number of Māori young people charged, and Māori comprise 64% of all youth in court (Ministry of Justice, 2017). Of the 260 young people who were placed in a secure youth justice residence in the year ended September 2016, 193 were Māori, and 209 were male (Ministry of Social Development, 2016).

Over representation of Māori in youth justice

Māori are over-represented at every stage of the criminal justice process. The rate of imprisonment of Māori adults is six times higher than the national average (Department of Corrections, 2007). Māori are also over-represented in the youth justice population. In 2016, Māori made up 71% of the total admissions to youth justice residences in Aotearoa New Zealand (Ministry of Social Development, 2016).

The Department of Corrections (2007) explored reasons for this over-representation across the life continuum, and discussed two explanatory models. The first is in regards to bias that operates within the justice system. Maxwell, Robertson, Kingi, Morris and Cunningham (2004) conducted a study on youth justice processes, and found that Māori were more likely to end up in Youth Court for less serious offences than European youth. They argued that this may be due to public perception of Māori youth, and greater public vigilance for reporting of offences, followed by increased police vigilance. This was acknowledged by Morrison (2009), who examined bias in the criminal justice system, particularly at moments of discretion such as Police decisions to stop, search, arrest and charge people, and court decisions related to prosecution, legal representation, bail, plea, mode of trial, pre-sentence reports, conviction and sentencing. At these points of discretion, decisions are likely to be more punitive for Māori than non-Māori. This bias explanatory model suggests that there is an accumulation of Māori individuals within the criminal justice system due to institutional bias.

The second compatible explanation is that Māori experience greater socioeconomic disadvantage, which places them at risk of offending behaviour (Department of Corrections, 2007). Māori disproportionately live in the more deprived areas of Aotearoa New Zealand and the consequent lack of resources has given rise to significant social consequences for Māori (White, Gunston, Salmond, Atkinson, & Crampton, 2008). The Department of Corrections (2007) report looked at the impacts of family dysfunction, exposure to violence, educational non-engagement, developmental disorders, and substance use, in which Māori are at greater risk, and which are also identified risk factors for future offending. They referred to the Christchurch longitudinal study by Fergusson and Horwood (2002), which found that ethnic differences in violent behaviour were not stastically significant when family and developmental factors were accounted for. The same longitudinal research was used to explore the role of Māori cultural identity in predicting future offending (Marie, Fergusson & Boden, 2009). The researchers found, after controlling for socioeconomic status and family functioning, that Māori cultural identity can be a protective factor against adversity and offending. They suggested that ethnicity itself is not a risk factor for offending behaviour, but that the socioeconomic factors are most predictive of offending.

Risk factors for offending

There are a number of risk factors for offending that have been identified in the literature, and are evident in the residences. Childhood conduct issues are predictive of offending behaviour in adolescence (Fergusson, Horwood & Lynskey, 1994; Fergusson, Horwood & Ridder, 2005; Fonagy, Target, Cottrell, Phillips & Kurtz, 2000; Hemphill et al., 2009; White, Moffitt, Earls, Robins & Silva, 1990). Farrington and West (1993) studied young British boys with Conduct Disorder, and found that 6% of these boys went on to become responsible for half of all convictions incurred by the general population by the age of 32.

Lower general intelligence is another risk factor for offending behaviour (Fergusson & Horwood, 1995, Fishbein, Miller, Winn & Dakof, 2009). Lower intelligence has a greater link to offending and recidivism in boys, while language deficits are correlated with female youth offenders (Fishbein et al., 2009).

Impulsivity can lead to offending through poor decision making, sensation-seeking, and lack of consequential thinking (Farrington, Loeber & Ttofi, as cited in Welsh & Farrington, 2012). Impulsivity can also be a symptom of a neurodevelopmental disorder, such as Attention-Deficit Hyperactivity Disorder or Foetal Alcohol Spectrum Disorder, both of which are over-represented among the youth justice population (Becroft, 2009).

Social deprivation, including poverty, exposure to violence, parental unemployment, parental incarceration, abuse and neglect, is a major risk factor for offending (Department of Corrections, 2007; Fergusson et al., 1994; Marie, Fergusson & Boden, 2009; Swanston et al., 2003; White et al., 1990). Young offenders are four times more likely to have had four or more adverse childhood experiences, and 13 times less likely to have faced no adverse experiences, compared to the general population (Baglivio et al., 2014). Bielas et al. (2016) examined the link between adverse childhood experiences, irritability, and mental health disorders among detained male youth offenders in Switzerland. They found that an increased number of adverse experiences increased the risk of mental health difficulties.

Youth justice residences

Youth justice residences provide residential services for young people whose offending poses a risk to themselves or others (Ministry of Social Development, 2017). There are four youth justice residences in Aotearoa New Zealand, which are managed by Oranga Tamariki (Ministry for

Vulnerable Children Oranga Tamariki, 2017). Korowai Manaaki in Auckland, has 40 beds, Te Maioha o Parekarangi in Rotorua has 30 beds, Te Au rere a te Tonga in Palmerston North has 30 beds, and Te Puna Wai ō Tuhinapo in Christchurch has 40 beds (Lambie, Krynen & Best, 2016). All four youth justice residences were built to a standardised custom design during the 1990-2000s. They are each surrounded by eight metre wire fences, and look like adult prisons from the outside (The Modernising Child, Youth and Family Panel, 2016).

Each residence comprises a number of units, each of which has its own common dining area, lounge and classroom. During the day the young people attend school classes and participate in structured programmes. From 8pm to 6am they are confined to their bedrooms, plain concrete rooms that can only be opened from the inside, except by key (Office of the Children's Commissioner, 2017).

Each young person has a case leader assigned to them. The case leader is part of the clinical team, is usually a qualified social worker, and is responsible for assessing the young people's needs and developing a care plan for each young person (Office of the Children's Commissioner, 2017). Each case leader may have young people on their caseload from different units within the residence.

Residential youth workers are members of the care team, and are on the floor all day with young people. A formal qualification is not essential to be a youth worker. Youth workers work in care teams with three rotating shifts in each unit (Oranga Tamariki, 2018).

Approximately 20-30% of young people in youth justice residences are on Supervision with Residence orders. This is a Youth Court sentence that a young person must remain in a youth justice residence for up to six months. The majority of young people, 70-80%, are remanded to a youth justice residence, awaiting their sentence. Only 25% of those who are remanded to a residence will receive a sentence of Supervision with Residence (Lambie et al., 2016). In practice, this means that many of the young people in secure residences are on remand, and do not have a fixed time they will remain in residence.

Expert Advisory Panel

Following a Government announcement that there would be major state care reforms and an overhaul of child welfare services in Aotearoa New Zealand, the Expert Advisory Panel released a report in December 2016 with a vision for a new Ministry, now known as Oranga Tamariki. The Expert Advisory Panel consisted of five people, with roles in governance, policing, strategy and influence, child advocacy, and psychological research (Tolley, 2015). There were no social workers

on the panel. A range of reforms were announced, including a child-centred operating model with a preventative focus, early intervention and direct purchasing of health, and education and counselling services to follow the child (The Modernising Child, Youth and Family Panel, 2016).

The panel highlighted the potential dangers in residences, where large groups of behaviourally challenged young people are separated from their communities and placed together (The Modernising Child, Youth and Family Panel, 2016). It was noted that young people learn maladaptive and aggressive behaviour from each other, and that the residential environment is not conducive to rehabilitation. The report recommended that all care and protection secure residences be closed, transitioning to family home-based placements. In regards to youth justice residences, it was recommended that far fewer young people be placed in a residence. Those young people who do go to a youth justice residence should be there as a last resort, with the highest end of offending, and should receive therapeutic care while in residence. Those placed in youth justice residences are to be considered vulnerable young people, and should have a positive and therapeutic experience in residence. There was a focus on providing both health and mental health care, and also evidence-based treatment to address criminogenic needs in order to reduce re-offending. This was based on the reports from the inter-agency Advisory Group on Conduct Problems (2009).

It was proposed that there be a stronger partnership between CYF, health and education, with a multi-disciplinary operating model for the youth justice residences. The report also recommended that CYF staff in general should have more specialist skills, and that there be increased access to clinical psychologists, youth workers, psychotherapists and counsellors for all young people involved with CYF. A new practice framework would be trauma-informed, focused on building resilience, attachment and child development, while also addressing criminogenic needs and drivers of offending. The youth justice residence function would include transition planning, and brokering and directly purchasing supports and services (The Modernising Child, Youth and Family Panel, 2016).

Office of the Children's Commissioner State of Care report

In 2017, the Office of the Children's Commissioner interviewed 44 young people in secure residences, and surveyed 43 young people as part of a review of the secure residences (Office of the Children's Commissioner, 2017). Feedback from the young people was that many were initially scared when entering the residences. They struggled with the structure and routine of the residence, and particularly the strict 8pm bed time. However, they also felt supported by some staff, and most of them settled into the routine.

Overall, it was noted that there was no systemic abuse, but there was room for improvement in the residences. In particular, there were concerns about regular bullying among young people, and a preference from young people not to use the complaints processes, a lack of understanding by staff of child-centred practice, young people with different needs being mixed together in residences, lack of staff therapeutic skills and knowledge, insufficient staff, and inadequate transition processes from residences to the community.

The review showed that none of the youth justice residences had adopted any form of therapeutic model of care. It was recommended that CYF provide national guidance to residences about a best practice therapeutic model. Trauma-informed practice was recommended, with a recognition of the effects of trauma on child development, attachment and mental health (Office of the Children's Commissioner, 2017).

Mental health needs of young offenders

Many young offenders who are placed within a youth justice residence have distinct mental health needs. In exploring the mental health needs of young offenders, there is an overview of the mental health needs of the general adolescent population in Aotearoa New Zealand, and Māori and Pacific mental health rates. International prevalence rates for young offenders are canvassed, followed by the limited data about prevalence rates for this population in Aotearoa New Zealand.

Mental health needs of Aotearoa New Zealand youth

Aotearoa New Zealand youth have high rates of mental health issues, particularly depression, anxiety, substance use and suicide (Adolescent Health Research Group, 2008; Feehan, McGee, Nada Raja & Williams 1994; Fergusson & Horwood, 2001; Fergusson et al., 2003; McGee et al., 1990; Mental Health Commission, 2012). Suicide rates for Aotearoa New Zealand youth are the highest in the developed world (United Nation's Children Fund, 2017). The rate of 15.6 suicides per 100,000 young people is twice as high as the United States rate and almost five times that of Britain.

Appleby and Phillips (2013) have argued that Aotearoa New Zealand child and adolescent mental health services (CAMHS) need to be creative and innovative in order to respond to the mental health needs in Aotearoa New Zealand, and enhance the engagement of young people in CAMHS. They have identified a number of barriers that prevent vulnerable young people from accessing mental health services, including psychological, cultural and practical barriers.

Assertive outreach approaches, which are still in their infancy in Aotearoa New Zealand CAMHS, have a growing literature base (French, Reardon & Smith, 2003; Naylor, Lincoln & Goddard, 2008; Ryall et al., 2008; Schley, Radovini, Halperin & Fletcher, 2011; Schley, Yuen, Fletcher & Radovini, 2012). In their discussion of a model of intensive outreach for vulnerable youth with mental health issues, Schley et al. (2011) reported that an intensive outreach approach is not dependent upon clients maintain attendance at clinic-based appointments. Their outreach team in Melbourne provides services in the community, including at the client's home, school or other public spaces. The ideal caseload is 8-9 young people per clinician, which is much lower than the typical CAMHS caseload (Schley et al., 2011). The theoretical framework of the approach is underpinned by developmental, trauma, attachment, and family systems theories, along with relationship management and collaboration (Ryall et al., 2008).

Māori mental health

The Christchurch Health and Development Study found that young Māori were twice as likely to experience a mental health disorder compared to young non-Māori (Fergusson et al., 2003). Both the Youth2000 study and its follow-up studies in 2007 and 2012 found that Māori school students were much more likely than non-Māori to report symptoms of depression, have thoughts about suicide, attempted suicide, and have higher use of both alcohol and cannabis (Adolescent Health Research Group, 2003; 2008; Fleming, et al. 2013).

Te Rau Hinengaro completed the first population survey of mental health issues amongst Māori (Oakley Brown, Wells & Scott, 2006). Their research was for Māori from age 16 upwards, and did not look specifically at youth. The findings confirmed that Māori rates of mental health issues are comparatively high, with high rates of comorbidity, and higher severity of mental health issues.

Simpson, Brinded, Fairley, Laidlaw and Malcolm (2003) explored the prevalence of psychiatric disorders in Aotearoa New Zealand adult prisons, and the role of ethnicity in mental health needs. Their research confirmed that there are high rates of mental health issues for both Māori and non-Māori in prison, with 90% of participants meeting criteria for a mental disorder. However, they found that Māori are less likely to have received mental health treatment.

Pacific mental health

In 2016, Pacific youth made up 10% of all youth justice residence admissions in Aotearoa New Zealand (Ministry of Social Development, 2016). Pacific students in Aotearoa New Zealand are more likely to report depressive symptoms, suicidal ideation, and have attempted suicide than non-

Pacific (Mila-Schaaf, Robinson, Schaaf, Denny & Watson, 2008). A recently published study of Pacific suicide rates over the last 17 years found that Pacific youth are three times more likely to attempt suicide than European youth (Tiatia-Seath, Lay-Yee & Randow, 2017). Pacific people experience structural and cultural barriers to accessing mental health services, despite experiencing higher rates of mental health issues than the general Aotearoa New Zealand population (Foliaki, Kokaua, Schaaf & Tukuitonga, as cited in Oakley Browne, Wells & Scott 2006; Tiatia, 2008).

International mental health prevalence rates for young offenders

The general youth population is estimated to have a 20-30% prevalence rate of mental health issues (The Werry Centre, 2009), however, international research repeatedly reports prevalence rates of mental health issues among young offenders at between 40% and 60% (Grisso & Barnum, 1998; Grisso, 1999). In particular, young offenders are at increased risk of conduct problems, substance abuse, affective disorders and suicide (Abram et al., 2008; Grisso & Barnum, 1998). These mental health issues tend to have a higher severity level amongst youth offenders, with one study of more than 1400 young offenders in the United States, where at least 20% of the sample experienced severe mental health disorders that significantly impaired their daily functioning (Skowyra & Cocozza, 2007).

The prevalence of mental health issues is even higher for youth in secure residences, particularly for schizophrenia, major affective disorders, and substance abuse disorders (Teplin, 1994). International rates of mental health issues for detained youth are estimated to be 60-100% (Gretton & Clift, 2011; New South Wales Department of Juvenile Justice, 2003; Richards, 1996; Skowrya & Cocozza, 2007; Teplin, Abram, McClelland & Mericle, 2002; Ulzen & Hamilton, 1998).

The literature indicates differences between the types of mental health issues for young female offenders compared to young male offenders. Females are at greater risk of substance abuse, depression, self-harm and post-traumatic stress, and have higher rates of co-morbidity than their male counterparts (Abram, Teplin, McClelland & Dulcan, 2003; Cauffman, Frances, Goldweber, Shulman & Grisso, 2007; Chitsabesan et al., 2006). Goldstein et al. (2003) found high levels of experiences of sexual and physical abuse with detained females, and high rates of suicidal ideation. They suggested that females often end up on an offending trajectory as a result of traumatic experiences, while males are more influenced by peers.

Aotearoa New Zealand mental health prevalence rates for young offenders

International literature about prevalence rates of mental health issues among young offenders are reflected in the limited Aotearoa New Zealand research. The Centre for Youth Health report about the health service provided to Korowai Manaaki youth justice residence showed that 56% of the young people had mental health needs (Newman & O'Brien, 2005). This report also showed higher rates for females, with 73% of girls in the residence experiencing mental health difficulties.

McKay and Bagshaw (2009) examined the health needs of young people at two youth justice secure residences in Aotearoa New Zealand, and one care and protection residence. Almost half of the young people surveyed reported excessive worrying, one third had self-harmed, one quarter had depressive symptoms, and one fifth had attempted suicide. The researchers also noted that young people reported experiences in the residence that negatively impacted their mental health, including bullying by peers and negative interactions with staff.

More recently, McArdle and Lambie (2018) used the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) to look at a sample of 204 young people admitted to a youth justice residence in Aotearoa New Zealand over 2014. They found 80% of the young people had MAYSI-2 scores above the level of 'caution'. Specifically, 66% had substance use issues, 38% were irritable and angry, 30% were depressed or anxious, 30% reported somatic complaints, 24% of the males reported thought disturbance, and 17% had thoughts of suicide. Half of those surveyed met criteria for two or more mental health problems, and many had experienced multiple traumatic events.

Mental health services

Forensic mental health services for adults were established in 1989, following the *Mason Report* (Mason, 1988). This later led to the establishment of youth forensic services (The Werry Centre, 2009). In 2012, *Blueprint II* was released (Mental Health Commission, 2012). This document outlined strategic plans for the development of mental health services, placing a large emphasis on the importance of early intervention, particularly for youth. Those involved with youth justice were identified as a group in need of quality mental health service provision.

In Aotearoa New Zealand, mental health services are provided to the youth justice residences by youth forensic services (YFS). YFS also provide mental health assessments in the Youth Court, section 333 psychological and psychiatric court reports for young offenders, input into multidisciplinary Youth Offending Teams, and coordination of referrals to Ngā Taiohi youth forensic inpatient unit (The Werry Centre, 2015).

Three of the youth justice residences receive mental health service provision from YFS teams located in District Health Boards. The other residence receives mental health service provision from Ngaa Ringa Awhina YFS, located in a large iwi-based organisation, contracted by two District Health Boards (Ministry of Health, 2011).

Legislative framework

Cross-sector information-sharing occurs within a legislative context. This final section of the introductory chapter provides an overview of the legislative and policy frameworks, including privacy and consent principles, movements towards interagency collaboration, and the more recent policy focus on vulnerable children.

Privacy

Historically, there has been a focus on maintaining privacy in the mental health treatment of young people. The *Privacy Act 1993* and the *Health Information Privacy Code 1994* emphasised protection of an individual's information, including health information. This was supported by the *United Nations Convention on the Rights of the Child* (ratified in 1989), with Article 16 protecting against arbitrary and unlawful interference with the privacy of children.

Aotearoa New Zealand approaches to consent to mental health treatment for young people under the age of 16 follow the decision of *Gillick v West Norfolk and Wisbech AH*, which is reflected in the Code of Health and Disability Services Consumer's Rights (Ministry of Health, 1998). The Gillick case was decided in 1985 by the House of Lords, with the decision resting on the principle that children grow in intelligence, competence and autonomy as they move towards adulthood. There is a presumption of competence, and a child may show the understanding and maturity to make their own decisions about their healthcare. Best practice is to encourage whānau involvement, although this is not required to treat young people (Ministry of Health, 1998).

The Aotearoa New Zealand guidance document on consent in child and youth health conceptualises consent as respect of someone's personhood. They make the following statement about cultural understandings of personhood:

> *The value of personhood has different meanings in different cultures. Within Anglo European culture individual independence is highly valued. Māori, Pacific and some other cultures understand the value of personhood as something realised*

> *more completely through collectivity. Therefore, respect for personhood should embrace a range of possibilities and encourage an understanding of consent processes which are similarly comprehensive.* (Ministry of Health, 1998, p. 2).

Emphasis on interagency collaboration

The approach to individual privacy was modified with the emerging emphasis on collaboration and information-sharing across government sectors. *Blueprint II* had five key future directions for the wider health and social service sector (Mental Health Commission, 1998). One of those directions was to improve partnerships across the whole of government.

Lips, O'Neill and Eppel (2009) investigated cross-government information-sharing in Aotearoa New Zealand. This was in the context of a recent focus on 'joined-up government' initiatives to transform service design to better meet the needs of vulnerable citizens, in response to fragmented and bureaucratic service silos. The rationale behind joined-up government is to better serve the vulnerable welfare-dependent families with complex, interrelated problems, with underlying causes located in a number of policy domains, such as health, justice, housing, education and unemployment. The approach is intended to move from organisation-centred to client-centred practice, providing a service that fits the client, rather than expecting individuals to 'join up' the existing government structures. This integrated approach of 'no wrong door' aims to be more effective in meeting complex needs. Lips et al. (2009) identified that improved information-sharing across government is essential for effective joined-up government.

The Office of the Prime Minister's Science Advisory Committee (2011) produced a report for the government, with aims of improving outcomes for young people in Aotearoa New Zealand. The report recommended targeting high risk communities, and suggested that improved outcomes can be enhanced through collaboration between different agencies and across ministries. Additionally, the Ministry of Health (2011) document about youth forensic services development stated that effective youth forensic services are dependent on collaborative relationships, especially with CYF. A report into young people's and professionals' experiences of Youth Court indicated that communication across sectors is the most significant contributing factor for improved outcomes for young people (Ministry of Justice, 2011). The report recommended proactive cross-sector communication, with electronic sharing of information.

In 2012 the government launched a programme to address significant problems in Aotearoa New Zealand society. The ten problems were known as the Better Public Service Results, and included reducing the crime rate, and reducing re-offending, as well as other factors relating to employment,

education, immunisation and child abuse (Scott & Boyd, 2016). The Better Public Services reform programme was designed to address fragmentation and service silos. The programme was aimed at fostering collaborative cross-sector work to overcome the lack of progress in addressing complex social problems. Shelton (2012) described it as the most significant change to how government services have been delivered in Aotearoa New Zealand in 20 years, looking at the entire system effectively delivering results across whole sectors.

Policy focus on vulnerable children

Effective information-sharing has been a recent focus in public policy, with aims to protect vulnerable children and ensure these children receive integrated and coordinated public and mental health services. The Green Paper for Vulnerable Children in 2011 was followed by the White Paper for Vulnerable Children in 2012 (Ministry of Social Development, 2011, 2012). The emphasis in those documents was on sharing responsibility across sectors for child care and protection. The introduction to the White Paper shows that the changes came about, in part, due to the recommendations made in the 2012 Coroner's report, regarding the death of twin infants Chris and Cru Kahui six years earlier.

The *Privacy (Information Sharing) Amendment Act 2013* and the *Vulnerable Children's Act 2014* established Approved Information Sharing Agreements (AISAs), including the AISA for Improving Public Services for Vulnerable Children in 2015. The signatories to this agreement include the Ministry of Social Development (under which CYF was located) and the Ministry of Health (under which mental health teams are located). In this context, Multi-Agency Team (MAT) meetings have been established in youth justice residences. These are weekly meetings attended by Oranga Tamariki, YFS, education and other providers to discuss the needs of young people in residence (Privacy Commissioner, 2017).

The *Vulnerable Children's Act 2014* describes vulnerable children as "children at significant risk of harm to their wellbeing, now and into the future, as a consequence of their environment and/or their complex needs". The AISA sets out that information sharing about "psychological or emotional difficulties" is allowed when fulfilling purposes of a needs assessment, determining appropriate referrals, and monitoring outcomes.

Overall, there has been a shift in the policy landscape, from protecting an individual's privacy, to the recognition that information-sharing is essential to provide the best service for the most vulnerable populations. Legislation has changed to allow more information-sharing, particularly regarding

vulnerable children, with recognition that those young people in a youth justice residence are considered vulnerable children (The Modernising Child, Youth and Family Panel, 2016).

Summary

This chapter has outlined the context of youth justice residences, the needs of the young people in residence, and the legislative framework for this field of practice. The four youth justice residences in Aotearoa New Zealand have been designed to provide a secure placement for young people who are involved in serious offending, and are a risk to the community. As has been discussed, the mental health needs of young people who end up in a youth justice residence are high. Most of the young people are Māori, and many of them have a range of social and intellectual difficulties. Youth forensic service (YFS) teams have been established to meet the mental health needs of these young people.

Over recent years there has been an increased emphasis on the importance of interagency information-sharing in a range of contexts, in order to provide the best service for young people. Inter-agency information-sharing has been encouraged within youth justice residences, with the establishment of Multi-Agency Team (MAT) meetings, protected through an Approved Information Sharing Agreement (AISA). While there has been acknowlegement of the importance of sharing information between agencies and across sectors, there have not been any guidelines about what information should be shared between YFS and youth justice residences, or how shared information is made sense of by each sector. This research project aims to explore the two sectors' expectations about information-sharing in youth justice residences, and to work towards the development of a model of information-sharing in this context.

Chapter Two
LITERATURE REVIEW

This literature review has been broadly categorised into three areas – general research and policy about information-sharing and collaboration; workforce issues that impact on information-sharing in a youth justice residence; and factors that affect information-sharing practices. The literature review has been intentionally wide-reaching, with no geographical or publication date limits. This is a reflection of the little existing research around sharing of mental health information for young offenders. The literature includes publicly available local policy, as well as peer-reviewed journal articles and published books. Journal articles were accessed through a range of databases, with a number of keywords used, including "mental health + offending", "inter-agency collaboration", "joined-up government", "inter-organisational communication" and "information-sharing". The chapter concludes with a summary of the literature, and how this has informed the design of this research project.

Information-sharing

This first section of the literature review examines the research and policy that supports the concept of cross-sector information-sharing, as well as the positive outcomes that have been associated with high levels of information-sharing. There is also exploration of client perspectives on agencies sharing client information, followed by a review of the literature on models of information-sharing that have been developed in other contexts.

Call for greater information-sharing

There is a wealth of literature, both in Aotearoa New Zealand and internationally, that recommends improved information-sharing and collaboration between youth justice providers and mental health providers. In Aotearoa New Zealand, The Werry Centre (2009) recommended a collaborative management system for young offenders with mental health issues, with improved information-sharing and joint decision-making between Child Youth and Family (CYF) and mental health services. The Ministry of Health (2011) published a document on youth forensic service development for young people involved in Aotearoa New Zealand's justice system. The *Review of Forensic Mental Health Services* identified a lack of a nationally consistent model of care, and

recommended stronger cross-sector relationships and collaboration (Ministry of Health, 2011). The Office of the Children's Commissioner (2015) identified that stronger relationships are needed between CYF and mental health services. Comment was also made about the tension between containment and therapeutic models within youth justice residences, and the impact this has on external services, such as mental health teams. Lambie et al. (2016) recommended a model of care within youth justice residences in Aotearoa New Zealand that includes an overarching framework used to understand the complex needs of young people in care, and high levels of interagency collaboration, particularly regarding transition planning.

In the United States, Skowrya and Cocozza (2007) developed a model for the identification and treatment of youth with mental health needs in contact with the youth justice system. They emphasised the need for improved collaboration between youth justice and mental health systems. They recommended cross-training to be available for staff of both systems, in order to understand the language of each system.

Maschi, Hatcher, Shwalbe and Rosato (2008) reviewed the social service pathways of young people through the juvenile justice system in America. They concluded that mental health services are not adequately meeting the needs of young offenders with mental health issues, due to a lack of coordinated services. They recommended system reform, with integration, information-sharing and collaborative leadership.

In his discussion on caring for young people with disabilities in care in Aotearoa New Zealand, Carter (2010) strongly supported a collaborative cross-sector approach. While acknowledging that collaborative work is not always easy for busy professionals in specific practice areas, Carter (2010) advocated that the quality of collaborative effort makes a significant difference for children with these difficulties.

Strengthening Families is an Aotearoa New Zealand initiative to improve life outcomes for vulnerable children and families. It involves joint policy work and collaborative service delivery between the welfare, education and health sectors (Majumdar, 2006). Strengthening Families provides an opportunity for the various sectors involved with a family, to come together and share information to make joint plans. There have been several evaluations of this programme, all of which found that the case management process of Strengthening Families does improve collaboration between sectors, resulting in improved role clarity, pathways of joint working, agreed goals, and improved problem solving (Bennett, 2002; Christchurch City Council, 1994; Parsons, 2002).

Bai, Wells and Hillemeier (2009) conducted a longitudinal study in the United States, looking at relationships between child welfare agencies and mental health services. They found greater contact

between the two services was associated with greater use of mental health services and improvement in mental health status for vulnerable children in the child welfare system, including young offenders. They suggested that higher levels of cross-sector cooperation lead to improved outcomes due to more informed and comprehensive assessment and planning.

Darlington, Feeney and Rixon (2004) also looked at collaboration between child welfare and mental health services in the United States. They highlighted the importance of good information-sharing, and suggested that lack of information can lead to inadequate care, with children falling through service gaps due to poor information-sharing practices.

Client perspectives

Kramer, Vuppula, Lamps, Miller and Thrush (2006) explored parent and child attitudes about information-sharing between mental health services and schools. They sampled 73 pairs of parents and their adolescents involved in a community adolescent mental health service in the United States. Most of the parents reported that the school should be informed that their adolescent was receiving mental health treatment, and that the parent should be the primary informant, rather than the mental health service. In particular, female and non-Caucasian parents were more likely to want information shared with the school. However, the adolescents reported a preference for more discretion about their involvement in mental health treatment. Younger adolescents were more likely than older adolescents to want their information shared.

Research into the experiences of English parents of young children showed that parents were in favour of interagency information-sharing between health and welfare professionals (Siraj-Blatchford & Siraj-Blatchford, 2010). Parents reported frustration with repeating their story to different professionals, especially when their child had additional needs. Wilson, Pillay, Kelly and Casey (2015) surveyed 159 carers of Irish adults with mental illness. The found that most of the carers had encountered difficulties accessing information from the treatment mental health team, often citing lack of consent as the stated reason. The authors suggested that confidentiality should not be used as a reason for completely excluding carers, and that carer involvement is essential for the effective management of people with mental illness.

In Aotearoa New Zealand, the National Research and Evaluation Unit (2013) looked at client perspectives on information-sharing between government agencies. Concerns were raised by participants about privacy breaches by Aotearoa New Zealand government departments. There were also concerns about sharing of inaccurate information, perpetuating a false understanding of an individual. Māori participants shared that personal information is part of who they are, but when it is

shared, it no longer belongs to them, and may be disempowering for Māori. Māori participants also highlighted culturally sensitive topics, including historic records, the significance of hand-written information, and information about deceased family members, and suggested that there be greater sensitivity when sharing this information across agencies.

Models of information sharing

While there is no existing model of information-sharing in youth justice residences, Lennox, Mason, McDonnell, Shaw and Senior (2012) surveyed 250 criminal justice and National Health Service (NHS) workers in the United Kingdom about interagency information-sharing. Their results showed that prison staff wanted basic information about an offender's mental health history, particularly the name of their keyworker, and any previous detention under the Mental Health Act. Respondents from the NHS wanted risk information, and information about previous sentences. The results showed that NHS staff usually received the information they wanted, but the prison staff more often did not receive the information they sought (Lennox et al., 2012).

Senior, McDonnell, Lennox, Yao and Zhang (2012) developed a multi-agency information sharing system in Liverpool for offenders with mental illness. The network provided a single, accessible internet based system through which health and risk information about recently released prisoners with severe and enduring mental illness could be shared promptly, securely and reliably between community mental health and criminal justice agencies. Both sectors were receptive to sharing specific health and risk information.

Workforce issues

This second section of the literature review explores the workforce issues that impact on information-sharing practices. The concepts of institutional milieu and workplace culture are unpacked, and then applied to the Oranga Tamariki and YFS workforces.

Institutional milieu

Corbett, Dimas, Fong and Noyes (2005), in their work on cross-sector integration, use the term 'institutional milieu' to describe the underlying values and norms that shape how organisations operate. The organisational culture is shaped by the professional disciplines, dominant discourses and implicit assumptions. It is also called 'institutional logics', the unwritten rules on how things are (Bryson, Crosby & Middleton Stone, 2006).

Grace, Bowes, McMaugh and Gibson (2009) suggest that institutional milieu is an important factor in cross-sector collaboration. The theories and practice that have developed within services as explanatory frameworks for work with young people, are not necessarily the same theories and practice that have developed within other services. Grace et al. (2009) provide the examples of the tension between priorities focused on the family versus an emphasis on the rights of children and young people, or the tension between focus on crisis management versus preventative work. It is argued that these frameworks are fundamental in influencing service planning and delivery.

Bornholdt and Ritchie (2014) discussed the development of the CYF Hospital Social Worker role in Aotearoa New Zealand, a collaborative initiative between CYF and District Health Boards (DHBs). They noted significantly different organisational cultures between CYF and DHBs, which has made collaboration difficult. Carter (2010) also described difficulties between the organisational cultures of CYF and the Ministry of Health, with a history of unmet expectations and resulting conflict. Bornholdt and Ritchie (2014) emphasised the importance of listening to others' perspectives, ensuring role clarity, developing trust over time, and having the courage to have difficult conversations. In that example of a collaborative initiative, it relied on individual relationships, with the role eventually formalised after eighteen months.

Reder and Duncan (2003) also addressed the importance of organisational and professional belief systems as a lens through which all cross-sector communication is filtered. As a result, they suggested that the psychological and interactional dimensions of communication must be addressed before any practical remedies will be effective. Morrison (2007), in his examination of partnership and collaboration, suggested that anxiety distorts organisational behaviour, by creating an unconscious defence system. This system minimises or reframes that nature of information and concerns, resulting in fight, flight, defensiveness and denial behaviours.

In their work on collaboration between child protection and mental health services, Darlington et al. (2004) surveyed staff from child protection, adult mental health, and child mental health services in Queensland, asking about their experiences of collaborative work with parents with mental health issues. The primary difficulties they identified were communication, role clarity, lack of resources and different primary focus between the groups. They suggested that each sector is influenced by their own training, workplace environment, legislation and policy, leading to different interpretations of concepts such as mental health and risk. This is coupled with varying thresholds for identifying problems. They concluded that cross-sector collaboration is more difficult when there is greater diagnostic uncertainty, and therefore a lack of a common language. Darlington et al. (2004) recommended joint training as a potential solution to the different frames of reference, with a chance to learn more about different service perspectives.

The use of specialised language highlights these different theoretical viewpoints, and can be an added barrier to cross-sector understanding (Anderson, 2005; Gask, 2005; Rothi & Leavey, 2006). Grace et al. (2009) posited that effective cross-sector communication requires the building of a common language, without sector-specific jargon. They gave the example of difficulties between child protective staff and school staff in an integrated team, who had different interpretations of the term 'preventative services'. Once this was realised by the integrated team, they identified this had been their primary difficulty. Gask (2005) suggested the use of joint training to build a common language across the services.

Oranga Tamariki workforce

Youth justice residences are overseen and staffed by Oranga Tamariki, and so it is useful to explore workforce issues related to Oranga Tamariki. Working in a secure setting with young offenders can be stressful, particularly due to the risk of assault (Armstrong & Griffin, 2006; Finn, 2001). Youth justice residential staffing issues have been highlighted in the media, particularly regarding under-staffing during moments of crisis (New Zealand Herald, 2016). Low staffing levels may increase the stress that residence staff feel working in this challenging environment.

In exploring job stress among 443 juvenile correction staff in Kentucky, Wells, Minor, Angel, Matz and Amato (2009) found that organisational factors are the most significant predictors of job stress. In particular, organisational satisfaction and commitment, job satisfaction, and a sense of personal efficacy were deemed most predictive. Additionally, staff who felt unsafe at work, and who had supervisory responsibilities were the most stressed. Armstrong and Griffin (2006) used self-report survey data from 3794 staff in 10 adult correctional facilities in southwest United States. They found sources of work stress to include role ambiguity, level of organisational support, relationships with co-workers, quality of supervision, and concerns about personal safety.

Generally, it has been found that youth justice residential staff in Aotearoa New Zealand have positive relationships with the young people (Office of the Children's Commissioner, 2015). However, it has been noted that there is no model of care for the youth justice residences. Lambie et al. (2016) have suggested that a model of care, with an overarching framework, may help to create a common understanding about the goals of the service, and promote consistent approaches from staff.

The work done by the Modernising Child, Youth and Family Panel (2016) suggested general upskilling of CYF staff, particularly in regards to mental health issues and trauma. The panel recommended a move towards trauma-informed and evidence-based practice, and an associated skill

specialisation among the workforce. They also suggested improved service planning, brokering and strategic partnering skills will be required for their vision of how services will be.

YFS workforce

Youth forensic services (YFS) provide mental health services in youth justice residences. They are provided through District Health Boards, located externally to Oranga Tamariki. There are a number of workforce issues for youth forensic services, including lack of training and knowledge, and recruitment difficulties (The Werry Centre, 2015).

In the 2006 publication, *Te Kōkiri*, the Ministry of Health identified a lack of youth forensic services (Minister of Health, 2006). This was followed by a stakeholder meeting, with agreement about the need for workforce development and stronger collaboration between youth justice services, forensic services, and CAMHS (Ministry for Health, 2011). The Werry Centre conducted literature reviews regarding models of youth forensic services and workforce issues in order to inform a Ministry of Health guidance document about youth forensic service development (Ministry of Health, 2011; The Werry Centre, 2007, 2008). The guidance document also relied on the *Review of forensic mental health services: Future directions* which reviewed all forensic services (Ministry of Health 2010). That report identified a lack of youth forensic services as an issue of national significance.

The guidance document made a number of recommendations about youth forensic workforce development. YFS clinicians must be competent in a wide range of areas, including assessment and response to mental health and drug and alcohol issues, along with an understanding of developmental issues and intellectual disability. They also need an understanding of the legislative framework for youth justice, and be skilled at cross-sector collaboration. Clinicians need to be skilled at engaging families and have an understanding of youth culture. Māori cultural competency is important, and strategies are required to train, recruit and retain Māori clinicians. Finally, clinicians need ongoing training and skill development, and to be skilled in sharing this knowledge within the various youth justice organisations (Ministry of Health, 2011).

The guidance document recommended a youth forensic forum to foster collaboration across the various sectors. Another result was the establishment in 2016 of a postgraduate youth forensic training programme at the University of Auckland, in order to upskill the youth forensic workforce (The Werry Centre, 2016).

In McKay and Bagshaw's (2009) research into the health needs of young people in residences, they used a qualitative approach to capture the voices of the young people. They found that young people

in residential care are most concerned about the quality of their interactions with mental health staff. They value clinicians who are genuine, caring and trustworthy, and who take them seriously, recognising that they are more than the sum of their problems. This research suggests that YFS clinicians in youth justice residences require sophisticated interpersonal and engagement skills, as well as mental health knowledge and skills.

YFS staff also experience job stress working in a residential environment. In Armstrong and Griffin's (2006) exploration about job stress in prisons, they compared data from correctional staff, and also those providing treatment within the prison. They found no significant difference between the two groups, with both finding prison to be at least a moderately stressful work environment. In their research on work stress for 80 forensic community mental health nurses in England and Wales, Coffey and Coleman (2001) found that a number of respondents were experiencing burnout. They found statistically significant associations between the caseload size and the level of stress. They also found that workplace support, from both managers and colleagues, was an important protective factor to ameliorate the experience of stress.

Factors that affect information-sharing

This final section of the literature review looks at the factors affecting information-sharing in general, across a number of various contexts. These factors include leadership, relationships, co-location, policy, joint training, privacy, and information systems. A common theme in the literature is that effective information-sharing and interagency collaboration is difficult to achieve in practice (Carter, 2010; Darlington et al., 2004; Richardson & Asthana, 2006; Shepherd & Meehan, 2012). Quality collaboration does not often come naturally, and requires a number of organisational and individual factors to support collaborative efforts.

Leadership

Leadership is an important factor in effective collaborative relationships (Daley, 2009). Darlington et al. (2004) highlight the importance of good leadership in order to manage the inevitable cross-sector tension and conflict when working collaboratively. Hudson (2004) refers to the achievement of goal consensus and trust as essential leadership outcomes for inter-organisational structures, and that the different individuals must be clear about the various roles and responsibilities for themselves and other members. Inter-dependence is seen as the fundamental basis for collaborative problem-solving efforts, which is influenced by leaders (Hudson, 2004).

Agranoff and McGuire (2001) suggest that the management skills required for effective cross-sectoral collaboration are different to the traditional management skills of planning, organising, staffing, directing, coordinating, reporting and budgeting. While single organisations have vertical and horizontal management, the skills required of managers for inter-organisational arrangements are more complex (Mandell, 1999). Facilitative leadership is required, due to the lack of central authority. This involves a move away from control-based leadership (Agranoff & McGuire, 2001). The skills required of facilitative leaders include activation (identifying skills and resources within the network of participants), framing (establishing the operating rules of the network and influencing the values), mobilising (inducing commitment from individuals to the joint vision) and synthesising (fostering a productive, collaborative environment, blending participants with various goals, perceptions). Rather than controlling, the focus needs to be on coordinating the various individuals within an inter-organisational network of relationships (Lips, O'Neill & Eppel, 2009).

Youth Offending Teams (YOTs) are a collaborative initiative to reduce youth offending in Aotearoa New Zealand. YOTs are interagency teams comprising education, probation, police, health and social services, with the aim of providing an integrated response to youth offenders, reduce youth crime, and address underlying causes of behaviour (The Werry Centre, 2009). YOTs require cross-sector information-sharing to meet these aims. Harland and Borich (2007) evaluated YOTs and found that leadership for this interagency approach is essential, and recommended a clearer mandate and leadership for the initiative. Alongside this, they recommended development of clear guidelines for the roles of each agency, and a higher level of reporting and information-flow at the senior leadership level.

Relationships

The quality of relationships between services has been identified as a significant factor in the effectiveness of cross-sector cooperation (Haight, Bidwell, Marshall & Khatiwoda, 2014; Iam, 2016; Richardson & Asthana, 2006). Daley (2009), in exploring cross agency collaboration, explained that game theory models suggest that cooperation is enhanced when there are a limited number of participants, no information constraints, and if participants understand there will be ongoing cross-sector interactions. In translating this to cross-sector collaboration, she theorises that staff who have had experience of collaboration are more likely to be informed about their collaborative partners, and to value the benefits of continued collaborative interactions. Trust is seen as a critical element for long standing collaborative relationships. The importance of cross-sector mutual trust and respect is echoed elsewhere in the literature (Darlington et al., 2004; Etten & Petrone, 1994; Gask, 2005).

Chuang and Wells (2010) looked at cross-sector collaboration for young people involved in both child welfare and youth justice. They found that the extent of information-sharing was often related to individual staff and the strength of their cross-sector relationships. They also found the individual relationships to be more significant than any policy about collaborative work, and highlighted the need for more research in this area.

Rothi and Leavey (2006) interviewed teachers about their experiences of working with child and adolescent mental health services (CAMHS). They found several barriers to effective collaboration, particularly in regards to the relationship between the two services. Rothi and Leavey (2006) reported that teachers often feel undervalued and excluded by CAMHS. The overarching theme of the interviews was inter-professional mistrust and mutual suspicion. Teachers reported that they felt excluded from the children's mental health care management, despite being affected by clinical decisions. They also criticised service delays and poor communication from CAMHS. Teachers reported that they refer to CAMHS, who accept the referral, but do not often consult with school staff, leaving the teachers uncertain about how to interact with the student and their family. This was interpreted by the teachers as a lack of professional respect, resulting in less motivation to refer to CAMHS in the future.

Similar results were found in Iam's (2016) research into senior education professionals' experiences of phoning CYF to report concerns about child abuse and neglect. The quality of these cross-sector relationships between child welfare and education was identified as a significant predictive factor of reporting behaviour, and was impacted by the degree of trust and the quality of feedback received. Her results mirrored an earlier study in the United States, where participants described an environment where social workers thought teachers wanted to know too much and teachers thought social workers withheld important information (Altshuler, 2003).

In their survey of child protection and mental health staff, Darlington et al. (2004) also found that trust is an important factor. They posited that a positive and respectful view of those in the other organisation is fundamental for effective cooperation and communication. When hostility and mistrust are present, all interactions are interpreted negatively, which serves to reinforce hostility (Sandfort, 1999). In their research, Darlington et al. (2004) found a generally high level of regard between workers across the different sectors, and low levels of animosity and mistrust. They asked about workers' attitudes about barriers to collaboration, and found that structural factors, such as resourcing and policies, were more important than individual factors, such as expectations and professional knowledge domains.

In their research into the mental health needs of foster children in the United States, Garcia, Circo, DeNard and Hernandez (2015) identified that there are tensions between child welfare services and mental health services. They commented on the frustration that social welfare services experience when they do not receive information from mental health services, and so don't know if the young person is engaging with the service, or how they are progressing.

Kurtz, Thornes and Bailey (1998) looked at the mental health needs of children in secure residences in England and Wales. They identified that relationship issues between youth justice and mental health services was a significant barrier to service provision. This suggests that enhancing cross-sector relationships has flow-on effects to effective and responsive mental health service provision.

Mills, Meek and Gojkovic (2012) explored the relationships between adult prison staff and 'third sector staff' in prisons in the United Kingdom. Third sector staff include a range of paid and unpaid staff that come into the prison to offer services to inmates, such as mentoring, drug and alcohol counselling, spiritual guidance, and housing assistance. Similarly to YFS providers in youth justice residences, these third sector staff are not employed by the prisons, but are allowed in to provide services. Mills et al. (2012) noted the different roles, with prison staff tasked with ensuring risk management and control, while third sector organisations tend to be more rehabilitative. They referenced the traditional prison officer culture, in which showing care for prisoners was culturally unacceptable. The researchers conducted qualitative interviews with 74 prison staff and 78 third sector staff in eight prisons, including one juvenile prison. They found that the most of those interviewed reported good professional relationships between parties. However, a minority of prison staff reported difficulties, such as third sector workers' lack of understanding of the risk issues within the prison, and potentially raising security issues. There were also concerns about a lack of information sharing from third sector staff, affecting risk management. In order to function well in the prisons, staff suggested that visiting services needed to consider security, risk and the appropriate boundaries in their relationships with offenders, and may need guidance and support to ensure they fully understand the implications of working in prison. Third sector staff reported frustrations with access to the prison, and a feeling that they were an 'institutional inconvenience', unable to see prisoners due to staff levels, individual staff willingness, or security concerns outside of their knowledge. They reported frustration with travelling long distances to the prison, only to be turned away at the gate due to an unexplained security incident.

Co-location

Gask (2005) also identified co-location as a factor that enhances cross-sector collaboration. She suggested that co-location increases the opportunities for informal face-to-face consultation, which

enhances relationships, and reduces the risk of misunderstanding. Lambie et al. (2016), in their review of youth justice residences in Aotearoa New Zealand, also suggested that mental health staff should be on-site in youth justice residences. In Laming's (2003) report into child abuse in the UK, it was suggested that bringing together teams into one location removes the physical barriers to interagency communication.

However, the literature review by The Werry Centre (2009) found a lack of agreement and evidence in the literature about whether there should be co-location of mental health services and youth justice residences. White and Featherstone (2005) researched a child health service, and suggested that physical merging of organisations did not result in more collaborative practice. They found that co-location did not address the different organisational cultures. They argued that conditions must be created where professional identity and practice is open to scrutiny, in order to foster the attitudinal change required for open cross-sector communication between professional groups.

Need for policy

The need for clear policies regarding cross-sector information-sharing is repeated throughout the literature (Bryson et al., 2006; Darlington et al., 2004; Harland & Borich, 2007). Bai et al. (2009) suggested that policies should be implemented at various organisational levels in order to increase cross-sector collaboration. Darlington et al. (2004) have recommended policies for cross-sector collaboration, with guidelines for information-sharing. Given that there are different degrees of staff autonomy across services, some standardisation of information-sharing and collaborative processes is suggested. Harland and Borich (2007) emphasised the importance of clear policy that sets out role expectations for participants in Youth Offending Teams in Aotearoa New Zealand.
Kurtz et al. (1998), in their review of how mental health needs are met for young people in care, found that a lack of working agreements was a significant barrier to effective cooperation. Bryson et al. (2006) conducted a literature review on the design and implementation of cross-sector collaborations, and suggested that written agreements must be one of the first steps in the process of effective cross-sector collaboration, followed by building trust, leadership and legitimacy.

Joint training

Joint training has been identified as a solution to many of the difficulties facing cross-sector collaborative initiatives (Anderson, 2005; Darlington et al., 2004; Frost, 2005; Grace et al., 2009; Sandfort, 2004). Joint training provides a chance to deconstruct myths and prejudices about the other service, while also offering a common language (Darlington et al., 2004). This was very helpful in the establishment of the CYF Hospital Social Worker role (Bornholdt & Richie, 2014). Grace et al.

(2009) discussed the importance of professional training when establishing an integrated service. They argued that effective multi-agency collaboration requires a shared knowledge base on relevant issues, and an understanding of the different theoretical models and cultures of practices. They argued that professional preparation and training is required before coordinated and collaborative work can be delivered. This was echoed in the report by Siraj-Blatchford and Siraj-Blatchford (2010), who cautioned that, without joint training of staff, integration initiatives are ineffective, and may deteriorate towards frustration and animosity towards partner organisations. Sandfort (2004) presented a case study of this happening in the United States, where there was a lack of understanding of each service's role, and limited cross-service communication. This led to staff frequently giving families wrong information about their partner agency, with high levels of scepticism about their partner's professional competency. This lack of service understanding led to poorer service delivery to clients, and no collaborative or integrated work.

Frost (2005) also cautioned against rushing into implementation of cross-sector initiatives without joint training, particularly for those in leadership and management roles. Effective cross-sector collaboration requires staff to understand the various roles and responsibilities, and what their partner agencies are providing. It is also suggested that staff need training specifically related to service integration and cross-sector collaboration (Siraj-Blatchford & Siraj-Blatchford, 2010).

Privacy concerns

Concerns about privacy requirements have been highlighted as a significant barrier to cross-sector information-sharing (Anderson, 2005; Darlington et al., 2004; Lawn, Delany, Sweet, Battersby & Skinner, 2015; Richardson & Asthana, 2006). Lennox et al. (2012), in their research into information-sharing for prisoners in the United Kingdom, described a culture of indecision and uncertainty about information-sharing, with particular lack of understanding about when to breach confidentiality.

In Aotearoa New Zealand, the Privacy Commissioner has provided a guidance document on sharing information about vulnerable children (Privacy Commissioner, 2017). The document has suggested that sharing information is often essential for the health and wellbeing of young people, and encourages practitioners to gain consent from the young person to share information. The emphasis is on attempting to get consent, with provisions in place to share information without consent, if required. The Privacy Commissioner advises use of the proportionality principle, to only share as much information as is reasonably necessary to achieve the objectives.

Shared information systems

Information-sharing often takes place within some form of technology. This adds another layer to the communication process, where information is interpreted by the receiver, and then inputted into electronic files (Iam, 2016). Some researchers have suggested shared information systems between sectors, which has been argued against on the basis of protecting health information privacy (Chuang & Wells, 2010; Frost, 2002). Gil-Garcia and Sayogo (2016) found that shared information systems was one of the top two factors predictive of success in cross-sector information-sharing initiatives.

In their survey of 119 Irish psychiatrists, Feeney and Moran (2007) found that over 80% of the psychiatrists had performed emergency mental health assessments, including forensic assessments, in the past year without access to key information. Most of those assessments would have resulted in different decisions made if all the information was available. Over 90% of the respondents were supportive of the idea of an electronic database designed to support these assessments. However, there were also concerns about how to maintain confidentiality of health information. The authors concluded that a shareable minimum data set could solve the problem of balancing confidentiality and information sharing. They suggested the shared information system should include any risk factors, alerts, and medication details. Anderson (2005) also suggested a minimum data set on a shared information system, with clear expectations of what information should be included.

Other factors

There are a number of themes spanning the literature on collaboration, as discussed above. However, there have also been some findings that are unique and more difficult to categorise. Those research projects with particular findings are summarised below.

In her work on interagency collaboration, Daley (2009) looked at factors promoting effective working relationships between environmental agencies in Wisconsin. She utilised institutional rational choice theory to explain that collaboration is enhanced with organisations that structurally reward collaboration. This can include performance objectives that specify collaborative efforts, and performance incentives for collaboration. Institutional rational choice theory posits that institutional rules directly influence how individuals behave. Daley's (2009) results indicated that institutional expectations of collaboration, such as an annual review emphasising collaboration, are more influential on collaborative behaviour than cross-sector trust and goodwill. She also found that annual evaluations that reward collaborative behaviour contributed to staff being more likely to perceive multiple positive outcomes from interagency collaboration.

In their systematic review of joint working between the National Health Service and social services in England, Cameron and Lart (2003) identified a number of organisational, cultural, professional and contextual factors that impact upon the effectiveness of joint initiatives. Organisational factors included having explicit objectives with clear roles and responsibilities, commitment to collaboration at a staff and management level, face-to-face communication, technical support for shared information systems, co-location, facilitative personalities, effective management and training, appropriate resourcing, and a positive history of working together. Cultural and professional factors included the ability to overcome negative professional stereotypes, mutual trust and respect, joint training, and whether different organisations can cross the divide of different professional philosophies or ideologies. When this cannot be solved, professional differences are at risk of declining into distrust, rivalry and defensiveness between services. Contextual factors identified included the political climate, the destabilising nature of restructuring, and the impact of resourcing and financial stability.

Shepherd and Meehan (2012) evaluated Australian interagency housing programmes for people with mental illness. They conducted 146 semi-structured group and individual interviews with staff involved in delivering housing programmes throughout Queensland. Shepherd and Meehan (2012) suggested that a key component of cross-sector collaboration is an 'integration coordinator' role. This involves a person whose role is to facilitate cross-sector relationships, and ensure effective information flow. This integration coordinator should span both organisations, and be someone with legitimacy and participatory leadership. They suggested that this role could solve the problem of a lack of shared information technology systems, and the difficulties of managing shared information about mental health needs, as the integration coordinator can act as an information hub. They also suggested that the difficulties of cross-sector information-sharing and effective collaboration need active investment into relationship-building, with specific time sanctioned for collaboration.

Horwath and Morrison (2007) suggested that organisations need flexible structures in order to be able to effectively collaborate with other services. The writing team behind the Green Paper for Vulnerable Children wrote about collaboration to solve the 'wicked problem' of child abuse in Aotearoa New Zealand (Cribb, Lane, van Delden, Penny & Irwin, 2014). They described the significant obstacles to effective collaboration, and suggest that successful cross-sector initiatives require organisational flexibility to be child-centred, rather than agency-centred. Service that is responsive to the complex needs of vulnerable children did not neatly fit into the existing Aotearoa New Zealand governmental agency structures, and so flexibility and innovation was required. In their project to protect vulnerable children, team members had to have the freedom to work outside of the constraints of agency positions, to relinquish their agency identity, and to be creative. They

also endorsed the value of having a common goal, and common language, and commitment from each party.

In the wake of the Better Public Services reform, Majumdar (2006) conducted a literature review of collaboration among Aotearoa New Zealand government agencies. He identified factors necessary for successful collaboration included mutual understanding and respect, informal and personal relationships, open communication, shared purpose and goals, flexibility and a favourable political climate. Effective cross-sector collaboration requires participating organisations to reduce the disparity in power, resources and skills. Majumdar (2006) identified research suggesting that Aotearoa New Zealand government agencies have a propensity to shift responsibility to other departments, or to withdraw from collaboration. Additionally, he referenced a report by the State Services Commission (2001) that highlighted difficulties with cross-sector collaboration in Aotearoa New Zealand government departments due to a lack of coordination, frequent re-structuring, risk aversion, power imbalance, unclear roles and responsibilities, inadequate staff expertise, and a lack of strong leadership.

In discussing his work to improve outcomes for young people with disabilities in Aotearoa New Zealand's care system, Carter (2010) made note of recent improved relationships between CYF and the Ministry of Health. He suggested that cross-sector relationships have improved as a result of a two-pronged approach of firm and formal commitment to collaboration at the management level of each Ministry, and good interpersonal relationships between cross-sector staff at the operational level. A Memorandum of Understanding between CYF and the Ministry of Health was created, following a report that looked at the various legislative and policy frameworks for children with disabilities, and a review of the various cross-sectoral interfaces. Additionally, effective cross-sector collaboration was enhanced through interagency meetings. This was particularly useful for agencies to learn more about the limitations of each service, thereby reducing cross-sector frustrations.

Summary

There are clear benefits to cross-sector information-sharing, both generally, and also specifically in youth justice residences. However, a review of the literature highlights the challenges associated with information-sharing in a youth justice residence. There are complex workforce issues in each sector, both of which operate in the stressful environment of a youth justice residence. These issues are compounded by factors that impact on information-sharing practices, particularly regarding individual and service relationships. These relationships are underpinned by leadership approaches

to information-sharing, the availability of joint training, and opportunities to meet face-to-face. Cross-sector frustration can result from differing approaches to privacy, lack of policy, and no shared information systems.

In deciding the methodological approach to this particular research project, the literature review shaped the questions that were asked, as I sought to understand more of the 'unseen' relational and cultural aspects of information-sharing practices. The next chapter contains a comprehensive description of the methodology, which has been informed by the literature review about information-sharing, workforce issues, and factors impacting on information-sharing.

Chapter Three
METHODOLOGY

This chapter describes the methodology used for this research project, including the theoretical approach, method, participants, procedures and ethical issues. This qualitative research sets out to explore the views of youth forensic service (YFS) clinicians and youth justice residence case leaders about information-sharing between each team. In particular, the aims were to explore both sectors' expectations about the content, form and function of sharing information within youth justice residences in Aotearoa New Zealand, and to identify factors that contribute to effective information-sharing in that context. I also wanted to explore what an information-sharing model may look like that is aligned to the needs of both sectors.

Theoretical orientation

As Suter (2012) explains, the research questions drive the design of the study. In deciding between quantitative and qualitative research approaches, it was useful to compare the two. Quantitative research is used to test a hypothesis, with numerical data, and deductive reasoning moving from general theories to specific hypotheses (Suter, 2012). It is based in positivism, which legitimises only those things the can be observed (Willig, 2001). Positivism locates the researcher as objective expert (Grant & Giddens, 2002). The anti-positivist movement arose in order to understand the person as a whole, and is situated within qualitative methodology (Cohen, Manion & Morrison, 2011). Qualitative research is more concerned with words than numbers, is useful to explore the meaning-making processes of humans, allows hypotheses to emerge, with inductive reasoning moving from descriptions to general principles (Suter, 2012). The researcher's role is to interpret the data to find what meaning people attach to events (Grant & Giddens, 2002). Given that my research question was about exploring professionals' experiences, expectations and solutions about the practice of information-sharing, I chose a qualitative design. I was interested in understanding my participants' experiences, rather than testing a hypothesis. I did not position myself as expert, but rather as an inquirer.

My methodological approach was informed by my views of the nature of existence in knowledge production (ontology), the nature of knowing (epistemology), and the best methods to build knowledge (methodology). Guba and Lincoln (2005) explain that every researcher has a paradigm

that guides their research. This qualitative research has been informed by my constructivist ontology. Carey (2013) describes ontology as the belief about the nature of social reality. A constructivist ontological approach sees reality as constructed by cultural and social norms. Carey (2013) explains that a constructivist ontology assumes that unbiased research is impossible, although the researcher is aware of their own biases and tries to mitigate these. Miller (as cited in Fortune, Reid & Miller, 2013) highlights the importance of the social work researcher understanding themselves, their history, and the inherent biases they bring to their research. He advocates for a reflexive approach, continually considering the impact of personal researcher history and experience on the research itself. This approach was particularly important given my dual role as both practitioner and researcher in this field.

I also took an interpretivist approach, which values the perspective of the participants, and seeks to understand their interpretation of events, which is influenced by cultural beliefs, attitudes and practices (Hammersley, 2013). My approach has been to explore people's experiences, frustrations and hopes with information-sharing, with the understanding that these views are formed within an organisational culture.

Epistemology considers what is deemed as knowledge, and defines the relationship between the knower and the known (Grant & Giddings, 2002). These theories of knowledge justify the knowledge building process of the researcher, as epistemological assumptions underlie decisions about research topics, questions, theories, methods, analysis and conclusions (Pascale, 2010). Gringeri, Barusch and Cambron (2013) argue that social work researchers must make their epistemology explicit in order to have integrity and legitimacy in contributing to the profession's knowledge base. My epistemology is subjectivist, and so I sought the opinions of my participants in order to inform a model of information-sharing that is meaningful for those who use it (Davidson & Tolich, 2003).

This research is exploratory with inductive theory generation. In discussing qualitative social work research, Thyer (2001) posits that qualitative research is inductive, with themes emerging through the data analysis, albeit through the researcher's personal lens. He argues that inductive qualitative research usually has a low generalisability. I was not seeking to establish a universal and generalisable model of all information-sharing across sectors, but instead a specific model of information-sharing to be applied in this particular field of practice. As the focus group data was gathered, it became clear that working in a youth justice residence brings a unique set of challenges that requires a specialised approach to information-sharing, particularly in regards to recommendations for care on the unit.

The research is solution-focused with the aim of conceptualising a model of information-sharing that aligns with organisational, clinical and privacy needs. This is based on the assumption that practices of information-sharing are developed in a social and organisational context, as I sought to find a model that best fits both sectors' needs.

Practitioner as researcher

I have been working as a mental health clinician in a youth forensic service since 2011. My role has involved mental health assessments for young people in the Youth Court, as well as the provision of mental health assessment and intervention for young people in a secure youth justice residence. My experience of working with multiple stakeholders within the youth justice arena led me to be curious about this topic of cross-sector information-sharing, and how my own cross-sector partners made use of the information I provided about young people.

I moved into the area of youth forensics after five years working in a community child and adolescent mental health team. This move signalled a transition from individual and family-focused assessment and treatment, with a strong emphasis on client privacy, and minimal information-sharing with other professionals, to a role with multiple stakeholders, and a mandate to share information about young people. I became interested in how my cross-sector partners experienced information-sharing with my own team, how that information was perceived and understood, and how other youth forensic services in Aotearoa New Zealand were practicing information-sharing.

Practitioner research has been defined as a "central commitment to the study of one's own professional practice by the researcher himself or herself, with a view to improving that practice for the benefit of others" (Dadds & Hart, 2001, p. 7). Practitioner research involves a practitioner carrying out a research enquiry for service improvement or to understand their own practice better (Shaw & Lunt, 2011). Practitioner research has been identified in recent years as a means for improving the evidence base of social work practice (Harvey, Plummer, Pighills & Pain, 2013; Lunt & Shaw, 2011). However, there are a number of barriers for embarking on practitioner research, including practitioner confidence in research methods, time demands, funding and the skill required in managing complex political and organisational factors (Harvey et al., 2013; Lunt, Ramian, Shaw, Fouche & Mitchell, 2012).

Obtaining voluntary consent for participant recruitment as a practitioner researcher was important, particularly for my own team, and the youth justice residence I work in. Ethical issues related to practitioner research are discussed further below. During the analysis, I attempted to avoid either

minimising or exaggerating the data about cross-sector frustration, while also maintaining a solution-focused approach. I did this by engaging in a reflective process, and also discussing these issues in supervision.

The benefits of practitioner research to the social work researcher themselves have also been identified in the literature, including reflection on 'practice puzzles', a fuller understanding of the evidence base, increased confidence in research methods, and increased communication with colleagues about practice issues (Lunt & Shaw, 2017). This was my experience as a practitioner researcher, as I became increasingly reflective about practice issues. Fuller and Petch (1995) suggest that it may be easier for practitioners to develop collaborative relationships with professionals, than it would be for academic researchers with limited experiential knowledge of the field of practice. This is due to participants feeling that the researcher has some understanding of the work, and they are part of the same community of professionals. Again, this was my experience during the participant recruitment phase. Additionally, Lunt and Fouche (2010) recognise that practitioners often have valuable institutional knowledge, and the social work skills of engagement, interviewing and problem solving can easily be transferred into the researcher role. Fook (2002) contends that when practitioners share knowledge generated through practice research, they make accessible to the profession the accumulated, tacit store of practice wisdom.

My experience as a practitioner in the field allowed me to have an experiential understanding of some of the roles, tensions and practical issues in a youth justice residence. My practitioner role assisted in navigating processes for all the teams to participate in the research, as I had knowledge about the structure of the teams, and who to contact. This also helped with engagement processes at the start of each focus group, as many professional connections could be made. In each residence there was at least one young person I had worked with previously, due to the high level of movement of young people between the four residences. I was familiar with several of the complex cases that were discussed, so was able to understand the mental health presentations, while participants shared with me their experiences of information-sharing.

Māori consultation

Māori cultural consultation for this research project was important due to the bicultural nature of the work. For many complex reasons detailed in my introduction section, youth justice residences are overwhelmingly filled with Māori young people. While the research question was around professionals' experiences of information-sharing, the information being shared was predominantly

about Māori young people, and the purpose of sharing it was to improve outcomes of those young people.

Kaupapa Māori methodology involves Māori researchers using Māori methods in order to benefit Māori people (Health Research Council, 2008). This research project did not use Kaupapa Māori methodology, as I am a Pākeha researcher. However, I was cognisant of the history of research in Aotearoa New Zealand done *on* Māori *by* Pākeha, and the negative impact this has had for Māori communities (Smith, 1999). Māori cultural consultation, therefore, was crucial for me to navigate access to the teams, and build strong relationships.

As the research involved four regions of Aotearoa New Zealand, Māori consultation was required for both local and national tikanga (protocols). Consultation occurred with my university primary supervisor, Dr Matt Shepherd. Matt is of Ngāti Tama descent, and is experienced in researching interventions for Māori young people. I also consulted with Patrick Mendes, Māori Cultural Advisor at Auckland District Health Board. He helped me prepare my pepeha (heritage introduction) for focus groups, and advised on Tainui protocols when visiting Ngaa Ringa Awhina, the iwi-based service. In order to access participants from that service, my research proposal was reviewed by their Board, who consented to the research. There was further consultation with the Māori Research Advisor for Auckland District Health Board, specifically looking at how the research may benefit Māori communities. Māori cultural consultation also occurred with the ethics applications through the University of Auckland and with Oranga Tamariki.

Māori rituals of engagement were utilised in the focus groups with karakia (prayer), mihimihi (greetings) and pepeha (introducing myself and sharing a little of my background). As per Tainui protocol, with the Ngaa Ringa Awhina focus group I used te reo Māori to acknowledge the Māori King and his royal family. Whakawhānaungatanga (establishing relationships) occurred when I made connections with my participants at the introduction stage of the focus groups, either through shared clients, previous shared employment, or via connections with my colleagues. This process increased the sense of familiarity within the focus groups, and a sense of national connectedness across a specialised workforce. I provided kai (food) for each focus group to assist the feeling of connectedness and comfort. By following these cultural practices I demonstrated cultural respect and a commitment to bicultural practice.

Participants

Given that the research question was about experiences of information-sharing between youth justice residences and youth forensic services, the research participants were case leaders from Oranga Tamariki secure youth justice residences, and YFS clinicians. Case leaders are responsible for the overall case management of a young person in a youth justice residence, and a conduit for information about them. They develop the young person's care plan and transition plan, and are the main contact person for professionals involved in the young person's care. Case leaders are all registered professionals, and many of them are social workers. I chose to invite case leaders, rather than care teams who work in each unit, as the case leaders are the people most involved in the practice of information-sharing, and take responsibility for the overall case management of a young person while in residence. The same approach was taken for YFS, seeking to understand clinicians' experiences of information-sharing, as they are responsible for the mental health treatment of the young people in youth justice residences. YFS clinicians are all registered professionals. They come from a range of disciplines, including social workers, psychiatrists, occupational therapists, nurses and psychologists.

As there are only four youth justice residences in Aotearoa New Zealand, I wanted to invite case leaders and YFS from all four regions. While this required eight focus groups, two in each region, I thought it was important to capture the voices from all relevant staff in the country. The specialised nature of this work, and the relatively small numbers of professionals involved, made a compelling case for including all four regions in this research project.

Procedures

My data collection method was focus groups, which were held with each service. Focus groups were chosen in order to get a wider range of data. I have been interested in organisational approaches to information-sharing, which fits well with a focus group representing one organisation. There were additional benefits, including providing a more relaxed setting to ask about standard practice and cross sector frustrations, and to encourage solution-focused group discussion (Alston & Bowles, 2003; Davidson & Tolich, 2003).

Research participants were sought via recruitment notices that were sent to managers of each residence and each youth forensic team, and can be found in Appendix A. This occurred after

managers had signed consent forms for their staff to participate in the research project. Those staff that wished to participate in the research then contacted the research team directly.

Participants were invited to attend a focus group in the region in which they worked, either Auckland, Rotorua, Palmerston North or Christchurch. There were two focus groups in each region, one for case leaders from the youth justice residence, while the other comprised YFS clinicians. The focus groups were separated organisationally, in order to explore each sector's unique views on content, form and function of information-sharing, as well as their experiences of sharing information with the other sector. The focus groups were separated regionally for practical reasons, and to increase the opportunity for participation.

Participant recruitment in this research project was fairly straightforward. Most of the services opted to participate as a whole team, with the support of their managers. Focus groups were held at times that suited the teams, and there was liaison with each team beforehand. It seemed that the only impediment to participation was that some potential participants were away on the day, or dealing with other work issues, such as matters in the Youth Court, or attending to crises on the units. Unfortunately, there was only one chance for participants to be involved in a focus group, due to the travel commitment required across each region of Aotearoa New Zealand. My other role as a practitioner in the field seems to have contributed to a high participation rate in the research, as many of the participants had some prior work experience with me, a court report written by me, or some experience with my team. It seems that this connection gave me some legitimacy, and therefore access to all of the teams (Shaw & Lunt, 2011).

Focus groups were held on-site at the participants' place of work. Each focus group began with an introduction of myself (or an introduction of my supervisor for the Auckland focus groups, as discussed in *Ethical issues* section below), and the research project, with food provided. The focus groups were relaxed, and characterised by whakawhānaungatanga (making connections), forthright sharing of practice examples, several periods of humour, and many practice-based suggestions for building on information-sharing processes and cross-sector relationships. Each focus group demonstrated an understanding of the pressures on the other sector, and there was a sense of goodwill between all teams. The focus groups lasted between 45 and 90 minutes. Each one was audio-recorded, and later transcribed. For the four youth justice residence focus groups, the numbers of research participants in each group were 2, 5, 5 and 6. For the four youth forensic focus groups, the numbers of research participants in each group were 1, 4, 4 and 9.

One planned focus group turned into an interview, as, unexpectedly, only one participant was available on the day. That participant indicated that they were happy to proceed with an individual

interview, and were asked the same questions as the focus groups. The University of Auckland Human Participant Ethics Committee was consulted after the interview in order to ensure that the interview still met my ethics protocol and could be included in this research. The content of that interview was similar to the focus groups held with that sector, with consistent themes of difficulties and opportunities.

Focus groups require preparation, and are moderated by the interviewer (Carey, 2013). Questions were prepared in advance, with time available to follow up on topics that emerged through the discussions. An ethical approach to focus groups necessitated that I made it clear to the groups that I was not committed to a particular position, while also being skilled at encouraging divergence of opinion and equal opportunities to participate (Davidson & Tolich, 2003). When meeting the research participants, I acknowledged my role within the Auckland YFS, and the knowledge and professional connection associated with that, while explaining my role as researcher for that particular meeting.

There was a high degree of participation in the research, with all Aotearoa New Zealand youth justice residences and their YFS teams agreeing to participate. Within each team there were good levels of individuals choosing to participate, with 18 out of 25 youth justice residence case leaders opting to be involved, and 18 out of 28 YFS clinicians. That translated to 72% of all youth justice case leaders, and 64% of all YFS clinicians working in a residence. Overall there was a 68% participation rate for all potential participants in Aotearoa New Zealand.

Table 1

Research participation uptake

Area	**YJ residence potential participants**	**YJ residence actual participants**	**YFS potential participants**	**YFS actual participants**
1	6	5	9	9
2	7	6	7	4
3	4	2	2	1
4	8	5	10	4
TOTAL	**25**	**18**	**28**	**18**

All eight focus groups were asked the same set of questions, with an attitude of appreciative inquiry (the focus group questions are attached as Appendix B). Appreciative inquiry is most often used as an organisational development tool for change, but can also be used in research (Reed, 2007). The approach is concerned with discovering what is already working in organisations, and then dreaming about how this could be even better (Norum, as cited in Given, 2008). Appreciative inquiry is a deliberate search for positives, as a catalyst for collaborative and inclusive organisational change. This approach sits within a constructivist paradigm, recognising the thin line between the researcher and the participants (Norum, as cited in Given, 2008). In particular, participants were asked to describe several cases where there had been good experiences of information-sharing, and asked to reflect on the factors that contributed to that. They were also asked for their own ideas about how there could be improved cross-sector information-sharing. While there was one question about frustrating experiences of information-sharing, the emphasis was firmly on building on strengths, and eliciting participants' ideas about improved practice.

Ethical issues

Ethics approval was gained from the University of Auckland Human Participant Ethics Committee and from the Oranga Tamariki Research Access Committee. As an employee of Auckland District Health Board (ADHB), I also gained research approval from the ADHB Research Office in order to involve ADHB staff in a focus group.

Conflict of interest

Perceived conflict of interest was perhaps the most significant ethical issue in this research project. The research was about information-sharing between Oranga Tamariki and YFS. I work in a YFS, and so have understanding of their perspectives and processes. One of the motivating factors for this research was to understand more about Oranga Tamariki perspectives. However, given the relational foundation of this research inquiry, there was potential for perceived conflict of interest. I may have been seen to be invested in protecting and promoting YFS, potentially at the expense of Oranga Tamariki. My role as an insider researcher may have impeded participants' ability to fully explain concepts if they thought that I understood the context. There was also the possibility that my own colleagues may have felt undue pressure to participate in the research project.

These ethical issues were addressed through removing myself from the Auckland focus groups, and asking my supervisor to conduct the two focus groups in Auckland, with my YFS team, and the local

youth justice residence. Those clinicians and case leaders from Auckland that wished to participate in the research were asked to contact my supervisor directly to be included. While I knew the pool of potential participants, I did not know who had elected to participate and I was out of the office when the focus group took place with my team. Additionally, I only had access to the anonymised typed transcripts of the Auckland focus groups, and so was unable to identify the participants through voice recognition. These processes were implemented in order to increase the opportunity for research participants from Auckland to feel able to speak freely, and for my direct colleagues to choose whether they participated in the research, without undue influence from me. I also adopted a stance of naïve inquirer during the focus groups. For example, I asked some questions that I already knew the answers to, such as questions about referral processes. I did this so that participants would provide a greater depth of explanation.

These issues come under the umbrella of completing insider research, and have associated issues regarding dual roles of practitioner and researcher (Sikes, 2006). Perceived researcher bias is an ethical issue when researching your own field of practice. In their work on the ethical issues of practitioner research, Lunt and Fouche (2010) describe a number of 'ethical trip-wires' raised through practitioners researching their own field of practice. These include negotiating access to participants, ensuring that participants do not feel coerced to participate, protection of ongoing relationships through careful writing of the study, and the dangers of 'role blurring' in qualitative practitioner research. Closely linked to perceived conflict of interest was my dual role as a practitioner researcher. The next section outlines how I managed this dual role.

Dual role

My own role clarity was important during this research project. My dual role of researcher and practitioner influenced this research project, from the initial planning of the research questions, through to the meetings with the research participants, and the analysis. The research questions were developed in the context of having experience of information-sharing, and being curious as to how my own cross-sector partner received and interpreted information I gave them, and wondering what information was most helpful in their role in the youth justice residence. I also wanted to find out if my own expectations about useful information from the residence were shared with other YFS clinicians around the country. I was aware of my role in a YFS team, when involved in a research project looking at relationships between YFS teams and youth justice residences. While the topic was information-sharing, at its core the research was about the relationship between the two sectors, and ways to strengthen the relationship.

This dual role required careful navigation of ethics applications, how I introduced myself to research participants, the inquiring stance I took during focus groups, and examination of the impact of myself on the research analysis. Fox, Martin and Green (2007) argue that practitioner research cannot be removed from the practitioner researcher, that this relationship exists and should be acknowledged, and that developing the skills to manage the relationship between the research and the research is imperative.

As a practitioner in a youth forensic service, I was aware of my potential bias towards over-identification with the perspectives of YFS. I was mindful that this potential for bias may have been considered by the participants, particularly the residential case leaders. I managed that bias by asking the same questions of both sectors, being transparent about my employment, and clearly stating that the research was being conducted in my role as researcher, rather than representing my employer. I maintained an open stance to understanding various perspectives, and encouraged participants to be frank with me, with the knowledge that their responses would be de-identified in any written analysis.

I was also aware of my own practice preference of erring on the side of sharing more information, rather than less. I adopted an inquiring stance during focus groups, in order to understand participants' reasons for the amount of information they chose to share. My interpretivist approach valued the opinions and meaning-making of the participants.

Fox, Martin and Green (2007), in writing about practitioner research, suggest that there are benefits to researching your own area of practice, with insider knowledge. I have been interested in the roles, relationships and expectations between Oranga Tamariki and YFS. The research has been set up to be solution-focused, rather than blaming. As I have been aware of this potential bias towards YFS perspectives, I used supervision to discuss this, particularly during the analysis of the data.

Confidentiality

Confidentiality was a potential issue, given the small potential pool of research participants, and the risk of participants being easily identifiable. I wanted participants to feel they could speak freely. It was important for their specific feedback to be confidential, so that they did not feel disadvantaged from either their own service or the service they share information with. Individuals and specific services have not been identified in the analysis and write up. There has been no comparison of each area, given that the focus is on a national understanding. Each area has local issues that have not been included in my results. After each focus group, I encouraged both local sectors to meet with

each other in order to discuss local issues raised during focus groups, and find local solutions for those outside of this research project.

Confidentiality can be an issue in focus groups. The participants knew each other well, and it could not be guaranteed that they would keep information from the discussion confidential. However, the participants had been asked to maintain confidentiality and they signed a consent form which stated that they would abide by this (see Appendix C). Most of the focus groups were transcribed by a professional who signed a confidentiality agreement (see Appendix D), while I transcribed some of the focus groups that I had conducted.

Often focus group participants asked me what their cross-sector partner had said about specific issues, and who had been included in the focus groups. I considered this to be a positive sign of investment in the cross-sector relationships and the research. However, I did not answer these questions, and instead encouraged each focus group to meet with their cross-sector partner after the focus groups, in order to discuss any localised issues.

Informed consent

Informed consent was another ethical issue, as potential participants were accessed through their managers. It was important that they did not feel coerced to participate by their managers, and that they had the right to say no initially. This was managed through the participant information sheet (Appendix E) and consent form for managers (Appendix C), where it was specified that an employee's participation or non-participation would not affect their position at work. Service managers were not made aware of who had or had not participated in the focus groups, and did not have access to information from the focus groups.

Informed consent was also important with the Auckland YFS and case leader participants, all of whom knew me and have worked with me. This was managed by asking potential participants to contact my supervisor if they wished to participate, and my supervisor conducted those focus groups in Auckland.

Participants' rights to withdraw

In general, focus groups can have issues with participants who wish to withdraw from the research without giving reason after signing the consent form. This was managed by specifying in the participant information sheet and consent form that participants could withdraw from the research without giving reason before the focus group. However, they could not withdraw after the focus

group has started, as removal of data from a focus group could affect the contextual meaning of the remaining data. During the focus group they could choose not to answer questions. However, once they had answered a question, it would have been audio-recorded and form part of the transcript of the group. The participant information sheet stated clearly that individual information could not be withdrawn as it is a focus group, and transcription would not allocate identifying participant names to information given.

There were times when some staff, at the last minute, were not available on the day of the focus group. In those cases the focus group went ahead without them, given the travel involved in this research project. This was decided with the permission of the remaining participants. In the instance when only one participant was available, the focus group became an individual interview with the participant's permission. This process was reviewed by the University of Auckland Human Participant Ethics Committee, who did not deem there to be an ethical issue. There were no times when a participant wished to withdraw during or after a focus group.

Analysis

Following the completion of all focus groups, thematic analysis was used to analyse the data, with themes identified from the inductive coding of the focus group transcripts (Carey, 2013; Thomas, 2006). Braun and Clarke (2006) offer the following process of thematic analysis:

1. Familiarisation with the data
2. Coding
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Writing up

Thematic analysis was supported by the use of NVivo11 software. Analysis of the data was initially done for the four residential case leader focus groups, and then for the four youth forensic service focus groups, in order to find themes distinct to each sector. I then analysed the data at an overall level of the eight services, looking for common themes across both sectors within the four regions.

My rationale for avoiding intra-sector comparison was that I was searching for commonalities nationally, shared experiences within a specialised field, rather than comparison or evaluation of services. The aim of this approach was to capture an overview of the experiences of each sector

(YFS and Oranga Tamariki), and to work towards a national model of information-sharing. Participants consented to the research on the understanding that their unique responses and team responses would not be identifiable, and that the research was solution-focused, rather than evaluative.

The analysis was influenced by my experience as a practitioner, as I found myself drawn to themes that were new learning for me. In particular, I found myself interested in new learning about the case leader's role, the practicalities of a residence, and some of my own experiences that I was surprised to hear repeated by youth forensic services nationally. While I was drawn to this new learning, I also wanted to capture the tacit knowledge that was reflected in the data. This was discussed in supervision, and I went back to the Braun and Clarke (2006) model again and again to ensure that the themes identified were reflective of the data as a whole, and not just the themes that appealed to me as personal new learning.

There was some discussion in supervision about whether to utilise a second person to check my coding in order to ensure inter-rater reliability. However, after reflecting on the literature around thematic analysis, and in particular the views of Braun and Clarke (2006) who advocate against external coding checking, I decided not to do this. The main reason was my constructivist approach to this research, particularly with my role as practitioner researcher. Braun and Clarke (2006) argue that themes do not 'emerge', as they are not distinct concepts to be discovered, but rather are always constructed within the lens of the researcher. Rather than searching for the absolute truth of the data, which is arguably an impossible task, I recognised my own biases, and tried to mitigate these as I identified codes and conceptual themes. The process for this included self-reflection during the analysis phase, and discussion in supervision.

As previously discussed, I was aware of my biases towards over-identification with YFS, and also my practice preference towards sharing more information. Within the analysis and writing of the results, I was also aware of my interest in enhancing intra and cross-sector relationships in this field as a researcher, but more significantly in my ongoing role as a YFS clinician. A significant theme of the research was relationships, and so I found myself analysing and writing the results and discussion with my participants in mind, hopeful that the writing of the research would in itself contribute to improved relationships. Enhancing relationships is a strong value of mine, which I brought to the research project. The challenge was to accurately portray the experiences, frustrations and hopes of my participants, within a framework of goodwill and optimism for the future.

The following chapter contains my analysis of the results of this qualitative inquiry. The analysis contains overall themes, as well as themes related to each of the two sectors. In keeping with my

interpretivist approach, participant quotes have been used liberally, as I have sought to represent the view of the research participants.

Chapter Four
RESULTS

This chapter outlines the findings from eight focus groups about information-sharing in youth justice residences, and answers the research questions about expectations of each sector about information-sharing. Four of the focus groups were with case leader teams from the four youth justice residences in Aotearoa New Zealand. The remaining four groups contained members of the youth forensic service (YFS) teams that provide mental health input into each residence. Members of each focus group were asked the same set of questions, with extra clarifying questions used as needed. The discussions explored participants' expectations of their cross-sector partner, experiences of information-sharing, service needs, and solutions for closer partnerships. The team-based focus groups provided reflective and insightful information which has been analysed and coded. Six themes have been identified, as depicted below. The first two themes were related to the case leader data, the second two were from the YFS data, and the final two themes were common to both sectors.

Table 2

Themes

Residence themes	**YFS themes**	**Overall themes**
Specialised work • Responsiveness and access • Medication • Recommendations	*Assessment* • Whose needs are met? • Quality vs quantity • National YFS disconnection	*Relationships* • Accessibility • Expectations and roles • Risk and trust
Case leaders as brokers • Competing frameworks • Translation	*Discharge planning* • Remand vs sentence • CAMHS	*Care teams are crucial* • The missing link • Processes

In writing about these themes, individual services have not been identified in order to protect their privacy. The emphasis in this analysis has been on exploring a national approach across the four regions, rather than conducting a comparison of the regions. When discussing the relationship between case leaders and YFS staff working together in the same geographical area, they are referred to as 'cross-sector partners'. Additionally, I have not commented on the number of participants or focus groups that provided a certain perspective. The rationale for this has been to protect the privacy of the participants, as it could be easy for participants to work out which team endorsed

certain themes. I have considered themes to be concepts that were discussed in at least half of the relevant focus groups.

All participants presented as invested in improved information-sharing, respectful of their cross-sector partners, and insightful into the complexity of this field of practice. They brought experience of sending and receiving information about young people in residence with their cross-sector partners. Members of each group offered ideas for improving information-sharing, and a willingness to examine their own practice.

Residence themes

Case leaders shared openly about their experiences of working in a residence. They shared their intricate knowledge of how residences operate, and a desire for YFS teams to also be fully-versed in the practicalities of residential life. The two themes from the case leaders were about how the residential environment necessitates knowledge of a specialist field of practice that YFS must operate within, and about the complexity of the case leader role in navigating relationships and ideological frameworks within that residential environment.

Specialised work

Overwhelmingly, residential case leaders reported that YFS clinicians need to understand the context of the youth justice residence, and tailor their approaches to fit the context. Case leaders spoke about the specialised nature of work in a residence, with a higher need for information-sharing, being aware of the practical limits of the residence, providing clinical recommendations that are possible to implement in residence, for YFS teams to work within the limitations around access to the young people, and that high levels of responsivity within a residential context are imperative. Case leaders identified that information-sharing with YFS works best when there is an understanding of the residential environment, and that information, including clinical recommendations, is tailored for this specialised field of practice.

> *A lot of the (YFS) staff that come, they are not aware of the processes prior to get the young person placed here and just understanding residence life also…that the young person is placed with nine other young people in one unit... [it] would be great for the staff to have that understanding when they work with them because youth justice is quite a different world.*

Within this field of practice, case leaders value responsiveness, navigating access to young people, clear information about medication, and YFS clinical recommendations that are able to be operationalised in residence.

Responsiveness

Case leaders described the importance of YFS teams who are responsive to the needs of young people in residence. When describing good examples of information-sharing and communication, all the examples included high levels of timely responsivity from YFS, usually seeing young people within a day or two of a request.

> *They're really good communicators in general, emailing and phoning… Pretty quick, which is important in a residence.*

> *What is really good is (YFS) sends [information] straight back. So before that young person has even arrived we will know whether or not something has to be put in place, what needs to be and [what] the engagement was. That information is crucial because we have to do original risk as soon as that young person comes, and also placed in a unit.*

Responsiveness included YFS making timely appointments, but also YFS being responsive to the needs of the residential organisation, and the needs of the residence staff.

> *If there's an incident on site, something goes down, they've offered to come out and do a group session with the kids and staff. We've had that before. As simple as just ringing, saying this is what's happened, and they just turn up.*

The rationale for valuing a high degree of responsivity was found in the descriptions of life in a residence. One case leader said that all mental health issues are "*magnified*" in a residence, due to the group dynamics and lack of intervention options available in a restrictive environment. Case leaders considered that YFS clinicians often did not appear aware of the impact that mental health symptoms, such as hyperactivity or irritability, could have on the environment of the unit of young people, as YFS staff did not often get to see the young people in their unit and with their peers. Some case leaders felt that YFS teams considered some mental health presentations to be of "*minor"* severity, however case leaders experienced those same presentations to be difficult to manage in a residential environment.

> *Conditions like foetal alcohol, post-traumatic stress and ADHD, oppositional defiance disorder and conduct disorders and things like that. Those are quite big*

conditions for us (case leaders)….For the forensic team, no they are minor, but they are minor especially outside of a residential environment where a young person has got those conditions but they can go for a walk to calm down and you can use all your DBT (Dialectical Behaviour Therapy), they can use sport, they can use music because they have got some headphones.

Accessing young people

Participants in most of the eight focus groups discussed difficulties of navigating access to young people in residence, with only three interview rooms available per residence. These rooms are for YFS, but also used for other professionals, including lawyers, police and social workers, as well as whānau. The meetings are also required to be supervised, with a residence staff member outside the room. The case leaders recognised the frustration this causes for YFS, but also spoke about the importance of YFS working within the existing structures.

They (YFS) are really frustrated about booking times. They want to come in whenever, during the day when they're available, but we have to say kids' health needs and education needs are just as important.

Participants suggested that a high degree of administrative communication is important. YFS teams need to coordinate their own schedules, alongside residence room availability, scheduled unit activities, and meetings young people have with other professionals. This included YFS staff being aware of the school timetable, particularly for favourite subjects such as art or physical education, when young people were less inclined to leave the unit for an appointment.

The booking systems vary across the country, with some bookings being completed by the case leader and some being done by the administration team. Case leaders recognised the usefulness of being aware of YFS assessment times, so that they can inform the young pepole and prepare them for the meeting. Generally, it was considered by the case leaders that preparing a young person before meeting with YFS led to better engagement of the young person in the mental health assessment.

Medication

Medication prescribed by YFS psychiatrists was an issue raised by the case leaders. There was national inconsistency about the amount of information given by YFS to case leaders about medication. The feedback was that case leaders would like to know what medication a young person is on, when they start to take the medication, what the medication is for, any potential side effects, and how long it takes for the medication to start working.

There were unclear processes around medication information-sharing, with some regions reporting that only those young people under the age of 16 have their medical information shared with the residence. The contracted health teams administer medication during the working week, however, on the weekend it is left to residence staff to administer. Some case leaders reported that all parents of young people in residence must be informed about medication. Sometimes it was left to case leaders to inform whānau about medication prescribed by YFS.

> *I think just to make us really aware that the medication is starting and how they are tracking for that….If we just know when it started, how come, and when will it be reviewed…So I have had younger boys start medication and their families have been contacted by the forensic nurses. But if they are older boys then it's sort of left to us to gather it up and put it all together…I have no knowledge around medication and, you know, that is why I refer them to the health team, because I'm not a specialist in that health area and you want to be giving the correct information.*

When members of a YFS focus group were asked about medication information-sharing and weekend prescribing, they moved from an initial stance of maintaining privacy around medication, to a recognition of the complexity of balancing privacy and safety in a residence where medication is administered.

> *There is probably a bit of confidentiality stuff coming in with medication of young people and should Oranga Tamariki know what they're on? Yes, they are going to know anyway, aren't they better to know…I suppose for the purpose we try and ring the parents of the young person who is under the age of 16. We try and make that standard practice. But as far as a broad thing at this time and place, they are in the care of Oranga Tamariki. So I see them as the parental guardian at that time to do with their medication and therefore they are the ones going to see the side effects, I ain't. I don't administer it, I don't do anything, you know, they need to know.*

Recommendations

All of the case leader groups spoke about the importance of YFS staff providing recommendations that are workable and possible within the residential environment. Generally, it was felt that those YFS clinicians who were more familiar with residence operations tended to provide more valuable feedback and recommendations for the residence staff. When asked what YFS information frustrates

case leaders most, each group spoke about recommendations that were impractical to implement in residence. In discussing unhelpful recommendations, several examples were provided:

> *We don't have the ability to be able to separate…three units, ten young people in each unit and then the secure unit. So one of the recommendations was for, I think for them to be able to go and have their couple of hours away from the others so that they could learn to self-regulate the emotions... we do not have the ability to.*

> *Even just temperature control, go to a bathroom and wash your face with a flannel, and we don't have flannels in the bathroom, so like an idiot…you flip the coin on who is going to tell the care team.*

> *There have been recommendations to bring him from his room to sit with staff in the night and have milo…because the other boys would all want…and putting our staff in an unsafe position having to bring him out by themselves late at night.*

All case leader groups described useful recommendations as *"practical"*, and most spoke about recommendations that could be understood by all levels of personnel within the residence, and that were possible to implement within the group dynamics and the restrictive environment. It was acknowledged that many of the YFS recommendations would be suitable for a young person in the community, but that they needed to be tailored for the residential environment, where there are restrictions on items that can be brought in, minimum staffing ratios, the need for adherence to a behavioural management system, and a lack of quiet spaces.

Case leaders valued having practical information about diagnoses, with lay-person language about common symptoms, ways for staff to respond, and any possible side-effects of prescribed medication. Most case leaders expressed a preference for more explanation from YFS than had been received, particularly information that could be passed from the case leaders to other staff within the residence. There was also a preference for YFS to be specific in what feedback or unit observations they would like from case leaders.

The discussion from case leaders highlighted the specialised nature of providing mental health services in a youth justice residence, where access, timeframes, group dynamics and available interventions differ markedly to those in the community. Case leaders value those YFS clinicians who become familiar with youth justice residence operations, and adapt their approaches to suit the environment.

Case leaders as brokers

The second theme from case leaders was about their brokerage role in the residences. The complexity of the case leader role was reflected in the focus group discussions. Case leaders spoke about the myriad of demands placed upon them, from YFS, other external providers, care teams (floor staff working directly with the young people on each unit), residence management teams, site social workers and whānau, along with the young people themselves.

> *Sometimes we need to encourage family to engage with them (YFS), 'this person is doing an assessment and haven't been able to get hold of you, they'll try and ring.' I'm that medium person, develop that relationship with whānau, don't want them to be scared to talk to professionals, let them know it's alright.*

Case leaders can be seen as brokers between various people, the conduits of information. They move fluidly between different worldviews, with an ability to translate information and concepts across different organisational frameworks.

> *Balancing act to be a case leader, sandwiched in the middle, pressure coming down and pressure coming up. We're in the middle, with nowhere to put it. We just have to cope with it.*

Competing frameworks in residence

A significant theme from the case leader data was the tension between different frameworks within the youth justice residences, and the impact this has on information-sharing. During the focus groups, these two models or frameworks were consistently labelled the 'clinical' and 'operational' models. Residence case leaders described being part of a clinical team within a residence that has relied on operational models. Figures 1 and 2 have been developed as a result of comments made in the focus groups.

Figure 1

Competing models in residence

Figure 2

Competing models in residence

Operational model	**Clinical model**
Residence is for containment	Residence is for rehabilitation
Behavioural incentives	Therapeutic interventions
Rewards	Sensory modulation
Risk management for the unit	Risk management for the individual
Business as usual	Individualised care
Behavioural language	Clinical language
Behavioural management scheme	Trauma-informed

Within the youth justice residences, the case leaders are often impacted from management pressures of risk management, and expectations of the care teams, which are mostly made up of youth workers, who are not required to hold a formal qualification, who work directly with the young people on the units on rotating shifts. Trauma-informed care training was underway during the research project, with the aim of increasing understanding of the impact of trauma on behaviour, and preventing re-traumatisation in residence. However, many case leaders spoke about the difficulty of implementing new approaches with long-serving care team staff who are practiced in behavioural management techniques.

> *That's a difficulty between (YFS) and our management. They'll (YFS) give us suggestions and what is best practice with this young person, and our staff are like 'nope we're not going to do that, we're going to do whatever the hell we want'. It's hard for us, but it's really hard for (YFS) too because it makes them go 'what is the purpose, we're here to provide you with clinical guidance, but you're just ignoring us and doing the opposite of what we know works'. Or some staff challenge the findings, 'I've been doing this for x number of years'. It's their set beliefs and values, and that can be really, really difficult.*

Many of the case leaders spoke about their shared understanding with YFS for a clinical approach to the young people. These cross-sector partners are often operating within the same framework of understanding. The tension between models arises when case leaders attempt to operationalise these clinical plans within a residence that operates from a different model.

> *They've (YFS) got a really therapeutic approach, and we've (case leaders) got a really therapeutic approach. We are really limited to what we can facilitate here because of what our leadership team decide for us. Us and (YFS) are on the same page, the rest of site aren't on the same page.*

Care teams are tasked with managing a group of young people, ensuring they stick to the schedule of activities, and reducing the risk of violence amongst the young people. Behavioural management schemes are used, with incentives provided for positive behaviour. A common difficulty occurs when mental health interventions are then viewed by care teams and other young people on the unit as undeserved 'incentives', which are seen as undermining the behavioural management scheme. Examples were given about the use of sensory items for emotional regulation, particularly in the secure unit.

> *Providing sensory items for young people in secure care, it's so important, but having a punitive stance of 'no, this is secure care you have to be miserable here'... That's the vision here, that secure is where they need to be punished.*

Another difficulty noted was case leaders' brokering role with the care teams, encouraging individualised approaches to young people.

> *Post-traumatic stress conditions… and how carefully you need to manage your responses. Unless it is very specifically decided, the team aren't going to be that specific about how they manage their response.*

Case leaders showed understanding of both the operational and clinical frameworks, and were working hard to increase cohesion and common understanding within the wider residential staff team.

> *I see both ways… We shouldn't take away things that are helping them, and it's really hard to get buy-in if there's nothing in front of them to work towards, and if it's unfair. You're trying to get this group of kids to do what they're trying to do, and then these ones over here are on their own path. You're always going to get ones on their own path. It's the nature of the place, but it's hard to convince these*

ones that 'you're on the right track, keep doing the right things, you'll get there, the things they're getting'.

Case leader as translator

Participants in every residence focus group spoke about the importance of translating clinical recommendations into operational language that can be implemented by the care team. This translation includes explaining jargon related to diagnoses and psychological language, a full explanation of diagnoses and possible medication side-effects, and also giving practical directions for how to respond to young people who have specific mental health needs. Case leaders would like YFS staff to provide feedback that has been translated into operational language, and are appreciative when this happens. However, they are also adept at doing this themselves, providing brokerage and translation services between YFS and care teams.

They [YFS] know the history of the young person. They know the other things they are looking for, but they can translate that down to a language that our care team can understand. Cause not all our team are clinicians.

Case leaders are constantly managing multiple relationships. While YFS clinicians share information with case leaders, the case leaders then have the challenging task of translating the information, to align clinical recommendations and operational plans, and to get buy-in from operational managers and care teams. Effective case leading requires a sound understanding of two competing frameworks, working to bring these together, and excellent interpersonal relationship skills.

Summary of Oranga Tamariki expectations

One of the research questions explored the expectations of Oranga Tamariki case leaders in terms of the function, form and content of information-sharing with YFS clinicians.

Case leaders want information from YFS so that they can provide the best care for young people in residence. Both sectors agree that this is the function of information-sharing.

Case leaders would like information from YFS in two forms – both written and verbal. The written feedback is more formal, including assessment letters. It is often received via email, and may end up on the young person's Oranga Tamariki file. Storage of this clinical information requires clarification, particularly whether the YFS information remains in the Oranga Tamariki file, and how it may be used in the future.

Verbal feedback is much less formal, and occurs in the context of multi-agency team (MAT) meetings and other face-to-face meetings between case leaders and YFS. Verbal feedback usually contains a greater depth of information, with opportunity to question and clarify, particularly in light of the residential environment. The verbal feedback also strengthens the cross-sector relationship. Case leaders would also like more training from YFS teams about mental health diagnoses, and for YFS teams to spend time with the care teams and on the units to understand the residential environment.

While some case leader teams were happy with the amount of information they received, overall case leaders would like YFS to provide more information, in a simplified format. The content that case leaders are requesting can be divided into the phases of a young person's involvement with YFS.

Pre-assessment

Ideally, case leaders would like information from YFS before the young person even arrives at the youth justice residence. The information that is most helpful includes their previous mental health history, which prepares case leaders to manage any risk of suicide or self-harm in the residence, to identify any additional needs they may have in residence, and it may inform which unit the young person is placed in.

Case leaders would like access to the section 333 reports when a young person first arrives in residence. Section 333 court reports provide useful information for case leaders, as they provide the full mental health history, family background, often a section on any risk of violence, and have recommendations for their wellbeing. Section 333 reports are most often completed by YFS teams. They are the property of the Youth Court, and are usually released to Oranga Tamariki. The difficulty for case leaders is that the section 333 reports are not always easily accessible, despite being in the Oranga Tamariki system already. This is particularly problematic when there is a lack of communication between the site social worker and the case leader, especially for those young people who arrive in residence from another area of Aotearoa New Zealand. Case leaders appreciate when YFS can locate these section 333 reports.

Assessment

After YFS has seen a young person for assessment, case leaders would like to receive both written and verbal feedback. An assessment letter with a formulation of their issues, diagnosis (including explanation), risk summary, practical recommendations for the care team, and YFS treatment plan is useful for the case leaders. In the assessment phase, when YFS are looking for information from residence, case leaders appreciate having specific requests of what observations are required, rather than a request for information about general behaviour on the unit.

Treatment

Once a young person is having therapeutic input from YFS, case leaders would like regular feedback. They understand that there are limitations to how much YFS can share due to the confidential nature of therapy, however they are keen to know any change to a young person's risk or changes to the level of engagement by the young person. Additionally, case leaders appreciate practical suggestions for how care teams can respond on the unit, and shared language around therapeutic interventions.

Medication

Once a young person is prescribed medication by a YFS psychiatrist, case leaders want to be informed. There have been challenges around this, as some YFS teams have not informed case leaders about medication for those young people over the age of 16 years. This has been problematic, as residence staff are required to administer medication on the weekend, and therefore will know what medication young people are taking, without any direct information from YFS. The other difficulty is that case leaders are informing whānau about medication, without having the information from YFS. Case leaders would like the medication information for all young people taking medication, and for YFS teams to discuss medication with whānau. In particular, case leaders would like to know the timeframe for medication to be fully effective, and any potential side-effects to be monitoring.

Youth forensic service themes

Data from the focus groups with YFS teams highlighted concerns about poor information-sharing at the assessment and the discharge phases. It was considered that more information-sharing, especially among YFS teams nationally, would prevent the risk of over-assessment in residence for new admissions. Systemic issues about unexpected discharges from residence, and difficulties getting community follow up for young offenders, were significant challenges for YFS teams.

Assessment

The first theme from the YFS teams was regarding the information-sharing challenges during the assessment phase. Most YFS teams reported a lack of information being provided prior to assessing a young person, particularly regarding previous assessments. It was felt by YFS teams that having access to this information would assist in reducing the risk of over-assessment of young people, and therefore increase the chance of good engagement with YFS for those young people who require input.

Three of the four YFS teams meet all new youth who are admitted into residence for a mental health assessment, while the fourth YFS team has a very low threshold for referrals. YFS teams are seeing a large number of young offenders for assessment. Many of the young people who move between residences may not be local to the region, or are only in residence briefly as a remand option. Not knowing how long a young person will be in residence, and not knowing which services in the country have seen the young person previously, means that having quick access to previous assessment information is very useful.

Many of those young people have also had comprehensive psychological or psychiatric section 333 reports through the Youth Court, which often includes information from whānau, Oranga Tamariki, CAMHS, drug and alcohol services, education, and health. YFS teams find these reports helpful to inform their assessment, although this can be difficult as the reports are the property of the Youth Court, and there are restrictions on release of the report to third parties.

> *I'm yet to see a young person that comes into residence with nothing. They've been seen by someone, they have a history, and it's that collateral information that will either help us make a decision that they don't need something, or we do see them and that information gets incorporated.*

Overall, it was considered that early access to previous assessment information is hugely beneficial for YFS assessments.

Assessment in residence – whose need does this fulfil?

Concerns were raised by YFS teams about the potential for over-assessment of young people in residence, and that this serves the needs of professionals, rather than being young person-centred. There are a number of potential assessments, including mental health, drug and alcohol, cultural, educational, and court reports that can all happen concurrently when a young person enters residence.

> *But sometimes the assessment can be a little bit frustrating because we are all going in there, we are all doing our systems, the kids give you like the same assessments. You can't do a mental health screen without asking about AOD and vice versa.*

> *Sometimes I feel that it is tick box, I have to come and do this because we've ticked it and we've done a good job, but sometimes that is frustrating and it is more complex.*

Some participants suggested that the YFS role should be to assist case leaders to collate and read all the previous assessments, and then decide on treatment priorities. This could happen instead of automatically assessing every young person, and was deemed a more effective form of assessment, without a 'tick box' requirement to see the young person before having the relevant background information.

Quality vs quantity engagement

Alongside concerns about over-assessment, YFS teams spoke about an ideological difference between YFS and case leaders about the ideal number of professionals that should be involved with a young person. YFS teams reported a preference to have fewer professionals with a more targeted approach, but felt that case leaders preferred more professionals involved to cover all bases.

> *It felt like, from res, if you get more and more people involved, it would make it better.*

YFS teams also identified differences between the sectors in beliefs about quantity of therapy sessions, with YFS preferring quality over quantity. This could be difficult to resolve when young people had been ordered by Youth Court Judges to attend therapy as part of their youth justice sentence.

> *Therapy is not a quantity thing… More is not always better. I see a lot of young people who turn up, don't want to be there, being encouraged to attend, thinking that just sitting in front of a therapist will fix them. If they (case leaders) understood that therapy is something the young people have a choice about. If they don't want to do it, there's no point doing it.*

> *I think sometimes they're (case leaders) under so much pressure to fix everything, they want us to fix everything and struggle that sometimes it can't actually be fixed in this time period.*

Lack of YFS national connection

Focus groups with the YFS teams often began with comments from participants that it was the first time they had met a clinician (the researcher) from another YFS team. Discussion in every YFS focus group included the frustration with having no national database for YFS and CAMHS information, and no way of knowing if a young person had been seen by another YFS or CAMHS without contacting the service to check. This was particularly problematic given the high rate of movement across geographical regions for young people who end up in residence.

Twenty DHBs and twenty different software systems, the ultimate would be to be all linked in. The idea that you're writing notes, and they're writing there, trying to share notes. It's an aspirational goal to have one system to have all the info.

A national health database where these young people move from residence to residence and chasing up to even get their previous health plan - that would be ideal.

The lack of easy access to national YFS clinical information was seen as an impediment to informed assessment of young people, with YFS teams valuing the input of their YFS colleagues across the country. Alongside the difficulties of information-sharing between YFS teams, there was also a lack of connection between these specialised teams, with little knowledge about how other YFS teams operate, and different processes and expectations for each regional team.

Discharge planning

Difficulties with discharge planning was the other major theme from the YFS focus groups. YFS clinicians spoke about the challenges of young people being discharged from residence unexpectedly, and transfers between residences occurring without warning, for reasons often unknown to the YFS teams. Lack of information shared about impending discharges was seen as both a lack of information from the case leaders, but also a reflection of systemic issues which meant that the discharge is often a surprise for the case leader. This results in a last minute 'scramble' to get everything ready for a young person's return to the community.

Sometimes we're not knowing they are being discharged until they've gone. We are scrambling around to get everything together and send it somewhere.

Additionally, there were difficulties noted by YFS teams with transferring care to CAMHS in the community, as many of the young people do not meet CAMHS referral criteria.

I think we (case leaders and YFS) have the similar frustrations actually, which is always an interesting concept that residence have frustration with site for transition planning, and we have the same similar frustrations. And about not only with site for us, with organisational stuff with Oranga Tamariki, but we also have our own frustrations with our own mental health services, you know, we are not going to meet the threshold [for CAMHS input].

Within difficulties associated with discharge planning, there were sub-themes of issues affecting remanded young people, attachment issues, and problematic transfers of care to CAMHS, each of which is discussed further below.

Remand vs sentenced

The focus group data showed significant regional differences between the proportions of young people remanded versus those who are sentenced in each residence. Remanded young people are in residence for an unknown amount of time, pending further Court decisions. Sentenced young people have a set time they will be in residence, and are further along their Court process. For those residences with a high number of remanded young people, there is a high turnover of young people, with frequent moves in and out of residence. The flow on effect from this is that unit dynamics are often changing, and there are a high number of new admissions. Young people, and the professionals working with them, are often unaware of when they are likely to leave residence.

> *You are constantly trying to find out how long they are going to stay there…. it is only the Judge that decides on the day…And the kids will go to court and they will have no idea whether they are coming back or not.*

For those residences where there are more sentenced young people, there are far fewer movements in and out of residence. When a young person is sentenced to residence, they will have an opportunity for early release at a set date, and another option for the full sentence, which does not exceed six months. Therefore, for those young people who are sentenced, there is a timeframe in mind for the YFS clinicians working with them. Some YFS clinicians expressed a preference for working with sentenced young people, due to knowing that there will be a reasonable amount of time to work with them, and it is easy to prepare for discharge.

> *It's different if they're under orders (sentenced), but when in and out in two weeks, no point starting something if it does more damage.*

However, other YFS clinicians who work predominantly with remanded young people spoke about the importance of getting background information in a timely manner for remanded young people, in order to start mental health treatment before the young person is moved again.

> *I would rather do more assessments and send the people back to the GP myself than miss people.*

Whether a young person is in residence as a remand option or as a sentence can often affect the approach taken after assessment, and will certainly have implications for the work required for a

successful transfer of care to CAMHS or the YFS team at another residence. There were difficulties with transfers of care for most of the young people, but particularly for those who were remanded and who leave residence unexpectedly.

> *We find that quite destabilising, because we have got a treatment plan starting…and then all of a sudden the kid is in the community or they are in… another youth justice residence somewhere, and that means we have to handover.*

Alongside the difficulties for YFS clinicians to prepare for sudden discharges, there were also concerns noted about the impact of high levels of movement in and out of residence for the young people, many of whom have attachment difficulties and experiences of loss.

> *But I mean one of the difficulties is most of the young people we see have got some issues around attachment, and so then to suddenly lose everything unexpectedly without any ending, and then not have any transition or anything, I mean it is a really big deal.*

While there were examples provided about case leaders not informing YFS about plans for discharge, there was also an acknowledgement that the youth justice system contributes to the problem of quick movements in and out of residence. YFS clinicians were concerned about the implications for remanded young people, who often do not know when they will be leaving. YFS clinicians would like to be able to prepare for discharges, both with transfers of care to other services, and also with the young people themselves, with opportunities to have positive experiences of saying goodbye.

Difficult transfers of care to CAMHS

Alongside difficulties associated with discharge planning, several members of YFS focus groups spoke about the challenges of transferring care to CAMHS for young people who return to the community. There was a recognition that YFS services are highly responsive, with high levels of assessment, and many young people receiving mental health treatment, including therapeutic groups, sensory intervention, psychological therapy and psychiatric medication. However, there are challenges with getting those young people to have positive experiences with CAMHS. Possible reasons that were discussed included higher referral criteria thresholds for acceptance into CAMHS and/or young people's lack of motivation, in combination with non-assertive engagement approaches by CAMHS. YFS teams are realistic about these challenges, and would also like improvement in this area, to know CAMHS referral criteria for young offenders, and for more assertive follow up of

young people in the community, often where they are at greater risk of encountering difficulties, due to access to substances.

> *The problem is that CAMHS isn't that responsive either. They subscribe to a different kind of model which emphasises motivated treatment of people really, and so we can't guarantee that, but we have to work within the constraints we've got.*

> *These guys get seen on a way less threshold by us (YFS), and it is really sad, and if they do meet the threshold [of CAMHS] they are not going to be followed up because they are not going to engage, because they are not being assertively followed up.*

There was some sense of hopelessness about young people transferring to CAMHS care, with an expectation that it would be unsuccessful, and the young person would end up back in residence for YFS to start again. However, it was also felt that YFS could build better relationships with CAMHS in order to get more young people seen by CAMHS. It was also discussed that smoother transfers of care could be achieved through knowing in advance when young people would be leaving residence, and then being able to share information in a timely manner with CAMHS.

Summary of YFS expectations

One of the research questions was about the expectations of YFS in terms of the function, form and content of information-sharing with Oranga Tamariki case leaders.

As with case leaders, YFS clinicians agree that the function of information-sharing in residence is for improved outcomes for young people. Additionally, they want accurate information to assist young people after they have left residence.

YFS clinicians would like access to all previous written assessments for young people. For those section 333 reports that have not been written by the treating YFS team, YFS clinicians reported difficulties with accessing the reports. When requesting release of section 333 reports from the Youth Court, there is often a delay, which is problematic within the short timeframes of assessment in residence, particularly for remanded young people who may move quickly.

Alongside formal written reports, YFS clinicians appreciate emails and verbal feedback from case leaders. YFS clinicians identified that more communication with care teams is an area for improvement.

The content that YFS clinicians are seeking from case leaders can also be divided into the phases of involvement. The discharge phase is particularly important for YFS clinicians.

Pre-assessment

Before YFS sees a young person for assessment, they like to have a summary of their family background, including any care and protection history. Given that most of the young people in youth justice residences have a care and protection history, YFS clinicians are seeking summaries of traumatic experiences. Alongside this, YFS appreciate receiving the Towards Wellbeing (TWB) risk summary, which outlines their history of self-harm or suicidal behaviour, with risk and protective factors. The TWB risk summary is provided to Oranga Tamariki through Clinical Advisory Services Aotearoa, a private external clinical provider who consults to Oranga Tamariki social workers, with no direct contact with the young people. There has been some confusion about whether Oranga Tamariki can release this information to YFS, although it is very helpful when it is shared.

Assessment

When YFS are completing an assessment of a young person, they often like to receive feedback from case leaders about general behaviour on the unit, including the young person's sleeping patterns, eating, and any interpersonal difficulties. Alongside this, YFS like to have some indication of a discharge timeframe, which may inform if YFS decides to engage with the young person for treatment.

Treatment

For those young people who are having therapeutic input, often weekly sessions, YFS clinicians would like updates from case leaders about any changes to their behaviour, upcoming court dates, any admissions to the secure unit, as well as any positive achievements that they can reinforce during sessions. YFS teams also like to see a young person's operational plan, and provide input into it.

Medication

When YFS prescribes medication for a young person, they would appreciate being informed about any instances of medication refusal, as well as any potential side-effects noticed by the care team and/or the case leader.

Discharge

Information to prepare for discharge is very important for YFS teams. They want to know from the beginning about a young person's discharge plan. Once a discharge date has been set, YFS teams want to know this straight away, as well as contact details for where they will be discharged to. While YFS teams will see anyone in residence, they are aware that CAMHS teams often require parental/caregiver consent for young people to be accepted into their service. Therefore, discharge

address contact details are important for YFS teams to gather consent for transfer of care to CAMHS in the community.

Overall themes

Looking at all the data from the eight focus groups spanning the two sectors, there were two key themes. The first was about the quality of relationship between the two sectors, the impact this has on information-sharing, and factors that contribute to positive relationships. Participants from each of the focus groups also discussed the crucial role of care team staff members in the information-sharing process, and identified increased YFS contact with care teams as an area for improvement.

Relationships

Discussions about cross-sector information-sharing inevitably resulted in participants commenting on cross-sector relationships. Unsurprisingly, those teams who described close relationships with their cross-sector partner, tended to also report higher levels of information-sharing. Overall, there were good working relationships between YFS and residence case leaders, with reasonably high levels of understanding of each sector and respect for each other. Those services with close relationships with their cross-sector partner reported high levels of trust, and fewer barriers to effective information-sharing than those services who had lower levels of cross-sector trust. Table 3 provides a summary of the factors that participants considered helpful for improved cross-sector relationships.

Table 3

Factors that improve relationships

Accessibility	Role clarity	Knowing each other
Visibility	Shared expectations	Predictability
Feeling like part of the team	Trust	MAT meetings

Accessibility

All services reported a high level of accessibility with their cross-sector partner, feeling comfortable to "*pick up the phone and call*" if they wanted information clarified, or had a specific request. This level of accessibility between the two services occurred at the individual level of case leaders and YFS clinicians, and also in regular meetings between the managers of each cross-sector partner.

Accessibility was also helped through each team knowing the members of their partner team, having contact details for them, and opportunities to see each other face-to-face. The regular multi-agency team (MAT) meetings, held on-site at the residence with YFS, education, health and other providers were valued opportunities to see each other, and there was a general feeling that a higher quality of information-sharing was experienced in those meetings. Participants who were frustrated with a lack of written feedback tended to be satisfied with the quality of verbal information shared in MAT meetings.

> *I think the information they (YFS) do bring to MAT is very valuable though, and they elaborate a little bit more on what we've got, and even when the boys are at their meetings, they are really breaking it down for them in a way that they understand, in a way they think the intervention is needed. That is really cool to see.*

Accessibility was also linked to levels of visibility of the YFS team within each residence. Relationships were enhanced with YFS clinicians who attended MAT meetings, and made a point to meet with case leaders face-to-face before or after appointments with young people.

> *That is really helpful actually, if you manage to get a case leader and have a chat with them before or after and have that communication.*

Part of the team

Many focus groups spoke about their cross-sector partners as an extension of their own team. There was a high degree of collegiality across the sectors, and a sense of being in this specialised work all together. Cross-sector partners often gave the same practice examples in the focus groups (unbeknownst to them), and there was an acknowledgement of the other sector's point of view for complex cases.

> *I think also one other aspect of them (YFS) is they are very well informed and knowledgeable, but we never feel like we are inferior to them. They are our colleagues and we work together and all of them are working with us.*

> *I think we've got to know them on a slightly personal level too. We don't just have professional conversations, we can ask about their family and things like that. We've got to know them. It feels like an extension of our team. We invite them to Christmas lunch. We've got to know them more than a professional.*

Trust

None of the case leader focus groups reported any psychological barriers to sharing Oranga Tamariki information with YFS, feeling that they could be trusted with information, and would use it to inform their assessment and interventions with young people. Case leaders even spoke about sharing information with YFS that young people did not want widely known, believing that YFS would treat the information sensitively, and could be trusted to act in the best interests of the young person.

From the YFS teams, there was a mixed response about the trustworthiness of Oranga Tamariki as a Ministry. Half of the teams considered Oranga Tamariki to be appropriate guardians of information, however the other half had concerns that historical information about young people's behaviour was exaggerated, continued to remain on their file, and dramatised stories about a young person were repeated. This concern appeared to be more related to the wider Ministry, rather than the case leader team in residence.

> *Some of the stuff that we are told is quite historical stuff… I would hate that youth to be burdened with it all his way through Oranga Tamariki's process…We have found that too when we've got referrals or talked to someone up there, they found something that happened historically, but they drag it on and made it a big hoo-ha and when you actually go and see them it is not a big hoo-ha. I've found that a few times.*

This lack of trust from YFS clinicians about how sensitive information may be used by Oranga Tamariki as a Ministry, over a long period of time was the most commonly cited reason to withhold clinical information from the case leaders.

Expectations and role clarity

Participants were each asked what information they would like from their cross-sector partner, and also what they thought their partner wanted from them. The results have been collated nationally, and compared in the table below. The results show similar expectations with shared understanding of the information that is most useful for each service in their role. Of note, all four YFS teams reported that residence case leaders want "*everything*".

Table 4

Expectations of YFS information

What information case leaders want from YFS	**What information YFS *think* case leaders want**
• Diagnosis and explanation of what this means • Formulation of issues • Medication, including side effects • Recommendations about how staff should respond to the young person • Risk assessment and management • Practical recommendations • Mental health history • Direction about what behaviour to observe • Therapy plans • Input into plans • Feedback if the session was difficult • The young person's progress and engagement • Advice about treatment priorities • Mental health training	• Diagnosis • Formulation of issues • Medication • Recommendations about how staff should respond to the young person • Risk assessment and management • Recommendations • Any changes to treatment • Themes of therapy • "Everything"

Table 5

Expectations of case leader information

What information YFS wants from case leaders	**What information case leaders *think* YFS wants**
• Demographic information • Family contact details • Discharge plans • Incident reports from secure admissions • Reports including s333 and s335 court reports • Care and protection history • Health information • Weekly update with any concerns about mood, behaviour or other major issues. • Any violent behaviour • Any positive achievements • Past mental health history • TWB risk history and summary • Social worker contact details • Court dates • If young person is remanded or sentenced • Any self-harm in residence	• Demographic information • Family contact details • Discharge plans • Secure admissions • Reports including s333 and s335 court reports • Family history • Health information • Behavioural patterns • Sleep observations • Education information • Liaison with young person to prepare for appointment

Participants often spoke about role clarity as a factor that improved cross-sector relationships.

> *Consistent staffing helps with them knowing who to call and what kind of intervention they will get from each one of us. Helps with that trust, knowing what we can and can't do.*

Different expectations between YFS and case leaders about what could be provided by YFS could be problematic. In particular, some YFS teams spoke about the expectation from residence that they could 'fix' young people, or that all behavioural issues would come under mental health, and therefore be treatable. The distinction between mental health and behavioural problems has localised solutions. Treatment of criminogenic needs (risk factors for offending, such as antisocial attitudes) was identified by both sectors as a need within the residence, but there is a lack of clarity about who provides this, and whether this falls under YFS input. There was also comment about the distinction between mental health and disability services, with a number of young people in residence diagnosed with Foetal Alcohol Spectrum Disorder. Case leaders reported that they would like YFS input about these cases, and appreciate any training and advice that could be given.

High-risk cases

Complex and high-risk cases were often used as examples to demonstrate either very good or very bad communication between the sectors. These cases, particularly those that involved suicide risk or psychotic symptoms, tended to be 'make or break' for cross-sector relationships. Case leaders often relied on YFS input into risk management plans, and valued timely responses and clear communication. When there were shared expectations about risk management, there tended to be more cross-sector trust and less anxiety about managing difficult situations. Most of the examples of positive experiences of high-risk cases involved a young person being admitted to an inpatient unit, as discussed further below. Some participants demonstrated the inverse, with complaints about unmet expectations for high-risk cases.

> *One case, it felt like there was lots of confusion on how best to manage her, what was going to happen, lots of concern about risk, and how we should be doing this or that, and disagreement.*

Many of the same high-risk cases were discussed by both YFS staff and case leaders during focus groups, and these tended to be the stand out examples of communication. These high-risk cases can be seen as opportunities for YFS and case leaders to ensure role clarity, shared expectations, and to build trust between the services.

There were examples given about admissions to the recently established Ngā Taiohi forensic inpatient unit. YFS teams have brokering roles in getting young people into Ngā Taiohi, and case leaders expressed much appreciation for the work YFS teams have done to get mentally unwell young people out of residence and into Ngā Taiohi.

> *Another case I can think of is the last one who went to Ngā Taiohi. Yeah the service (YFS), they worked quickly, very quickly. So as soon as they received the information of what the staff had seen, what I had seen, they were quickly onto it. Then worked quickly in terms of getting the referral and they supported the staff's observations, and next minute he was in the youth forensics unit. She went out of her way for that.*

Positive and trusting cross-sector relationships were considered to be critical for effective information-sharing. Relationships were enhanced through positive experiences with each other, particularly for high-risk cases, and when there were clear expectations of each other.

Care teams are crucial

The final overall theme was related to the role of care teams in information-sharing. Three care teams work in each unit on a rotating shift, with a team leader per shift and an operational team leader per unit. The care teams are considered to usually work within an operational model, and there can be tension between care teams and case leaders, as care teams are at the frontline of daily care of the young people in a unit, and may feel they know the young person best. Case leaders are responsible for overall case direction for a young person, and spend less time with young people than the care teams. YFS and case leader teams spoke about the importance of having care teams within the information-sharing link, and recognised room for improvement in this important area. The participant quote below highlights how information is shared between YFS and case leaders, but then has to be passed on to a number of people within a residence, including care teams. There is a continuum of understanding of clinical matters within these staffing groups in the residence, from those who are in a clinical role, to those who have no clinical knowledge or training. When the information is passed on through these layers, the essence of what YFS have recommended can get lost. Having clear written feedback from YFS that could be understood by all of these levels in residence was considered to be important.

> *Case leaders might get it [feedback] verbally, but you really need a pretty good run down, because the case leaders then have got to go, it is the whole difficulty of having second or third hand. Trying to explain it to another operational manager.*

So we go from a very experienced clinician, to somebody that has got a little bit of an idea, you know, is more clinical than the rest of the care team, and then you have got to convince the operational managers.

The missing link

Care teams are considered to be the missing link in existing information-sharing practices. YFS teams usually send through clinical feedback to case leaders. It can often be written in a way that is not accessible or meaningful for care teams, and so case leaders translate the information within an operational framework. The problem occurs when the information that is received by the care teams is not representative of the original recommendations.

We (YFS) put in a recommendation, depending on which case leader got it or which care team was on, when you talk to the person on the floor, it was nothing, it didn't even resemble what we'd first recommended.

Very little direct contact between [YFS] and floor staff, usually mediated through someone…. The ones on the floor who needed the direct support, weren't getting it. They were basically getting it third hand, and it was very different to what we'd said. If we're going to put in behavioural strategies, we need those people there.

There were some positive examples shared of when YFS had put effort into creating communication channels with care teams, with successful outcomes. Case leaders thought that YFS communicating with care teams led to improved relationships and greater understanding of clinical approaches, and therefore higher chances of care teams implementing YFS recommendations in the unit.

So usually the young person will be brought in with a member of the care team staff and they (YFS) will have a good conversation with the care team staff, asking them what they noticed and making them feel like their input is also important.

Sometimes it's nice for them (care teams) not to be listening to us (case leaders) all the time, as much as we do get on with care team, to have that external professional come in and say they're doing a good job.

YFS teams and case leaders thought that care teams benefitted from direct information from YFS in order to allay their fears, as well as YFS receiving more direct information about a young person's behaviour on the unit.

We had a complex kid, and they (YFS) ended up coming to every change over in the secure unit, just discussing with the team about what she was presenting with, what they could do, offering that support every change over, just weekdays. Reassuring the team with such a high case, that they're doing an OK thing. Staff think they need to fix things, make it right, you can feel the panic and fear. Reassuring, saying 'hey look we have everything in place, just follow the plan, go back and read it'. Floor staff get stressed out, reassurance that as long as you follow your plans, being able to explain to them why, the psychological reason why we've chosen to have that plan implemented. A lot of the time the staff don't get it because they don't have the education or knowledge.

Processes

While all focus groups identified that including care teams in communication is important, there was a lack of process around how to do it. There was much discussion about this issue, with suggestions raised about identifying a key care team member who is attached to each young person, YFS providing training sessions with the staff, YFS being part of unit team meetings in order to increase visibility, YFS teams spending time in the units (rather than just seeing young people in the visitor rooms), and YFS casually chatting to care team members who bring young people to appointments. There was acknowledgement that part of the case leader role is to share information between YFS and care teams, but that this did not preclude YFS from having more interaction with care teams.

One of the biggest barriers you just touched on for us communication in (residence). We (YFS) pass on all our information to case leaders and more often than not it seems it doesn't filter down to the people that are actually working with them on the floor, and that is where intervention should be done… I don't know how, it's a large number of staff up there…I don't know what the answer is, because there are three shifts as well, and at any one time I don't know who is working with that young person. So I don't want to email the whole 150 of them about one young person, but somehow getting that information from the case leader to everyone that works with the young person would be really helpful.

Case leaders reported that it is important for care teams to see YFS clinicians, rather than just being forwarded their recommendations. It was also identified that YFS recommendations would be improved through having more of a relationship with care teams, and therefore understanding the practicalities of their work.

> *At the moment (YFS) are seen as the people who think they know lots…well, the care team will recognise that they (YFS) know lots, but they will believe that they don't understand how you practically do it. So ultimately if you want to bridge that, you come along and talk 'this is what I'm trying to do how, do you think I can do it'… I deliberately ask them for it and start to see and they are more willing to try.*

All teams agreed that care teams are the missing link for information flow, they hold valuable information about young people, and are the ones who often implement any YFS recommendations. The research participants are invested in finding solutions for including care teams in information-sharing practices.

Hopes and dreams

The focus groups contained thirteen standard questions asked of each group, along with clarifying questions. The first twelve questions were analysed thematically, as has been discussed. The final question asked participants for their ideas about how to improve information-sharing between YFS and Oranga Tamariki. For this question, I wanted to provide a summary that captured all the ideas put forward by participants. Their responses spanned the themes discussed above, and demonstrated hope for improved information-sharing and specialised practice. The responses have been grouped into suggestions for how residences and case leaders operate, how YFS teams practice, system improvement, and hopes for improved CAMHS uptake in the community.

Table 6

Ideas for improvement

Residences
• Consistency within clinical team • Provide training to YFS about residence • Weekly updates about young people in treatment • Share operational plans • Include YFS in discharge planning • More meeting rooms • Wi-Fi and computer access for YFS • Share calendars for young people's appointments and school schedule

YFS practice • Translate recommendations for care teams • Increased contact with care teams • Provide training for residence • Describe diagnoses • Increased visibility at residence, with dedicated time on-site and in the units • Practical recommendations that work in residence • Weekly updates about young people in treatment • Increase national connection between YFS teams
Systems • National health database • Shared database between YFS and residence • Up-to-date contact lists and updates about personnel changes • National standards about what information to share in residence • Shared plan with contribution from involved parties
Community • Improved outcomes with CAMHS • Greater understanding of young offenders by CAMHS

Research participants provided thoughtful ideas about improved information-sharing processes. These are discussed more fully in the next chapter, contrasting the suggestions with the literature base. Many of these participant suggestions have been included in the practice recommendations in my final chapter.

Summary

A number of themes have been identified from the focus groups. The data analysis has occurred within each sector's data, first from Oranga Tamariki case leaders, and then from YFS teams. The

data has also been analysed at an overall level. Finally, there has been a summary of participants' ideas for improved information-sharing.

The two themes from case leaders are the specialised nature of working a residence, and the case leader's brokerage role within that environment. The specialised nature of residential work necessitates that YFS teams become familiar with the residential environment, and responsive to the needs therein. Case leaders would like YFS teams to deliver mental health services that are responsive in terms of being able to see young people shortly after referral, while navigating access to young people amongst other limits in residence. Case leaders would like YFS approaches to medication information to be tailored to this environment, with more information available for weekend medication administration. Case leaders would also like YFS to make clinical recommendations that are tailored for the residential environment. The second theme from case leader data was regarding their brokerage role. Case leaders shared their experiences of clinical and operational frameworks within residence, and the tension this can cause. Case leaders work hard to translate clinical recommendations into operational plans, and also to translate this information in a meaningful way for young people and their whānau.

The themes from the YFS data were around assessment and discharge planning. The assessment phase of mental health input was considered to be difficult due to a lack of information-sharing prior to assessment, particularly between YFS teams nationally. There were also concerns about over-assessment of young people in residence, and the impact this may have on engagement. The second theme from YFS was regarding discharge planning, which was also seen as problematic due to a paucity of information. Difficulties were noted with discharge planning for remanded young people, who may leave residence with little warning or may transfer between residences across the country. YFS teams also spoke about their frustration with attempts to get young people seen by CAMHS after they have left residence.

The data analysis from all eight focus groups resulted in two overarching themes from both sectors. The first was that relationships are at the heart of information-sharing practices. Cross-sector relationships are strengthened through accessibility, trust, shared expectations, role clarity, and having positive experiences of managing high-risk cases together. The second overall theme highlighted the importance of care teams, who have often been neglected in the information-sharing practices between YFS and Oranga Tamariki. The care teams are considered to be crucial for effective operationalisation of YFS recommendations.

The data analysis was concluded with a summary of participants' ideas about how to improve information-sharing. These ideas were organised into suggestions for YFS, and suggestions for

residences as a whole. There were also suggestions for system reform to support information-sharing, and also ideas for improved mental health service for young people after they return to the community.

The data from participants was rich, highlighting the complexities of information-sharing in the context of youth justice residences. The next chapter brings this information together with the literature review, reflecting on the themes of specialised work, brokerage, assessment, discharge, relationships and care teams.

Chapter Five
DISCUSSION

This research set out to explore the expectations of Oranga Tamariki case leaders and youth forensic service (YFS) clinicians regarding cross-sector information-sharing about young people in youth justice residences, to identify factors that enhance information-sharing, and to develop a model of information-sharing in this specific field of practice. The research project arose out of my experience working in a YFS team, providing mental health input into a youth justice residence, and my curiosity about cross-sector information-sharing experiences.

In the first four chapters of this thesis I introduced the context of youth justice residences and youth forensic services, reviewed the literature about cross-sector information-sharing, described the methodological approach I took, and provided an analysis of the data. In this chapter I provide a comparative discussion of the research findings with the local and international literature and policy reviewed in the first two chapters. This chapter begins with the same structure as the literature review, with a discussion about the need for information-sharing, followed by exploration of workforce issues, and then factors that affect information-sharing. There is an additional section discussing participants' ideas for improved information-sharing in the context of the literature. The chapter is concluded with a discussion of the limitations of this particular project, and scope for further research.

Research findings within the literature context

Information-sharing

The literature review in chapter two canvassed the local and international call for greater information-sharing, client perspectives of information-sharing between professionals, and discussed a model of information-sharing that was developed in the United Kingdom. As has been discussed, there has been recent increased emphasis on cross-sector information-sharing, particularly about vulnerable young people (Ministry of Health, 2011; Ministry of Justice, 2011; The Office of the Children's Commissioner, 2015; The Office of the Prime Minister's Science Advisory Committee, 2011; The Werry Centre, 2009). This was a key component of the *Vulnerable Children's Act 2014*. While this need has been identified at a governmental level, there is also general consensus among case leaders and YFS clinicians that information-sharing is important in relation to the shared clients.

Both sectors want to receive information, and are reasonably aware of information needs of their cross-sector partner. Broader policies that encourage information-sharing are reflected in professional practice, despite limited knowledge of the relevant policies by case leaders and YFS teams.

From case leaders' perspectives, information-sharing is useful in order to ensure that young people's needs are met in residence, and to ensure the safety of the other young people and staff. For YFS staff, the emphasis is more on information-sharing for informed assessments, and to avoid over-assessment of young people. This client-centred approach fits well with research into client experiences of cross-sector information-sharing, with frustration about repeating information to various professionals (Siraj-Blatchford & Siraj-Blatchford, 2010).

Research into Māori whānau perspectives on governmental information-sharing highlighted concerns about sharing culturally sensitive information (National Research and Evaluation Unit, 2013). The concerns raised in this research project by YFS teams were less to do with culturally sensitive information, much of which is included in a mental health assessment, but about the sharing of information that may create prejudice about a whānau. This includes information about trauma and behaviour, which remain on a young person's file, and may be inaccurate. This particular issue highlighted an issue of mistrust between some YFS teams and Oranga Tamariki as a Ministry, and how information is used once a young person has left the youth justice residence. While there appear to be good levels of trust between YFS and case leaders, YFS are less trusting of Oranga Tamariki as a Ministry.

The work done by Lennox et al. (2012), in establishing a model of information-sharing for adult prisoners in the United Kingdom, is reflected in this current research project. Lennox et al. (2012) identified that prison staff want information about mental health history, while mental health staff want information about risk and sentences. Their finding that mental health teams usually received more information than the prison staff received, was similar to the current findings. Most case leader teams wanted more information from YFS, but they also wanted that information to be more appropriate to the youth justice residence setting. Overall, YFS teams reported satisfaction with the information received from case leaders, on the basis that they received most of the information that case leaders had available to them. The identified issue was a lack of Oranga Tamariki information available to the case leaders upon a young person's admission to residence. YFS teams usually proceeded with assessments while case leaders gathered a range of information from site social workers and other professionals. However, often the information gathering and dissemination occurred after the assessment had been completed by YFS. This highlights systemic information-sharing issues within Oranga Tamariki, where there is a lack of quick access to relevant Oranga

Tamariki information to case leaders, despite working within that sector and having a shared database. There are also issues of poor information flow between the various YFS teams, although this is compounded by the lack of a shared mental health database.

While the findings of this research project align with both policy and literature about information-sharing, it is also clear that the existing policies and literature doesn't provide the specificity required for this particular field of practice. There has been no other research looking at information-sharing in youth justice residences. The theme of specialised work was apparent across the focus group data. Case leaders were keen to emphasise the specialised nature of work in a residence, and by extension, the specialised nature of the form and content of cross-sector information-sharing in a residence. This research project is the first of its kind, and is hopefully used as a catalyst for further cross-sector information-sharing policy and practice clarification.

Workforce issues

The second section of the literature review explored workforce issues, including general findings about institutional milieu and the ways in which organisational culture is developed, and then specifically looking at Oranga Tamariki and YFS workforce issues. While the literature focused on the tensions between sectors, this current research project offers a different focus. It seems that case leaders and YFS clinicians generally operate within similar frameworks of clinical understanding, however the tension arises from competing frameworks within youth justice residences. There was some hint of this in the Office of the Children's Commissioner (2015) report, which identified tensions between containment and therapeutic models within youth justice residences. This was supported by the report into youth justice residences that suggested one overarching framework for the residence (Lambie et al., 2016). However, I hadn't anticipated the degree to which case leaders struggle with adapting YFS recommendations into operational models that are palatable to the majority of the care teams. Instead of thinking about navigating organisational culture issues between the two sectors, this research project has highlighted that the careful navigation occurs within the residence, between case leaders and the other residential staff. The organisational cultural tensions are intra-sectoral rather than cross-sectoral.

It was pleasing to note that many of the recommendations made by the Ministry of Health (2011) about YFS workforce development appear to have been implemented, particularly about youth forensic training. While case leaders wish that YFS knew more about the residential environment and the operational framework, there is still a high value placed upon YFS input. Case leaders appreciate YFS clinicians' clinical expertise and ability to engage with young people. There was one important recommendation made by the Ministry of Health (2011) that has not yet been

implemented. This was in regards to a national YFS forum. It is unclear why this has not yet occurred, particularly as this current research project clearly demonstrates the need for a national approach to YFS. Those research participants from YFS teams indicated interest in a national forum. It is hoped that this current project can add to the momentum towards the establishment of a national YFS forum. This is discussed further in the recommendations section in the final chapter.

Factors that affect information-sharing

One of the research questions was to identify factors that contribute to effective information-sharing in youth justice residences, which was the basis of the final section of the literature review. From the research findings, factors that improve cross-sector information-sharing and collaboration can broadly be grouped into relationships, role clarity, training, and processes. Each are discussed in further detail below, and contrasted with the literature.

Relationships

Unsurprisingly in this study, the quality of cross-sector information-sharing reflects the quality of cross-sector relationships. This aligns with the literature on cross-sector cooperation, which emphasises the importance of relationships (Haight et al., 2014; Iam, 2016; Richardson & Asthana, 2006). In each of the four geographical regions there are positive professional relationships, with mutual respect. Trust is a significant factor in positive cross-sector relationships, and those cross-sector partners with higher levels of trust and respect described more positive relationships.

Chuang and Wells (2010) researched cross-sector collaboration in child welfare and youth justice, and found that individuals' relationships were linked to information-sharing practices. This finding was also apparent in the current research project, where participants often identified specific staff members with whom they enjoyed better relationships, and thus shared more information with those individuals.

Interestingly, there was little participant discussion about the impact of leaders and managers on information-sharing practices. This is in contrast to the literature that suggests leadership is influential on collaborative efforts (Agranoff & McGuire, 2001; Daley, 2009). The lack of comment about leadership supports the notion that information-sharing practices are developed at the interface between case leaders and YFS, and that this is often affected by the quality of relationships between those individuals, irrespective of management approaches to cross-sector information-sharing.

Co-location has been identified as a possible enhancing factor for relationships (Gask, 2005; Laming, 2003). The recent review of youth justice residences recommended that YFS teams should be onsite

at the residence (Lambie et al., 2016). Case leaders expressed a desire for YFS to be more available at residence, in order to have those informal conversations and time in the units to build relationships with care teams, observe young people, and be available to answer staff questions. However, having YFS teams based permanently onsite at residence was not an option that was raised by the participants. It sems that those YFS teams that are able to spend unstructured time in the residence, chatting to case leaders and using the staffroom, are strengthening the cross-sector relationship, without the need for permanent co-location.

Cross-sector relationships were enhanced through positive experiences with each other, participation in MAT meetings, getting to know each other informally and personally, and having the opportunity for conversation about young people. Face-to-face communication was key for those conversations, with give and take, opportunities to clarify and explain, and negotiate about the best way forward.

The lack of relationship between the different YFS teams nationally may contribute to the paucity of information flow between each YFS team, despite seeing many of the same young people who move between residences. While there are certainly issues of different information systems among the YFS teams, the difficulties with information-sharing appear to be exacerbated by the lack of relationship between clinicians across the forensic teams, many of whom do not (yet) know each other.

Role clarity

Those teams that enjoy good cross-sector relationships tend to have clear expectations of their own role within the residence, and also understand their cross-sector partner's role. Role clarity has been identified in the literature as a factor to improve information-sharing (Cameron & Lart, 2003; State Services Commission, 2001). Getting clear about what YFS provides, and what is possible in the residence, was seen as important to smooth cross-sector relationships and expectations. Written agreements about what YFS provides were seen to be useful, although only some YFS teams have done this, and each seems to have been done in isolation.

This research found that there is a reasonably good level of role clarity currently, particularly between case leaders and YFS. The two areas to improve upon are having clearer expectations about what information can and should be shared, and improving role clarity between YFS and care teams.

Training

Joint training was identified in the literature as a means of establishing role clarity and strengthening cross-sector relationships (Darlington et al., 2004; Sandford, 2004). Training about the roles of each sector was seen as crucial to set up appropriate expectations and work collaboratively (Grace et al.,

2009; Siraj-Blatchford & Siraj-Blatchford, 2010). Lambie et al. (2016) had recommended trauma-informed care training at youth justice residences, in order to have a framework of understanding young people that moves beyond a simple behavioural explanation, to take account of the impact of trauma, and reduces the risk of further traumatisation in residence. This training was being rolled out during the course of the current research project. It was seen as a way of bridging the operational and clinical models.

The data from this research project also supported the idea of joint training as a factor to enhance cross-sector understanding and appropriate information-sharing. In particular, YFS teams would like to provide training about mental health diagnoses, and case leaders would like to provide training to YFS teams about the residential environment. This is aligned with the research about adult prisons in the United Kingdom, where prison staff would like external providers to have more understanding of the risk issues within a prison (Mills et al., 2012). Given the high quality cross-sector relationships, and the functional information-sharing practices already in place, it is surprising how little joint training has been provided thus far.

Processes

The final category of factors to enhance information-sharing is processes. Processes occur at the individual level and the service level.

As has already been discussed, effective information-sharing often happens at an individual level between professionals who have good working relationships and understand each other's role. Those individuals have often set up individualised, effective processes of information-sharing, outside of any formalised service-level agreement. Most often, it involves cross-sector partners sharing weekly updates about the young people they are working with. A case leader may email YFS with an update about the week's events and the young person's behaviour. The YFS clinician will then see the young person for an appointment, followed by a brief visit to the case leader to provide a handover, or an email with themes of the session and recommendations for the care teams. It is these processes, developed by individuals, and performed week after week, that exemplify excellent information-sharing.

Service level processes include dedicated information gatherers and new admission processes. Some YFS teams have staff in dedicated roles to gather information for the assessments, and to disseminate information to stakeholders, including case leaders. This is similar to the 'integration coordinator' role described by Shepherd and Meehan (2012), although the role is firmly within YFS, rather than joint ownership across both sectors. Some residences have processes for gathering information about young people as soon as they are known to be arriving at residence. This helps to get all the

education, health, drug and alcohol, and mental health information gathered and prepared before a young person even arrives at the residence. These service-level processes help to ensure good information flow, with systems in place, rather than relying on individuals.

There are further potential processes that have been identified as helpful for information-sharing. The first is for increased national consistency about the individual and service-level processes, having some formalised understanding of how much information to share, and when to do so. Additionally, processes could be implemented to develop a residence orientation programme for YFS staff, and a regular joint training schedule for both sectors.

Each of the four categories of effective factors – relationships, role clarity, training and processes – all work together. While most of the existing research has listed the contributing factors, this research demonstrates the interrelationship between each factor, and how positive cross-sector relationships are strengthened through continued positive experiences. It is relationships that often underpin practice, and relationships are strengthened through role clarity, which is informed by training. Effective relationships and shared expectations are assisted through formal and informal processes that reinforce patterns of information-sharing practices.

Participants' ideas for improvement

The research participants offered a number of suggestions for improved information-sharing practices in youth justice residences. A full list of recommendations are provided in the final chapter. Many of those recommendations have been discussed above, including joint training, national YFS connection, and opportunities for face-to-face discussion. These are all supported by the literature base.

There were some practical suggestions about the residential environment, including having more meeting rooms available, access to computers for YFS staff, Wi-Fi, and access to calendars for young people's appointments. These are specific practical barriers when working in a youth justice residence, and do not appear to have been identified in previous research. This research project involved direct input from YFS clinicians who regularly work in youth justice residences, and the identification of such practical barriers seems to be a unique finding.

Research participants' recommendations regarding YFS input were around the use of language. Finding common language about risk and mental health terminology has been identified as an important factor for collaborative work (Darlington et al., 2004; Cribb et al., 2014; Skowrya & Cocozza, 2007). While case leaders appreciate the input from YFS teams, they would like the

recommendations to be translated into operational language. The use of language should not be underestimated, and common language can be found through joint training.

It was also suggested, by case leaders and YFS teams, that there should be more direct communication and interaction between YFS teams and care teams. There is existing research that supports the idea of having contact between mental health teams and those staff working directly with people, including in prisons (Lennox et al., 2012) and schools (Rothi & Leavey, 2006). However, this was the first research project to identify this need within a youth justice residence.

There were a number of participant recommendations about the need for clear policy in this area, which is widely recognised in the literature (Bai et al., 2009; Bryson et al., 2006; Darlington et al., 2004; Harland & Borich, 2007). However, it did not appear that a lack of policy was an impediment for effective information-sharing. What was identified as a major barrier for information-sharing was the lack of a national health database. If such a database was implemented, YFS teams could easily discover tha a young person had perviuosly been seen by another YFS team, and then access information from each region. The Health Information Strategy Steering Committee (2005) identified that national access to health information was a priority, however this is yet to result in a shared database across the 21 District Health Boards for mental health services, including YFS.

Finally, there were suggestions made about improved referral outcomes from child and adolescent mental health services (CAMHS). YFS teams expressed frustration with the low levels of retention of young offenders within community CAMHS teams, which they attributed to the model of care utilised by CAMHS. General CAMHS teams are not funded to provide assertive outreach services. However, there is a wealth of literature showing the positive effects of this approach for 'difficult to engage' young people (French, Reardon & Smith, 2003; Ryall et al., 2008; Schley et al., 2011; Schley et al., 2012). Naylor, Lincoln and Goddard (2008), in their review of a specialist mental health service for young offenders in the United Kingdom, found that flexibility and outreach appointments helped young offenders to engage in the service. Given the significant mental health prevalence rates among the young offender population (The Werry Centre, 2009), and the structural, cultural and practical barriers to engagement in traditional CAMHS (Appleby & Phillips, 2013), investing in assertive outreach approaches within CAMHS is important.

Limitations

A model of information-sharing is proposed in the final chapter, which is based on the themes identified, and the specific requests of each sector raised during focus groups. There are limitations

to the model I have proposed, and to the research project as a whole. The model has been developed based on the feedback from case leaders and YFS clinicians. It has not been reviewed by the managers of the various services, or by the Privacy Commissioner. The model is based on the assumption that a young person consents to information-sharing between case leaders and YFS clinicians, which happens for the majority of cases. However, difficulties arise when a young person does not consent to their information being shared. This is particularly problematic for medication, when residence staff administer medication on the weekend, and thus are privy to what is being administered.

While this is the first research project of its kind, exploring case leaders' and YFS clinicians' experiences and expectations of cross-sector information-sharing, the scope of the research is limited. Participants did not include service managers, as the research was about the staff members; experiences of information-sharing. While all eight services were included in the research project, not all potential participants chose to be involved. It may be that those professionals who were most interested in the topic opted in, and so I was unable to capture the perspective of staff who are less invested in information-sharing.

Further research

This research project provided rich information about the perspectives of case leaders and YFS clinicians on information-sharing. However, it also raised several other questions that have not been answered.

This research project did not include the voices of the young people themselves. This was a deliberate decision, due to the constraints of a Masters thesis. However, it would be interesting to hear from the young people about their experiences of professionals sharing information about them, their views about re-telling their stories in multiple assessments, and what they wish case leaders and YFS understood about their experiences in residence.

The role of the care teams was a significant finding from the research, and one that I did not expect. The research project did not include the perspective of the care team staff, which would have provided valuable information about their experiences and expectations of YFS staff in residence. This is a possible area for further research.

There is scope for evaluative research following any implementation of an information-sharing model. While this research project was concerned with expectations of cross-sector partners, an

evaluative research project could examine any link between information-sharing practices and outcomes for young people.

There could also be an evaluation of information-sharing practices between YFS teams following the establishment of a national YFS forum, and whether improved intra-YFS relationships contribute to improved information-sharing between YFS teams, and how this may impact on the service that young people receive.

Summary

This chapter has contrasted the research findings with the literature. The findings are well aligned with local and international research about factors that enhance collaborative efforts and cross-sector information-sharing. While much of the research has focused on factors affecting information-sharing across sectors, this research highlighted the importance of effective information-sharing and communication across different ideological models within the same sector. Specifically, this was identified with the clinical and operational frameworks within youth justice residences.

This research project is unique in its particular focus on information-sharing in youth justice residences in Aotearoa New Zealand, and the specific nature of the residential environment was an important theme from the findings. There is scope for further research in this area, and in particular regarding the role of care teams in information-sharing practices, and the voice of the young people themselves.

The final chapter contains a model of information-sharing, and proposes a number of recommendations for practice, which have been identified through the data collection and analysis. There are also concluding remarks on the research project, and the impact on my own practice.

Chapter Six
RECOMMENDATIONS AND CONCLUSION

Against a backdrop of increased emphasis on information-sharing across sectors, this was the first study into the expectations of Oranga Tamariki and YFS regarding information-sharing. Participants from each sector contributed well-thought through ideas for how information-sharing should occur, based on their experience of working in this sector, and the shared goal of improved outcomes for young people who spend time in a youth justice residence.

In this final chapter, the research questions are answered and a model of information-sharing is presented, along with recommendations for practice, and concluding remarks on this research project. The practice recommendations have been based on the feedback from research participants. They are separated into recommendations for case leaders, recommendations for YFS clinicians, and other recommendations for external parties.

Research questions

Most of the research findings are aligned with the existing literature, with additional insights that are specific to this area of practice. At this stage it is useful to return to the research questions.

What are the expectations of Oranga Tamariki case leaders and YFS clinicians about the function, form and content of information-sharing with each other?

The expectations of both Oranga Tamariki case leaders and YFS clinicians were captured in the results chapter, with specific information identified as useful for their respective roles in the youth justice residence. This information has been summarised in the model of information-sharing in the next section. On the whole, there is an adequate level of satisfaction with the information received, although both sectors would like more information. In particular, case leaders would like clinical recommendations that are translated into operational language for care teams. YFS teams would like more information about a young person before their assessment and as they prepare for discharge from the residence. It is recognised that there are systemic barriers to this information, rather than

unwillingness from case leaders to share information. The difficulties lie in case leaders accessing young people's background information when they first arrive at residence, including previous reports, and also difficulties associated with speedy discharges from residence for remanded young people.

What factors contribute to effective information-sharing in youth justice residences?

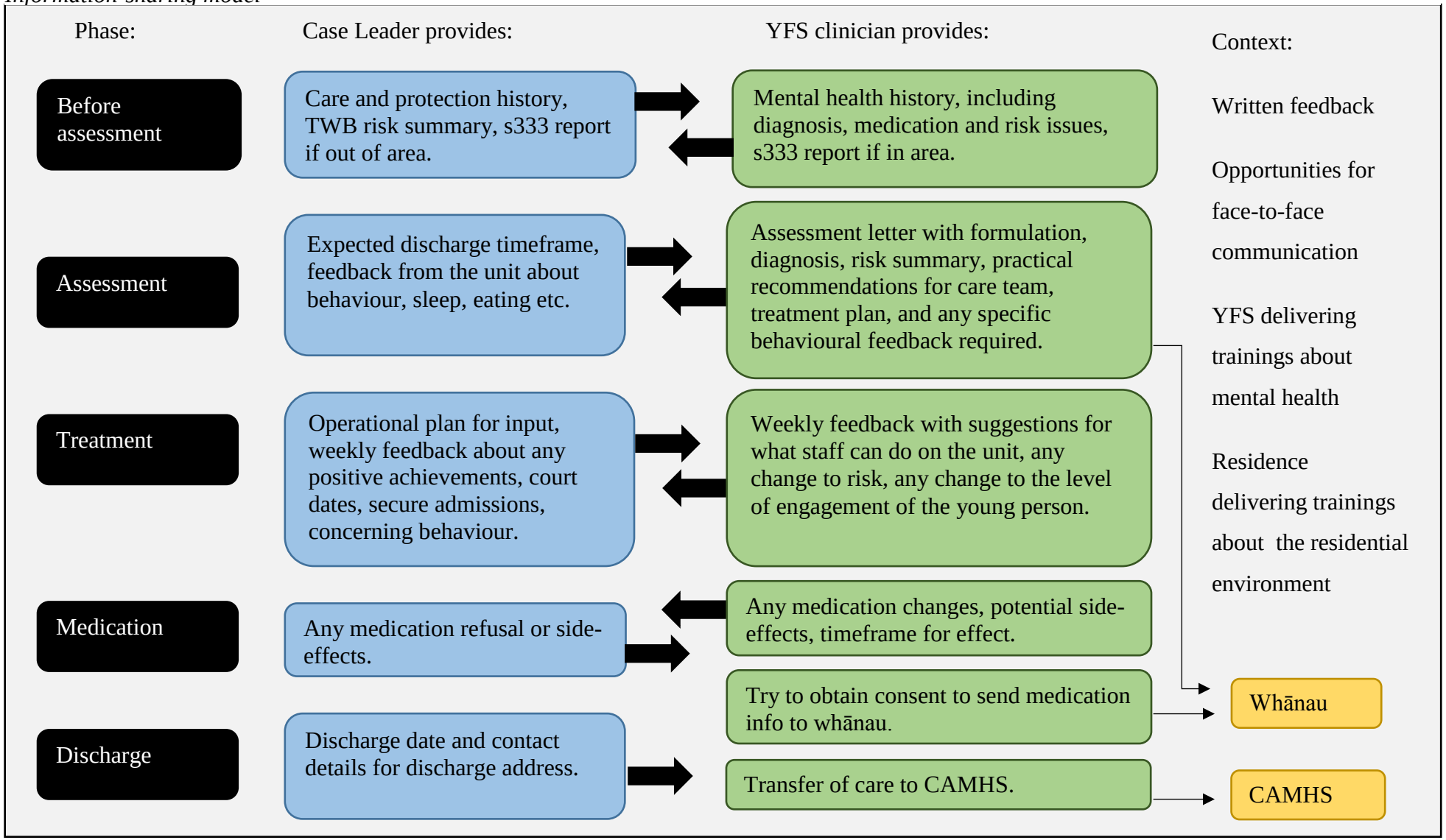
From the research findings, factors that improve cross-sector information-sharing and collaboration can broadly be grouped into relationships, role clarity, training, and processes. As discussed, these factors are interrelated and build upon each other. Case leaders and YFS teams have worked hard at building positive working relationships, and have mutual respect. An area for improvement is information-sharing between YFS teams nationally, which would be assisted through the same four factors of relationships, role clarity, training and processes.

What is a model of information-sharing in youth justice residence that meets the needs of both sectors?

Collating all the findings about what each sector would like, and the factors that enhance information-sharing, I have developed a model of information-sharing in youth justice residences, as depicted on the following page.

Figure 3

Information-sharing model



Practice recommendations

A number of practice recommendations are made, based on the data from this research project. The recommendations are separated into three sections. The first are recommendations for residence case leaders, and predominantly come out of the data from YFS clinicians. The second section of recommendations are for YFS clinicians, and are based on the data from case leaders. The final section includes recommendations for a range of other parties, including Ministry-level decisions.

Recommendations for residence case leaders

1. Information about when young people are due to leave residence is very valuable for YFS teams. A priority is to ensure that YFS have information as early as possible about upcoming court dates, the likelihood of bail, early release hearings, expected discharge dates, and discharge addresses in the community. Letting YFS teams know earlier will assist with young people getting appropriate service follow up in the community, and will help YFS clinicians to facilitate positive final sessions with young people.

2. While case leaders are experts in navigating residential procedures, YFS teams need support. Case leaders can assist in arranging training for YFS teams about the youth justice residential environment. This will help to ensure safety in the residence, and will result in more appropriate recommendations being made by YFS.

3. Case leaders have a role in transforming systems so that care teams are more involved with YFS. As case leaders are often brokers within residence, they should take the lead with exploring ways in which to include care teams with YFS information.

4. It would be helpful to have a clear policy about how clinical information received from YFS will be stored and used by Oranga Tamariki, and what happens to that information when the young person leaves residence.

5. There are a number of practical barriers to YFS appointments, including room bookings, unit schedules, and access to computers. It would be helpful for case leaders to consider localised solutions for these barriers.

Recommendations for YFS clinicians

6. A priority for YFS is to develop a national YFS network, which has already been identified by the Ministry of Health (2011). This could include shared contact lists, opportunities to meet face-to-face, and an annual national forum. Developing a national YFS network will help to form a distinct YFS identity, reflecting the highly specialised nature of the role.

7. YFS clinicians need to understand the residential environment in order to provide effective services and appropriate recommendations. It is recommended that YFS teams have orientation processes for new staff, including training about residence. This requires collaboration with Oranga Tamariki about how best to deliver a training programme.

8. When YFS clinicians are familiar with the residential environment, it will become apparent that many of the community-based mental health interventions have to be modified in residence. It would be helpful for YFS teams to develop a toolkit of recommendations that are suitable for residence, and even better if these are shared nationally amongst the YFS teams.

9. Work is required on processes of information-sharing about medication, rather than automatically not sharing medication information for those young people 16 years and older. YFS teams would benefit from training about Gillick consent, which presumes competence, deeming the delineation of information-sharing for those under and over 16 years irrelevant (Ministry of Health, 1998). Instead, adopting a stance of requesting consent to share medication information, particularly within a context where Oranga Tamariki staff administer weekend medication, seems a more appropriate approach within residential YFS work. It would also be helpful to obtain consent to share medication information with whānau, particularly in those residences where case leaders will share the information if YFS does not. Having clinically accurate information from the treating team is the best option.

10. Thought needs to be put into how to include care teams in communication pathways. Having contact between YFS and care teams leads to improved understanding, greater YFS legitimacy, and more effective implementation of YFS recommendations. Care teams can be included through training forums during team meetings, asking care teams for feedback about a young person when they are brought to appointments, and YFS spending time in the units. Re-thinking how to include care teams will require discussion and negotiation between Oranga Tamariki and YFS.

Recommendations for other parties

11. It would be helpful for information-sharing practices to be formalised at a Ministry level, with clear expectations about what information each sector can and should share. This research project assists with this, but still requires careful consideration of complex privacy issues, and mandate by the respective Ministries.

12. It would be useful for policy clarity about which service provides treatment for criminogenic needs in residences, and whether this falls within the YFS remit.

13. Section 333 reports are useful for YFS teams, particularly when treating young people from another region of Aotearoa New Zealand. YFS teams are not part of the group of professionals that section 333 reports are routinely released to by Youth Court Judges. Currently YFS teams can request release of the report for the purposes of assessment and treatment in residence, but this can take time, which is problematic in a residence. It would be useful for this issue to be explored by the Ministry of Justice, with consideration of including YFS teams in standard report releases, particularly for those young people in residence.

14. It would also be useful for Oranga Tamariki to clarify how section 333 reports and indicative mental health assessments, completed by YFS in Youth Court, are filed by the Oranga Tamariki Youth Court Supervisors. Having an electronic version of these reports on the Oranga Tamariki database would make it easier for case leaders to locate the reports without relying on site social workers to forward them.

15. Research participants have strongly identified the need to establish a national health database, particularly for YFS teams to easily find mental health information for young people they are treating.

16. There is already an acknowledgement that fewer young people should be remanded into a youth justice residence due to the impact this has on their overall wellbeing (Lambie et al., 2016). This research project confirms this, highlighting the difficulties of providing mental health care for young people who are remanded in residence, and then leave unexpectedly. This research supports the proposal for more community-based remand options, particularly

within a young person's own community, where there can be continuity of care for mental health provision.

17. Decisions by Oranga Tamariki about transfers of young people between residences should be made carefully. Consideration of the impact of disrupted YFS input is important. Additionally, these decisions could include consultation with YFS teams who are actively providing mental health treatment for those young people.

18. Work is required for CAMHS to become more responsive to the mental health needs of young offenders. One of the barriers occurs when CAMHS teams require caregiver consent for mental health treatment, which can be problematic for young people with care and protection needs who are motivated to engage with services. Although aligned to a whānau approach, strict adherence to requiring caregiver consent as a referral criterion means that some young people miss out. This policy seems to meet the needs of CAMHS, rather than the needs of young people, and requires further thought and legal clarification.

19. Additionally, it would be helpful for CAMHS to develop assertive outreach teams for difficult-to-engage young people, such as the typical young person who has been in a youth justice residence. Improvement is required in the transitions between YFS and CAMHS, with greater understanding of each service, and a commitment from CAMHS to assertively meet the mental health needs of young offenders. This is particularly important given the high rates of mental health needs among young offenders.

Conclusions

Youth justice residences are fascinating places, filled with young people with multi-faceted challenges, staffed by a dedicated workforce, with multiple external providers. Cross-sector information-sharing about young people in residence is important due to the high rate of mental health issues among this population, the multitude of professionals involved, and the risk issues associated with residence life.

The aim of this research project was to explore the views of youth justice residence case leaders and youth forensic clinicians regarding sharing information about young people with mental health needs. The additional purpose was to identify ways to improve information-sharing with shared

expectations across the two sectors, with the development of an information-sharing model specifically for this context.

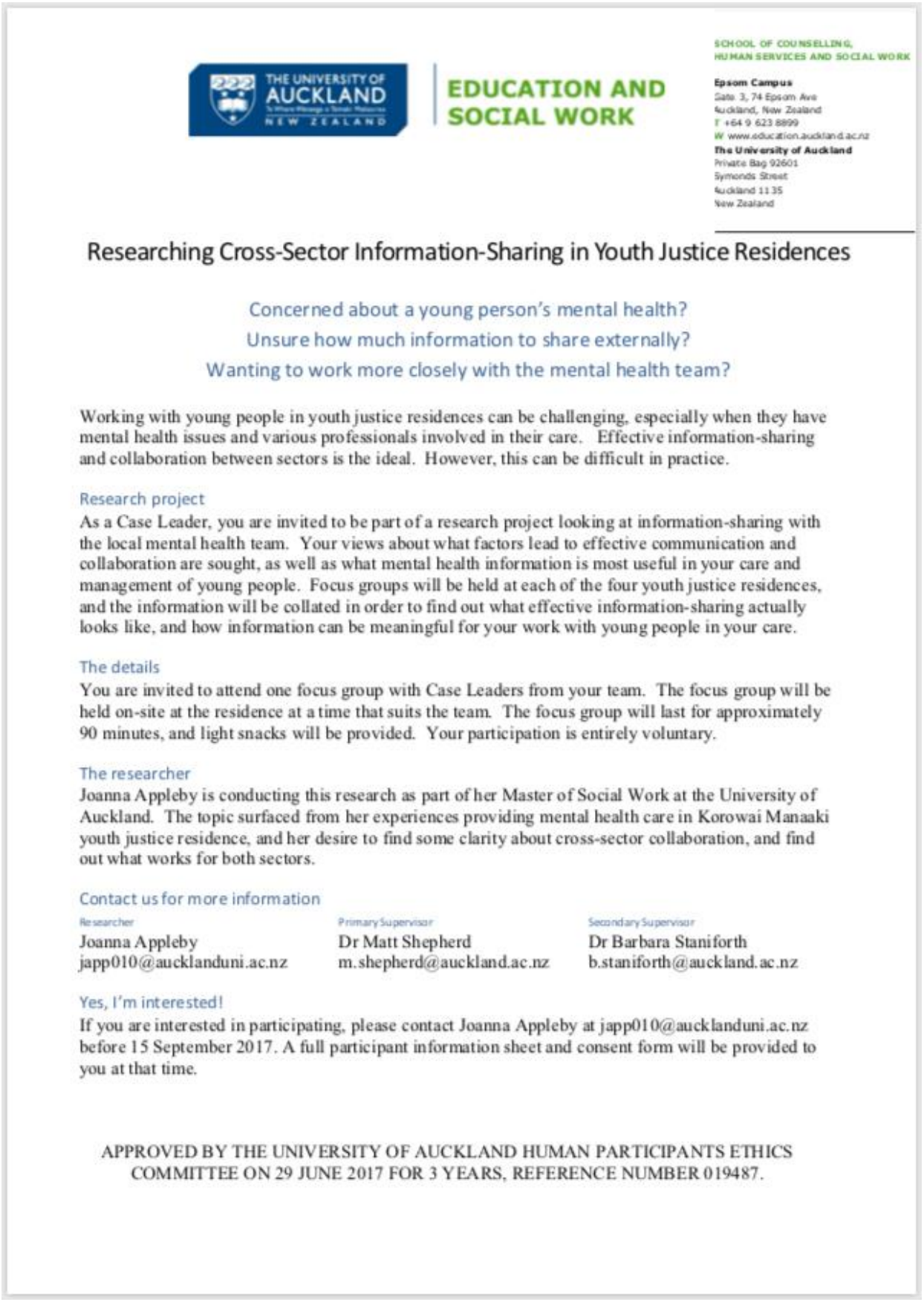
The research involved focus groups with each of the four case leader teams, and the four YFS teams for each residence. As a practitioner researcher with YFS experience, it was a privilege to meet all the research participants, to be invited into their workplace, to learn about roles, and to reflect on my own practice.

The overall impression was that case leaders and YFS clinicians are a committed group of professionals, enjoying the challenge of working with young offenders, and working hard to improve outcomes for this population. The literature strongly suggests that effective cross-sector information-sharing is difficult to achieve in practice, and yet these teams have navigated this complex issue without any information-sharing guidelines for youth justice residences.

Cross-sector information-sharing appears to be working well currently, although there is room for improvement. This research project has provided the first chance to explore information-sharing expectations of each sector from a national perspective. The next steps are to look at what is possible within our legal framework, and get clearer policy to support this specialised workforce, along with exploring the views of the young people themselves.

On a personal level, this research has led me to reflect on my own practice. Since completing the focus groups I have changed my practice as a YFS clinician. I now provide more specific feedback to case leaders, and am mindful of how care team staff working within an operational framework may receive and interpret the information I send. I have also been intentional about meeting with care teams, and creating opportunities to share our formulations about young people in mutually beneficial ways. Understanding the residential environment and the institutional milieu has improved my practice. It is hoped that other YFS clinicians and case leaders can have similar experiences of understanding as a result of this project. This research project has allowed me to meet with the other YFS teams around the country, which has been invaluable. This has provided a relational foundation upon which I have been able to practice increased information-sharing between the YFS teams nationally, with a direct link between the research project, building relationships, and increased regular cross-YFS communication. I am very interested in all the YFS teams meeting together to build relationships and share practice knowledge. It is hoped that improved cross-sector and inter-YFS relationships and communication will lead to improved outcomes for young offenders. This is the shared goal of both sectors in this exciting and dynamic field of practice.

Appendix A: Recruitment notices



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New Zealand

Researching Cross-Sector Information-Sharing in Youth Justice Residences

Concerned about a young person's mental health?
Unsure how much information to share externally?
Wanting to work more closely with the mental health team?

Working with young people in youth justice residences can be challenging, especially when they have mental health issues and various professionals involved in their care. Effective information-sharing and collaboration between sectors is the ideal. However, this can be difficult in practice.

Research project

As a Case Leader, you are invited to be part of a research project looking at information-sharing with the local mental health team. Your views about what factors lead to effective communication and collaboration are sought, as well as what mental health information is most useful in your care and management of young people. Focus groups will be held at each of the four youth justice residences, and the information will be collated in order to find out what effective information-sharing actually looks like, and how information can be meaningful for your work with young people in your care.

The details

You are invited to attend one focus group with Case Leaders from your team. The focus group will be held on-site at the residence at a time that suits the team. The focus group will last for approximately 90 minutes, and light snacks will be provided. Your participation is entirely voluntary.

The researcher

Joanna Appleby is conducting this research as part of her Master of Social Work at the University of Auckland. The topic surfaced from her experiences providing mental health care in Korowai Manaaki youth justice residence, and her desire to find some clarity about cross-sector collaboration, and find out what works for both sectors.

Contact us for more information

Researcher	Primary Supervisor	Secondary Supervisor
Joanna Appleby	Dr Matt Shepherd	Dr Barbara Staniforth
japp010@aucklanduni.ac.nz	m.shepherd@auckland.ac.nz	b.staniforth@auckland.ac.nz

Yes, I'm interested!

If you are interested in participating, please contact Joanna Appleby at japp010@aucklanduni.ac.nz before 15 September 2017. A full participant information sheet and consent form will be provided to you at that time.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 29 JUNE 2017 FOR 3 YEARS, REFERENCE NUMBER 019487.

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Researching Cross-Sector Information-Sharing in Youth Justice Residences

Providing mental health services in a youth justice residence?
Unsure how much information to share with residence staff?
Wanting to work more collaboratively with the residence team?

Providing mental health services in a residence can be challenging, especially when there are various professionals involved in a young person's care. Effective information-sharing and collaboration between sectors is the ideal. However, this can be difficult in practice.

Research project

As a mental health clinician providing services to a youth justice residence, you are invited to be part of a research project looking at information-sharing with residential staff. Your views about what factors lead to effective communication and collaboration are sought, as well as what information from Case Leaders is most useful in your assessment and treatment of young people in residence.
Focus groups will be held with the CAMHS providers for each residence, and the information will be collated in order to find out what effective information-sharing actually looks like, and how information can be meaningful for your work with young people in residential care.

The details

You are invited to attend one focus group with clinicians from your team. The focus group will be held on-site at your place of work, at a time that suits the team. The focus group will last for approximately 90 minutes during work hours, and light snacks will be provided.
Your participation is entirely voluntary.

The researcher

Joanna Appleby is conducting this research as part of her Master of Social Work at the University of Auckland. The topic surfaced from her experiences providing mental health care in Korowai Manaaki youth justice residence, and her desire to find some clarity about cross-sector collaboration, and find out what works for both sectors.

Contact us for more information

Researcher	Primary Supervisor	Secondary Supervisor
Joanna Appleby	Dr Matt Shepherd	Dr Barbara Staniforth
japp010@aucklanduni.ac.nz	m.shepherd@auckland.ac.nz	b.staniforth@auckland.ac.nz

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If you are interested in participating, please contact Joanna Appleby at japp010@aucklanduni.ac.nz before 15 September 2017. A full participant information sheet and consent form will be provided to you at that time.

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Researching Cross-Sector Information-Sharing in Youth Justice Residences

Concerned about a young person's mental health?
Unsure how much information to share externally?
Wanting to work more closely with Taiohi Tu Taiohi Ora?

Working with young people in youth justice residences can be challenging, especially when they have mental health issues and various professionals involved in their care. Effective information-sharing and collaboration between sectors is the ideal. However, this can be difficult in practice.

Research project

As a Case Leader, you are invited to be part of a research project looking at information-sharing with Taiohi Tu Taiohi Ora mental health team. Your views about what factors lead to effective communication and collaboration are sought, as well as what mental health information is most useful in your care and management of young people. Focus groups will be held at each of the four youth justice residences, and the information will be collated in order to find out what effective information-sharing actually looks like, and how information can be meaningful for your work with young people in your care.

The details

You are invited to attend one focus group with other Korowai Manaaki Case Leaders. The focus group will be held on-site at Korowai Manaaki at a time that suits the team. The focus group will last for approximately 90 minutes, and light snacks will be provided. Your participation is entirely voluntary.

The researcher

Joanna Appleby is conducting this research as part of her Master of Social Work at the University of Auckland. She will be conducting focus group at the three other youth justice residences. Her supervisors, Matt Shepherd and Barbara Staniforth, will conduct the focus group at Korowai Manaaki, due to her role in Taiohi Tu Taiohi Ora.

Contact us for more information

Researcher	Primary Supervisor	Secondary Supervisor
Joanna Appleby	Dr Matt Shepherd	Dr Barbara Staniforth
japp010@aucklanduni.ac.nz	m.shepherd@auckland.ac.nz	b.staniforth@auckland.ac.nz

Yes, I'm interested!

If you are interested in participating, please contact Dr Matt Shepherd (m.shepherd@auckland.ac.nz) before 15 September 2017. A full participant information sheet and consent form will be provided to you at that time.

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Researching Cross-Sector Information-Sharing in Youth Justice Residences

Providing mental health services at Korowai Manaaki?
Unsure how much information to share with residence staff?
Wanting to work more collaboratively with the Korowai Manaaki team?

Providing mental health services in a residence can be challenging, especially when there are various professionals involved in a young person's care. Effective information-sharing and collaboration between sectors is the ideal. However, this can be difficult in practice.

Research project

As a mental health clinician in Taiohi Tu Taiohi Ora, you are invited to be part of a research project looking at information-sharing with residential staff. Your views about what factors lead to effective communication and collaboration are sought, as well as what information from Case Leaders is most useful in your assessment and treatment of young people in residence. Focus groups will be held with the CAMHS providers for each residence, and the information will be collated in order to find out what effective information-sharing actually looks like, and how information can be meaningful for your work with young people in residential care.

The details

You are invited to attend one focus group with other Taiohi Tu Taiohi Ora clinicians. The focus group will be held on-site at your place of work, at a time that suits the team. The focus group will last for approximately 90 minutes during work hours, and light snacks will be provided. Your participation is entirely voluntary.

The researcher

Joanna Appleby is conducting this research as part of her Master of Social Work at the University of Auckland. She will be completing the focus groups with the three other CAMHS providers. Due to her role in Taiohi Tu Taiohi Ora, her supervisors (Matt Shepherd and Barbara Staniforth) will conduct this focus group.

Contact us for more information

Researcher	Primary Supervisor	Secondary Supervisor
Joanna Appleby	Dr Matt Shepherd	Dr Barbara Staniforth
japp010@aucklanduni.ac.nz	m.shepherd@auckland.ac.nz	b.staniforth@auckland.ac.nz

Yes, I'm interested!

If you are interested in participating, please contact Dr Matt Shepherd (m.shepherd@auckland.ac.nz) before 15 September 2017. A full participant information sheet and consent form will be provided to you at that time.

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Appendix B: Focus group questions

1. Tell me about the current arrangement between your team and Oranga Tamariki/YFS.
2. What is the referral process?
3. What information from Oranga Tamariki/YFS is most helpful for you?
4. Tell me about examples when there has been good communication between Oranga Tamariki and YFS. What do you think made these cases work so well?
5. Tell me about any times when you've been frustrated or confused by the information you've received from Oranga Tamariki/YFS. What do you think would have helped?
6. If it was completely up to you, what information would you like from Oranga Tamariki/YFS?
7. What information do you think they want from you?
8. What do you wish Oranga Tamariki/YFS knew about your work?
9. In what ways are Oranga Tamariki and YFS similar and different in their approach to mental health issues?
10. What do you think Oranga Tamariki/YFS does with the information you give them?
11. What is your understanding of how much to share with Oranga Tamariki/YFS?
12. Tell me any ideas you have to improve information-sharing with Oranga Tamariki/YFS.

Appendix C: Consent forms

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Consent Form for Managers

Cross-sector information-sharing in youth justice residences

Researcher: Joanna Appleby
Supervisors: Dr Matt Shepherd and Dr Barbara Staniforth (Faculty of Education and Social Work)

I have read and I understand the information sheet for the research on 'Cross-sector information-sharing in youth justice residences'.

- I consent to staff from my organisation being invited to take part in this research project.
- I have been given the opportunity to discuss this study with a researcher.
- I am satisfied with the information I have been given.
- I understand that participation by my staff is entirely voluntary, and they can withdraw from the research at any time without giving a reason, but information provided before that point must remain in the group.
- I give my assurance that a staff member's decision to participate or not participate will in no way affect their employment.
- I consent to the research being undertaken in the organisation workplace.
- I understand that neither the individual staff nor the organisation will be identified in any reports arising from the research. I also understand that due to the small number of participants and residences, there is a slight possibility that someone may recognise a person or service based on information that has been provided in the focus group.
- I understand that information obtained will be stored securely by the researcher for a period of 10 years after which time it will be destroyed or erased.

I wish to receive the summary of findings: Yes / No
If yes, please provide contact details for summary of information:

_____

Declaration by manager:

I hereby consent to staff from my organisation being invited to take part in this research project.

Manager's name: Organisation:

Signature: Date:

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Consent Form for Participants

Cross-sector information-sharing in youth justice residences

Researcher: Joanna Appleby
Supervisors: Dr Matt Shepherd and Dr Barbara Staniforth (Faculty of Education and Social Work)

I have read the Participant Information Sheet and I have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction, and I understand that I may ask further questions at any time.

- I agree to take part in this research under the conditions set out in the information sheet.
- I understand that the focus group will take approximately 90 minutes of my time.
- I understand that the information from this focus group will be used for the purpose of completing a MSW thesis, and possibly for future conference presentations, articles in academic journals or teaching purposes.
- I understand that participation is voluntary and that I can withdraw from participating or decline to answer questions at any time. I will not be able to withdraw any information once it has been provided.
- I understand that my manager has approved employee participation in this research and that they have agreed that my participation or non-participation will in no way impact upon my employment. My manager will not have access to the information disclosed in the focus group outside of what is later published in a de-identified format.
- I agree to not disclose anything discussed in the focus group.
- I agree to be audio recorded.
- I understand that the audio recording and the transcripts from the focus group will be kept securely on the researcher's password protected computer, in a locked office of supervisor Dr Matt Shepherd and on a password protected University of Auckland drive.
- I understand that all attempts will be made to ensure participant confidentiality but that due to the nature of focus groups, confidentiality cannot be guaranteed. I also understand that due to the small number of participants and residences, there is a slight possibility that someone may recognise a person or service based on information that has been provided in the focus group.
- I understand that a third party who has signed a confidentiality agreement will transcribe the recordings.
- I understand that data will be kept for ten years and then destroyed as per University of Auckland protocols.

I wish to receive the summary of findings: Yes / No
If yes, please provide contact details for summary of information: _____

Declaration by participant:

Name: Organisation:

Signature: Date:

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Appendix D: Transcriber confidentiality agreement

THE UNIVERSITY OF AUCKLAND
FACULTY OF EDUCATION
School of Counselling, Human Services and Social Work

University of Auckland
Faculty of Education
Epsom Campus
Private Bag 92601
Symonds Street
Auckland

TRANSCRIBER CONFIDENTIALITY AGREEMENT

Project Title: Cross-Sector Information-Sharing in Youth Justice Residences

Researcher: Joanna Appleby

Supervisors: Matt Shepherd and Barbara Staniforth

Transcriber: (name of transcriber to be inserted) Lynette France

I agree to transcribe the audio-recordings for the above research project. I understand that the information contained within them is confidential and that I must not disclose or discuss it with anyone other than the researcher and her supervisors. I shall delete any copies that I may have made as part of the transcription process.

Name: Lynette France

Signature: L. France

Date: 28.9.17

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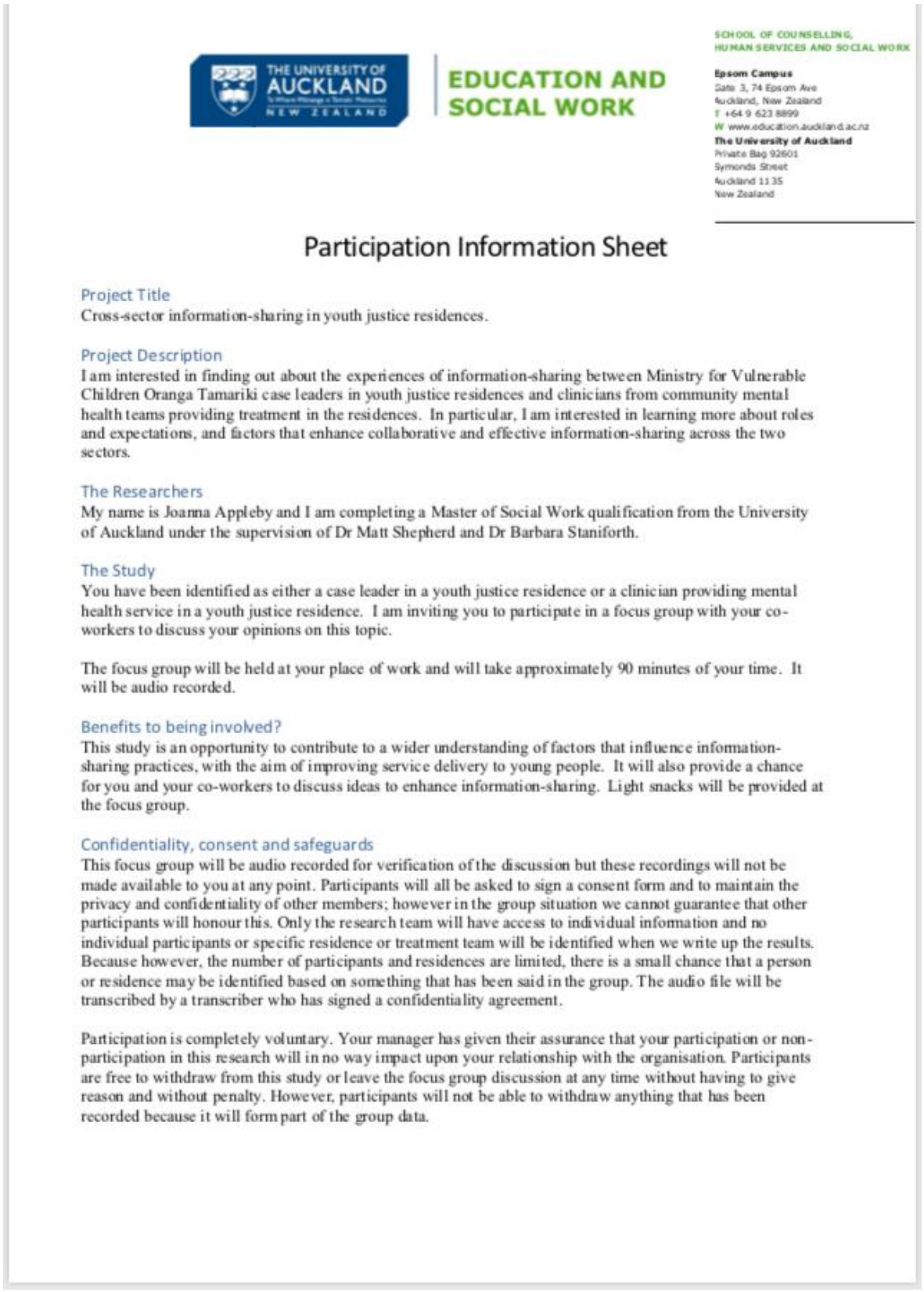
REFERENCE NUMBER 019487.

Appendix E: Information sheets



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NEW ZEALAND

EDUCATION AND SOCIAL WORK

Participation Information Sheet

Project Title
Cross-sector information-sharing in youth justice residences.

Project Description
I am interested in finding out about the experiences of information-sharing between Ministry for Vulnerable Children Oranga Tamariki case leaders in youth justice residences and clinicians from community mental health teams providing treatment in the residences. In particular, I am interested in learning more about roles and expectations, and factors that enhance collaborative and effective information-sharing across the two sectors.

The Researchers
My name is Joanna Appleby and I am completing a Master of Social Work qualification from the University of Auckland under the supervision of Dr Matt Shepherd and Dr Barbara Staniforth.

The Study
You have been identified as either a case leader in a youth justice residence or a clinician providing mental health service in a youth justice residence. I am inviting you to participate in a focus group with your co-workers to discuss your opinions on this topic.

The focus group will be held at your place of work and will take approximately 90 minutes of your time. It will be audio recorded.

Benefits to being involved?
This study is an opportunity to contribute to a wider understanding of factors that influence information-sharing practices, with the aim of improving service delivery to young people. It will also provide a chance for you and your co-workers to discuss ideas to enhance information-sharing. Light snacks will be provided at the focus group.

Confidentiality, consent and safeguards
This focus group will be audio recorded for verification of the discussion but these recordings will not be made available to you at any point. Participants will all be asked to sign a consent form and to maintain the privacy and confidentiality of other members; however in the group situation we cannot guarantee that other participants will honour this. Only the research team will have access to individual information and no individual participants or specific residence or treatment team will be identified when we write up the results. Because however, the number of participants and residences are limited, there is a small chance that a person or residence may be identified based on something that has been said in the group. The audio file will be transcribed by a transcriber who has signed a confidentiality agreement.

Participation is completely voluntary. Your manager has given their assurance that your participation or non-participation in this research will in no way impact upon your relationship with the organisation. Participants are free to withdraw from this study or leave the focus group discussion at any time without having to give reason and without penalty. However, participants will not be able to withdraw anything that has been recorded because it will form part of the group data.

The hardcopy notes from the focus group, the consent forms and the audio recording will be securely stored in a locked filing cabinet in the office of the Primary Supervisor, Dr Matt Shepherd for ten years, after which point they will be confidentially destroyed in compliance with the University of Auckland's secure destruction of research data procedures. The anonymised notes shall be entered into an electronic file and stored on the principal investigator's password protected computer indefinitely and they will also be stored for safekeeping on a University of Auckland password protected drive.

We do not believe that there will be any risks to individuals taking part in the focus group. However, you should not feel obliged to answer any questions you feel uncomfortable about. If you experience any discomfort following the focus group, please discuss with your supervisor or Clinical Lead. If you would like to discuss any concerns arising from the focus group you are welcome to contact me, my supervisors, or the Chair of the University of Auckland Ethics Committee at any time using the contact details at the bottom of the form.

Conflicts of interest

I am a practicing social worker with Taiohi Tu Taiohi Ora, the mental health provider for Korowai Manaaki youth justice residence in Auckland. As a result, my supervisors will be completing the focus groups with Taiohi Tu Taiohi Ora mental health team, and with Korowai Manaaki case leaders.

Dissemination

The findings will form part of my Master of Social Work thesis and may be published in academic journals or discussed in presentations or at conferences. The final report and outcome of the research shall be made available to you once it is completed in 2019. There is a space on the Consent Form for you to indicate if you would like a copy of the results.

Please contact me using the email below if you are interested in participating. I will then get back to you with details of the time and location for the focus group.

Thank you for your consideration to participate in this focus group. If you have any concerns or questions, please contact us at any time.

Contact details for the researcher, supervisors and Head of Department

Researcher
Joanna Appleby
Phone: 021 534 663
Email: japp010@aucklanduni.ac.nz

Head of Department
Dr Allen Bartley
Phone: 09 373 7999 ext 48140

Primary Supervisor
Dr Matt Shepherd
Phone 09 623 8899 ext 46368
Email: m.shepherd@auckland.ac.nz

Secondary Supervisor
Dr Barbara Staniforth
Phone: 09 623 8899 ext 48349
Email: b.staniforth@auckland.ac.nz

Ethics Chair contact details

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711; email: ro-ethics@auckland.ac.nz

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Information Sheet for Residence Managers

Cross-sector information-sharing in youth justice residences

My name is Joanna Appleby and I am a registered social worker providing mental health services at Korowai Manaaki youth justice residence. I am also completing my Master of Social Work at the University of Auckland. My Masters research topic is cross-sector information-sharing in youth justice residences, looking at factors that improve information-sharing and collaboration between youth justice residence case leaders and community mental health services, in order to provide more integrated services to those young people in youth justice residences.

I am writing to ask your permission to invite case leaders in your residence to participate in a focus group.

What would be involved?

I would like to invite the case leaders to participate in one focus group. The focus group will be approximately 90 minutes long, and will involve questions about case leaders' experiences of information-sharing with mental health providers, what information is most useful for case leaders in their management of young people on the unit, and their ideas about how to improve this important working relationship.

The focus group will be audio recorded. It can be held at a time that is convenient for the team, and ideally would be held on-site, and potentially within staff work time.

With your permission, I would like to send you a notice about the project via email, so that it can be forwarded to your case leaders for their consideration. The case leaders that wish to participate can then register their interest in taking part in the study by contacting me directly. I will then liaise with the interested parties to arrange a time to visit the residence and conduct the focus group. Snacks will be provided during the focus group.

What about confidentiality?

It is not possible for me to guarantee confidentiality or anonymity when people meet for a discussion in a group. However, I will ask everybody who takes part to treat the information shared as confidential. My supervisors and I will treat all information provided confidentially and while no person or service will be named in the MSW thesis or future publications, due to the small pool of residences and mental health services there is a slight chance that some people may be able to recognise a person or service based on the quotes provided.

The focus group discussions will be recorded and then transcribed. Copies of transcripts and signed consent forms will be stored securely at in my supervisor's office at the University of Auckland on

my password protected computer and on a University of Auckland drive for a period of 10 years after which time they will be destroyed. Consent forms will be stored separately from data and will also be destroyed after 6 years.

What if the discussion makes participants upset?

The focus of this research is on finding what works in terms of cross-sector collaboration, rather than a deficit-focus or blaming. The questions are unlikely to cause distress. However, if a case leader is upset as a result of the focus group, I will encourage them to speak to their own supervisor or Clinical Team Leader. This information will be clearly noted in the Participant Information Sheet given to each study participant.

More questions?

I are happy to give you more information and answer questions. You can contact me directly, or you can contact my supervisors, Dr Matt Shepherd and Dr Barbara Staniforth.

Researcher:
Joanna Appleby
japp010@aucklanduni.ac.nz
Phone: 021 534663

Head of Department:
Dr Allen Bartley
Email: a.bartley@auckland.ac.nz
Phone: 09 373 7999 ext 48140

Primary Supervisor:
Dr Matt Shepherd
Faculty of Education and Social Work
The University of Auckland
Private Bag 92019
Auckland 1142
+64-9-623-8899, x.46368
Email: m.shepherd@auckland.ac.nz

Secondary Supervisor:
Dr Barbara Staniforth
Faculty of Education and Social Work
The University of Auckland
Private Bag 92019
Auckland 1142
+64-9-623-8899, x.48349
Email: b.staniforth@auckland.ac.nz

If you agree to this study being undertaken in your residence, please sign the accompanying consent form and return it to me as soon as possible.

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711; email: ro-ethics@auckland.ac.nz

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Information Sheet for Korowai Manaaki Residence Manager

Cross-sector information-sharing in youth justice residences

My name is Joanna Appleby and I am a registered social worker providing mental health services at Korowai Manaaki youth justice residence. I am also completing my Master of Social Work at the University of Auckland. My Masters research topic is cross-sector information-sharing in youth justice residences, looking at factors that improve information-sharing and collaboration between youth justice residence case leaders and community mental health services, in order to provide more integrated services to those young people in youth justice residences.

I am writing to ask your permission to invite case leaders in your residence to participate in a focus group.

What would be involved?

I would like to invite the case leaders to participate in one focus group. The focus group will be approximately 90 minutes long, and will involve questions about case leaders' experiences of information-sharing with mental health providers, what information is most useful for case leaders in their management of young people on the unit, and their ideas about how to improve this important working relationship.

The focus group will be audio recorded. It can be held at a time that is convenient for the team, and ideally would be held on-site at your service and potentially within staff work time.

With your permission, I would like to send you a notice about the project via email, so that it can be forwarded to your case leaders for their consideration. The case leaders that wish to participate can then register their interest in taking part in the study by contacting my supervisors directly.

Given my treatment role in Korowai Manaaki, my supervisors will conduct the focus group in your residence. They will liaise with the interested parties to arrange a time to visit the residence and conduct the focus group. Snacks will be provided during the focus group.

What about confidentiality?

It is not possible for me to guarantee confidentiality or anonymity when people meet for a discussion in a group. However, my supervisors will ask everybody who takes part to treat the information shared as confidential. My supervisors and I will treat all information provided confidentially and while no person or service will be named in the MSW thesis or future publications, due to the small pool of residences and mental health services there is a slight chance that some people may be able to recognise a person or service based on the quotes provided.

The focus group discussions will be recorded and then transcribed. Given my role in the residence, I will only have access to the transcripts, rather than the audio recordings. I will be unable to link responses to specific case leaders. Copies of transcripts and signed consent forms will be stored securely at in my supervisor's office at the University of Auckland on my password protected computer and on a University of Auckland drive for a period of 10 years after which time they will be destroyed. Consent forms will be stored separately from data and will also be destroyed after 6 years.

What if the discussion makes participants upset?

The focus of this research is on finding what works in terms of cross-sector collaboration, rather than a deficit-focus or blaming. The questions are unlikely to cause distress. However, if a case leader is upset as a result of the focus group, my supervisors will encourage them to speak to their own supervisor or Clinical Team Leader. This information will be clearly noted in the Participant Information Sheet given to each study participant.

More questions?

I are happy to give you more information and answer questions. You can contact me directly, or you can contact my supervisors, Dr Matt Shepherd and Dr Barbara Staniforth.

Researcher:
Joanna Appleby
japp010@aucklanduni.ac.nz
Phone: 021 534663

Head of Department:
Dr Allen Bartley
Email: a.bartley@auckland.ac.nz
Phone: 09 373 7999 ext 48140

Primary Supervisor:
Dr Matt Shepherd
Faculty of Education and Social Work
The University of Auckland
Private Bag 92019
Auckland 1142
+64-9-623-8899, x.46368
Email: m.shepherd@auckland.ac.nz

Secondary Supervisor:
Dr Barbara Staniforth
Faculty of Education and Social Work
The University of Auckland
Private Bag 92019
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+64-9-623-8899, x.48349
Email: b.staniforth@auckland.ac.nz

If you agree to this study being undertaken in your residence, please sign the accompanying consent form and return it to me as soon as possible.

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711; email: ro-ethics@auckland.ac.nz

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Information Sheet for ADHB Service Manager

Cross-sector information-sharing in youth justice residences

My name is Joanna Appleby and I am a registered social worker providing mental health services at Korowai Manaaki youth justice residence through my role in Taiohi Tu Taiohi Ora, Auckland District Health Board. I am also completing my Master of Social Work at the University of Auckland. My Masters research topic is cross-sector information-sharing in youth justice residences, looking at factors that improve information-sharing and collaboration between youth justice residence case leaders and community mental health services, in order to provide more integrated services to those young people in youth justice residences.

I am writing to ask your permission to invite clinicians from Taiohi Tu Taiohi Ora to participate in a focus group.

What would be involved?

I would like to invite the clinicians that are involved in providing treatment in the youth justice residence to participate in one focus group. The focus group will be approximately 90 minutes long, and will involve questions about clinicians' experiences of information-sharing with case leaders at the residence, what information from case leaders is most useful for clinicians in their assessment and treatment of young people in residence, and their ideas about how to improve this important working relationship.

The focus group will be audio recorded. It can be held at a time that is convenient for the team, and ideally would be held on-site at your service and potentially within staff work time.

With your permission, I would like to send you a notice about the project via email, so that it can be forwarded to the clinicians for their consideration. The clinicians that wish to participate can then register their interest in taking part in the study by contacting my supervisors directly.

Given my role in Taiohi Tu Taiohi Ora, my supervisors will conduct the focus group. They will liaise with the interested parties to arrange a time to visit the service and conduct the focus group. Snacks will be provided during the group.

What about confidentiality?

It is not possible for me to guarantee confidentiality or anonymity when people meet for a discussion in a group. However, my supervisors will ask everybody who takes part to treat the information shared as confidential. My supervisors and I will treat all information provided confidentially and while no person or service will be named in the MSW thesis or future publications, due to the small pool of residences and mental health services there is a slight

chance that some people may be able to recognise a person or service based on the quotes provided.

The focus group discussions will be recorded and then transcribed. Given my role in the team, I will only have access to the transcripts, rather than the audio recordings. I will be unable to link responses to specific clinicians. Copies of transcripts and signed consent forms will be stored securely at in my supervisor's office at the University of Auckland on my password protected computer and on a University of Auckland drive for a period of 10 years after which time they will be destroyed. Consent forms will be stored separately from data and will also be destroyed after 6 years.

What if the discussion makes participants upset?

The focus of this research is on finding what works in terms of cross-sector collaboration, rather than a deficit-focus or blaming. The questions are unlikely to cause distress. However, if a clinician is upset as a result of the focus group, my supervisors will encourage them to speak to their own supervisor or Clinical Lead. This information will be clearly noted in the Participant Information Sheet given to each study participant.

More questions?

I are happy to give you more information and answer questions. You can contact me directly, or you can contact my supervisors, Dr Matt Shepherd and Dr Barbara Staniforth.

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If you agree to this study being undertaken in your residence, please sign the accompanying consent form and return it to me as soon as possible.

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711; email: ro-ethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 29 JUNE 2017 FOR 3 YEARS, REFERENCE NUMBER 019487.

References

Abram, K. M., Choe, J. Y., Washburn, J. J., Teplin, L. A., King, D. C., & Dulcan, M. K. (2008). Suicidal ideation and behaviors among youths in juvenile detention. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(3), 291-300.

Abram, K. M., Teplin, L. A., McClelland, G. M., & Dulcan, M. K. (2003). Comorbid psychiatric dis orders in youth in juvenile detention. *Archives of General Psychiatry, 60*(11), 1097-1108.

Adolescent Health Research Group. (2003). *New Zealand youth: A profile of their health and wellbeing*. Auckland, New Zealand: The University of Auckland.

Adolescent Health Research Group. (2008). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Initial findings*. Auckland, New Zealand: The University of Auckland.

Advisory Group on Conduct Problems (2009). *Conduct problems: Best practice report*. Wellington, New Zealand: Ministry of Social Development.

Agranoff, R. & McGuire, M. (2001). Big questions in public network management research. *Journal of Public Administration Research and Theory, 11*(3), 295-326.

Alston, M. & Bowles, W. (2003). *Research for social workers: An introduction to methods*. London, England: Routledge.

Altshuler, S. J. (2003). From barriers to successful collaboration: Public schools and child welfare working together. *Social Work, 48*(1), 52-63.

Anderson, C. (2005). The integrated children's system: challenges of information sharing. *Paediatric Nursing, 17*(10), 34-36.

Appleby, J. & Phillips, D. (2013). Enhancing engagement in CAMHS. *Aotearoa New Zealand Social Work, 25* (1), 24-34.

Armstrong, G.S. & Griffin, M.L. (2006). Does the job matter? Comparing correlates of stress among treatment and correctional staff in prisons. *American Journal of Criminal Justice, 30*, 577-592.

Baglivio, M.T., Epps, N., Swartz, K., Huq, M.S., Sheer, A., Hardt, N.S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice, 3*, 1–23.

Bai, Y., Wells, R. & Hillemeier, M.M. (2009). Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. *Child Abuse and Neglect, 33*, 372-381.

Becroft, A. (2009). *What causes youth crime, and what can we do about it?* Retrieved from http://www.justice.govt.nz/courts/youth/publications-and-media/speeches/whatcauses-youth-crime-and-what-can-we-do-about-it.

Bennett, T. (2002). *Evaluation report: Agency workers participating in the strengthening families programme.* Wellington, New Zealand: Ministry of Social Development.

Bielas, H., Barra, S., Skrivanek, C., Aebi, M., Steinhausen, H., Bessler, C. & Plattner, B. (2016). The associations of cumulative adverse childhood experiences and irritability with mental disorders in detained male adolescent offenders. *Child and Adolescent Psychiatry and Mental Health, 10*(34), 1-10.

Bornholdt, J. & Ritchie, M. (2014). Collaboration in Action: Child, Youth and Family Hospital Social Worker role in District Health Boards. *Children, 80*, 16-18.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bryson, J.M., Crosby, B.C., Middleton Stone, M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. *Public Administration Review, 66*(1), 44-55.

Cameron, A. & Lart, R. (2003). Factors promoting and obstacles hindering joint working: A systematic review of the research evidence. *Journal of Integrated Care 11*(2), 9–17.
Cameron, C. (2009). *Education of Children in Need*. Retrieved from http://www.communitycare.co.uk/2009/07/10/education-of-children-in-need/.
Carey, M. (2003). *The social work dissertation: Using small-scale qualitative methodology*. Berkshire, England: Open University Press.
Carter, P. (2010). Working together to improve outcomes for children and young people with disabilities. *Social Work Now, 45*, 15-19.
Cauffman, E., Frances, J. L., Goldweber, A., Shulman, E. P., & Grisso, T. (2007). Gender differences in mental health symptoms among delinquent and community youth. *Youth Violence and Juvenile Justice, 5*(3), 287-307.
Chitsabesan, P., Kroll, L., Bailey, S., Kenning, C., Sneider, S., MacDonald, W., Theodosiou, L. (2006). Mental health needs of young offenders in custody and in the community. *British Journal of Psychiatry, 188*(6), 534-540.
Christchurch City Council (1999). *Evaluation of the Canterbury strengthening families project conducted for the Canterbury strengthening families management group*. Christchurch, New Zealand: Author.
Chuang, E. & Wells, R. (2010). The role of inter-agency collaboration in facilitating receipt of behavioural health services for youth involved with child welfare and juvenile justice. *Children and Youth Services Review, 32*, 1814-1822.
Coffey, M. & Coleman, M. (2001). The relationship between support and stress in forensic community mental health nursing. *Journal of Advanced Nursing, 34*(3), 397-407.
Cohen, L., Manion, L. & Morrison, K. (2011). *Research methods in education*. New York: Routledge.
Corbett, T., Dimas, J., Fong, J. & Noyes, J. (2005). The challenge of institutional "milieu" to cross systems integration, *Focus, 24*(1), 28-35.
Crawford, R. & Kennedy, P. (2008). *Improving interventions to reduce violent offending by young people in New Zealand.* Wellington, New Zealand: Ministry of Justice.
Cribb, J., Lane, R., van Delden, K., Penny, H. & Irwin, K. (2014). Like the story of Maui capturing the sun: the value of collaboration to solve the wicked problem of child abuse and neglect. *Children, 80*, 11-12.
Dadds, M. & Hart, S. (2001). *Doing Practitioner Research Differently*. London: Routledge.
Daley, D.M. (2009). Interdisciplinary problems and agency boundaries: Exploring cross agency collaboration. *Journal of Public Administration Research and Theory, 19*(3), 477-493.
Darlington, Y., Feeney, J.A. & Rixon, K. (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review*, 26, 1175-1192.
Davidson, C. & Tolich, M. (Eds). (2003). *Social science research in New Zealand: Many paths to understanding* (2nd ed.). Auckland, New Zealand: Pearson.
Department of Corrections. (2007). *Over-representation of Māori in the criminal justice system: An exploratory report.* Wellington, New Zealand: Author.
Etten, T.J. & Petrone, R.F. (1994). Sharing data and information in juvenile justice: Legal, ethical, and practical considerations. *Juvenile and Family Court Journal 45*(3), 65–90.
Farrington, D. P., Loeber, R., & Ttofi, M. M. (2012). Risk and protective factors for offending. In B.C. Welsh & D.P. Farrington (Eds.), *The Oxford handbook of crime prevention* (pp. 46-69). Oxford, England: Oxford University Press.
Farrington, D.P. & West D.J. (1993). Criminal, penal and life histories of chronic offenders: risk and protective factors and early identification. *Criminal Behaviour and Mental Health*, 3, 492–523.
Feehan, M., McGee, R., Nada Raja, S., Williams, S.M. (1994). DSM-III-R disorders in New Zealand 18-year-olds. *Australian and New Zealand Journal of Psychiatry* 28(1), 87–99.
Feeney, L. & Moran, P. (2007). Information sharing and risk: A survey of psychiatrists. *Irish Journal of Psychological Medicine, 24*(3), 94-98.

Fergusson, D.M. & Horwood, L.J. (2001). The Christchurch health and development study: review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry*, *35*(3), 287–96.

Fergusson, D.M. & Horwood, L.J. (2002) Male and female offending trajectories. *Development and Psychopathology*, *14*, 159-177.

Fergusson, D.M., Horwood, L. J. & Ridder, E. M. (2005). Show me the child at seven: The consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology and Psychiatry, 46*(8), 837-849.

Fergusson, D.M., Horwood, L. J., & Lynskey, M. (1994). The childhoods of multiple problem adolescents: a 15-year longitudinal study. *Journal of Child Psychology and Psychiatry, 35*(6), 1123-1140.

Fergusson, D.M., Poulton, R., Horwood, J., Milne, B., Swain-Campbell, N. & Baxter, J. (2003). *Comorbidity and coincidence in the Christchurch and Dunedin longitudinal studies*. Wellington, New Zealand: Ministry of Social Development.

Finn, P. (2001). Addressing correctional officer stress: Programs and strategies. *Corrections Forum, 10*(5), 14-22.

Fishbein, D., Miller, S., Winn, D.-M., & Dakof, G. (2009). Biopsychosocial factors, gender, and delinquency. In M. A. Zahn (Ed.), *The delinquent girl* (pp. 127-145). Philadelphia, PA: Temple University Press.

Fleming, T., Clark, T., Denny, S., Bullent, P., Crengle, S., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Lucassen, M. (2013). Stability and change in the mental health of New Zealand secondary school students 2007–2012: Results from the national adolescent health surveys. *Australian & New Zealand Journal of Psychiatry, 48*(5), 472-480.

Foliaki, S., Kokaua, J., Schaaf, D., Tukuitonga, C. (2006). Pacific people. In M.A. Oakley Browne, J.E. Wells, K.M. Scott (Eds). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington, New Zealand: Ministry of Health.

Fonagy, P., Target, M., Cottrell, J., Phillips, J. & Kurtz, Z. (2000). *A review of the outcomes of all treatments of psychiatric disorder in childhood. Final report to the National Health Service executive*. London, England: Department of Health.

Fook, J. (2002). Theorising from practice. *Qualitative Social Work, 1*, 79-95.

Fox, M., Martin, P. & Green, G. (2007). *Doing practitioner research.* London, England: Sage Publications.

French, R., Reardon, M. & Smith, P. (2003). Engaging with a mental health service: Perspectives of at-risk youth. *Child and Adolescent Social Work Journal, 20*(6), 529-548.

Frost, N. (2005). *Professionalism, Partnership and Joined-Up Thinking. A research review of front-line working with children and families*. Retrieved from https://www.rip.org.uk/~ftp_user/professionalism_partnership_and_joined_up_thinking/files/assets/basic-html/page9.html.

Fuller, R. & Petch, A. (1995). *Practitioner Research: The Reflexive Social Worker*. Buckingham, England: Open University Press.

Gask, L. (2005). Overt and covert barriers to the integration of primary and specialist mental health care. *Social Science & Medicine, 61*, 1785-1794.

Gil-Garcia, J.R. & Sayogo, D.S. (2016). Government inter-organisational information sharing initiatives: Understanding the main determinants of success. *Government Information Quarterly, 33*, 572-582.

Gillies, W.M., Boden, J.M., Friesen, M.D., Macfarlane, S., Fergusson, D.M. (2017). Ethnic differences in adolescent mental health problems: Examining early risk factors and deviant peer affiliation. *Journal of Child and Family Studies*, 1-11.

Goldstein, N.E., Arnold, D.H., Weil, J., Mesiarik, C.M., Peuschold, D., Grisso, T. & Osman, D. (2003). Comorbid symptom patterns in female juvenile offenders. *Law and Psychiatry, 26*, 565-582.

Grace, R., Bowes, J., McMaugh, A. & Gibson, F. (2009). Working in integrated child and family services: A case for specialised skills and understanding. *Developing Practice: The Child, Youth and Family Work Journal*, *24*, 13-21.

Grant, B. M. & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13,* 10-28.

Gretton, H.M. & Clift, R.J.W. (2011). The mental health needs of incarcerated youth in British Columbia, Canada. *International Journal of Law and Psychiatry, 34*(2), 109-115.

Grigorenko, E. L. (2012). At the junction of personality theories: Working with juvenile offenders. In E.L Gringeko (Ed.), *Handbook of juvenile forensic psychology and psychiatry* (pp. 253-279). Washington, DC: Springer.

Gringeri, C., Barusch, A. & Cambron, C. (2013). Epistemology in qualitative social work research: A review of published articles 2008-2010. *Social Work Review, 37*(1), 55-63.

Grisso, T. & Barnum, R. (1998). *Massachusetts Youth Screening Instrument (MAYSI): Preliminary manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

Grisso, T. (1999). Juvenile offenders and mental illness. *Psychiatry, Psychology & Law, 6*(2), 143-151.

Guba, E. & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.). *The Sage Handbook of Qualitative Research* (3rd ed., pp. 183-216). Thousand Oaks, CA: Sage Publications.

Haight, W.L., Bidwell, L.N., Marshall, J.M. & Khatiwoda, P. (2014). Implementing the crossover youth practice model in diverse contexts: Child welfare and juvenile justice professionals' experiences of multisystem collaborations. *Children and Youth Services Review, 39*, 91-100.

Hammersley, M. (2013). *What is qualitative research*? London: Bloomsbury.

Harland, A., & Borich, A. (2007). *Evaluation of Youth Offending Teams in New Zealand.* Wellington, New Zealand: Ministry of Justice.

Harvey, D., Plummer, D., Pighills, A. & Pain, T. (2013) Practitioner research capacity: A survey of Social Workers in Northern Queensland, *Australian Social Work, 66(4),* 540-554.

Health Information Strategy Steering Committee (2005). *Health Information Strategy for New Zealand*. Wellington, New Zealand: Ministry of Health.

Health Research Council. (2008). *Guidelines for Researchers on Research with Māori.* New Zealand: Author.

Hemphill, S. A., Smith, R., Toumbourou, J. W., Herrenkohl, T. I., Catalano, R. F., McMorris, B. J, & Romaniuk, H. (2009). Modifiable determinants of youth violence in Australia and the United States: A longitudinal study. *The Australian and New Zealand Journal of Criminology, 42*(3), 289-309.

Horwath, J. & Morrison, T. (2007). Collaboration, integration and change in children's services: Critical issues and key ingredients. *Child Abuse & Neglect, 31*, 55-69.

Hudson, B. (2004). Analysing network partnerships: Benson re-visited. *Public Management Review, 6*(1), 75-94.

Iam, S. (2016). *Calling for help: Primary school professionals' experiences of phoning CYF to report suspected child abuse.* (Unpublished Master's thesis). University of Auckland, Auckland, New Zealand.

King, G. & Meyer, K. (2006). Service integration and co-ordination: A framework of approaches for the delivery of co-ordinated care to children with disabilities and their families. *Child: care, health and development, 32*(4), 477–492.

Kramer, T.L., Vuppala, A., Lamps, C., Miller, T.L. & Thrush, C.R. (2006). The interface between mental health providers, families and schools: Parent and child attitudes about information-sharing. *Journal of Child and Family Studies,* 15(4), 377-392.

Kurtz, Z., Thornes, R. & Bailey, S. (1998). Children in the criminal justice and secure care systems: How their mental health needs are met. *Journal of Adolescence, 21*, 543-553.

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

Laming, L. (2003). *The Victoria Climbié inquiry: Report of an inquiry by Lord Laming.* London, United Kingdom: The Stationary Office.
Lawn, S., Delany, T., Sweet, L., Battersby, M. & Skinner, T. (2015). Barriers and enablers to good communication and information-sharing practices in care planning for chronic condition management. *Australian Journal of Primary Health, 21*, 84-89.
Lennox, C., Mason, J., McDonnell, S., Shaw, J. & Senior, J. (2012). Information sharing between the National Health Service and criminal justice system in the United Kingdom. *Journal of Forensic Nursing, 8*, 131-137.
Lim, S. (2014). *Violent female youth offenders: an exploration of the correlates of violence motivation, victim type and ethnicity*. (Unpublished PhD thesis). University of Auckland, Auckland, New Zealand.
Lips, M., O'Neill, R. & Eppel, E. (2009). I*mproving Information Sharing for Effective Social Outcomes*. Wellington, New Zealand: Victoria University of Wellington.
Lunt, N. & Fouché, C. (2010). Practitioner Research, Ethics and Research Governance, *Ethics and Social Welfare, 4*(3), 219-235.
Lunt, N. & Shaw, I. (2017). Good practice in the conduct and reporting of practitioner research: Reflections from Social Work and Social Care, *Practice*, *29*(3), 201-218.
Lunt, N.T., Ramian, K., Shaw, I., Fouche, C. & Mitchell, F. (2012). Networking practitioner research: synthesising the state of the 'art'. *European Journal of Social Work, 15*(2), 185-203.
Majumdar, D. (2006). Collaboration among government agencies with special reference to New Zealand: A literature review. *Social Policy Journal of New Zealand, 27*, 183-198.
Mandell, M. P. (1999). The impact of collaborative efforts: Changing the face of public policy through networks and network structures. *Policy Studies Review, 16*(1), 4-17.
Marie, D., Fergusson, D.M. & Boden, J.M. (2009). Ethnic Identity and Criminal Offending in a New Zealand Birth Cohort. *Australian and New Zealand Journal of Criminology, 42*(3), 354-368.
Maschi, T., Hatcher, S.S., Shwalbe, C.S. & Rosato, N.S. (2008). Mapping the social service pathways of youth to and through the juvenile justice system: A comprehensive review. *Children and Youth Services Review, 30*(12), 1376-1385.
Mason, K.H. (1988). *Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients.* Wellington, New Zealand: Ministry of Health.
Maxwell, G., Robertson, J., Kingi, V., Morris, A. & Cunningham, C. (2004). *Achieving effective outcomes in youth justice: An overview of findings.* Wellington, New Zealand: Ministry of Social Development.
McArdle, S., Lambie, I. (2018). Screening for mental health needs of New Zealand youth in secure care facilities using the MAYSI-2. *Criminal Behaviour and Mental Health, 28*, 239-254.
McGee, R., Feehan, M., Williams, S., Partridge, F., Silva, P.A. & Kelly, J. (1990). DSM-III disorders in a large sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *29*(4): 611–19.
McKay, S., & Bagshaw, S. (2009). *The health needs of young people in CYF residential care.* Wellington, New Zealand: The Collaborative for Research and Training in Youth Health and Development.
Mental Health Commission (2012). B*lueprint II: How things need to be.* Wellington, New Zealand: Author.
Mila-Schaaf, K., Robinson, E., Schaaf, D., Denny, S., Watson, P.D. (2008). *A health profile of pacific youth: Findings of Youth2000. A National Secondary School Youth Health Survey*. Auckland, New Zealand: The University of Auckland.
Miller, R. L. (2013). Deconstructing the epistemological question with a focus on the knower. In A. E. Fortune, W. J. Reid, & R. L. Miller (Eds.), *Qualitative research in social work* (pp. 61-78). New York: Columbia University Press.
Mills, A., Meek, R. & Gojkovic, D. (2012). Partners, guests or competitors: Relationships between criminal justice and third sector staff in prisons. *Probation Journal, 59*(4), 391-405.

Ministry for Vulnerable Children Oranga Tamariki (2017). *Youth Justice Residences*. Retrieved from https://www.mvcot.govt.nz/youth-justice/residences/.
Ministry of Health (1998). *Consent in Child and Youth Health: Information for practitioners*. Wellington, New Zealand: Author.
Ministry of Health (2006). *Te Kōkiri: The Mental Health and Addiction Plan 2006–2015*. Wellington, New Zealand: Author.
Ministry of Health (2010). *Review of Forensic Mental Health Services: Future directions.* Wellington, New Zealand: Author.
Ministry of Health (2011). *Youth forensic services development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug, and intellectual disability services for young people involved in New Zealand's justice system.* Wellington, New Zealand: Author.
Ministry of Health (2012). *Rising to the challenge: The mental health and addiction service development plan 2012-2017*. Wellington, New Zealand: Author.
Ministry of Justice (2011). *Youth Court Research: Experiences and views of young people, their families and professionals*. Wellington, New Zealand: Author.
Ministry of Justice (2017). T*rends in Child and Youth Prosecutions.* Retrieved from www.justice.govt.nz/assets/Documents/Publications/Trends-in-child-and-youth-prosecution-Dec-2016.pdf.
Ministry of Social Development (2011). *Green Paper for Vulnerable Children*. Wellington, New Zealand: Author.
Ministry of Social Development (2012). *White Paper for Vulnerable Children*. Wellington, New Zealand: Author.
Ministry of Social Development (2016). *Kids in Care – National and local level data*. Retrieved from http://www.cyf.govt.nz/about-us/key-statistics/kids-in-care.html.
Ministry of Social Development (2017). *Residence regulatory inspection summary reports.* Retrieved from http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/residential-care-inspection-report/.
Morrison, B. (2009). *Identifying and responding to bias in the criminal justice system: A review of international and New Zealand research*. Wellington, New Zealand: Ministry of Justice.
Morrison, T. (1996). Partnership and collaboration: Rhetoric and reality. *Child Abuse & Neglect, 20*(2), 127–140.
National Research and Evaluation Unit (2013). *Information sharing between government agencies: Cultural perspectives.* Wellington, New Zealand: Inland Revenue Department.
Naylor, C., Lincoln, J. & Goddard, N. (2008). Young People at Risk of Offending: Their Views on a Specialist Mental Health Service in South East London. *Clinical Child Psychology and Psychiatry, 13*(2), 277-286.
New South Wales Department of Juvenile Justice (2003). *NSW Young People in Custody Health Survey: Key findings report*. New South Wales, Australia: New South Wales Department of Juvenile Justice.
New Zealand Herald (2016). *Boys overpower staff, steal their keys at south Auckland youth justice facility*. Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11733979.
Newman, J. & O'Brien, M. (2005). *Six-month report on the experience of Centre for Youth Health clinical staff at Youth Justice North (YJ North).* Unpublished.
Norum, K. (2008). Appreciative inquiry. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 22-23). Thousand Oaks, CA: Sage.
Oakley Browne, M.A., Wells, J.E. & Scott, K.M. (Eds). (2006). *Te rau hinengaro: The New Zealand mental health survey.* Wellington, New Zealand: Ministry of Health.
Office of the Children's Commissioner (2015). *State of care 2015: What we learnt from monitoring Child, Youth and Family.* Wellington, New Zealand: Author.
Office of the Children's Commissioner (2017). *State of Care 2017.* Wellington, New Zealand: Author.

Office of the Prime Minister's Chief Science Advisor (2018). *It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand.* Retrieved from www.pmcsa.org.nz

Office of the Prime Minister's Science Advisory Committee (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence. A report from the Prime Minister's Chief Science Advisor*. Auckland, New Zealand: Author.

Oranga Tamariki (2018). *Residential Youth Worker.* Retrieved from https://www.seek.co.nz/job/35348877.

Parsons, J. (2002). *Evaluation report: Agencies involved in the Palmerston North, Manawatu and Horowhenua strengthening families management groups*. Wellington, New Zealand: Ministry of Social Development.

Pascale, C.M. (2010). *Cartographies of knowledge: Exploring qualitative epistemologies*. Thousand Oaks, CA: Sage Publications.

Privacy Commissioner (2017). *Sharing personal information of families and vulnerable children: A guide for interdisciplinary groups*. Retrieved from https://privacy.org.nz/privacy-for-agencies/sharing-information-about-vulnerable-children/.

Reder, P. & Duncan, S. (2003). Understanding communication in child protection networks. *Child Abuse Review, 12*(2), 82–100.

Reed, J. (2007). *Appreciative Inquiry: Research for change.* Thousand Oaks, CA: Sage.

Richards, I. (1996). Psychiatric disorder among adolescents in custody. *Australian and New Zealand Journal of Psychiatry, 30*(6), 788-793.

Richardson, S. & Asthana, S. (2006). Inter-agency information sharing in health and social care services: The role of professional culture. *British Journal of Social Work, 36,* 657-669.

Rothi, D. & Leavey, G. (2006). Child and adolescent mental health services (CAMHS) and schools: inter-agency collaboration and communication. *The Journal of Mental Health Training, Education and Practice, 1*(3), 32-40.

Ryall, V., Radovini, S., Crothers, L., Schley, C., Fletcher, K., Nudds, S. & Groufsky, C. (2008). Intensive youth outreach in mental health: An integrated framework for understanding and intervention. *Social Work in Mental Health, 1*(3), 153-175.

Sandfort, J. (1999). The structural impediments to human service collaboration: Examining welfare reform at the front lines. *The Social Service Review, 73*(3), 314–339.

Schley, C. Radovini, A., Halperin, S. & Fletcher, K. (2011). Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and 'high-risk'. *Children and Youth Services Review, 33*(9), 1506-1514.

Schley, C., Yuen, K., Fletcher, K. & Radovini, A. (2012). Does engagement with an intensive outreach service predict better treatment outcomes in 'high-risk' youth? *Early Intervention in Psychiatry, 6*(2), 176-184.

Scott, R.J. & Boyd, R. (2016). *Collaborating for results in New Zealand: Evaluation using mixed methods and triangulation*. Retreived from https://www.researchgate.net/publication/304629090_Collaborating_for_results_in_New_Zealand_Evaluation_using_mixed_methods_and_triangulation.

Senior, J., McDonnell, S., Lennox, C., Yao, L. & Zhang, N. (2012). *The development of a pilot electronic multi-agency information sharing system for offenders with mental illness*. Retrieved from https://www. escholar.manchester.ac.uk/uk-ac-man-scw:15499.

Shaw, I. & Lunt, N. (2001). Navigating Practitioner Research. *British Journal of Social Work, 41,* 1548–1565.

Shelton, L. (2013). *Al Morrison leaving Conservation Department, joining State Services Commission.* Retrieved from http://wellington.scoop.co.nz/?p=54803.

Shepherd, N. & Meehan, T.J. (2012). A multilevel framework for effective interagency collaboration in mental health. *Australian Journal of Public Administration, 71* (4), 403–411.

Sikes, P. (2006). On dodgy ground? Problematics and ethics in educational research. *International Journal of Research & Methods in Education, 29*(1), 105-117.

Simpson, A.I., Brinded, P.M., Fairley, N., Laidlaw, T.M & Malcolm, F. (2003). Does ethnicity affect need for mental health service among New Zealand prisoners? *Australian and New Zealand Journal of Psychiatry 37*, 728–34.

Siraj-Blatchford, I. & Siraj-Blatchford, J. (2010). *Improving developmental outcomes for children through effective practice in integrating early years services.* London, England: Centre for Excellence and Outcomes in Children and Young People's Services.

Skowyra, K. R. & Cocozza, J. J. (2007). *Blueprint for change: A comprehensive model of the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. New York: Office of Juvenile Justice and Delinquency Prevention.

Smith, L. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. New York: Zed Books Ltd.

State Services Commission (2001). *Report of the Advisory Group on the Review of the Centre*. Retrieved from www.ssc.govt.nz/roc.

Suter, N. (2012). *Introduction to educational research: a critical thinking approach.* Thousand Oaks, CA: Sage.

Swanston, H. Y., Parkinson, P. N., O'Toole, B. I., Plunkett, A. M., Shrimpton, S., & Oates, R. K. (2003). Juvenile crime, aggression and delinquency after sexual abuse. *British Journal of Criminology, 43*, 729-749.

Te Rau Matatini. (2007). *Whakapakari Ake Te Tipu – Māori child and adolescent mental health workforce strategy*. Wellington, New Zealand: Author.

Teplin, L.A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health, 84*(2), 290-293.

Teplin, L. A., Abram, K. M., McClelland, G. M., Mericle, A. A. (2002). Psychiatric disorders of youth in detention. *Archives of General Psychiatry*, *59*(12), 1133-1143.

The Modernising Child, Youth and Family Panel (2016). *Expert panel final report: Investing in New Zealand's children and their families.* Wellington, New Zealand: Ministry of Social Development.

The Werry Centre (2009). *A literature review: Mental health and alcohol and other drug screening, assessment and treatment for youth justice populations*. Retrieved from http://www.werryworkforce.org/professionals/publications-and-resources?tid=All&tid_1=All&tid_2=All&field_released_date_value[value]&page=2.

The Werry Centre (2015). *2014 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand. Auckland:* Retrieved from http://www.werryworkforce.org/professionals/publications-and-resources?tid=All&tid_1=All&tid_2=All&field_released_date_value[value]&page=1.

The Werry Centre (2016). *Youth forensic course update*. Retrieved from http://www.werryworkforce.org/news/youth-forensic-update.

Thomas, D. R. (2006). A general inductive approach for analysing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

Thyer, B. A. (2001). *The handbook of social work research methods*. California: Sage Publications.

Tiatia, J. (2008). *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health.

Tiatia-Seath, J., Lay-Yee, R., & von Randow, M. (2017). Suicide mortality among pacific peoples in New Zealand, 1996-2013. *The New Zealand Medical Journal, 130* (1454), 21-29.

Tolley, A. (2015). *Independent expert panel to lead major CYF overhaul.* Retrieved from https://www.beehive.govt.nz/release/independent-expert-panel-lead-major-cyf-overhaul.

Ulzen, T.P.M., & Hamilton, H. (1998). The nature and characteristics of psychiatric comorbidity in incarcerated adolescents. *Canadian Journal of Psychiatry, 43*, 57-63.

United Nations Children's Fund (2017). *Building the Future: Children and the sustainable development goals in rich countries.* Retrieved from https://www.unicef-irc.org/publications/pdf/RC14_eng.pdf.

Walker, J. (2017). *When the vulnerable offend, whose fault is it?* Retrieved from www.districtcourts.govt.nz/assets/.../YC-Speech-PYCJ-J-Walker-27-Sept-2017.pdf.

Ward, T. & Beech, A.R. (2014). Dynamic risk factors: A theoretical dead-end? *Psychology, Crime & Law, 21*(2), 100-113.
Wells, J.B., Minor, K.I., Angel, E., Matz, A.K. & Amato, N. (2009). Predictors of job stress among staff in juvenile correctional facilities. *Criminal Justice and Behavior, 36* (3), 245-258.
White, J.L., Moffitt, T.E., Earls, F., Robins, L., & Silva, P.A. (1990). How early can we tell?: Predictors of childhood conduct disorder and adolescent delinquency. *Criminology, 28*(4), 507-533.
White, P., Gunston, J., Salmond, C., Atkinson, J., & Crampton, P. (2008). *Atlas of Socioeconomic Deprivation in New Zealand.* Wellington, New Zealand: Ministry of Health.
White, S. & Featherstone, B. (2005). Communicating misunderstandings: Multi-agency work as social practice. *Child & Family Social Work*, 10(3), 207-216.
Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, England: Open University Press.
Wilson, L.S., Pillay, D., Kelly, B.D. & Casey, P. (2015). Mental health professionals and information sharing: carer perspectives. *Irish Journal of Medical Science, 184*(4), 781-790.