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Mind the Gap

A process evaluation of a wraparound approach to treating childhood offending

Craig Anthony Barretto

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Abstract

Childhood offending is an increasingly worrying issue due to its immediate risks as well as the long-term negative outcomes for these children. Children who offend at young ages continue a pattern of offending well into adulthood, causing major damage to society and their own lives and communities. To date in New Zealand, there has been no treatment programme specifically targeted at child offenders under age 14. The programme described in this research was the first attempt at creating such a service based on a wraparound framework. The aims of this research were to describe and evaluate the operation and processes of this programme via interviews with the staff involved in the programme. The qualitative study examined the successes and shortcomings of the programme and which of its components or systemic issues contributed to these outcomes. Results of broad themes showed that: (1) There was a clear need for this programme due to a gap in services, a deficit-based attitude among professionals, transience of services and young people and their families not having a voice; (2) Programme implementation was made difficult by institutional processes but helped by supervision, training and gaining recognition from other services; (3) The programme resulted in significant relational change between the social workers, the young people and their families, characterised by improved communication, trust, and adopting a broader focus; (4) Behaviour change was difficult to sustain as children were not in the programme for long enough, had strong antisocial influences and plans were not robust enough, although positive outcomes were seen when plans were flexible and included increased contact with families; (5) Systemic issues that hindered programme success included the reputation of statutory social workers among families, poor interagency collaboration, a risk-averse attitude to case management and not enough time and resources. The findings from this research are discussed in relation to their implications for such programmes, as well as the systems which guide how programmes are implemented and operated. An understanding of why children offend so early in their lives and how best to intervene is crucial to changing their negative life trajectories.

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Chapter One
Introduction

Children and young people who offend have taken a unique place in both social and political spheres in New Zealand due to high profile cases, as well as the wider issues of poverty, violence and inequality that tend to precipitate antisocial behaviour. The weight on the collective conscience of members of government and the public has led many to question whether enough is being done for this group. In the year ending June 2017, there was a general increase of 5% in the number of children (aged 10 to 13 years) and adolescents (aged 14 to 16 years) charged in court, rising to a rate of approximately 40 per 10,000 young people in New Zealand. This increase was ethnically disproportionate with 7% more Māori than non-Māori being charged, in line with increased rates for Māori from 46% in 2007 to 63% in 2017. This group was predominantly male (80%) and a majority were between 15 and 16 years old. These figures are within the context of youth offending in New Zealand showing a general decrease, down 40% since June 2012 (Statistics New Zealand, 2017).

Despite being the minority in this group (under 5%), those who offend early in their childhood (between the ages of 10 and 13), and particularly those who begin offending prior to age 12, are more likely to continue offending into adulthood (Loeber & Farrington, 2011). In addition, children who engage in offending behaviour are two to three times more likely to go on and become violent, serious and chronic offenders, and have longer involvement in delinquency than those who begin offending in adolescence. Therefore, the detection of these young people at an early age and intervention with them are important to reduce the likelihood of these young people becoming ‘chronic’ offenders. Early intervention is also desirable due to patterns of behaviour being less entrenched, and given that risk factors and co-occurring difficulties increase with age.

In New Zealand, childhood offending results in involvement in both the ‘care and protection’ and youth justice systems. They have been shown to display outcomes that are even worse than the general statutory care population. Figures show that by the age of 21, those who have been in the care and protection system are more likely to have left school without an NCEA level 2 qualification, to be on a benefit and to have contact with youth justice or receive a custodial or community sentence in the adult corrections system (Chrichton et al., 2015). These trends are especially true for child offenders. In the year 2013-

2014, 12,000 young people aged between the ages of 10 and 16 were arrested by the police, out of which 2700 were referred to the then statutory agency, Child Youth and Family (now Oranga Tamariki) and various youth courts. Despite overall trends of youth offending decreasing in recent years, critical issues are of concern in the current system.

The large number of children presenting very young with indicators that are risk factors for future offending are not being responded to in a way that changes this trajectory. It is well documented that physical violence in the household and maltreatment during childhood are major factors which lead to future offending (Fergusson & Lynskey, 1997) but indicators such as lack of engagement with school, early apprehension by police and care and protection involvement of siblings and parents are opportunities for early intervention and prevention that are not being seized (Ministry of Social Development, 2014). High rates of childhood maltreatment in adolescent and adult offenders are a sign that the interventions are not put in place early in these individuals' contact with care and protection to divert them away from offending. In a similar vein, high reoffending rates among youth offenders between the ages of 17 to 21 (Chrichton et al., 2015) suggest that future offending is not being adequately prevented. The apparent inevitability of offending behaviours becoming more pervasive and consequences more severe leads to young adults who present with extremely high levels of educational deficiency, financial dependency on the state, early parenting and then having involvement with care and protection again as adults with their own children (Ministry of Social Development, 2015).

In order to address this gap in services for child offenders, leaders and experienced clinicians in the field affiliated with Child Youth and Family, the University of Auckland and various non-governmental organisations began informal discussions about what could be done differently. This process will be discussed in more detail in Chapter Two under Programme Development and Implementation. I was commissioned as a researcher to document the implementation, conduct a process evaluation and informally describe the outcomes of this programme. My responsibility was to design interview schedules, collect and analyse data.

A process evaluation was chosen because it helps our understanding of a programme's operation and outcomes across varied domains (Dehar, Casswell, & Duigan, 1993), as opposed to outcome studies which focus predominantly on recidivism rates. For this study, the lack of matched control groups available and difficulty measuring reoffending accurately and finding a sample size large enough to obtain statistically significant results were reasons why an outcome study was not possible. It was also decided that changes in

other areas of a young person's life, such as improved relationships with parents, peers and members of the public, as well as engaging in prosocial activities, were important to take into account, not just a narrow measure of offending behaviour alone.

The broad aims of this study were to investigate how the programme was run, with a goal of identifying the strengths and weaknesses. This was achieved by my documenting the operation and clinical characteristics at the different points in the development and implementation of the programme. It was hoped that this process evaluation would provide information which would help develop interventions for this group and bring awareness of the wider systemic issues that get in the way of positive outcomes for these young people and their families.

My interest in this area stems from previous work experience with children and a wish to do my part in changing the outcomes and shifting structures to look after children the way we should. Through this work experience, I developed an understanding of the effects of childhood poverty, early life adversity, negative experiences of education and difficulties navigating important transitions in childhood and adolescence. Meanwhile, my study provided me with an appreciation and knowledge of the systemic structure, methods of interventions and clinical issues related to this group. I completed a dissertation and published an article on public opinion towards youth offenders and the New Zealand criminal justice system (Barretto, Lambie, & Miers, 2016), which gave me unique insights into the way this group is perceived in society in terms of public opinion and led me to wonder about the balance of influence between public opinion and the needs of children on policy makers and governmental ministries. As a result, this study captured my interest as it was an opportunity to be a part of something new and exciting, placed firmly at the forefront of child offender treatment in New Zealand. I would also have the unique chance to gain a lived experience of a programme's implementation and to understand the perspectives of the professionals running it.

In the following sections of this chapter, the relevant literature regarding childhood offending will be reviewed, paying particular attention to the theories of childhood offending and evidence-based approaches used to treat offending behaviour. The pathways that lead to offending and how therapeutic and case management processes intervene on these pathways will be explored with consideration of service implementation issues. Finally, the implications of this research for this study and the study's specific aims will be outlined.

Childhood Offending in New Zealand

The prevention, treatment and management of antisocial behaviours in children and adolescents have been a consistent matter of interest in political, public and scientific spheres. These efforts have been focused on the minority of young people who show recurring patterns of aggressive, violent and dishonest behaviours. There has been useful data from the New Zealand's Christchurch Health and Development Study (CHDS) and the Dunedin Multi-disciplinary Health and Development Study (DMHDS) which tracked one thousand New Zealand youth from birth to age 30 and beyond. These studies found that those with conduct problems in childhood and adolescence had increased risk of later crime, substance abuse, mental health problems, suicidal ideation, teenage pregnancy, inter-partner violence, and poorer physical health than those without (Fergusson, Boden, & Horwood, 2009; Fergusson, Horwood, & Ridder, 2007; Fergusson, Horwood, & Ridder, 2005; Fergusson, Woodward, & Horwood, 1999a, 1999b). Crime is disproportionately committed by young people, with offending behaviours peaking during adolescence, particularly in the mid to late teens, followed by a decrease thereafter (Henry, Caspi, Moffitt, Harrington, & Silva, 1999). Furthermore, a small proportion of young people are accountable for the large majority of offences committed by adolescents (Henry et al., 1999). These trends are especially significant for Māori as they make up approximately 50% of all youth offenders and in some courts this figure reaches as high as 80% or 90%. This is especially worrying given the fact that Māori make up only 25% of the New Zealand population under age 17 (Haonga, 2002).

Due to these severe negative trajectories, there has been extensive research on the causes of serious conduct problems; specifically, their aetiology, developmental trajectory and amenability to treatment. This research is consistent in showing the substantial variability in the emotional, cognitive and social characteristics of this group, thus alluding to the possibility of a number of different causal pathways leading to these problem behaviours (Frick & Viding, 2009). This has resulted in an increasing interest in developing classification methods in order to designate clinically meaningful subgroups. These have typically involved focusing on variations in behavioural typologies of conduct problems, such as frequency, levels of aggression (Dodge & Pettit, 2003; Lahey & Loeber, 1994) and age of onset (Moffitt, 2006).

Regardless of whether or not serious violent offending by youth is increasing, it imposes a heavy cost on victims, the community, the perpetrators and their families. A small minority of violent youths go on to serious violent offending as adults, are much more likely

than others to be perpetrators of family violence as adults, and are likely to be disproportionately represented in the prison population (Moffitt, 2006; Moffitt & Caspi, 1999).

Defining Childhood Offending

This group has been described in psychiatric and clinical psychology terms as having oppositional defiant disorder (ODD) or conduct disorder (CD) (APA, 2013; Moffitt et al., 2008) and as having emotional and behavioural disturbance (EBD) in educational fields. For the purposes of this review, the phrase 'conduct problems' will be used as a general term and as defined by the New Zealand Advisory Group on Conduct Problems (AGCP):

> *Childhood conduct problems include a spectrum of antisocial, aggressive, dishonest, delinquent, defiant and disruptive behaviours. These behaviours may vary from none to severe, and may have the following consequences for the child/young person and those around him/her: stress, distress and concern to adult care givers and authority figures; threats to the physical safety of the young people involved and their peers; disruption of home, school or other environments; and involvement of the criminal justice system. (Blissett et al., 2009).*

As is made clear in the above definition, serious conduct problems represent major concerns at societal, familial and individual levels. These behaviours are highly related to adult criminal behaviour (Frick, Stickle, Dandreaux, Farrell, & Kimonis, 2005) as well as a range of other negative outcomes, including mental health, education, emotional and social functioning (Kimonis & Frick, 2011). Specifically, conduct problems in childhood have been shown to predict future problems with increased risk of arrest, substance abuse, school dropout, poor job performance and difficulties adapting to interpersonal relationships (Odgers et al., 2007; Odgers et al., 2008).

Developmental Theories of Childhood Offending

This section provides a summary and review of the existing literature on the theories of childhood offending. It is organised into subsections outlining the broad developmental theories of offending and then delving into risk factors and the psychological and social mechanisms by which they result in a higher risk of developing antisocial attitudes and behaviour. Theories are proposed as a way of understanding the set of conditions and factors

that form part of a causal pathway to offending behaviour. Understanding this pathway in detail and across different internal and external environments allows interventions to be more accurately targeted on the mechanisms which are driving the behaviour one wants to change.

Developmental theories explain offending by mapping a trajectory for individuals over time rather than explaining between-group differences. Research in this area uses longitudinal, prospective methodologies such as New Zealand's own Dunedin study (Moffitt, 2001). The theories described below were chosen because of their validity, influence and amount of empirical support they have received. They all aim to explain the underlying, internal, causal factors leading to offending, what promotes and inhibits offending, and the mechanisms of 'desistance' across a young person's lifespan (the factors that help them 'desist' from offending and make other choices) – thus ensuring that any ensuing intervention is developmentally appropriate to the life-stage of the individual.

Adolescent-Limited and Life-Course Persistent Offenders

Arguably the most famous developmental theory of offending was developed by Moffitt (1993), who described a developmental taxonomy where she distinguishes between two groups of young people who engage in antisocial behaviour during adolescence. The two groups are those termed 'life-course persistent offenders' and those young people for whom offending is 'adolescent-limited' (Moffitt, 1993). The signature trait of the life-course persistent group is continuity. These young people typically engage in antisocial behaviour from a young age (for example, biting or hitting in their preschool years), and maintain different forms of these behaviours across multiple settings (such as with peers and at school or home) throughout adolescence. They get involved in youth offending and continue to engage in criminal activity into adulthood. Life-course persistent offenders tend to have a wide repertoire of offending behaviours which are characteristically more violent than adolescent-limited offenders, who engage predominantly in non-violent offences such as vandalism (Moffitt, 2001). Offending by the life-course persistent subgroup is caused by factors such as cognitive deficits, temperament dysregulation, hyperactivity, poor parenting and societal factors such as low socioeconomic status and poverty leading to an antisocial lifestyle (these factors are discussed in more detail below). By contrast, adolescent-limited offending is influenced by a lack of maturity, boredom and peer influence. In this group, desistance (moving away from offending) occurs as they adopt adult roles and are able to achieve and obtain things legally. A key factor contributing to differences in desistance are

neuropsychological deficits in executive functioning, resulting from factors like otherwise normal brain functioning that has been affected by exposure to alcohol and drugs in-utero, or early childhood head trauma. In this way, this theory posits that it is these neuropsychological deficits and their interaction with environmental factors that lead to the development of antisocial behaviour.

While life-course persistent offenders are uncommon, such young people account for the majority of the crimes committed by adolescents. The remainder of crimes are carried out by the larger group of adolescent-limited offenders who engage in criminal behaviour only in the course of adolescence. Their offending is rarely precipitated by a childhood history of antisocial behaviour, usually only presents in one environment and desists before adulthood. In fact, Moffitt (1993) suggested that adolescent-limited offending is carried out by 30% to 40% of young people, and as such could be considered as normative to a certain degree.

Developmental Propensity Theory

In an attempt to distinguish a group of people on a continuum of trajectories, rather than two categories as Moffitt did, Lahey and Waldman (2005) proposed their developmental propensity theory. They proposed that the propensity for antisocial behaviour has a variety of behavioural indicators which explain the variability and high levels of comorbidity found with conduct disorder. They suggested that the key factors contributing to antisocial behaviour fall into four domains: low cognitive ability, low prosociality (capacity for sympathy and empathy), levels of inhibition (leading to daring/risk-taking behaviour) and negative emotionality (easily angered, bored). These are described as having gene-environment foundations (Beaver, Schwartz, & Gajos, 2015; Morizot, 2015)

Social and Interactive Models of Offending

Catalano et al. (2005) introduced the Social Development Model as a way of integrating social bonding and social learning theories implicating bonding to society as a key construct of our behaviour. They suggested that ideally an individual achieves a balance between prosocial and antisocial bonding, based on the premise that offending behaviour is driven by a motivation to follow self-interest regardless of its consequences to wider society. This theory makes no assumptions about types of offences but provides an environmental understanding of the distinction between prosocial and antisocial behaviour (Hawkins et al.,

2003). They suggested two causal pathways for the development of antisocial and prosocial behaviours. Environments that provide children with plenty of opportunities for prosocial interactions lead to children developing the skills, relationships and beliefs that match this environment and they are rewarded for this prosocial behaviour. Those who are exposed to antisocial environments develop skills for antisocial behaviour which leads to antisocial bonding and beliefs. Therefore, the antisocial pathway outlines factors which encourage offending while the prosocial pathway outlines protective factors that inhibit antisocial behaviour. As with other developmental theories, the social development model maintains that demographic, biological and psychological factors impact on opportunities and the processes of socialisation, which are different at each developmental stage – such as socialisation with family for younger children and socialisation with peers in later adolescence. Tests of the validity of this model have been promising generally (Roosa et al., 2011; Sullivan & Hirschfield, 2011), as well as with specific populations of young people with drug and alcohol use (Catalano, Kosterman, Hawkins, Newcomb, & Abbott, 1996) and violent behaviour (Huang, Kosterman, Catalano, Hawkins, & Abbott, 2001).

Thornberry and Krohn (2005) introduced an interactional theory of offending which touches on themes similar to the social development model but also elaborates on specific mechanisms at work. They produced more well-defined developmental stages and mechanisms which increased risk of offending. They posit that neuropsychological deficits and problematic temperament are the most common factors related to problem behaviour before the age of six; between the ages of six and 12, neighbourhood and family factors are particularly relevant; and between ages 12 and 18, school and peer factors, through deviant social networks and gangs, are most salient (Thornberry & Krohn, 2005). A feature of this theory that distinguishes it from the social development model is its emphasis on how an individual child's or young person's interactions with their environment cause the targets of their behaviour to react in ways that contribute to antisocial beliefs and an increase in severity of behaviour.

Effects of Early Abuse and Neglect

Child abuse, as defined by the World Health Organization (2006), includes any maltreatment as a result of physical, emotional, or sexual harm as well as supervisory neglect or exploitation that threatens a child's health, development or the quality of their relationships with others and their view of themselves. Child abuse has been associated with conduct

problems and early offending. However, desistance is also possible if social influences change or the responses to the abused child's problem behaviour are constructive, as opposed to coercive (Thornberry & Krohn, 2001). To this end, stigmatisation and ongoing contact with care and protection or youth justice systems have shown an effect of enhancing future offending due to an internalisation of labels to do with such systems (Bernburg & Krohn, 2003; Krohn, Lopes, & Ward, 2014; Lopes et al., 2012). This theory also accounts for intergenerational antisocial behaviour as due to the reciprocal impact of parent and child antisocial behaviour (Thornberry, 2009).

The general effect of trauma on the psychological and social development of children can be seen as an attack on what should ideally be a predictable and safe environment (Cicchetti & Valentino, 2006). This safe foundation is crucial in the child forming healthy and secure attachment patterns with their caregivers, which are fundamental to important developmental milestones such as emotion regulation, trust of others, perspective taking, self-control, interpersonal effectiveness, social understanding and many more attitudes that act as key factors in being a prosocial member of human society (Cicchetti & Toth, 2005; Cicchetti & Valentino, 2006; Wenar & Kerig, 2000). For example, a lack of interpersonal effectiveness leads to relationships that operate by coercion and manipulation where there is a power imbalance of some kind. Not only is this use of power to manipulate a predictor of antisocial behaviour (Kochanska & Kim, 2013), it also provokes further conflict with parents and peers leading to rejection from family systems and isolation from peers and prosocial environments (Kim & Cicchetti, 2010; Ladd, Herald-Brown, & Reiser, 2008), therefore further exacerbating the lack of interpersonal and social skills as well as protective prosocial relationships. Further information regarding attachment and its impact is provided under the Family Influences section.

Social Learning Theory

Based on seminal research by Bandura and Walters (1959) on modelling theory, this school of thought posits that behaviours are learned through a process of observing and imitating the behaviours of others. This research is supported by findings of transmission of aggressive behaviour between parents and children (Hill, 2002; Kazdin, 1997). From a trauma perspective, children who are victims of violence or observe violence in their environment are more prone to recreating that violence through modelling (Akers, 2011). This is especially the case when children learn the contingencies around using violence as a means of gaining dominance and as a way to obtain goals.

General Strain Theory

Another major theoretical understanding of how trauma increases the risk of antisocial behaviour is General Strain Theory (Agnew, 1985). It posits that traumatic environments cause strain in children who have yet to develop the regulation and executive functioning skills to cope and make sense of these experiences. Thus, they respond with negative affect based on primary emotions of anger, frustration and aggressive behaviour. While this can be seen as a natural, evolutionary response to threat, such strong, negative emotions that are not able to be regulated by the child themselves or soothed by their caregiver results in a growing desire for aggression and disinhibition which increases risk of other-directed violence (Agnew, 1992). More recent studies have reinforced this finding, showing that negative affect is a consequence of trauma and a predictor of antisocial behaviour (Aseltine Jr, Gore, & Gordon, 2000; Haynie, Petts, Maimon, & Piquero, 2009; Maschi, 2006; Maschi, Bradley, & Morgen, 2008).

Longitudinal Research Linking Trauma with Antisocial Behaviour

Various meta-analyses and cross-sectional studies have shown that trauma and neglect are associated with high rates of involvement in the youth justice system (Kerig & Becker, 2012; Kerig, Becker, & Egan, 2010). Prospective longitudinal studies analysed by Wilson, Stover, and Berkowitz (2009) showed that exposure to violence before the age of 12 resulted in antisocial behaviour. Randomised controlled trials have also demonstrated similar effects: Stouthamer-Loeber, Loeber, Wei, Farrington, and Wikström (2002) found that of 503 boys studied with histories of maltreatment, 50% were involved in offending behaviour by the age of 13, compared to 19% in a matched control group. Using a large sample of 1000 New Zealand children in the longitudinal Dunedin study, Fergusson, McLeod, and Horwood (2013) found that exposure to physical and sexual abuse was associated with a range of negative outcomes which included conduct disorder and antisocial personality traits. These and many other studies provide evidence of this link between early childhood maltreatment and offending behaviour later in adolescence.

Prenatal and Perinatal Factors

Early childhood adversity can also extend to before or during a child's birth through prenatal and perinatal factors that can have an influence on antisocial behaviour. Prenatal factors such as maternal alcohol and drug use during pregnancy, exposure to other toxins and malnutrition result in abnormal foetal development (Raine, 2013a), which has been linked to future offending by biopsychosocial mechanisms. The most commonly researched example

has been exposure to alcohol in the womb and subsequent foetal alcohol syndrome. This is associated with learning disabilities, low IQ (Raine, 2013a), as well as inappropriate sexual behaviour. These factors are examples of biological determinants of conduct difficulties which include neuropsychological deficits, brain injuries, arousal levels and genetic factors (Raine, 2002).

Neuropsychological deficits in children who offend are typically seen to be in areas associated with language, verbal reasoning and executive functioning which underpin an individual's ability to self-regulate (Moffitt, 1993). By similar mechanisms outlined earlier, this results in higher risk of developing offending behaviour due to frustration with school and aggressive behaviour manifesting as a result (Hill, 2002; Raine, 2002). Children presenting with conduct disorder also show lower levels of arousal than other children who do not present with the same difficulties. This interferes with treatment because these children do not show the same levels of fear and are less responsive to punishment (Raine, 2002, 2013b). This is especially true of the so-called 'callous-unemotional' (CU) subgroups who are insensitive to punishment cues on tasks which require a reward-dominant response and an increasing ratio of punishment-driven responses (Fisher & Blair, 1998; Frick et al., 2003). This is reinforced by studies which show those with lower CU traits are more receptive to gradual punishment compared to youth high on CU traits (Blair, Colledge, & Mitchell, 2001). Those with high CU traits also underestimate the likelihood of punishment as a consequence for their actions (Pardini, Lochman, & Frick, 2003).

Family Influences

The family is the first environment a child is exposed to and a place where they learn how to manage themselves and how to navigate their world. Numerous meta-analyses have summarised the influence of family factors on the development of conduct disorder and antisocial attitudes (Avinun & Knafo, 2014; Tanner-Smith, Wilson, & Lipsey, 2013; Waller, Gardner, & Hyde, 2013). The highlights and main features of this research will be outlined below.

Firstly, research has shown that family size can be a significant predictor of later conduct problems. This is not due to the number itself but the effect overcrowding of houses has on family dynamics and conflict (Farrington et al., 2006), financial stability and reduced parental capacity for effective discipline and monitoring of children. Households managed by single parents also present with similar risks, due to the limited amount of time a parent can spend monitoring each child, leading to problem behaviour going unnoticed and escalating.

Lack of parental monitoring and control has been shown to be associated with a higher risk of children developing conduct problems (Gardner, Sonuga-Barke, & Sayal, 1999; Mize & Pettit, 1997). Parental supervision allows management of behaviour and provides scaffolding for adhering to rules and structured activities (Dishion et al., 2008; Forgatch, Bullock, Patterson, & Steiner, 2004).

Single-parent households and children who experience transience of caretakers present with adjustment problems and increased problem behaviours (Henry, Moffitt, Robins, Earls, & Silva, 1993; Loeber et al., 2005). These disruptions impact on the parent-child relationship leading to increased conflict, emotional distress caused by moving schools and homes (Fergusson, Horwood, & Lynskey, 1992), as well as the potential for increased exposure to observed conflict between parents, the effects of which were previously outlined.

Family socioeconomic status is also a multifaceted factor that impacts on children's behaviour problems in a number of ways. Factors such as low family income, low-quality housing and lack of parental education have all been shown to be associated with the development of conduct problems (Bjerk, 2007; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Magnuson & Votruba-Drzal, 2008). This association seems to be mediated by a number of other risk factors such as parental stress (Hay, Pawlby, Angold, Harold, & Sharp, 2003; Loeber et al., 2005), peer group instability, negative socialising experiences (Murray, Loeber, & Pardini, 2012), antisocial role models (Farrington, 2003; Sellers et al., 2014) and lack of cognitive stimulation via school or other extracurricular activities (Dodge, Pettit, & Bates, 1994).

Parenting practices are among the most comprehensively researched contributing factors to childhood offending (Hoeve et al., 2009; Hoeve et al., 2012), especially due to their links to theory-driven, systemic interventions such as MST, TFM and MTFC (described in more detail in Chapter Three). As previously stated, attachment is the foundation of successful socialisation and development of self (Kochanska et al., 2010). A secure attachment is primarily formed through comfort and responsiveness to a child's distress (Bowlby, 1982). Longitudinal studies have shown that an insecure attachment can result in early-onset conduct problems (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; Hoeve et al., 2012). Thus, it is key that parents provide warmth and an environment in which a secure attachment can be cultivated. Research has shown that children who experience high parental warmth and are able to spend time with their parents have fewer conduct problems in early childhood (Gardner, Burton, & Klimes, 2006; F. Gardner, Ward, Burton, & Wilson, 2003). Longitudinal research also points to parental

warmth as being a distinguishing factor between those high and low on callous-unemotional (CU) traits. Those with high CU traits are a subgroup of children with conduct problems that present with shallow emotions, use of others for their own gain, egocentricity and a lack of empathy and guilt. High levels of CU traits have been predicted by less parental warmth (Pardini, Lochman, & Powell, 2007). Lack of parental warmth has also been shown to be driven by the behaviour of the child, causing a cycle of harsh parenting leading to increasing levels of CU traits and problem behaviours over time (Hawes, Dadds, Frost, & Hasking, 2011; Larsson et al., 2007; Salihovic, Kerr, Özdemir, & Pakalniskiene, 2012). These developmental factors result in characteristics that are different from populations of children with conduct problems who do not present with elevated CU traits.

From a theoretical standpoint, two of the main understandings of the mechanisms behind how parenting practices influence the development of conduct problems are the coercive family process theory and the structural family systems theory.

Social Coercion Theory

Developed by Patterson and his colleagues (Patterson, 1982; Patterson, Reid, & Dishion, 1992), social coercion theory posits that children learn antisocial behaviour through interactions with family and peers at home and in the community. They suggested that three specific characteristics in these interactions were indicative of a coercive parenting style: little position interaction, frequent punishment and intermittent reinforcement of antisocial behaviour by responding aggressively to problem behaviour and then withdrawing when this problem behaviour escalates. This signals to children that escalation leads to parental withdrawal. Prolonged exposure to this parenting style leads to an aggressive relational style which leads to rejection by prosocial peers and teachers, and impacts on academic and social achievement.

Structural Family Systems Theory

Similar but with more emphasis on how problem behaviours are maintained in families, structural family systems theory provides a framework for understanding the roles and patterns in families (Colapinto, 1991; Madanes, 1991). Families who have young people with conduct problems are typically characterised by disorganisation where there is confusion regarding the roles of different members and their responsibilities to the family unit. These families are also characterised by unclear or hostile communication, lack of empathy and less cohesive problem-solving (Carr, 2015). The concept of ‘structure’ alludes to hierarchies within the families, preferably starting with a coalition between parents, which is distinct

from child and sibling subsystems. When this boundary is not well-defined, children struggle to carve out a role for themselves in the family which can result in challenging of parents and violent behaviour towards siblings, which then generalise to systems outside of the family unit.

Resilience and Protective Factors

The vast amounts of literature discussed above paint a bleak picture of the effects of childhood adversity and what can sometimes be a fine line between a successful, prosocial life and an antisocial one, which involves a host of other negative outcomes. This line is most often crossed through the heinous acts of abusive individuals and society's failure to take care of our youngest and most malleable but, in some cases, also in subtle and inadvertent ways; leading to questions about the inevitability of the link between childhood adversity and future offending. For example, research has pointed to a significant proportion of children who fall into high-risk categories, who are raised in environments such as those described, and yet who do not engage in antisocial behaviours (Laub & Sampson, 2001; Turner, Hartman, Exum, & Cullen, 2007; Werner, 1989). This suggests that resilience, in the form of positive adaptation and a resistance to criminogenic risk factors, in response to early childhood adversity is a possibility.

'Protective' factors allude to the influences that deter individuals from an offending pathway by mediating the effects of risk factors (Rutter, 1985). The mechanisms by which protective factors are thought to function vary (Lösel & Farrington, 2012), from interrupting the sequence of events leading to an increased risk of offending or mitigating the effect of the risk factor all together. Broadly, protective factors have been shown to be extrinsic (family, peer and community factors) or intrinsic (personality, temperament, social beliefs and biological factors). The most consistently validated protective factors in the available research are outlined below.

Prosocial engagement in activities that promote self-actualisation, purpose and control (Mahoney & Stattin, 2000) have been shown to be characteristic of youth who are deterred from problem behaviours (Taylor et al., 2003). Several family factors, such as a secure attachment to at least one parent, consistent discipline, adequate supervision and constructive models of family coping, have also been shown to have protective effects. School engagement, indicated by motivation to study, academic goals, support from teachers and adherence to rules, has protective effects on conduct problems (Lösel & Farrington, 2012). Finally, a safe neighbourhood in which an individual is able to meet their basic physical

needs, and feel safe and connected with prosocial peers, also has protective effects against violent behaviour (Cattelino, 2000; Herrenkohl, Tajima, Whitney, & Huang, 2005; Loeber, Farrington, Stouthamer-Loeber, & White, 2008).

It is important to elaborate on what positive adaptation is specifically, especially when resilience can be shown in multiple domains. The important distinction here is between external adaptation in order to survive the challenges of the environment and an internal sense of wellbeing and living according to one's own values (Masten & Obradović, 2006). Thus, it is important to have an appreciation of the socio-cultural contexts in which behaviour is being assessed, as antisocial behaviours can serve as survival and attempts to protect oneself and one's family, but such actions would not be considered indicators of resilience at the behavioural level. Research has reinforced that resilience in all adaptive domains is difficult to achieve, so it is therefore important to recognise a young person's resilience in specific domains (Luthar, 2003). Primary and secondary resilience are two such domains which help narrow and specify the broader concept of resilience. 'Primary' resilience refers to the absence of a disorder despite the presence of risk factors (Luthar, Cicchetti, & Becker, 2000; Masten & Obradović, 2006), while 'secondary' resilience refers to the process of re-engaging in a prosocial life (Born, 2011; Cyrulnik, 2008).

Primary resilience can also be seen as low severity and minimal offending in the face of an array of risk factors. This can also be seen as characteristic of adolescent-limited offenders (Moffitt, 1993) and fits with the idea that some problem behaviour is to be expected and considered the norm in childhood as a result of testing boundaries (Klein, 2012). Secondary resilience is a step further towards developing a prosocial life after committing offences (Maruna & Immarigeon, 2013). Drapeau, Saint-Jacques, Lépine, Bégin, and Bernard (2004) found several factors that were important for developing resilience; namely, external factors of having healthy emotional ties with prosocial adults and positive experiences in academic, sporting or creative domains, and internal factors of a sense of agency and control of their own lives, self-confidence and self-efficacy with being able to live the lives they wanted to. This internal ability to withstand the pressures of one's environment appears to be crucial to divert away from antisocial behaviour (Boët & Born, 2001). External factors such as the ability of parents to model prosocial behaviour and respond constructively to their child's emotions are key in adapting positively to their environment. If lacking, these should also be central components of therapeutic and rehabilitative approaches.

Summary

The number of different theories and casual pathways to childhood offending described above can feel overwhelming and paints a picture of infancy and childhood that is fraught and where there are multiple opportunities for starting on a negative trajectory. This highlights the importance of these early formative years in all our lives and the sheer number of influences that have the potential to shape us. The theoretical approaches above point to developmental understandings of offending, in terms of knowing that if important internal regulation or coping skills and external relational skills are not achieved in a timely and adaptive manner, this has the potential to lead to problem behaviour. The theories all propose an interaction between multiple factors; for example, a deficit in internal regulation leads to difficulties with external socialising, which then alters peer groups and beliefs about self and the world. These mechanisms are complex and the permutations endless; however, the importance of family dynamics, parenting practices and peer influences, as outlined as part of structural family theories and social coercion hypotheses, are understandably crucial. Infant and childhood adversity and traumatic experiences also have a profound impact on a child's whole system and lead to a specific set of responses which are often seen as more difficult to change because they have developed as a means of survival. All of these together are important to understand because they are all factors that change the way an individual child and their family need to be responded to when they present to statutory services. In addition, such understanding enables interventions to be planned with a sound formulation that is grounded in evidence-based theory. It is also important to be aware of resilience and protective factors that have served to keep the child and family in question functioning as members of society and adapting the best they can to often incredibly harsh and demanding environments. These complement interventions and assist professionals by enabling the use a child and family's existing resources and ability to thrive in certain areas as an accelerant towards positive outcomes.

Evidence-Based Approaches to Childhood Offending

This section provides a summary of the highly regarded and evidence-based interventions that are used for children and families who are accessing treatment while remaining in their communities. While children presenting with challenging behaviours and early offending oftentimes find themselves in residential treatment, the basis for outlining

community-based approaches is that they most closely fit the conditions which the programme investigated in this thesis aimed to create. Engaging a child within their own environment and involving them as much as possible in decision-making are ways of treating a child in the least restricted and isolated environment possible. These approaches have also been included because they have been shown to be effective for this age group, and for the psychological and behavioural profiles of the young people involved in this programme. They are also discussed because they included principles that would be useful to reflect in our programme or were models being used in services, such as non-governmental organisations (NGOs), to which we could potentially contract work out.

Therapeutic Models

Multisystemic Therapy

Multisystemic Therapy (MST) is a multidimensional family and community treatment used to address severe conduct problems, antisocial behaviour, and other behavioural and emotional problems in children and adolescents. It adopts a multimodal approach that is based on Bronfenbrenner's (1979) social-ecology theory which states that a child's development is mediated by their social, familial and peer environments. It posits that change is brought about by targeting the systems thought to be maintaining conduct problems. For children, these are most commonly family dynamics and interactions at school. MST empowers families and caregivers to facilitate change within their families (Henggeler & Sheidow, 2012) seeing them as the agents of change in this process.

Henggeler, Schoenwald, Borduin, Rowland, and Cunningham (2009) outlined nine treatment principles which form the basis of the intervention: (1) Assessments are based on understanding the link between an individual's problems and their broader systemic context. (2) Strengths of different systems are elicited in order to form the basis of change. (3) Interventions promote behaviour change from all members in the system – not just the referred young person. (4) Interventions are targeted on current behaviours in real time as opposed to targeting future contingencies. (5) Interventions act to change sequences of behaviour within the systems involved. (6) Interventions are developmentally appropriate. (7) Interventions are ongoing and require commitment to weekly monitoring and action from family and caregivers. (8) The effectiveness of interventions is evaluated from the perspective of multiple systems i.e., does changing something at home produce a desired change at school or vice versa. (9) Treatment generalisation is a core focus whereby long-

term maintenance of therapeutic change is measured by how well families and other systems are able to manage behaviour on an ongoing basis.

Guided by these principles, MST is typically undertaken within the family home following the construction of a personalised treatment plan for the young person and their family. The specific interventions include evidence-based interventions such as behavioural parent training, structural family therapy and systemic family therapy (Henggeler et al., 2009). Interventions within school systems include social interventions aimed at managing antisocial relationships and increasing the ability to communicate and work in alliance between the young person, teacher and parent. At an individual level, a young person receives one-to-one therapy and is guided in the direction of prosocial activities that cultivate prosocial attitudes with peers and facilitate academic and vocational achievement (Henggeler et al., 2009).

MST therapists are required to adhere to certain quality assurance measures which include ongoing training, support from the organisation for which they work and ongoing reporting on how implementation is progressing, in order to sustain positive outcomes and troubleshoot difficulties in treatment plans (Henggeler, 2012). Therapists typically have a master's level therapy qualification and are supervised by doctoral level staff (Henggeler & Sheidow, 2012). Caseloads in MST programmes are typically four to six families. These small caseloads are indicated due to the on-call approach of these therapists who are available to these families 24 hours a day, 7 days a week. Due to the involvement of the therapist in the lives of all the members of the family and not just the referred child, research indicates that exceeding this caseload would not lead to the same positive outcomes.

MST has been utilised around the world and is one of the most researched and validated treatment models for children and adolescents with problem behaviour. Various randomised controlled trials have shown that MST has been efficacious with child welfare and conduct-disordered, antisocial populations (Dopp, Borduin, Wagner, & Sawyer, 2014; Ogden & Hagen, 2006; van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014). These trials have shown positive effects on behaviour problems (Ogden & Hagen, 2006), delinquency, psychopathology, substance use, parenting skills and mental health (van der Stouwe et al., 2014). Van der Stouwe et al. (2014) found that MST was most effective for young people under 15 years of age; however, positive treatment outcomes have also been found for those aged over 15, given that treatment targeted peer relationships – which is in line with the principle of MST that requires interventions to be developmentally appropriate.

MST is currently run in four regions across New Zealand with six distinct teams. Efficacy in a New Zealand context matches the success of overseas studies with positive effects in pre-test/post-test studies being found in a population of adolescent offenders (Curtis, Ronan, Heiblum, & Crellin, 2009). However, what was also found was that the attrition rate of staff was 42%, lending weight to the fact that MST is a high-resource and high-demand intervention for therapists and supervisors.

Functional Family Therapy

Functional family therapy (FFT) adopts a relational emphasis maintaining that behaviour problems are a result of dysfunctional family interactions (Barton, Alexander & Sanders, 1985; Waldron & Turner, 2008). Thus, interventions as part of this approach establish and generalise new patterns of family interaction by integrating communication training, cognitive behavioural interventions, anger management skills and assertiveness training. The first studies to display the efficacy of functional family therapy were by Alexander and Parsons (1973), which outlined a phase-based implementation strategy. Phase one described a process of enhancing engagement and eliciting hopeful, positive expectations of a child's behaviour and family functioning. Phase two was centered on behaviour change, establishing new patterns of interaction to replace the previous maladaptive ones through a range of techniques that are described in detail in various texts (Alexander & Robbins, 2011). Finally, phase three described generalisation of behaviour across environments, for example ensuring adapted, positive behaviour at home translated to school and with peers. This phase also described relapse-prevention planning by creating contingencies that ensured behaviour and relational change was sustainable and putting plans in place for problems that occurred.

The positive outcomes of functional family therapy on recidivism are well-documented. From early randomised controlled trials (Barton, Alexander et al., 1985; Friedman, 1989) to large international collaborations with just under 1000 young people with externalising problems and substance use (Sexton & Turner, 2010), FFT shows higher rates of family engagement, decrease in antisocial activity and similar reoffending rates to outcome studies described for MST. These findings, however, were not any better than some matched control parenting and other behavioural programmes, but these studies suggested that these results were influenced by therapist adherence to FFT protocols.

Teaching Family Model

The Teaching Family Model (TFM) is used to treat young people who have shown escalating antisocial behaviour and emotional dysregulation leading to self-harming or

outward violence. These young people also come from families who are known to child protection agencies and are at risk of having these children uplifted from their homes (James, 2011). TFM is used in combination with other approaches as a diversion method (to keep children away from having to go into full youth justice residences) or as a transitional service for those leaving residential care to be returned to their families of origin.

TFM is implemented in a group home scenario but its main goal is to be the most natural equivalent to ordinary home life possible for treating antisocial behaviour without being overly restrictive and isolating of the children. As a result, they are run in the family home of so-called 'Teaching Parents' who are highly trained in the use of supportive techniques, skill acquisition and how to teach and model appropriate behavioural interactions, learned via manualised training (James, 2011; McLean, Price-Robertson, & Robinson, 2011). The homes can involve up to eight children under the age of 17 and typically utilises a therapeutic community framework, which does not necessarily need to be within the setting of a family home; TFM has also been implemented in foster care, school and psychiatric settings (Fixsen, Blasé, Timbers, & Wolf, 2007; James, 2011)

Teaching parents work with the children to help them learn interpersonal and life skills, and facilitate a therapeutic community where peers are encouraged to take leadership and ownership of their own behaviours (Fixsen et al., 2007; James, 2011). The aim is to provide a natural, functional family environment where parenting is caring and consistent, and desired behaviour is reinforced (Lee & Thompson, 2008). Evidence from a randomised controlled trial (Lewis, 2005) found that TFM was associated with significant improvement in family functioning, child behaviour problems and parental effectiveness. Other studies have shown improvements in academic outcomes (Thompson et al., 1996), such as grade point average, school retention and higher graduation rates.

In New Zealand, Youth Horizons Trust is the sole provider of TFM. They have four residential therapeutic homes for adolescents mainly in the Auckland region and one in Hamilton. Two of their foster care programmes also operate according to a TFM model.

Multidimensional Treatment Foster Care (MTFC)

Chamberlain (2003) developed a foster care intervention approach for young people who showed signs of severe behavioural challenges that required input outside of the home. MTFC incorporates cognitive-behavioural, behavioural and social learning theories. Within the MTFC model, the role of the foster parent is to provide a prosocial environment. It is suggested that MTFC be implemented for at least six months before the young person

transitions back to their family home. The model is designed to be implemented for young people between the ages of 12 and 18 years (Chamberlain, 2003).

Every young person in MTFC is placed with foster parents who are part of a treatment team. The treatment team consists of individual therapists, family therapists, skills trainers, behaviour support specialists and supervisors. The aim of the MTFC is to place young people with adults who provide positive reinforcement and encouragement in a structured and closely monitored way. Boundaries and rules need to be clearly established, with the young person's behaviour being discussed and supervised (Chamberlain, 2003).

MTFC is the only foster care intervention which is evidence-based. MTFC is implemented in the United States and throughout Europe. There have been many randomised controlled trials (RCTs) that have evaluated the implementation of MTFC (Leve & Chamberlain, 2007; Leve, Chamberlain, & Reid, 2005). RCTs have concluded that MTFC is effective in decreasing the number of violent offences post-treatment, quantity of criminal referrals and time spent in locked facilities (Chamberlain, Leve, & DeGarmo, 2007; Eddy, Bridges Whaley, & Chamberlain, 2004).

The implementation of MTFC requires a lot of resource from the treatment team involved and research has shown that several sites have failed to progress from the pre-implementation phase (Chamberlain, Brown, & Saldana, 2011). MTFC is only provided by Youth Horizons Trust in Auckland for young people aged 12 to 16 with significant behavioural problems. This links with research examining MTFC as being primarily implemented with young people engaging in offending behaviour.

Rehabilitation Programmes

Due to the complexity of these young people's presentations, certain individual therapy interventions are required to complement and enhance the therapeutic care models described above. These evidence-based interventions target various mental health and behavioural difficulties co-morbid with offending behaviour. This section will outline some of these interventions that have been replicated and validated on multiple samples worldwide.

Trauma Focused Therapies

Trauma Focused Cognitive Behavioural Therapy (TF-CBT) is a therapy used to address symptoms of post-traumatic stress disorder (PTSD) and is commonly used to assist young people in care and protection residences to deal with the traumatic experiences that

often underpin their behavioural issues (Holstead & Dalton, 2013). TF-CBT can also be seen as an integrative approach which combines humanistic, attachment and family therapy techniques (Holstead & Dalton, 2013).

Within secure care and protection residences, many of the residents have experienced high levels of trauma. Traumatic experiences can add to difficulties with trust and attachment and significant developmental delays (Brown, McCauley, Navalta, & Saxe, 2013; Holstead & Dalton, 2013). Young people impacted by trauma also commonly experience sleep disturbances, difficulty concentrating, increased aggression and issues regulating emotions (Cohen, Mannarino, & Murray, 2011).

Trauma focused therapy uses strategies to support young people in residences with emotional regulation skills training, real-life exposure and processing of trauma. It is important to have parents or caregivers involved in the treatment process (Cohen et al., 2011; Holstead & Dalton, 2013). As the young people in care and protection residences are taken from their usual environments and placed in confinement, surrounded by other young people who may display problematic behaviour, placement can in fact be a traumatic experience in itself for the residents. TF-CBT involves supporting young people to be able to distinguish between current threats and historical trauma triggers (Cohen et al., 2011).

Multiple randomised controlled trials have been conducted evaluating the use of TF-CBT for young people who have experienced trauma, with results suggesting that, post-treatment, young people demonstrated a decrease in PTSD symptoms and reduced behavioural issues (Cohen et al., 2011; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). TF-CBT is well supported by research evidence for young people exposed to trauma; however, at this stage there is a lack of evidence evaluating the impact of TF-CBT among young people in care and protection residences per se, although due to the prevalence of traumatic experiences and maltreatment among this population in residences, it is likely that TF-CBT would be useful.

Alcohol and Drug Interventions

A combination of motivational enhancement and cognitive behavioural therapy was introduced by E. H. Hawkins (2009). This approach first focuses on increasing motivation by navigating the ‘stages of change’ model in order to address barriers to treatment and then uses CBT approaches to learn and implement new coping skills to manage situations which would otherwise result in alcohol and drug consumption (Hawkins, 2009).

The evidence for motivational enhancement together with CBT has shown significant improvements in abstinence and recovery (Dennis et al., 2004) in a population of adolescents, 53% of whom presented with conduct disorder. Significant findings have also been shown a randomised controlled trial in a home-based care approach for adolescents transitioning from residential care (Godley et al., 2010) and outpatient treatment programmes for adolescents with substance abuse issues (Ramchand, Griffin, Suttorp, Harris, & Morral, 2011).

Cultural Approaches

As stated previously, Māori populations are over-represented within care and protection services and, as a result, any intervention needs to be seen through a lens of cultural appropriateness. Durie (2005) suggested that in order to address the cycle of offending, services provided to Māori must strengthen their sense of cultural identity and address their cultural needs. Research has suggested that for Māori, feeling a strong connection to their culture can decrease offending behaviours (Marie, Fergusson & Boden, 2009). Therefore, in order to create more meaningful outcomes for Māori, it is essential to be able to provide interventions that are culturally responsive and evidence-based.

The residential care facilities within Oranga Tamariki (formerly Child Youth and Family CYFS) use a bi-cultural framework for working with Māori. The following kaupapa Māori programmes were found to be the most comprehensive and appropriate programmes for addressing Māori needs around the conduct problems and early offending of children and young people (AGCP, 2013).

The Meihana Model was created for the health and education sector (Pitama et al., 2007). The framework incorporates Durie's (1985) Te Whare Tapa Wha principles: tinana (physical wellbeing), hinengaro (psychological wellbeing), wairua (spirituality) and whānau (family). The Meihana Model expands on this by adding two other domains—taiao, which reflects the physical environment, and iwi katoa, which refers to the societal context (Pitama et al., 2007). This practice model aims to guide health professional in the assessment and treatment of Māori service users and highlights that whānau should be at the centre of any intervention. It challenges the practitioner to view the individual's identity within a collective identity (Pitama et al., 2007).

Te Pikinga ki Runga: Raising Possibilities is a model for programme planning and analysis and was designed as a guide for practitioners working with Māori who display challenging behaviours in education settings (Macfarlane, 2009). The framework provides tools for professionals to be able to put culturally inclusive theory into practice. Te Pikinga ki

Runga is based on Treaty of Waitangi principles – participation, partnership and protection. A key feature of the model is Te Huia grid which guides practitioners through four domains: tinana (physical), hohonga (rational), hinengaro (psychological) and mana motuhake (self-concept). The grid features reflective questions to assist practitioners with assessment and planning (Macfarlane, 2009).

Te Hui Whakatika is based on the traditional hui, a framework centred on creating a supportive and culturally sound space where Māori can gather to achieve resolution and cohesion (Hooper et al., 1999). This ideology uses traditional Māori approaches and emphasises collaborative decision-making, finding an outcome that works for the whole whānau, not allocating blame and focusing primarily on restoring harmony. This model has four phases: preparing for groundwork, the hui proper, forming/consolidating the plan and follow-up and review (Hooper et al., 1999).

Summary

The literature presented above on the evidence-based interventions for children who offend has a number of common characteristics that were important to consider when developing this programme. They acknowledge the importance of the effects of trauma and early childhood adversity on a child's ability to regulate emotions, learn prosocial behaviour and effectively maintain interpersonal relationships. They also provide the resources that children and families need to change problem behaviour – either through teaching skills or facilitating positive learning environments and connection to wider structures of family, community and culture. Most importantly, they are all inherently systemic; they are provided at a family level, acknowledging that the family is a child's most important environment, regardless of its apparent dysfunctionality. They also engage with other systems of school, peers and the wider community as opportunities to model and facilitate prosocial behaviour, so that prosocial behaviour generalises and is sustained through adolescence and into adulthood.

Statutory Care in New Zealand

This section will provide an overview of the structures and processes of statutory care in New Zealand. The aim of this section is to describe the system these young people and their families are required to navigate in New Zealand and the needs of this population. This section will also outline some of the gaps and shortcomings of the care and protection system in its form at the time of the programme's development, so as to better understand and contextualise the part the programme needs to play within the broader statutory structure.

Legislation

The New Zealand 'care and protection' system is directed by primarily the Children, Young Persons and their Families (CYPF) Act 1989 but also informed by a range of other acts, including the Adoption ACT 1985, the Adoption (Inter-Country) Act 1985, and the Care of Children ACT (2004). The CYPF Act applies to children and young people from birth until they turn 17 years old and relates to children who are in need of care/protection outside of their family as well as those who offend. The act is based on principles that put children's safety and wellbeing as a priority. Its specific aims are outlined as:

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

With regards to this responsibility to protect these children, the Vulnerable Children Act 2014 also forms a significant part of the measures implemented. This act enables the enacting Minister (in liaison with other children's Ministers) to set government priorities to improve the wellbeing and safety of children and makes heads of children's agencies (NZ Police, Ministries of Health, Education, Justice and Social Development) accountable towards these priorities. It also outlines a mandate for District Health Boards, Boards of Trustees in schools, non-governmental organisations as well as other related groups or individuals to adhere to these child protection policies. This piece of legislation also includes amendments to acts outlined above such as:

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

Roles and Responsibilities of Child, Youth and Family

At the time of the programme operation and data collection, Child Youth and Family was the service line of the government-operated Ministry of Social Development and part of New Zealand's public child protection service. As governed by the Children, Young Person's and their Families Act 1989, Child Youth and Family's core function was to:

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

Thus, Child Youth and Family had a central role in the management and delivery of services for children in this care and protection population. For those who are in the care of Child Youth and Family, this involves placement with extended family/whānau or placement with non-family. For children with high and complex needs, services may include residential placements in one of four secure residences, Child Youth and Family Group Homes, Supervised Group Homes and homes that align with the Teaching Family Model, and other one-to-one specialist care and therapeutic services such as Multidimensional Treatment Foster Care (MTFC). For children who offend, these responsibilities extend to receiving referrals from police, coordinating Family Group Conferences to plan prevention of offending and undertaking action directed by the Family and Youth Courts.

Towards the end of the research procedures, Child Youth and Family was replaced by Ministry of Children Oranga Tamariki. The roles, functions and responsibilities of this organisation are outlined in further detail in the discussion section as they pertain to the implications of this research and its dissemination.

Childhood Adversity in New Zealand

Broadly speaking, children come to the attention of Care and Protection when basic safety, developmental, physical, emotional and social needs are not being met in their home or community. As a result of the deficits in these areas, these children are at significant risk of harm in the present and the future as a consequence of these family and community environments, as well as their own complex needs. This is especially true for children who have offended or will offend in the future (Ministry of Social Development, 2012). Analysis of birth cohorts suggests that 20% of children born in New Zealand come to the attention of Child Youth and Family by the age of 17 through either the Care and Protection or Youth Justice pathways. This contact can take the form of a single notification and no further involvement, repeated notifications, ongoing statutory care or in cases of offending, police arrest and referral to Youth Justice. At any given time, Child Youth and Family is responsible for service provision for up to 450 children and adolescents who have complex needs.

The Modernising Child Youth and Family Expert Advisory Panel estimated that there are approximately 230,000 children and young people who experience severe adversity at some point before the age of 18 (Ministry of Social Development, 2015). Based on present trends in child protection in New Zealand, it is estimated that approximately a quarter of this group will require frequent and intensive contact with statutory services at some point in this time period. Unfortunately, there have been significant shortcomings in the way this system serves this relatively large subset of the child population of New Zealand. The ways in which the system did not meet the high and complex needs of this group is outlined below.

A Repeating Cycle of Trauma and Neglect

Due to the very nature of the acts themselves, a consequence of children coming to the attention of care and protection services is that they have experienced significant trauma and/or neglect. This ranges from physical, sexual and emotional abuse, witnessing ongoing family violence and ongoing neglect, and not having the basic needs met that are required to adequately meet developmental milestones, as described above. Longitudinal analysis of Child Youth and Family data showed that of children born in 1993, 8% experienced trauma or neglect at some point in their childhood which, given the well-known issue of underreporting, is a figure that can be expected to be considerably higher.

Unfortunately, these children's lives while in state care can be characterised by high instability and, in some cases, further maltreatment while in group or foster homes. Child Youth and Family Administrative data in 2014 showed that, on average, children in state care

live in around seven or eight houses before they are eight years of age. This leads to high levels of anxiety, confusion and disempowerment as a result of not having any say in decisions or a stable base from which to form secure attachments and meaningful, trusting relationships. Children who leave care also show high levels of abuse following this period. A study from the Centre for Social Research and Evaluation showed that out of children who were discharged from Child Youth and Family care in 2010, 30% re-presented within 18 months, having experienced further abuse. The same analysis of data showed that those who returned home or remained in the care of their family were more likely to experience repeat abuse.

Families with Complex Needs

The above statistics of abuse and neglect and the high rates of re-traumatisation within the statutory system, and even if and when they are returned to their families, is indicative of the families these children come from. Most families referred to Child Youth and Family present with complex and pervasive disadvantage in many areas of their current and historical lives. This includes long-term unemployment, financial and housing difficulties, unaddressed physical and mental health needs, caregiver substance addiction, family violence and gang involvement. Of children born between 2005 and 2007 who had been referred to Child Youth and Family before the age of 5, 39% had mothers who had been receiving a benefit for more than four years preceding their birth and 60% had a primary caregiver who was on a benefit when the child was born; 37% had a parent with a criminal conviction within five years of the child's birth; 69% had parents involved with a family violence notification to the police; and 36% had parents who were known to Child Youth and Family when they were a child themselves (Ministry of Social Development, 2015).

The complex needs of these families and the consequential harmful environments in which their children are raised are a prime target of early intervention, which is unfortunately largely lacking in the system's current form. In 2014, Child Youth and Family received 152,000 family violence notifications which, given the demographics of these families, would have involved around 97,000 children. Most of these notifications did not reach Child Youth and Family's threshold for responding and due to the lack of other services in the community, these children did not get the support they required. This is an especially pressing issue because of the higher chance of poor life outcomes, higher rates of perpetration and victimisation as adults as a result of childhood exposure to family violence, and because of

the risk of learning antisocial behaviour through observation and modelling as discussed above.

Disproportional Representation of Māori

Of those in care and protection, Māori children are especially disproportionally represented in this sample. They make up 30% of all children under the age of 5, yet 57% of children seen by Child Youth and Family under 5 are Māori (Ministry of Social Development, 2015). These figures are similar with children who offend, with Māori making up 25% of all children aged 10 to 16, but comprising 60% of those in the youth justice system. Even more damning are the figures that suggest that as the severity and intensity of criminal-justice system interventions increase, the percentage of Māori in those cohorts also increases: making up 49% of those cautioned by police, 64% of those given a Family Group Conference, 70% of those on court-imposed supervision order and 69% of those on a Youth Justice placement.

Child Offenders – 'Crossover Youth'

While the Care and Protection and Youth Justice systems are otherwise distinct in their operation and processes, there are certain exceptions and groups of young people who move between the two systems, colloquially known as 'crossover youth'. Typically, this movement between systems is due to the effects of childhood abuse and neglect leading to a requirement for care and protection but also increased risk of offending behaviour (Thornberry, 2008; Widom, 1989). This effect is exacerbated when children also lack a stable home or school environment, supportive peer and family relationships and have unaddressed physical health needs (Bilchik & Nash, 2008).

This subgroup of the youth justice population has significantly more complex needs and require more comprehensive and intensive interventions, the absence of which results in long-term involvement in both Care and Protection and Youth Justice systems. In 2014, 12.5% of clients with a Youth Justice Family Group Conference were already in the custody of Care and Protection, which was an increase from 11.3% in 2013.

In New Zealand, young people aged between 10 and 13 years who have offended and have been determined as requiring placement in secure residential care are admitted to care and protection residences, group homes or with specialist caregivers. Under the provisions of

the Crimes Act 1961, a child under the age of 10 cannot be convicted of a criminal offence; however, children aged between 10 and 13 can be prosecuted for severe crimes of murder, manslaughter, rape or serious arson. Those in that same age bracket who commit such indictable offences face Youth Court prosecution and are detained in youth justice residences otherwise reserved for young people aged between 14 and 16 who have offended. At the age of 17, the Children, Young Persons, and their Families Act no longer makes provisions for adolescent legal status and any offending is dealt with by the adult justice system (Spier & Lash, 2004).

There is limited information available that adequately describes this population in New Zealand. There is also little that differentiates this under 13-year-old population from adolescent offenders 13 years and older. Internationally, research has shown that females with foster care (care and protection) histories were 10 times more likely (and males five times more likely) to enter the youth justice system than the general population (Jonson-Reid & Barth, 2000). Studies also showed higher recidivism rates (Ryan & Testa, 2005) and that those referred to care and protection due to problem behaviour were more likely to be arrested than those referred due to maltreatment (Ryan, 2012).

Summary

This section outlined the organisational structure of statutory care in New Zealand in order to place this programme in perspective. It is a structure which unfortunately has historically shown poor outcomes for children, particularly children who offend. This is widely due to increasing complexity in the presentations of family circumstances, poor educational outcomes and inability of services to respond in a flexible way. Furthermore, an indictment on wider society are the disproportionate outcomes for indigenous Māori families which make up a majority of this group. It is in light of this that research projects like this one and future endeavours in this area are of utmost importance in order to resolve these disparities and increase positive outcomes for all New Zealand families.

Implications of Literature for the Current Study

It is apparent from the literature reviewed above that the individual and environmental factors underlying childhood offending are complex and interventions need to be equally well-considered and targeted in order to be effective. The results of the Dunedin longitudinal studies in particular are an invaluable resource for the New Zealand context. They provide an insight into the degree of childhood adversity in New Zealand and the longitudinal effects of this on a host of biopsychosocial outcomes. It allows programmes to use this knowledge to consider the needs of this population and tailor interventions accordingly.

Despite this research pointing to the importance of childhood development and the effects of problem behaviour and escalating antisocial offending, there are no specific programmes in New Zealand specialised for childhood offending. The provision of in-depth information on existing expertise in the area allowed the developers of the programme to create an intervention that was grounded in evidence-based research. The programme took into consideration the importance of family and of feeling a sense of connection to them and to the individual's wider cultural and community environment by adopting a wraparound framework (outlined in more detail in the following chapter). Given that Child Youth and Family did not have the mandate to provide psychological or skills-based therapies, they also enlisted the support of non-governmental organisations that conducted MST, FFT and operated MTFC homes and carers in order to provide a holistic treatment for this group and their families. The existing literature also informed the way these professionals interacted with the young people and their families; for example, by trying to reduce the power imbalance that operates between staff members of a statutory organisation and the children and families they deal with, and eliciting the voice and opinions of young people and their families with a view of adopting a genuinely collaborative approach to child offender treatment. Furthermore, such a collaborative approach needed to be one that met the needs of the children and families it served in a flexible way that complemented the complexity of their presentation as described in the literature review above.

Aims of the Current Study

The present study is a report on the process evaluation of a wraparound intervention for child offenders in New Zealand. It attempts to provide an insight into the provision of this service in a New Zealand context with a view towards providing recommendations and directions for future treatment programmes for children who offend. Simultaneously, it hopes

to extend the existing knowledge of treatment in this field. While there are examples of specific child offender treatment programmes internationally, no such programme has been implemented in New Zealand.

The design of this study was developed to address issues of process and implementation and to obtain staff perspectives on wider systemic issues that enabled or inhibited the success of interventions. It was hoped that obtaining the perspectives of staff would provide an insight into the operation of the programme from those responsible for its implementation. The specific aims of this study were to:

1) Describe the context, characteristics and operation of the programme.
2) Identify successful and less successful programme components with particular reference to staff perspectives.
3) Identify factors that impacted on successful delivery of programmes.
4) Evaluate the successes and shortcomings of the programme with particular reference to staff perspectives.
5) Identify areas of improvements to the programme and wider service experiences for this group of rangatahi (youth).

This introductory chapter has provided an empirical and organisational background to this study; placing it in the context of the existing literature on children who offend and the New Zealand statutory Care and Protection and Youth Justice systems. In the following chapters, the design and methodology of the study will be presented along with how the programme came to be. This will be followed by examining the results of the study with reference to staff perspectives. Finally, findings of the study will be summarised and their implications for the research base and service development in New Zealand and internationally will be explored.

Wraparound Programme Description

This section outlines the underlying theory, principles and phases of a wraparound framework, which was the foundational model used in this programme. The literature discussed above outlines the therapeutic means by which antisocial behaviour may be changed while what follows is an outline of wraparound a philosophy of case management that was the core element of the programme. It was chosen because of its fit with evidence-based interventions such as MST and FFT as it is inherently systemic in nature and advocates for problems to be formulated in a dynamic way that does not place blame solely with the child. It was also chosen because of its validity for the population as well as its ability to address the gaps that were identified in service provision for children who offend in New Zealand.

Underlying Theoretical and Practice Framework

The programme was based on a *wraparound framework*, a service delivery model widely practised internationally. This framework provides practice principles for teams, organisations, and system levels in order to guide work done directly with youth and their families. Wraparound is an intensive and holistic philosophy of engaging with children with complex needs and their families so that they can achieve their goals whilst living at home and within their community. It is defined as an intensive, individualised care planning and management process. It is not a treatment approach but a planning process that is aimed at being more effective and relevant to the child and family by being more creative and individualised than planning as usual (Bruns & Walker, 2010). Wraparound also aims to develop problem-solving and coping skills and self-efficacy for the individual and their family while emphasising the integration of youth into their community and building the family's prosocial network.

Wraparound has been implemented widely across the world for young people in residential, inpatient and community settings. In New Zealand (prior to this programme), wraparound was run only by the Ministry of Education for intensive support for young people between the ages of 3 and 10 with complex behavioural, social and/or educational needs. This is implemented by the Intensive Wraparound Service through a 'Resource Teacher: Learning and Behaviour' (RTLB). The service's aims are to support children to cope and behave in different ways and learn skills that enable successful reintegration into school in a positive and prosocial way. Experimental and quasi-experimental research has shown that wraparound, when compared to control conditions, shows positive impacts on

residential placement, mental health, academic success and youth offending recidivism (Suter & Bruns, 2009).

Principles of Wraparound

The wraparound process involves creating a team of individuals who contribute to the lives of the child or young person that is the focus of the intervention. This team can include family members, members of the family's support system, service providers, teachers and other members of their community. This team collaboratively develops an individualised plan and implements this plan together, carefully monitoring its effectiveness towards predetermined goals (Bruns & Walker, 2010). Wraparound strongly advocates 'family voice and choice' and all its processes are driven by the perspective of the family and young person. Plans reflect their understandings of the problem and what sort of service and support they need in order to improve outcomes for themselves and their families. Formal services and interventions are involved together with community services and other social support structures provided by family, friends and community leaders. These plans and interventions are persisted with until the team determines that they are no longer working – indicated by failing to meet measures of success. All aspects of the process are also designed to prioritise a young person and family's strengths, and cultural competence.

Phases and Processes of Wraparound

The wraparound process involves four phases: engagement and team preparation, initial plan development, implementation and transition. These phases involve core activities which are described below as outlined by Walker and Bruns (2008):

Phase 1: Engagement and team preparation **–** The first step for implementing wraparound is developing the groundwork for trust and a shared vision within the team as it is established. During this phase, wraparound principles guide the way a team starts to interact with each other; especially during conversations about strengths, problem behaviour/the young person and family's needs and culture. This involves orienting the family to wraparound, addressing ethical and legal issues, stabilising crises, facilitating conversations with the child and family and engaging the team members.

Phase 2: Initial plan development **–** The focus of this phase involves building mutual respect and trust between group members. Meanwhile, initial plans of care are developed including establishing ground rules, documenting strengths, prioritising needs, outlining indicators for each goal, selecting strategies and assigning action steps. Safety plans are also made in this phase by determining potential risks and creating appropriate crisis safety plans. It is also the point at which any documentation and logistics are completed before

implementation begins.

Phase 3: Implementation – During this phase, the wraparound plan is implemented by carrying out action steps, revisiting and updating the plan if necessary and maintaining and building on team cohesiveness.

Phase 4: Transition – This phase outlines the steps for planning for the end of formal wraparound processes: creating a post-transition, crisis management plan, document the team's work, celebrating success and checking in with the family.

Mechanisms of Change within a Wraparound Framework

The overall, underlying assumption of wraparound is that if principles and processes are adhered to, change is an outcome of an effective team process which engages the commitment and expertise of all team members while simultaneously giving a voice to the young people and their families. The theory draws from various lines of research to support this rationale. These include research on elements of effective teamwork, collaboration and the importance of natural social supports.

Research on teamwork consistently outlines the importance of a cohesive, long-term goal or mission that guides practice (Cohen, Mohrman, & Mohrman Jr, 1999; West, Borrill, & Unsworth, 1998), which also involve intermediary goals that act as markers of being on the right pathway (Latham & Seijts, 1999; Weldon & Yun, 2000). In making these decisions on goals, research suggests that teams should generate a range of options in order to gain a more accurate understanding of the issues being addressed and evoke more creative and comprehensive solutions than would individuals who were in a 'team' but working separately (Hirokawa, 1990; O'Connor, 1998; West et al., 1998). Selected strategies should then comply with a set of objective criteria with the purpose of judging whether they help work towards goals (DeNisi & Kluger, 2000). The National Wraparound Institute's guidelines for implementing wraparound (Walker et al., 2004) are consistent with this research outlining elements of effective teamwork, from the initial process of developing a family vision for the future through to prioritising small goals which are monitored to ensure that they are being effective towards this end. Wraparound principles add further expectations that goals (specific to wraparound) should be strengths-based and community-based.

Effective planning is a precursor to positive outcomes but the ability to be collaborative is a key component of successful teams and core to wraparound processes. This is collaboration in the sense of members of a team sharing the same goals, equality in perspectives and opinions, and clear expectations about the roles and responsibilities of individual members (Beugre & Baron, 2001; Cohen & Bailey, 1997). These factors result in

team members who are more invested in goals because they see the worth of their contributions to an overall plan, whereas team members who fail to see the significance of their perspectives are more likely to disengage and not follow through with tasks(Cropanzano & Schminke, 2001). Wraparound should be inherently collaborative in that all team members feel their ideas and expertise are important and contribute to successful outcomes. This collaboration extends beyond the professional members of the team to the young people and families through 'voice and choice' principles; collaborating not only at a case management level but at values, beliefs and cultural levels which draw on the families' knowledge.

This level and type of teamwork leads to a host of short- and long-term outcomes for young people and their families. Having goals chosen by the families ideally leads to higher quality of life and increased stability in relationships, not only between family members but also between families and professionals (Walker, 2008).

Routes to Positive Outcomes

The two main mechanisms towards positive outcomes proposed by wraparound are through enhancing the effectiveness of the chosen support systems and building the capacity and resources for successful coping. This is especially important given the ever-present challenge of retention and engagement in the delivery of youth offender treatment (Kazdin, 1996). Internationally, statistics have shown that dropout rates can be as high as 60% (Morrissey-Kane & Prinz, 1999) and such retention rates for children show immediate improvements when families are engaged and involved in the treatment (Huey Jr, Henggeler, Brondino, & Pickrel, 2000; Tolan, Hanish, McKay, & Dickey, 2002).

From the perspective of wraparound, if implemented as designed, it leads to high levels of family motivation and engagement due to the influence of the following factors. *Choice* is consistently shown to be a crucial factor for commitment and motivation towards a goal in individuals (Ryan & Deci, 2000) and groups (Maddux & Kleiman, 2012). The collaborative, family-driven decision-making as part of wraparound has been found to enhance the child's and family's views of acting on their own volition, as opposed to being controlled and forced into certain aspects of their treatment. *Relevant and realistic* treatment aims and models are also a consequence of this collaborative process, which leads to positive outcomes (Kazdin, Holland, & Crowley, 1997; Morrissey-Kane & Prinz, 1999). Morrissey-Kane and Prinz (1999) found this to be especially true for minority groups who found that the more relevant and realistic interventions were in relation to their family, community and culture, the better the outcomes were. The feasibility and relevance of interventions is a by-product of *shared expectations* of treatment and coming to a joint definition of the purpose of

service involvement in specific families. Understandably, this results in increased treatment effectiveness (Dew & Bickman, 2005), due to children and young people being involved in this process and ensuring that the interventions they sign up for are ones they can realistically envision themselves undertaking and doing successfully (Walker, 2008). Similar mechanisms are also true for the impacts of adopting a *whole family focus* which supports engagement and retention. Finally, modelling and having a commitment to *strengths-based understandings of behaviour* leads to reassurance that the behaviour that gets young people into strife and worries their families is malleable, rather than condemning and irreversible, which not only enhances motivation but instils hope.

The other proposed route to change is through building capacity and resources for coping at individual, family and community levels. At an individual level, having the permission—or rather, being encouraged—to make your own choices and contribute to the goals of your treatment has a profound impact on young people; especially those who have been involved with services for so much of their lives and are used to being 'ordered' to comply with most of their treatment. This contributes to children feeling *empowered and develops capacity for self-efficacy and self-determination* which are crucial to believing that one can make meaningful decisions in one's life and overcome the difficulties experienced (Snyder, Rand, & Sigmon, 2002). This is supported by research which shows that children who believe they can achieve the goals they set for themselves display a host of positive mental health and wellbeing outcomes and are more likely to persist when faced with adversity (Maddux & Kleiman, 2012; Ridgway, 2004; Snyder et al., 2002). This ability to persevere through adversity is enhanced by the use of *social supports* (Cox, 2005), which is central to wraparound.

In summary, change as a result of wraparound processes is often described as a positive spiral (Walker, 2008). Improvements in perceived self-efficacy mean individuals and families are better able to change problem behaviours and to benefit more from treatment (Maddux & Kleiman, 2012). This spiral reinforces itself through the interaction of these two mechanisms of building engagement/motivation and increasing capacity for coping in different, more adaptable ways.

Research on Wraparound

Wraparound has been implemented across the United States for over 30 years and has been endorsed by the government for its systemic care philosophy. In a large review of wraparound research (Coldiron, Bruns & Quick, 2017) attempted to collate a comprehensive

list of all literature that was produced on wraparound in the years between 1986 and 2014. These included studies which focused on implementation of wraparound, effectiveness across different populations, fidelity and cost-effectiveness to name a few. For the purposes of this study the literature on effectiveness and implementation are most relevant. Out of 123 empirical publications on wraparound 62.6% of studies were based on a community/system of care, 15.5% on schools, 9.8% on child welfare and 6.5% on juvenile justice. In terms of methodology most of the research on wraparound (85.4%) adopted quantitative methodologies while only 37% were qualitative.

In a meta-analysis on the effectiveness of wraparound for children with emotional and behavioural disorders, Suter and Bruns (2009) examined 7 controlled studies which adhered to high fidelity wraparound principles and included a total sample of 802 children and adolescents. Of these 7 studies, 4 were conducted on child welfare or youth justice populations similar to the one used in this study (Carney & Buttell, 2003; Clark et al., 1998; Pullmann et al., 2006). Overall wraparound demonstrated a small to moderate effect size (0.33) on these populations. Given the preliminary stage at which wraparound research on youth offending populations is, these findings would appear to be neither grounds for accepting or dismissing it as an evidence-based approach.

Given the relatively little research conducted on wraparound with this youth offending population the current study has a unique place to shed light on the implementation of wraproud by adopting a methodology that is less commonly used in this area and with a group that is under-researched. It has the potential to add qualitative substance and nuance to existing experimental research on the effectiveness of wraparound by shedding light on the process issues that promote or inhibit high fidelity wraparound. Obtaining the perspectives of staff allows not only a ‘on-the-ground’ perspective but also commentary on wider systemic and organisational factors that impact programme implementation.

Chapter Two
Methodology

This chapter presents an overview of the research framework and outlines the type of qualitative methods used in this study. This is followed by information regarding the researcher and research setting, including an outline of the participants, and the procedures for developing interview schedules, conducting the interviews and analysing data. Finally, the initial process of discovering a need for the programme, conceptualising a plan and developing an intervention for this population will be described.

Programme Evaluation

At its conception, the primary goal of programme evaluation was to determine whether programmes worked and were effective enough to justify allocation of limited resources (Coryn, Noakes, Westine, & Schröter, 2011; Sanders, 1998). During this period, quantitative methodologies dominated the field by testing hypotheses about the causal interactions between the factors of the intervention and its impact and outcome (Coryn et al., 2011; Sanders, 1998). Over time, however, this level of strictness in measurement limited evaluation to single-intervention programmes, set in controlled environments, that were not robust enough to capture the complexities of comprehensive community programmes set in dynamic, real-world environments.

By focusing almost exclusively on programme outcomes, knowledge about how the programme works and why it works is limited (Coryn et al., 2011; Sanders, 1998). In time, there was increasing recognition of the importance of evaluating how programmes can be improved and, while the emphasis remained on demonstrating programme efficacy, researchers started to consider programme procedures and operational issues as well (Patton, 2002). This influenced evaluation designs to explore and understand how or why outcomes were or were not met and identify ways the implementation of programmes could be improved, instead of primarily focusing on whether a programme was effective (Franzen, Morrel-Samuels, Reischl, & Zimmerman, 2009; Saunders, Evans, & Joshi, 2005). Due to this shift in focus, many researchers started to use qualitative research methods as these created an in-depth evaluation of programme processes, programme outcomes and procedural issues

(Patton, 2002). This evaluation uses qualitative methods, which will be discussed further later in this chapter.

In addition to including process and implementation issues in programme evaluation, there was a broadening of different evaluation types (Silverman, 2013). Michael Patton (2002) discussed different evaluation methods based on enquiry, such as outcomes evaluation, process evaluation, implementation evaluations and prevention evaluation, and reflected that there were many other forms of evaluations. There is no single approach which is applicable to all situations (Coryn et al., 2011). In order to select the most appropriate evaluation method, it is important for researchers to consider the purpose of the evaluation, the results that need to be determined and what will provide the most useful information (Patton, 2002; Sanders, 1998). In this study, a process evaluation was considered to be the most appropriate method, for reasons described below.

Process Evaluation

Process evaluation examines what occurs through a programme's implementation. The primary purpose of process evaluation is to analyse the way in which a programme operates in order to determine the programme outcomes and to inform what changes are necessary to improve the programme (Stetler et al., 2006).

Process evaluations explore the origins of a programme by examining the programme's delivery format and environmental factors. As stated in the introduction, the aims of this study were to describe the development of the programme over time with regards to service delivery issues, systemic issues, the experience of service users and service providers and to elucidate the success and shortcomings of the programme from the perspectives of the service providers. While ideally this evaluation would also include the perspectives of the service users, this was not practically possible, given the client group and the contexts in which the study was undertaken. Focusing on the experiences of staff, however, is vital to understanding the barriers from a systemic level, and the professional attitudes and processes that impact on service delivery at an operational level.

It is commonly acknowledged that process evaluations are useful for supplying information on how a programme can be improved (Stetler et al., 2006). Thus, process evaluations provide valuable feedback not only to the treatment providers but to funding agencies and external organisations so they are able to make informed choices about programme delivery. By highlighting the strengths and limitations of a programme, this

allows treatment providers in other locations to develop a better understanding of how to make positive changes to their programmes (Stetler et al., 2006). Where a programme is shown to be successful, process evaluations can provide useful insight into how the programme can be distributed or replicated. Therefore, this study also provides relevant information to programmes offering similar interventions in countries outside of New Zealand.

Qualitative Research

Qualitative research methods are commonly used for process evaluation research as it provides an in-depth analysis of programme procedures (Patton, 2002). Qualitative methods tend towards a deeper understanding of the participants' perspectives and knowledge (Silverman, 2013). Below, some of the characteristics of qualitative research are outlined.

Firstly, qualitative research is characterised by a focus and interest in capturing the perspectives and experiences of participants of the phenomena being studied (Merriam & Tisdell, 2015). This study aimed to understand how the implementation and processes of the programme were experienced by the staff because of their specialised view of the system in which they work and what they feel that the people they serve need, from a professional standpoint. Qualitative researchers take upon the task of interpreting and making sense of participants' experiences in the context of the aims and outcomes of what is being studied (Silverman, 2013).

This process of meaning-making and examining behaviour in depth involves a number of different models of enquiry. For this study, in-depth interviews made up the data collected. The small and specifically chosen sample size of the current process evaluation was designed to gain an in-depth understanding of the programme from those who knew the processes the best and who knew the needs of the stakeholders they served. Interviewing participants in this way also allowed for natural inquiry, which described the desired phenomena the way it existed without any experimental manipulation (Patton, 2002). This approach included descriptions of the programme, its aims and purposes, as well as its impacts on the people who received and delivered treatment, the impact it had on the individuals involved as well as broader systemic impacts (Patton, 2002).

These data were then analysed using inductive methods (Stetler et al., 2006), which involved identifying and describing key themes that emerged from the data. This contrasted with quantitative methods which are typically deductive; testing whether data collected meet

a predicted hypothesis. There are numerous qualitative methodologies that fit this inductive philosophy; for the aims of this study, a thematic analytic method was used due to its flexibility and ability to deal with richness and variety.

Thematic Qualitative Analysis

Thematic analysis is a method used to identify, analyse and organise key themes within data (Braun & Clarke, 2006). It allows researchers to develop an understanding of shared experiences. Thematic analysis offers a qualitative research method that is accessible and flexible. It allows research to be analysed systematically, which can then be linked to theoretical discussions.

Thematic analysis was chosen as the method of data analysis for this study for a number of reasons. Firstly, the evaluation required a method that was flexible and efficient in identifying themes in the interview data which related to the aims of the evaluation. The evaluation relied heavily on the experiences and opinions of the participants and therefore an inductive approach was most suitable. The flexibility of thematic analysis allows for one to simultaneously interpret results in relation to the original research aims and the themes that are interpreted from the data (Braun & Clarke, 2012). Braun and Clarke (2012) introduced six phases of thematic analysis which are outlined below. These phases were applied to this study to address the data and evaluation goals.

Phase 1: Familiarising yourself with the data

This phase is necessary in any form of qualitative research and involves becoming engrossed in the data and reviewing the data multiple times. This is usually done by listening to audio recordings or rereading transcripts until the researcher is familiar with the concepts and ideas present in the data. The analyst should give attention to every form of data and make notes as they read transcripts and listen to audio recordings to highlight points that could be of importance. Note-taking is a significant part of critically analysing the content and prompts thinking about what the data means in a broader sense. Annotating transcripts and highlighting areas of interest for following phases is key to this stage.

Phase 2: Generating initial codes

This phase uses coding to initiate the systematic analysis. Coding involves grouping together the interesting points of the data content and beginning to make interpretations of the content that further develops understanding of participants' experiences. Interpretive codes identify deeper meanings to what seems apparent at the surface of the data. Coding can be

influenced by the research aims and questions and can be done at semantic or latent depth of meaning.

Phase 3: Searching for themes

During this phase, the analysis moves from codes to themes. The relevant coded data is gathered to form key themes and subthemes. A theme represents an important aspect of the data which addresses the research question, which also reflects a patterned report within the data.

Phase 4: Reviewing potential themes

This phase involves evaluating the themes and how they fit with the data. This phase is important as it provides the opportunity to check the quality and relevance of the themes. If themes are found that do not relate to coded data, then this might mean having to discard codes, move them to link with other themes, split themes or discard themes. This phase also involves rereading all of the entire data set to ensure that the themes adequately cover the data.

Phase 5: Defining and naming themes

When defining the themes, it is important to articulate what makes each theme specific and each definition should be able to be summed up in just a few sentences. Thematic analysis should have a singular focus, not relate to other themes, and should also address the research question.

Phase 6: Producing the report

The final phase pertains to the production of the report. The purpose of the written analysis is to provide a convincing narrative about your data. It should go further than a description of the data by delivering a compelling argument that addresses the research question.

Methodology

Researcher Orientation

Given the role of the researcher as the primary analysis tool in qualitative research, it is necessary to reflect on one's own experience and knowledge and how this may impact on how findings are perceived (Patton, 2002). In this study, I had sole responsibility for collecting, analysing and interpreting the data and therefore a consideration of my past

experience handling and interpreting data and working with this population is warranted. Before undertaking this research, I had experience support-working and counselling children and adolescents in mental health and social support services but no clinical experience in child offender service delivery. My interest in this topic stemmed from a previous research project on public opinion about youth offenders and the New Zealand justice system. As a result, I had an extensive knowledge of the system and the services available for youth offenders. I was also aware that there were few, if any, services for children who offended at a young age. This was evident from records showing little to no service input specifically for offending behaviour until they turned 14 years of age and met criteria for the Youth Justice system, despite offending which dated back to early years. In order to mitigate the effects of any bias related to my views on this, I was deliberate in asking about the successes and shortcomings of the programme as well as interpreting these aspects with integrity, regardless of whether they fitted with my experience of the programme or my views of what should be done for children who offend.

Settings and Participants

Data were collected from staff involved in the planning, development and implementation of the programme. These staff (n = 10) were predominantly based in the geographic site where the programme was run but also included staff in other Care and Protection, Youth Justice, Ministry of Education and NGO offices. This group was made up of clinical, educational and general scope psychologists, social workers, managers and clinical advisors. Due to the small sample size of this study and the fact that at this time it is the only such programme being run in New Zealand, the specific demographics of the staff and number of staff of each profession have been omitted to preserve confidentiality.

Procedures

Programme Documentation

In addition to my role as a researcher, I was responsible for developing a narrative describing the early stages of programme conception and development. This was done as part of the normal interviewing procedure described below but with an emphasis on the need for the programme within the wider array of services and the events and perceived gaps that the programme was developed in response to. I was also tasked with documenting the ongoing process and procedures involved as parts of the programme developed. This involved

collecting documentation, brochures and handouts pertaining to the implementation and interventions. This information provided detail regarding the programme's processes and served as a basis for evaluating how useful these were and how the programme could be replicated.

Interviews

In collaboration with my supervisor and with consideration of the goals and aims of the programme, an interview schedule was developed. This schedule was designed to elicit the participant's views and experiences of the past year of the programme, aiming to achieve the purposes of evaluation but also flexible enough to allow for new perspectives we had not considered. A literature review was undertaken and past programme evaluation studies were examined in order to inform and guide the development of the schedule used for this study. The schedule was intended to be used flexibly; only acting to orient participants to important areas of discussion but not containing specific and narrow questions leading to desired or expected answers.

All interviews were conducted by me face-to-face with the exception of two interviews which were conducted over the phone due to geographical distance and an inability to travel to these participants. All interviews were conducted in the workplaces or from the workplaces of the participants – including CYF offices across the North Island. I observed, took notes and audio-recorded the conversations. Interview length ranged from 45 minutes to 90 minutes. At the start of the interview, participants were given consent forms, the particulars of which were discussed. They were given the option to turn off the recording at any point and contact me after the interview if they wanted certain parts or the whole interview redacted. I took handwritten notes as cues for myself to ask further questions, return to topics or deepen conversation in certain areas. These notes were destroyed after the interview and did not contribute to data collected. Each participant was interviewed according to the interview schedule and additional questions were asked if topics of interest emerged that needed further detail and elaboration.

Development and Documentation of the Programme

Part of my role as a researcher on this project was to document the process of development and implementation which is outlined in the section below. This involved attending meetings held with the staff involved in the programme and taking notes on the content and process of what was happening in order to describe these stages in detail and allow for future attempts at running this programme to replicate it.

Identifying a Need

The idea for the programme was born out of discussions between practice supervisors, operation managers and leading professionals in the field. These discussions began with the observation of 8- to 12-year-olds who were offending at high severity and frequency, who were engaged in services from a very young age and would go on to have longstanding involvement with the youth justice system. The question was asked: Can we be doing better for this group of early-onset child offenders?

This led to liaising with researchers in the field to discuss how to make the most of assessments that are conducted when children and families first come to the attention of services in order to create a holistic picture of the needs of these families. This was based on the observation that there were numerous assessments done at the time of referral to Child Youth and Family, or previously when children or families come to the attention of police, that did not seem to serve an ongoing purpose for intervention planning and case management. These discussions also led to realisations that there was a lot that was unknown about this group of children from psychopathology and developmental perspectives.

In order to resolve this, a small focus group was formed which commissioned explorative research analysing data taken from the Child Youth and Family electronic database (CYRUS), specifically on those who had committed offences in the 2009-2010 fiscal year. They examined what was known about these children before they were referred to Child Youth and Family, what interventions were put in place and what happened to them over time. They found that supervisory neglect and parents struggling in caretaking roles predicted negative outcomes. They felt that neglect was something that was overlooked while more ‘severe’ cases of trauma, such as physical and sexual abuse, were being followed up, which led to neglect cases being closed or lacking comprehensive plans when trauma was not obviously present. They realised that there were many factors that contribute to childhood offending that go unnoticed, or that professionals are unaware of as being linked to offending outcomes, and that these factors needed to be identified and addressed earlier.

Programme Development

Pre-planning stages involved deciding on whether the programme filled this need for 8- to 12-year-olds. An evidence-based appropriate model (Wraparound) was chosen and implemented with a view to attempting something new in New Zealand and evaluating the process as it unfolded. They chose a site that was able to facilitate social workers reducing their workloads in order to implement wraparound processes and have a clinical supervision team available. It was a site that also had a manager who was seen as dynamic, open and willing to change the system. In looking at the existing data, it was clear that there was not a consistent way of identifying child offenders – those who were offending before the age of 14 and before other systems were in place. The question was also raised by the programme developers: if intervention occurred before these children reached the age they would enter the juvenile justice system, would fewer follow this pathway?

The initial information gathered indicated no consistent way that interventions were applied for this group. The logical step was to look at what had been found to be effective for this group. However, even internationally, the research was limited. Therefore, programmes that were showing some success for populations that have similar characteristics, where children present with antisocial behaviour and are placed in out-of-home care due to family dysfunction, were considered.

Youth Horizons Trust is a non-governmental organisation that provides services for children with severe conduct problems and their families. These programmes include multisystemic therapy (MST) and functional family therapy (FFT). Within education, the development of the Intensive Wraparound Service (IWS) has shown that a systems approach to intervening with children and young people with difficulties has resulted in positive results for students who are having difficulty staying engaged in education and that the results that are being seen are at least as effective for Māori as non-Māori.

These three approaches had a number of basic principles in common. Of particular importance was the significance of family being involved in the solution and the child/young person's voice being heard. This aligned well with the way that Child Youth and Family intended to work. For these reasons, it became clear that a wraparound approach would fit well with this population and these additional treatments (such as MST and FFT) would be part of a treatment package which was held by the social worker as the 'lynchpin'.

Cultural Considerations

To obtain assurances that the programme was meeting the needs of Māori and Pasifika, consultation with members of those cultures who worked in the service resulted in an approach which amalgamated the principles and processes of wraparound with traditional cultural understandings and world views. Utilising indigenous frameworks maintains the integrity and distinctiveness of Māori and Pasifika beliefs and practices within the context of the statutory social work role in the everyday engagement with youth and their families. Bi-cultural frameworks are an amalgamation of indigenous frameworks with western models and practice knowledge. In order to ensure that wraparound was culturally appropriate, discussions with Māori and Pasifika staff involved with the programme and wider organisation was an important step in the adaption of wraparound for this population.

Utilising a bi-cultural framework in order to engage with rangatahi and whānau Māori progresses through *Te Toka Tumoana* (the Child, Youth and Family Indigenous and Bi-Cultural Principled Framework). This process was guided by the three overarching principles of *Tiaki mokopuna* (describing the roles and responsibilities to keep our young people safe according to vulnerable children legislation), *Mana ahua ake o ngā mokopuna* (the potentiality and uniqueness of our young people), and *Te Ahureitanga* (the distinctiveness of being Māori).

When working with Pasifika youth and their families, the *Va'aifetu* framework can apply. Va'aifetu is a Samoan metaphorical term that is derived from the words 'va'ai' which means to take care of, look, see, observe, consider; and 'fetu' which means star or stars. Va'ai is the role of families, communities, practitioners and organisations. Va'aifetu is about the guardianship of people - their light, intelligence, wisdom, aspirations, strengths and potential. The stars are the children, families, and practitioners. Va'aifetu does not attempt to provide a comprehensive review of the vast diversity presented by the cultures of Oceania, including the diasporic. Instead, it illustrates some of the differences and similarities between the larger groups in Aotearoa, and for the purposes of statutory social work intervention.

The wraparound model adopted by the project was able to incorporate and blend with the *Te Toka Tumoana* and *Va'aifetu* bi-cultural practice frameworks of Child, Youth and Family. Particularly in regard to *Te Toka Tumoana,* the central principle or value of the wraparound model is 'Family Voice & Choice', which naturally makes the worldview of rangatahi and whānau of paramount significance to meaningful engagement and effective intervention (*Rangatiratanga, Whakamanawa*). This is further emphasised by the principles

of cultural competence (such as understanding of *Te Reo* and *Tikanga Māori*), individualisation (*Mana ahua ake o ngā mokopuna*, *Te Ahureitanga*), collaboration & integration (*Manaakitangi*, *Wairuatanga*), and use of natural supports (including whānau, hapū and iwi).

Early Stages of Implementation and Ongoing Case Management

The implementation of a wraparound philosophy involved a significant change in the approach and practice of the staff involved. As a result, a number of training days were included during the early stages to get familiar with the framework, attempt to make sense of how this would fit these young people and what would have to change/remain the same in relation to existing procedures.

Initial training was on the theoretical basis of wraparound. Resources were obtained from the International Wraparound Service website in the form of free online webinars and readings of principles and processes. Meetings were then held to determine how the team could shift to wraparound as seamlessly as possible, with planning workshops based on real cases. An important part of this process was emphasising the change that needed to occur and normalising the possibility of behaviour becoming worse before it improved due to a change of approach from the social workers which was more goal focused and involved more ownership and accountability from the children and their families. Ground rules were also discussed to set up a respectful, professional, non-judgmental and supportive supervision and training environment that was sensitive to the needs of the team.

Staff were given the practice guidelines outlined above for the first stages of implementing wraparound: engagement and initial plan development. Trainings were then held in collaboration with the Multisystemic Therapy (MST) team at YHT. Here the MST team shared knowledge and practical advice on how to conduct assessments and engage from a multisystemic focus to build engagement and develop a plan that fits for all stakeholders. This involved watching video examples of real assessments and workshopping cases from the programme. Formal training on Motivational Interviewing was also provided across three days with an aim to provide the social workers with further skills in establishing engagement and evoking talk of change in young people and their families. The aims of these trainings were to increase social workers' knowledge and clinical skills in order to work with this population.

The next training was focused on the stage of implementation. This involved introducing a team review and case management tool based on outcome measures of

wraparound. These forms were then used in team supervision meetings fortnightly to determine how on-model the team was during that period and how families were tracking with regards to their goals, successes, barriers and next actions. Ongoing case management also involved liaising with other services responsible for the provision of individual and family therapies, facilitating educational engagement and liaising with local police to reinforce plans and ways of communicating and responding to these children and their families that fitted under the broader wraparound principles.

Chapter Three

Results - Staff Perspectives

This chapter reports the results of the interviews with staff members involved in the programme delivery. Participants were asked a broad range of questions designed to elicit their views of the programme, what worked well and what could be improved, and specific questions regarding offending behaviour changes and relationship with the families, which align with the goals of a wraparound treatment. These fell into five main categories of (a) need for the programme, (b) programme implementation, (c) behaviour change, (d) impact on relationships and (e) systemic issues.

Theme 1: Need for the Programme

Participants were asked their understanding of why this programme came about and what its purposes were from an institutional/service delivery standpoint as well as a service-user experience standpoint. Their answers to this broad discussion topic were analysed into five subthemes: early intervention is required for severe offending; a targeted intervention is needed for 'crossover children'; services are not ongoing and committed; families and young people do not have a voice; and professionals have negative, deficit-based attitudes towards these young people.

Early intervention is key to prevent severe offending

Participants alluded to the need and importance of having an effective intervention at the first signs of problem behaviour in children and young people and disengagement from prosocial activity.

> *The problem we were looking at was basically trying to prevent early onset offending turning into life-course persistent offending. Basically. Yeah trying to change that trajectory.*

Under this broader idea of changing young people's offending trajectory, staff also talked about other specific indicators of risk which needed early attention, as well as the importance of building engagement and a positive relationship with families. They emphasised the importance of intervening the first-time children/families came to the attention of social services in order to offset an expectation of being hassled and imposed upon by an institution.

They also recognised the growing concern for siblings being exposed to offending behaviour, either as victims or in having such behaviour modelled to them, and that the fact that these young people knew each other seemed to be causing unique difficulties in the neighbourhood.

> *…to steer them away from offending and try and manage them in a way where there was lots of disengagement from school, lots of drug and alcohol use – so targeting those to give them a better outcome and keep them away from the justice system as much as possible. But also finding a better way of working with the families that wasn't quite so adversarial.*
>
> *This site had a number of families where we had kids with severe conduct problems in large families where there was concern that the siblings were also at risk. This group of boys had also formed - were also connected in with one another in this area.*

Finally, participants also felt like this early intervention had to be comprehensive and holistic to make up for the current gaps in service delivery. This was made especially clear given the severity and high-risk nature of their offending; something which demanded more attention from social workers rather than acting on the urge to retreat and disengage.

> *Really their behaviour is a result of what they have been through as younger kids and we can't just stop caring, just because they are challenging or difficult. I think if anything we need to work harder and in more different ways.*
>
> *As kids become more complex and out of control, our current system is almost like singling them out. So the wraparound approach as really more thinking about the child within a whānau system because they are always connected. If you look at these kids they keep heading home so removing them from their families isn't working as a way to deal with it.*

Targeted intervention is required between Care and Protection and Youth Justice

Staff members saw a large gap in services between Care and Protection and Youth Justice. They spoke about an inevitability of early-onset offending ending up in engagement with Youth Justice and when of age, able to be tried and charged in court. They described this gap being characterised by a lack of available services as well as a lack of understanding about how to best intervene with these children. They spoke about a general approach of doing the best with the existing structures and expertise but this not being targeted enough to divert these children and young people away from antisocial behaviour.

It's been seen a bit of a gap between Care and Protection and Youth Justice where 12 and 13-year olds who are offending or heading towards offending were kind of just left to drift towards that until Youth Justice picked them up and met criteria as child offenders or turned 14 and starting getting arrested and going to court.

Participants spoke about the unique profile and needs of this age group as being both an opportunity but also something that complicated what services needed to be put in place and how to best implement these effectively and efficiently, given the small but crucial 'window' while in Care and Protection custody.

Everybody can see the influence that is happening on these young people. On the one hand, they want to be able to remove those influences from those young people so that they can steer them off another way. The problem is at that age and level of development even though they are starting to get some autonomy from their families, still exploring who they are, where their place is in the world, where they belong and how they identify, is very much still tied up with family.

Services are transient

While participants acknowledged that there were many services in place for this group, these services were not ongoing and committed to staying engaged with the young people as their behaviour got worse or as existing plans did not come to fruition.

There were a lot of gaps and inconsistencies and one of the interesting observations I have made was around how as things became more difficult and complex for the young people and their whānau how services do drop out of the way and we very much go into crises modes of just acting in the moment which doesn't really match well in some regards to the actual behaviours themselves we are trying to stop.

One participant alluded to the complexity and severity of offending as the major factor contributing to this drop-off in services. Another elaborated on this further, suggesting that their behaviour required a more specialised and intensive intervention provided by highly skilled clinicians, something that was not available given the current resources of social services.

These kids all the way along are getting less, and less choices about the pathway that they can go on and it becomes a smaller and smaller group of people that can actually know how to respond to those behaviours as well, as you would expect of course.

Families and young people don’t have a voice

A number of staff spoke about how they felt like families and their children did not have enough say on what plans and interventions were put in place for them. They felt like a majority of decisions, although made with family present, were made for them by professionals, especially with regards to goal setting and treatment targets. They acknowledged that this occurred because of the severity of offending. This severity causes services to isolate and alienate the young person and give them the impression that they do not belong with their family and peers.

> *Family is family but they have a growing responsibility to decide for themselves what actions and decisions they should make going forward for themselves and what that might look like and to have a sense that there are some choices around that. I get the feeling that lots of these kids do not see some choices around them. Their past experiences tell them that they actually do not fit in with the general community, with the other kids in school.*

One participant noted that family involvement had a significant role in predicting positive outcomes for their children.

> *Even if they can't live with family, the family is still involved in the plan and has a big say in what - because they still know their child, they still have some hopes and dreams for their child and so even if they're not living there, to still have that connection and be part of the wider plan.*

They saw this as a significant problem in the existing structures and services in the system and when they found out about wraparound, were encouraged that this was such an integral component of the programme. This subtheme related to the theme of *Relationship Change* where staff described the process of providing the opportunity for these young people and families to have a voice, which reduced the power imbalance and allowed for more collaborative relationships.

Negative, deficit-based attitude among professionals

Staff described observations they made around the office where this group of young people had a negative reputation and that many other staff who did not have regular contact with them saw them as dangerous and unpredictable.

> *The police would bring them in and people would sort of roll their eyes and hide their wallets and all that sort of stuff which is sensible sometimes.*

A number of staff members also noted that working with this group of challenging young people was not everyone's professional interest and that most social workers would prefer to not work with this group.

> *Coming to realise that engaging with kids with these sorts of behaviours and challenges around them is not everybody's interest or some people feel uncomfortable with kids like this. It's certainly not for everybody. So matching up people's skills, interests and expertise and thinking that whole generic way of social work just can't be the way we work.*

Overall, this theme described a gap in services for child offenders and that this programme filled it in some ways. They were clear that the programme was designed with a specific purpose in mind and all the staff involved had a sound knowledge of this purpose. These included issues related to service provision for children who offended as well as attitudes and approaches that resulted in disconnection from family and a negative self-belief and self-image.

Theme 2: Aspects of Programme Implementation

Participants were asked broadly about their experience of implementing wraparound principles and the programme as a whole. Questions were asked to elicit the successes and shortcomings of programme implementation and what they thought could be done better. That is, if the programme were to be replicated, what factors would increase the chance of it being more successful. Their responses fell into four subthemes: doing something different in an institution, supervision, ongoing training and practice, and recognition from other services.

Challenging the institutional approach

A theme that came through from all staff located on site was that it was a considerable challenge trying to do something different while also being governed by the mandates and philosophies of Child Youth and Family.

> *I remember sitting in a number of different trainings that we have had and thinking to myself, 'How are we going to put this into practice? How are we going to make this work because it is so different to the way we work on a daily basis?'*

At the core of this theme, many participants said that, due to the intensive demands of the job and formal processes being the focus of their professional role, there was little space to adopt

a therapeutic, change-focused stance. Specifically, they spoke about how the amount of administration and documentation required meant that they did not feel as though they were practising social work the way they intended to when they began their careers.

> *Unfortunately, social work can become just very task driven and not we don't have the real time to make it about the kids and give it that focus, I do not think it's particularly ground breaking what we are doing. I think it's really getting back to the core, grassroots of what social work is and it drills into us what the importance of actually spending time with the kids is and spending time with the family is and making that a priority. Because it's so easy just to go off task and be spending time with paperwork, court reports and doing those things which are important but I think we have got to stay focused on why we became social workers in the first place.*

> *The programme itself really sticks to the core of what social work is and what it should be and I think a lot of what we are talking about in our clinical sessions is quite similar to what we learnt at university but a lot of that gets drilled out of you in statutory social work because you do not have the resources and time.*

From a practical standpoint, participants spoke about how high caseloads and an emphasis on managing risk made it difficult to carve out time in their schedule to implement a programme where they were required to see young people more frequently and adopt a therapeutic, change-focused lens.

> *If you've got high caseloads and there are a lot of people that need stuff sorted today it's a whole lot easier to just do things to them instead of spend that time and go through a smaller approach that will hopefully have better maintenance over time but actually doesn't solve today's issue right here where people are saying, 'What have you done about this family?' and 'This needs to stop and this needs to stop, go in and tell them'. That can't happen anymore. They literally go around fighting fires.*

Supervision was essential and valuable

Supervision was seen by staff as a vital part of the implementation process. They found the availability and expertise of the clinical supervision group extremely valuable in helping them adhere to wraparound principles. They felt like the ongoing workshopping of cases helped to consolidate knowledge and assisted in efficiently putting action steps into place.

> *Having the supervision every 2 weeks we were like, 'OK, what are their motivations? What do they want? What is their plan? What does the world look like from their*

point of view?' Just repeatedly brought up as opposed to the CYFS kind of like, 'What are the risks and how are we managing behaviour?' It sort of pushes - creates the thing in the back of your mind like at least you're getting a sense of what the families want and what the kids want or trying to anyway and trying to incorporate that.

One participant also spoke about appreciating *"therapeutic lens on supervision rather than just case management"*, which involved the validation of the challenge of working with this group and the emotional toll it took on them as social workers. They spoke about especially appreciating their stability and knowledge *"when the alarm bells were going off"*. Staff involved in the programme commented on how supervision was intended to *"lift them up to being not just social workers – bringing them up to the confidence to do things more independently and speak more confidently about their own knowledge and in their own skills which I think they now do very, very well. Valuing them more and their experiences and what they bring to social work practice."*

The main area for improvement staff noted was the need for someone on site who, in addition to clinical and theoretical knowledge, had an understanding of the day-to-day requirements of being a statutory social worker. This was suggested as a way of better being able to advise on plans that were realistic and achievable, given the restrictions and limitations that come with working as part of the service.

It would be great to have someone here on site that we could bounce some ideas off and just have that oversight and guidance would be great. Someone who could really navigate all the services that we do not always have time to do.

While not being involved in the frontline operation of the programme, staff described this person's role as having knowledge of the young people and the families as well as organisational policies and procedures. They would be available to provide advice and guidance but do so from within the organisation. The transience of the clinical advisory team was useful in bringing in outside influence, ideas and advocacy but, as stated above, these recommendations did not always translate to actions that were possible within the statutory framework. (The clinical advisory team comprised psychologists who were experienced in working with children with challenging behaviours and were consulting to the programme, but who worked outside CYFS, and were only on-site for planned supervision, training and other meetings.)

Ongoing training and practice was needed

All staff spoke about requiring more training and practice in how to implement wraparound skills correctly. Participants described the initial training sessions were valuable for gaining a theoretical knowledge of the framework but saw a need for ongoing refreshers in order to consolidate this knowledge and to know how to effectively implement the principles in practice with this unique population of young people and their families.

> *I think with the training that we did I know I was pushing and pushing for this – to following up and reinvigorate the training because we did find the workshops and day trainings we did were awesome but again there was just never that time to, in the course of your work reflect back on that. Check in – am I putting this into practice?*

The impact of this gap in the implementation process was named by a participant who saw that some aspects of wraparound principles were not adhered to and if it were to be done again, a better grounded understanding was required in order to use the framework to its full potential.

> *They were supposed to be part of the wraparound approach and yet there wasn't that joint planning between the social worker and the others, like when things escalated everybody else literally wasn't there and the social worker took the lead. I do not think it was one person or the other person's fault, I think they both would have liked to keep working together, but somehow or other neither of them did - some of that was due to lack of understanding as opposed to lack of willingness.*

This subtheme had considerable overlap with some of the difficulties outlined under the *Systemic Issues* theme. As stated above, the fidelity with which the social workers were able to implement the programme was not due to a lack of willingness but rather due to a lack of understanding, knowledge and other agencies doing their part in the broader wraparound plan. More often than not, social workers were left holding the whole plan, which is not indicated as a successful outcome for a fully wraparound approach.

The programme got more recognition from other services

Staff members commented on how, through the implementation process and the communication and liaison with other agencies, they noticed changes in how seriously their plans were taken and how relationships changed.

> *Better relationships between us and the community providers like better relationships with the police, our relationships with [NGOs]. Internally like I said with our national office and regional office has been a real benefit to us to have those good positive relationships.*

Social workers described feeling more recognised and visible to other services and less isolated in their work. There were exceptions to this as outlined in the *Systemic Issues* theme, but they did notice some shift in the levels of collaboration they were able to achieve.

> *There is more awareness of what we are trying to do. That comes down to lots and lots of really good communication between site manager and our national and regional office and probably also a willingness to look at things in a different way and try to do things a bit differently.*

Staff described themselves and their work being more visible to services involved in these young people's lives. They felt less isolated and pressured to make all the decisions and hold all the responsibility which impacted on how responsive they were able to be.

Theme 3: Behaviour Change

Staff were asked broadly about what changes they noticed in the young people's behaviour over the year and what, in their eyes, contributed to this change. Overall, all the staff acknowledged that, while there were fluctuations in the severity of their offending behaviour and positive patches, for most of the children, the programme did not meet its overall goals and most of the young people, by the end of the year and as they turned 14, came to the attention of Youth Justice. Five subthemes emerged: young people showed a better ability to communicate with social workers, flexibility and increased contact led to positive outcomes, plans needed to be more robust, barriers of antisocial peers/family, and more time was needed in the programme.

Young people showed improved ability to communicate with professionals

The main area of behavioural improvement in the young people was their ability to communicate with social workers and other professionals involved in their care in a respectful and constructive way. Staff reported that while this was hard to quantify in terms of psychometric or behavioural measures, they noticed a considerable improvement in how the young people related to the people and the environments they were in. They were more

forthcoming with information and would tell their social workers about their offending, something which was unheard of previously.

> *It is better that we know about it [offending] and they're talking to us about it than us having no idea about it or having no engagement with them and being able to plan. If things happen at least we can plan in more detail to try and prevent it. If we know more and if they are talking to us about everything that is going on as opposed to kind of getting a police report or a report from someone else.*

Ideas discussed in this subtheme were closely linked to those mentioned in the *Relational Successes of the Programme* theme and the young people's behaviour change was attributed to the change in attitude towards social workers and the increased levels of trust. This seemed to have flow-on effects where the young people believed that these professionals had something to offer them and that this was a prerequisite to giving permission to influence their lives in any way.

Flexibility and increased contact led to positive outcomes

Participants commented on how increased contact with the young people and more of an involvement with the family and wider system provided them with more knowledge than they ever had previously. This knowledge allowed for more informed and nuanced decision-making and an ability to ask the right questions to most efficiently get the answers they required to put plans into action.

> *It's much more detailed in the understanding of people. There is a lot more observation, we have not got the answers but thinking now about his absconding which is behavioural but is there something more that is underpinning it? Like do we really get this kid? Like what are we missing?*

One participant described the following example of a social worker having this increased understanding of a young person which resulted in his behaviour being put in a context of a wider set of difficulties, as opposed to being stereotyped as a 'hopeless case'.

> *I just think of some of the time that [social worker] spent with [young person] for instance, he noticed physically how he would change when he was on the street with himself, the traffic and the kids and the noise. He just physiologically changed whereas opposed to, it was almost like observing that, it was almost out of his control sort of, I guess, as opposed to prior, without that level of engagement and observation*

and understanding of how he operates, you could just categorise him as a - you could just write him off - it's hopeless, he's just a runner.

This led to an appreciation of the complexities of these young people's psychological and behavioural presentations and that they required a flexible approach which was unique to each young person. Another participant recounted an example of this flexibility put into practice to manage an escalated situation.

I remember one day [social work student] and [social worker] went in and I can't remember what we were doing with him [young person] - we had him in here and we were going to tell him something. I think it was about a placement and he just reacted and [social work student] went to him and he just flipped out and smashed things and attacked [social work student], we hadn't briefed him properly so [social worker] just opened the door, walked him through and said, "I know that you're going to run but when you get to the road just don't run across the road, I just want you to walk across the road, I'm going to watch you, I just need you to get safely across the road" so rather than have this kid fly out, you'd see him trying really hard not to run and then he got to the other side and he ran. [Social worker] knew him well enough to know you can't negotiate. Running away was a way he would get away so he wouldn't do things that would make things worse or hurt people but [social worker] understood, it was that sort of harm-reduction approach to managing it.

Plans needed to be more robust

Staff spoke about how the young people's behaviour was so erratic and fluctuated in response to a complicated array of factors and that plans needed to be robust in order to account for this level of complexity. While this happened on some occasions and the young people settled and had positive short-term outcomes, plans were not robust enough to effect lasting behavioural change.

It was really up and down I think. It's really difficult to say what kind of impact it has had. I think for [young person 1 and young person 2] who had periods of stability and things seemed to be going quite well then further offending happened. Probably because we didn't immediately put them into custody or move them elsewhere probably seeing that dynamic unfold. Like how did the family respond to that at that time and at that time having enough of an in with the family to have pretty honest

> *conversations about if this is working or not or what are we going to do and not necessarily having the answers straight away.*

On a case-by-case basis, this involved an understanding of the dynamics of families, which change rapidly, as well as the various policies and mandates of different organisations. Staff recalled examples where a young person was *"missing his mum and missing his friends and went on a tear. But then mum came down and he settled right down but then mum stayed, and he's gone back into the previous dynamic with mum where she was permissive and 'You do what you want'- where no one really knows where he is"*. There were other situations where, for example, Child Youth and Family issues stopped engagement with other members of the extended family, even though the young person and their parents wanted these people to be part of the planning process. One staff member summarised this stating, *"How do we create this service with keeping both systems and philosophies (of statutory social work and a therapeutic wraparound framework) intact?"*

Barrier of antisocial peers and family

Participants commented on a long and complicated list of risk factors these young people had and how their offending could be seen as an inevitability, given this history. This quote is an example of some of the factors which contributed to the challenges they faced. It was reinforced throughout the interviews that these young people have had little modelling of prosocial activities and interactions and lack the environmental and internal resources to effect change without intensive wraparound interventions that involved multimodal and multisystemic methods.

> *For some of these boys it's just a really long history of violence in their families and you know not being connected or having good role models or a combination of things like poverty, family violence, lack of school attendance, unemployment, crowded houses, transience, you know, all those things. Alcohol issues, gang associations with parents and siblings, just a whole lot of factors like that, some of these boys have a very long history of that.*

One participant also spoke about the family dynamics in more detail where small changes could result in vast improvements in behaviour but equally small shifts could also cause a deterioration in the same way.

> *Like the boy who went up north and came back down south here, was living with family doing really, really well. He was not offending, he was going to school, he was still with family where he wanted to be and where family wanted him to be. There was a change in that circumstance in terms of additional family moving in with him and things went downhill from there. We can't control situations like that.*

A lack of control was central to this theme as well as a conflict between acknowledging the importance of family and peer contact and trying to facilitate this as much as possible and also being unsure as to where to draw the line at which point this family and peer involvement had a detrimental effect on the young people's behaviour. A number of participants noted that this was an 'unsolved' part of the process and something which needed further consideration if the programme was to continue.

Not enough time in the programme

All participants agreed that the main contributor to the lack of behavioural change was that the young people did not spend enough time in the programme. Most of them were 13 years old when the programme was implemented which put a one-year time limit on reducing offending behaviour and increasing prosocial engagement. Staff members reflected on how this proved to be unrealistic as *"they were all well into their offending at 12 and 13 and they were all turning 14 at the same time. And they already had a bad reputation with the police. So the police had that mind-set, as soon as they hit 14, boom, charge them, we got them now."* They also spoke about the influence of peers increasing and influence of family decreasing at this age, so a wraparound framework would be more effective with a younger cohort.

> *Well, obviously the best thing to do would be to identify these kids before it happened, hopefully we can affect a greater level of change. The thing is keeping them engaged in some form of education. The kids that we started more intensely to work with them were disengaged so we would ideally be getting them as they started to disengage or were showing signs that they might. Showing some antisocial behaviour as opposed to by the time we started trying to work with these kids differently, they were massively out of control and all of them were using drugs and alcohol and doing top-end teenage offending type stuff and they were just kids.*

Participants spoke about identifying children as young as eight or nine, citing research that suggests *"you can see aspects of you know would develop into antisocial behaviour when kids are quite young. You can recognise some precursors from school or other settings that are precursors for that and I think the younger, the better, basically. You've got more time and they're potentially more pliable."*

Theme 4: Relational Successes of the Programme

When asked broadly about the successes of the programme, all the participants focused predominantly on its relational successes. Staff commented on how the procedures and principles of the programme which advocated for family voice and choice led to positive outcomes in their relationships with these families and shifts in attitudes that were unheard of for statutory social workers. These ideas fell into four subthemes: young people and families were more trusting of social workers, social workers were no longer seen as adversaries, the programme resulted in more natural and mutual relationships, and social workers adopted a broader perspective of the families.

Young people and families were more trusting of social workers

All staff spoke about a shift in attitude towards social workers. They observed that families were considerably *"more open and trusting of social workers"* and, as one participant said, more willing to give information on their children's behaviour and whereabouts.

> *In terms of when something goes wrong or the boys have offended, the families have been more inclined to contact me directly or to share that information: "OK, my son was here last night I know he's missing and wanted by police but try here because I'm pretty sure he'll be at this address or he's gone with so and so". In the past, it would've been: "This is my son, I'm going to protect my son so I'm not telling you shit." Kind of like the attitude they have to police.*

The participants put this down to a mutual transparency between professionals and service users where the family were part of the plan-making process and had more of a voice in the decisions that were made for their children. This was even more impressive given the multi-generational involvement with government agencies and a pervasive lack of trust before this point.

They became very transparent, we were transparent, and they were transparent and that was pretty big for both of those types of families. They have had a lifetime of engagement with government agencies, police, WINZ, CYF, both of those families when they were young people themselves, so it was quite a significant thing that they were actually able to be as honest as we thought they were being.

Social workers no longer seen as adversaries

Participants reported that there was a shift in the role social workers played in these families' lives. The young people would approach the social workers and engage in a way that was unexpected, given the nature of their relationship in the past.

We had our chief social worker here early last year, he did two days on site. He wanted to do frontline social work. I sent him out with [social workers] one afternoon down to the park. [Three boys] were loitering, I think one of them had been missing for a period of time, and they just came running over and introduced themselves to [social worker] and then they went and got pies and they opened up the boot of the car and sat around having a pie, it was pretty cool. Kids like that would usually run a mile if they saw their social workers.

Some families even went so far as to request whether they could continue seeing their social worker even when they were moving out of area or when social workers were leaving to work in different departments. This was described as being unheard of, as most, if not all, families connected with a statutory service like Child Youth and Family do not want to engage or have professionals involved in their family life.

They have seen that and really appreciated it and in that situation, they have come up to [social worker] and said we want you to keep coming up north, we want you to keep being our social worker for as long as possible. Because we trust you and we want you as our social worker. Which might not seem like a big thing for maybe a community social worker but for CYF social worker is a big deal for a family to say that, because there are all kinds of barriers that come with the label of being a CYF social worker.

This was an important indicator of wraparound principles and processes being prioritised and resulting in the desired outcomes. Crucially, social workers on the frontline of programme implementation were able to position themselves as agents of change as opposed to punitive figures in the lives of these young people and their families. Although done in subtle ways

that just involved more time, attention and genuine interaction, the ramifications of this were substantial.

Natural, mutual relationships with young people and their families

In addition to being less adversarial, staff noted that overall their relationships with the young people and their families were not dissimilar to any other human relationships and no longer focused on the power struggle they had been familiar with.

> *[We had] a more open relationship with the families. So just getting to know them a bit better. What their dreams are for themselves, for their family, for their individual sons or daughters we're working with. Just willingness to engage. But definitely relationship because a couple of the families I might just visit, not talk about social work or their boys, just catch up, "What you been doing?", have a chat on the front door on the steps. It's not necessarily about, "What have your boys done now?!"*

As evident from the quote above, this was down to the fact that social workers had a genuine interest in the families' values, hopes and dreams for themselves and their children but also adopted an approach of working in partnership with families. This participant attributed the change to adopting a flexible, compassionate approach, rather than being heavy-handed with their consequences for plans falling through.

> *I think having that sense of - if we're kind of expecting some hiccups to happen along the way and rolling with those a bit more and getting them back on track. Whereas maybe their previous experience of social workers might have been too – yeah, one mistake means something is just going to fall apart. So, you sometimes wonder whether they're sabotaging things or just pushing boundaries because that's what they used to do to kind of get out of a situation where they're feeling uncomfortable and sometimes start to settle and sometimes not, as a result.*

Internally, there also seemed to be a shift in attitude towards the young people as evidenced by this quote from a participant.

> *So when [young person] came down in the middle of the year and went to Rainbows End (theme park) with his family and took like [other young person in programme] as his plus one - like his best bud. And the fact that that happened and was celebrated like isn't that cool that these kids who are seen as real troubled kids are just going and doing something normal and fun together with the family. These kids get -*

stereotyped isn't the word but kind of - everyone after a while knows they're the ones that are in trouble, so they are assumed to be troubled kids.

This example fitted in with much of what participants reported about how having increased contact and *"being encouraged to get out and know the kids more genuinely means a lot to the kids and their families"* and humanised them. They began to see them as the children they were, children who liked to have fun, misbehaved from time to time, missed their parents and friends rather than just having their problem behaviour under the microscope at all times. It positioned them as people who were there to help, not *"another bureaucrat that shows up to fill the paperwork or whatever"*.

They saw these relationship changes as being the early indicators of imminent behaviour change, the young people were starting to realise that the social workers had their best interests at heart, as opposed to being punitive and wanting to separate them from their families. Similarly, families were beginning to work together with social workers as opposed to refusing to comply with plans or provide information about their children due to natural protective instincts.

Staff obtained a broader view of the families they work with.

Staff members spoke about having a broader understanding of the young people they were working with, which enabled these natural human relationships described above, but also brought to light the complexity in these families' lives. It made clear to them why some of their interventions in the past had not worked because of being targeted at possibly the wrong aspect of the problem or where there were wider systemic factors they weren't taking into consideration.

Yeah and I guess looking at them with that broader picture of like, you know, you're just a kid with a family. You've got some stuff going on but just as with any case, there's lots of different factors in your life, your family, your school and your health. All of that. And this offending is part of that, but we also want to remember it's important to have family and it's important to preserve those relationships and take care of them and living in foster care is not conducive to that. So again, that perception of them as being that kid that keeps offending and running away. Like yes he is but he's also part of this family that wants to go to school here and yeah. Having a bit more fuller picture of them is not prohibitive to them continuing to offend but it's

then not just saying, "Oh, this is just who they are, that it's their destiny to be X the criminal".

They also discussed an issue unique to the population in this programme where the young people knew each other. Staff talked about trying to use this to their advantage but also had an awareness of the negative impacts of antisocial peers. Having a broader perspective allowed them to be resourceful and adaptable to use this knowledge to triangulate information. One staff member spoke about how it decreased the amount of 'finger pointing' and 'he said, she said' because they were all managed by the same social workers. However, this remained a point of contention and confusion throughout the year the programme was run.

Knowing them as a group was quite interesting. It's something we hadn't really had before. If we saw them as a group, because we were both their social workers, we could easily engage them. It didn't necessarily mean you got terribly far in terms of outcomes but um and I guess in that respect as well it wasn't like jumping on - well they are a group of friends if we're standing here saying you guys can't ever talk to each other or see each other or anything, it's kind of like shooting ourselves in the foot because they're probably going to anyway and they'll just be secretive about it and run away and what-not, so yeah that was a really interesting but pretty unsolved part of it.

From a practice standpoint, these broader perspectives allowed staff to be precise with their plans and interventions and from a personal standpoint, they were better able to understand the children they worked with. This in turn led to an understanding of offending as a consequence of a childhood filled with vast amounts of adversity, which enabled increased ability to be empathic and patient.

Theme 5: Systemic Issues

Although not explicitly asked to reflect on this with specific questions, all the participants spoke about wider systemic issues which hindered the successful implementation and ongoing procedures of the programme. These systemic ideas made up most of the discussion in the interview and seemed to feed into a lot of the other themes and were issues that combined them together. From this theme emerged four subthemes of poor interagency collaboration, not enough time and resources, pressure to respond in typical ways and a problematic, risk-averse attitude.

Poor interagency collaboration

Given the goals of wraparound and its emphasis on engaging multiple professionals and people in the young people's lives, participants' experiences of not being able to collaborate with other agencies was a central shortcoming of the programme. This was unfortunately beyond the control of the staff involved because it essentially rested on different services having referral criteria and mandates which did not coincide with the needs of this group. As a result, these young people were left without the services they required. One staff member poignantly expressed this as feeling *"more like a Venn diagram we're trying to wraparound from this side and someone's trying to wraparound from here – there were different plans going on and different agendas"*.

> *At the moment a lot of these kids miss that (finding a pathway) because if they were not in school regularly they got lost. Or if they got swapped around, they got lost in the system. For others, the supports were there but they were not coordinated. So the supports that they needed were available but there was not the coordinated response and they need that coordinated response because of the complexity in their lives.*

One participant spoke about how this is a symptom of governmental agencies working in 'silos' with certain goals and objectives they need to meet and strategies they use towards those ends. They used the example of mental health services: *"Take mental health is funded to address the top 7% or 2%, it's probably getting smaller and smaller, of mental health issues. Straight away you've got a problem, so their priority is that. That's their target. To meet that. If they don't meet it they're held to account. And then comes along someone like me saying, 'We've got a kid that's acting out with conduct disorder and he's suicidal - how about it?' and they say, 'Well, you don't meet my criteria', that sort of thing."* In this way, funding streams are one of the factors that get in the way of interagency collaboration as every service is operating under a different mandate.

Some participants also reflected on examples where interagency collaboration ran smoothly and suggested that if this programme was to be replicated, these should act as guidelines.

> *The good thing about Integrated Safety Response [for family violence] is that all the agencies sit around the table. So, we have Corrections, ACC, Ministry of Health and CYF and us [Ministry of Education] and NGOs as well. So, it's a way of getting everybody on the same page together with one plan. We are beginning to work more*

and more this way. I think now is a really good time that we push forward and see what we can do in terms of child offenders.

They suggested that being explicit about asking for other services' involvement and commitment to this young person right from the beginning was needed, saying to them: *"Hey, we're running this programme and we've picked this kid because we think he needs some extra whatever so here's what we're doing - how do you feel about being part of the key team for this?"* They acknowledged that this would be a 'tough sale' as it is another meeting people have to attend but also maintained that *"we need to start with what's best for that child and then work out the resource afterwards"*.

Social workers' role and reputation precedes them

Participants experienced balancing the role as an agent of change with that of having a statutory mandate difficult throughout the year. They spoke about how due to the history that many of these families had had with statutory services, families had come to expect certain things from professionals and social workers. Specifically, families had pre-defined notions of the role and responsibilities of a Child Youth and Family social worker, none of which were positive. As described earlier, in the past, this had led to distrust and withholding of information but also diminished the ability to make meaningful change because families were always engaged with an air of scepticism.

For social workers it's difficult because they have got that dual role - they have got to be there working with the families, but they also have to be the people who say, "You are not doing a good enough job, we are taking your kids away from you." It's a very hard role for them to play and I think it still needs to be explored a bit further.

For the young people, social workers were seen as punitive (much like the police) and their presence signaled that they had some something wrong and were about to be reprimanded in some way.

The kids themselves end up only seeing or hearing from a social worker when a crisis comes up. And I suppose then social workers get associated with this crisis rather than actually someone - what we're trying to achieve is social workers that have a really strong relationship, that the kids know them in times of when they're doing something well, doing something positive.

Staff spoke about this reputation as being one which is pervasive throughout the Care and Protection and Youth Justice systems and is something which gets in the way of delivering interventions in a way that has the most potential for success. They saw this as an important first step, where young people and their families had to believe that services were not only capable of instilling change but that they trusted and believed in professionals having good intentions. They acknowledged that without this, behaviour change was unlikely and, if achieved, was difficult to maintain.

Services' risk-averse attitude can be problematic

Participants expressed concerns about the overly risk-focused approaches of the organisation. While acknowledging that they had their purpose and that assessing and managing risk is a necessity, the overwhelming majority of participants felt as though this was overly emphasised. The overall concern was that the higher the risk that the young people posed, *"we try and keep them in a smaller box, which doesn't make sense"*. One staff member summarised this approach as the following.

> *What I've seen for some of these kids is that we've kind of gone from crisis to crisis and that for some of these kids it hasn't felt like we've looked at all the information and had a comprehensive strategic plan with these kids. It's gone from crisis to crisis, oh the kid's run away or something happened at school and we turn up at those incidents and it's been quite incident-focused. Basically, we're looking at isolated events for these kids and trying to plaster over them.*

In addition to the pressures from the organisation, staff also felt pressure from families to respond to traditional risky situations; most commonly absconding or being picked up by police for offending.

> *Yeah, you kind of get drawn in because I think part of it is everyone else is the same, right? Mum and Dad are like, "He's been missing!" That's scary as a parent! That's the thing that's freaking them out! Not, you know, it's like, "Oh yeah, he hasn't been to school and that's frustrating and not good but that doesn't make me worry about his immediate wellbeing" and the police are saying, "He's at home all day, that's not very good," but if we're getting calls every other night to pick him up or whatever then they're like, "Come on! Do something about this!" That's a red herring that draws you towards like, "What are we doing to do to address that thing?!" whereas these are the things that will, over time, help eliminate that cycle of risk.*

What they felt and what was reinforced in other responses was that immediate risk is important to be aware of and address but the mantra of "*responding as opposed to reacting*" was one used by many to describe what needed to be done from now on. As the quote above outlines, they began to see their professional role to manage risk in a more balanced way which fixed the immediate problem but crucially, this response was not an overreaction that diverted from the overall plan for this young person and their family. One participant also expressed that this was something that was largely determined by governmental policy and that, on the ground, they had little power to make change, other than to express their views of what they see working and what hinders change.

> *Yeah, and I think that's a huge big government and policy question and that's so driven by a government that just wants to be able to report that we didn't let any children die and whatever else, so they're just like, "All right, let's really hone all your report templates and practice tools on tracking risk," whereas if they balance them more, you wonder – systems shape practice, right, whether you like it or not, for better or worse.*

Lack of resources impacted on fidelity of implementation and led to staff burnout

Participants overwhelmingly expressed a feeling of not having adequate time and resources to do what they thought professionally needed to be done to achieve the best outcomes for these young people and their families. All the staff spoke about feeling burnt out or noticing this in other colleagues which impacted on work satisfaction and staff retention and inevitably on having a stable service for the families that needed it.

> *That was one thing I really struggled with – it was probably my biggest angst with the process - this is all such good information and such a good process and such a good philosophy to apply to these kids, if only I had time to do it properly.*

They spoke about how this pressure interacted with the risk focus of the organisation when, if you have limited resources, you are forced to prioritise - and immediate risk, understandably, comes first. Given the lack of resources, however, there is little to no energy remaining to then pay the attention required for this extremely complex population and to adopt a therapeutic, change-focused approach that would effectively reduce risk long term.

> *I guess if you have got more time and have got more energy and more able to spend more time with families and more time with the kids, then it's going to be less reactive to risk and it's just going to be a more natural thing as opposed to really sort of ... at*

the moment, when things happen we sit down and we thoroughly talk about how we are going to react to the situation, so that we aren't just going out there and reacting, so that it's more of a planned approach.

One participant warned of a more concerning and impactful consequence of this under-resourcing being that social workers not only burn out but make crucial mistakes, which amount to serious consequences down the track for both the families which they serve and the organisation they work for.

I mean the workload thing for social workers in general is just out of control. It's nothing to do with this project but I think it's just absolutely a recipe for disaster. You've just got overworked social workers being asked to account for every little thing so of course they're going to miss stuff, fabricate stuff, you know – it'll go bad sooner or later. All in the name of efficiency.

This was a significant issue over the year that cannot be captured accurately by the term 'burn-out'. Due to the requirements of the wraparound programme for more intensive engagement, staff were more emotionally involved and invested in the lives and outcomes for these families. This meant that the factors described above impacted on how effective and true to the programme they were able to be, and led to feelings of dissatisfaction, hopelessness and frustration that worsened over the year.

Chapter Four
Discussion

This chapter begins by outlining the major findings of the study and its strengths and limitations. It will then explore the implications these have for services for this population of young people and their families. These will provide a basis for outlining the components and wider factors required for an ideal programme within a well-suited systemic structure. Finally, the strengths and limitations of the study will be examined followed by future directions for research and how the research findings could be utilised.

Overview

The aim of this process evaluation was to document the operation and processes of a new and innovative programme designed to treat childhood offenders. While the New Zealand Care and Protection service has a vested interest in the programme, the outcomes of this study also provide insights into the development and enhancement of treatment for child offenders internationally.

Qualitative research methods were used in order to facilitate a detailed and in-depth exploration of the programme and accurately gauge the intricacies of staff perspectives. Data were collected from a series of semi-structured interviews with staff involved in the development, implementation and supervision of staff and processes as part of the programme as well as collating written documentation and forms pertinent to the implementation of wraparound.

With regards to its overall aim of deterring youth from transitioning from Care and Protection to the Youth Justice system, the programme was not a success. All of the young people involved in the programme had contact with Youth Justice at some stage (through admittance to youth justice residences or via court proceedings) or were being transitioned to Youth Justice by the end of the programme as they were turning 14 years old. Staff saw that this lack of behavioural change (indicated by continued offending) was due to the programme coming too late in the children's lives and that there had not been enough time to coordinate interventions to effectively treat the complex presentations of this group, due to the size of

the social workers' caseloads and the lack of a liaison person with the Ministry of Education. This complexity also proved challenging from a knowledge point of view, where staff felt like they were not resourced enough to effectively address these issues. They were extremely appreciative of the trainings and the increased knowledge in the area of child offending but felt like they needed more time to consolidate this learning in order to then put it into practice clinically. In this way, just one year of programme operation was not enough for the children, their families or the staff to build an alliance strong enough to evoke behavioural change. However, what was achieved by the programme was a catalyst for a programme with even better processes being implemented in the future.

The successes of the programme were in the relationships that were built between the staff and the children and their families. These relationships were characterised by a trust and mutual respect which resulted in a far less adversarial attitude from families and young people and a far more compassionate and understanding view of children's behaviours and family circumstances from social workers. Consequentially, families and young people were more open and willing to engage and were beginning to show motivation and an interest in interventions that the programme offered. This was significant to staff because they were familiar with having to battle against the negative reputation of being a professional that worked for Child Youth and Family and how that was a barrier to implementing effective interventions because of the scepticism and lack of trust. This was especially so for these families who had had long and, in most cases, intergenerational involvement with social services. For the young people, this translated into more curiosity and willingness to engage in prosocial activities and comply with plans set in place together with their social workers, which in some cases led to some behavioural change.

Behavioural change was not, however, maintained across the year due to broader systemic issues such as lack of interagency collaboration, specifically from the Ministry of Education and staff in the area that work with these children, under-resourced social workers, high caseloads and a risk-focused attitude which meant there was less time for focusing on behavioural change towards prosocial activities and school engagement. Over the course of the year, the social workers' caseloads became overwhelming, to the point where they were not able to adhere to wraparound principles and processes with high fidelity. At a systemic level, staff found it difficult to engage with other services involved in the overall wraparound plan for these young people and their families. Psychological assessments, individual and family therapy, and educational involvement, in order to re-engage in schools, were difficult to put in place due to differences in mandates, referral criteria and availability of resource.

This led to behaviour change being sporadic and not being consolidated in a therapeutic way that resulted in sustainable, prosocial involvement. Overall, the programme was seen as a step in the right direction of changing young people's and families' experiences of statutory agencies by shifting attitudes and developing trusting relationships that were no longer characterised by a vast power imbalance. The general consensus was that children and their families required more time in the programme for this relational change to translate into a behavioural one, and that plans and interventions developed needed to be robust and committed to by all stakeholders, in order to ensure that behavioural change was maintained and generalised to different contexts in the lives of the young people.

Key Findings

This section will discuss the implications of the key findings outlined above and their relationship to current research in this field. It will describe the nature of the issues that were raised by participants in the study and explore the relevant literature and processes being employed around the world in order determine how best to address these issues.

We do not fully understand the psychological profile and needs of this group of children

The adverse backgrounds which these children have experienced were detailed earlier in Chapter One and these were realities that all staff were aware of. However, many gaps remain in our knowledge of their unique psychological, cognitive and emotional profiles, particularly of those children who offend at severe levels at young ages. Specifically, there is a lack of understanding of how early childhood adversity impacts on these fundamental processes which influence how a child views themselves and their role in the world. This leads to interventions that are useful at some level but potentially miss crucial elements of a child's presentation beyond antisocial behaviour.

In recent years, conceptualisations of antisocial behaviour have focused on the presence of callous-unemotional (CU) traits, which refer to children presenting with shallow emotions, use of others for their own gain, egocentricity and a lack of empathy and guilt. This line of research has proven to be promising in distinguishing between different groups of children with severe conduct problems to the point of being included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA 2013) as part of the diagnostic criteria for Conduct Disorder. This group presents with a unique

emotional, cognitive and social risk profile (see Frick, Ray, Thornton, and Kahn, 2014, for a comprehensive review). Social workers in the programme did not have access to this knowledge or other typologies of child offenders or the psychopathology they present with. Given the lack of psychologists in frontline teams, it is vital that social workers receive training on these classifications if interventions are to be given the best chance of succeeding.

The ever-growing research base and new developments around children who offend point to the need for interventions to focus beyond the problematic behaviours of a child and to take into consideration the environmental and developmental factors that contribute to their entrenchment (Caldwell & Van Rybroek, 2013). Therefore, multimodal approaches are needed that extend beyond purely behavioural or psychological interventions and include educational, cultural, medical and speech and language therapies (as part of MST and MTFC, for example), issues which are often seen as on the edge of offending but can be important contributing mechanisms towards childhood antisocial behaviour.

It was difficult to work together with other services to achieve young people's goals or do what was clinically indicated

A major barrier to implementing a high-fidelity wraparound approach for this group of young people was the difficulty engaging with and enlisting the support of other agencies. Social workers were constantly confronted with restrictions on the conditions for children to be involved in each agency. They suggested that due to services not adequately meeting the needs of these young people, services needed to show flexibility rather than looking for reasons for exclusion. Participants commented that this was a function of services operating under different mandates and funded via different streams which resulted in plans not fitting between agencies. This indicates that change is required at a governmental level to make agencies more conducive to working collaboratively to reduce the silo effect commonly experienced.

Education needs

One of the instances where staff noticed this gap was in the provision of educational services in attempts to engage children back into school or alternative education. Research suggests that those who are engaged with Care and Protection services do not meet the same educational standards as their peers, progressing slower through education and achieving fewer qualifications (Gharabaghi, 2011; Zeller & Köngeter, 2012). This can be a result of multiple disruptions through different living situations in different areas as well as

neurodevelopmental delays caused by brain injuries or mental health difficulties (Gharabaghi, 2011; Zeller & Köngeter, 2012). Staff commented on how neurodevelopmental and mental health difficulties posed significant challenges because it was difficult to find professionals who were able to provide neuropsychological testing due to conflicting mandates and young people not meeting the criteria for that service. This meant that the underlying causes of lack of engagement in school were not addressed which then meant that children were also unable to engage with educational services that would reintegrate these children into school. This was significant because school was a means by which these children were able to have contact with prosocial peers or at least peers their age, were occupied physically and mentally and had a sense of purpose and belonging. Given that this was not facilitated as ideally as possible, it meant that any intervention or plan the team put in place had transient effects due to processes of wraparound not necessarily coming to fruition. Ideally, services would be streamlined in a way that allowed for collaboration where a young person has one plan and different organisations provide the services that are needed as part of this plan. Instead, there was a process of having to change and develop a new plan every time a referral or placement didn't eventuate.

Continuum of Care – Kibble Education and Care Centre

'Continuum of care' is a system which remains engaged with families and guides service users through the services over time that are appropriate to their stage of development. Engagement fluctuates in intensity as opposed to service users dropping in and out of services or changing between different ministerial organisations. Scotland's Kibble Education and Care Centre (Kibble) is an example of this being done at a high-quality level internationally (Kibble, 2015). Their approach is one that takes into consideration that there is a wider continuum of care involved, a fundamental childhood trajectory that all children are on, part of which involves offending for a subset of young people. This framework provides potentially valuable insights on how the New Zealand care and protection system could be more coordinated to match the natural development and trajectories of children's lives.

As part of this continuum, Kibble offers numerous and varied treatment modalities and settings. They provide secure residences for young people who are at risk to themselves or others, residential or day services, intensive fostering and education and youth training. Importantly, all of these services are integrated to ensure that regardless of the different treatment setting a young person has access to the full range of resources, including supported transitions between stages of treatment. Kibble also offers a range of programmes

that are integrated with care and education to enable young people to access the treatments that fit their specific, unique needs. These are primarily run by psychologists, social workers and family and programme workers who are proficient in work relating to trauma, emotional regulation, anxiety management, antisocial behaviour, social skills and suicidal and self-injurious behaviour. Their interventions include an offending programme which addresses criminal behaviour via a focus on moral beliefs, awareness of victim perspectives and consequential thinking. This programme has shown positive outcomes in reducing frequency and severity of offending and produces changes that are maintained over time (Glasgow Youth Justice Programmes Team 2008). Anger management programmes are also available which address the use of violence towards others and controlling anger by understanding the consequences of anger that is expressed uncontrollably, calming techniques and self-management to resolve conflict effectively.

Staff observed that an opposite approach was taken for children who offend in New Zealand. They commented that increasing severity and frequency of offending resulted in services disengaging and young people being separated from family, peers and communities. Besides the immediate negative outcomes of isolation and alienation, staff commented on how this process tends to foster antisocial attitudes, where children who offend see themselves as separate to society, something that further hinders prosocial engagement and reintegration into society. Integrating aspects of Kibble, for example, would set a mandate for child offending not being something that isolates children from their peers but something that requires extra attention and resource, while maintaining the fundamental services of health, education and social services that all children require.

Engagement and a strong relationship between services and families is a prerequisite for behavioural interventions/change.

The most noteworthy and crucial success of the programme was its impact on the relationship between professionals and the young people/their families. This was significant because it is consistently seen that a prerequisite to behavioural change is that the therapeutic relationship is a pivot on which professionals are either trusted and interventions adhered to or rejected, and interventions dismissed.

Despite its importance, the staff involved in the study noted that they had very little training in engaging with families and young people in a way that positioned them as agents of change as opposed to statutory professionals. They noticed that this approach was one that

had caused an expectation from families about statutory care and protection workers of being harsh, punitive and were only there to remove their children from their custody and not that they had the best interests of the family at heart. Understandably, changing this attitude was something that took considerable effort and skill, which staff did not always know how to approach. The motivational interviewing training was experienced by staff as a positive and useful experience to have towards setting up a working alliance with mutual respect, engagement and collaboration at its core. However, the impact of this relationship on behavioural change and how to maintain this relationship while simultaneously adhering to statutory mandates and roles was an ongoing challenge for staff over the year the programme was implemented.

Research on the therapeutic or working alliance between professional and service user defines it as the collaborative relationship that develops between a service user and their professional of whatever discipline in order to facilitate change (Horvath & Luborsky, 1993); in this case, psychological and behavioural change. This alliance is thought to be the combination of three core elements: a joint agreement of the goals of therapy, collaboration on the plan and means towards achieving these goals, and a relationship characterised by trust, respect and safety which enables self-exploration and personal development (Florsheim et al., 2000). Staff characteristics of genuineness, acceptance and empathy have also been shown to be associated with the development of a strong therapeutic alliance (Miller & Rollnick, 2012).

A strong alliance has been shown to result in decreased session conflict (Diamond & Liddle, 1996), improved parenting practices and increasing the engagement of young people reluctant to participate in treatment (Diamond et al., 2000). Studies have also shown that therapeutic alliances predict retention in functional family therapy (Alexander et al., 2000; Robbins et al., 2003). This literature validates its inclusion as a core part of wraparound principles and processes and was one of the reasons why wraparound was chosen for this group.

The children needed to be in the programme at a younger age

Staff recognised that the young people's offending behaviour and antisocial attitudes were well developed and were already starting to become resistant to change because of the increasing influence of antisocial peers and family members. They suggested that children be identified and treated earlier in their lives when they are more connected to prosocial

networks, more open to a different way of behaving and are cognitively and emotionally more malleable. This requires a more in-depth knowledge in order to identify and acknowledge early indicators of behaviour and know what the evidence-based interventions are for this younger group of children. This is also true of families who, with more time in the system, become increasingly disenfranchised and problematic family dynamics become more entrenched and pervasive. As a result, it is also important that future services have robust preventative models of care before and during first contact with these families.

Longitudinal development and offending trajectory research suggests that problem behaviour can be identified as early as 3 years old (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). As stated previously, those who begin antisocial behaviour at early ages tend to continue to commit offences throughout adolescence and adulthood (Fergusson, Horwood, & Lynskey, 1995; Moffitt & Caspi, 2001; Moffitt et al., 1996) as opposed to those who commit their first offences later in adolescence (Fergusson et al., 1995; Jaffee, Belsky, Harrington, Caspi, & Moffitt, 2006; Loeber & Farrington, 2000). One of the main mechanisms for this early development of antisocial behaviour is early parent-infant interactions and environments that are characterised by abuse, neglect and lack of parental supervision (Moffitt & Caspi, 2001; Tremblay, 2010). In order to change these trajectories, research suggests that early intervention and preventive strategies be targeted for children born with biological problems, children born to teenage parents (Woodward & Fergusson, 1999), children born to parents who are unable to interpret the needs of their child through the child's expressions of distress (Fergusson et al., 2007), children born into families with historical mental health, behavioural or substance abuse issues (Fergusson, Boden, & Horwood, 2008) and finally children who are living in poverty and neighbourhoods that experience high levels of violence and crime (Fergusson, Horwood, & Lynskey, 1994; Rutter & Sroufe, 2000).

Various services have been implemented under the premise of keeping in contact with families who present with these risk factors in order to identify early problems through regular screening and assessment. These services include antenatal services for families with children under the age of 4, screening for developmental problems in children and facilitation of referrals to service providers responsible for family and community-based providers (Fergusson, Horwood, Grant, & Ridder, 2005). For infants and parents who experience difficulties requiring more intensive psychological or developmental interventions, there are a number of evidence-based therapeutic interventions for the 2- to 6-year-old age group. These include: Parent-Child Interaction Therapy (PCIT) (Herschell, Calzada, Eyberg, & McNeil,

2002; Matos, Torres, Santiago, Jurado, & Rodríguez, 2006) which is a short-term behavioural intervention for children who present with a range of behavioural, emotional and familial interaction difficulties; and Child-Parent Psychotherapy for Family Violence (Lieberman, Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ippen, 2005) which is an integrated approach using psychotherapeutic, social learning and behavioural techniques for young children who have been victims of violence as a precursor for more intensive PTSD interventions.

These services provide a framework for care and protection services to include a targeted intervention from infancy to have more time to address problem behaviour before it reaches the severity of the offending behaviour shown by the children in this programme. They also provide the opportunity to intervene at a family level before dysfunctional dynamics and patterns of interactions become entrenched, using the resource of family during a time when children are more developmentally dependent on them. These prevention and early intervention strategies are ways that the gap between Care and Protection and Youth Justice systems in New Zealand can be mitigated; by having a cohesive organisation that tracks children across different life-stages.

Social workers did not have enough time, training and supervision to effectively implement the programme

Social workers involved in the operation and delivery of the programme as well as their managers and supervisors all commented on how restricted they were by the amount of people they had on their caseloads, the lack of opportunities for training and emotional support for what is an incredibly difficult job. All the staff spoke about believing in and feeling excited about the programme but were disappointed that they were not able to deliver it with the high fidelity that would have brought its potential to fruition for these families.

Research on professional quality of life has included explorations of compassion fatigue (Figley, 2002), often seen as vicarious trauma; burnout fatigue caused by discouragement and hopelessness in response to work or systemic environments; and compassion satisfaction (Stamm & Goto, 2002) which is the experience of positive emotions associated with doing effective and meaningful work. These aspects of professional quality of life have been shown to impact on the quality of decision-making and relationships with service users (Conrad & Kellar-Guenther, 2006; Huggard, 2003; Killian, 2008) as well as job satisfaction and retention (Bride, 2007; Sprang, Clark, & Whitt-Woosley, 2007). A

probability sample of 1000 social workers showed lifetime burnout rates of 75%, while 36% reported burnout at the time the study was conducted (Siebert, 2006), which are deeply concerning figures.

Staff as part of this programme noted that the work they were being asked to do was harder than any work they had done previously because of the high complexity of these young people and their families and the increased workload as a consequence. They spoke about appreciating the supervision towards this end, as it allowed them to focus and prioritise the aspects of clinical situations they were able to control and receive emotional and practical support for aspects they could not, a challenge which is also shown consistently in the literature (Vázquez & Hernangómez, 2009).

They also recognised that the work was made harder by having to learn new skills and techniques while they were applying them, due to time and resource pressure. They reported that it would have been more effective to receive additional and ongoing training that refreshed concepts and went into more depth about how to put theory into practice. Given the complexity of this population, it is essential that the staff working with this group be trained in family therapies, behaviour management skills teaching, basic cognitive behavioural therapies, motivational interviewing and how to engage and work with these families in a trauma-informed manner, as well as ongoing training and consultation on how to effectively work with Māori and Pasifika people. Supervision is also vital to staff feeling well-supported, appreciated and to reduce the frequency of burnout and staff turnover. Staff turnover can worsen the sense of abandonment and disruption these children feel, further exacerbating attachment issues prevalent in child offending populations and also having an impact on the consistency of treatment. It is also crucial for the inherently demanding roles and allows staff to maintain a high standard and develop their clinical work further (Church, 2003). However, while the content of the trainings and supervision is important the process of teaching and disseminating this knowledge in palliative way is important. That is, the question of ‘how do we learn new skills as professionals?’. This question is especially pertinent when considering the future of this programme or programmes like it. Additionally, it is important to reflect on the ways in which we can increase staff uptake of these new skills and ways of practicing.

All professionals working with the young people and families in this programme were held accountable for continuing professional development to maintain high-quality practice which is reinforced by registration procedures (Friedman & Phillips, 2004) as well as performance reviews. Research on how professionals learn new skills maintains that learning through experience, reflection on practice and learning that is contextually mediated are key

factors (Day, 1999; Garet et al., 2001; Lieberman & Miller, 2008). The seminal work of Kolb (1984) suggested that the core of learning from experience is more than a passive involvement in day-to-day activity but rather a cyclic process of active engagement in experiences, observation, reflection and formulation of these observances. Reflection is key because it is a process of questioning assumptions (Garrison, 2006) which is key to transformative learning.

Recent conceptualisations of professional learning have moved away from 'training',which provided on specific topics for a defined amount of time, to notions of professional learning that is continuous, active and related to practice (Garet et al., 2001; Wilson & Berne, 1999). The existing literature points to several factors that contribute to a reluctance to change including bureaucratic processes (Sandholtz & Scribner, 2006; Wood, 2007), time pressure and work stress (Hargreaves, 2003; Hochschild, 1997) and fear of change in unstable environments (Fullan, 2003; Hayward, Priestly & Young, 2004).

The difficulty staff experienced with learning and implementing a new approach reinforces this research base on professional learning. Trainings were held at the start of the programme and supervision involved a self-reflective component, however this reflection being based on practice and not the process of learning and implementing new skills. For this reason, future iterations of this programme should embed ongoing dynamic learning throughout the course of the programme as opposed to discrete trainings with a beginning and end. Factors that inhibit learning such as work stress, bureaucratic processes or fear of change should be kept track of in supervision and spoken about in an open and constructive way that enables these issues to be navigated effectively without deterring from the goals of the programme.

Conflict between responding to crisis and working towards treatment goals

A preoccupation with managing risk was described as getting in the way of spending resources on behaviour change and therapeutic engagement with young people and their families. Staff recognised the risk policies and procedures as vital to Child Youth and Family's role as statutory agency that is mandated to keep the children under their custody safe, but these approaches came with a diminishing rate of return. They called for a more balanced view of risk that took into consideration the chronic risk of these young people and families; acknowledging that while it was an immediate concern and one should never be

complacent or get used to risk occurring, it should not be a distraction from the ongoing plan for the family. The main area of risk staff referred to was absconding from out-of-home placements which more often than not led to offending. The practice guidelines and policies that outlined staff's response to this called for finding the children and then moving them to another placement. What eventuated was a process of finding the children a placement and then disengaging until something went wrong in that placement. This was primarily due to the social workers having other children on their caseload that were not part of the programme and therefore they could not give these children ongoing support while they were in a placement. The result was a reactive as opposed to a responsive way of practising.

When examining the literature on absconding, it is obvious why services are concerned with the safety of children when they run away from placements. At that age, children lack the ability to protect or provide for themselves (Guest, Baker, & Storaasli, 2008). This leads to an increased risk of physical and sexual assault (Kim, Chenot, & Lee, 2015), mental health issues (Dalley, 2010; Dobek, 2006; Guest et al., 2008) and developmental consequences due to school and social disruption (Crosland & Dunlap, 2015; McIntosh, Lyons, Weiner, & Jordan, 2010). Most importantly for this population, absconding has consistently been shown to be associated with antisocial behaviour including offending and substance use (Finkelstein, Wamsley, Currie, & Miranda, 2004; Hyde, 2005).

There are many variables that contribute to absconding behaviour; the ones most commonly seen by the staff involved in the programme were due to placement history and instability, family factors, peers and boredom. These children had experienced a large number of placements and separations from their homes, which has been shown to increase the risk of absconding compared to those who have had fewer placements (Kim et al., 2015; Lin, 2012). A key mechanism seems to be that young people who feel there is less chance that they will be reunited with their family are more likely to abscond than those who expect this to happen in the foreseeable future (Kim et al., 2015). Boredom was another aspect of placements that staff observed to be contributing to the likelihood of children absconding, with young people commonly absconding to the city centre (Biehal & Wade, 2000), towards more excitement and freedom, or to home where they had siblings and peers to spend time with. Staff also commented on youth who would commonly go home because they missed their family, siblings or friends. This remained an unsolved issue in the programme because while wraparound principles advocated for family voice and choice, in many cases these children's family situations were dysfunctional and it was a constant process of weighing up the costs of spending time with family (and the potential for antisocial influence) or the

benefits of feeling connected to one's family, regardless of dysfunction. In this way, the management of risk became difficult as they were required to adhere to the statutory requirements of responding to risk which were sometimes contradictory to wraparound principles or the goals that the young person and family had for themselves.

Internationally, therapeutic crisis intervention is a model that is used to solve such issues where staff to respond to crisis in a developmentally appropriate manner that is in line with therapeutic goals and processes. Staff trained in therapeutic crisis intervention interpret young people's aggressive behaviour as an expression of underlying needs that they are not able to express in other ways. This allows professionals to respond to this need rather than expressing defensiveness or counter-aggression in response to the young person's behaviour. Strategies thought to be useful include active listening and environmental management that is conducive to de-escalation. Despite being a mode that is primarily used and has been shown to be effective in secure residences (Leidy, 2003), therapeutic crisis intervention provides a relevant model for how crisis could be responded to as an organisation; an approach where physical safety as well as the goals of treatment are considered equally.

Strengths and Limitations of this Study

The strengths of this study lie in the involvement of multiple professionals working with this unique population. The perspectives across the disciplines of social work, service management, programme development, clinical supervision, clinical psychology and educational psychology as well as advisory roles allowed for a multifaceted view of the programme's operation, successes and shortcomings that did not bias the views of a particular discipline. This view allowed for a range of implications and recommendations to be drawn from the data that have the potential to impact on individual, professional and systemic levels.

Another strength of the study is the in-depth focus on the programme and its implementation but also a broad systemic focus that looked forward to what could be done differently if this programme were to be done again, and if not, what would be the characteristics of a programme that would follow. In this way, I believe a good balance was achieved: one that neither aimed to indulgently celebrate nor was overly defensive of the programme but placed due stock on it as a year-long endeavour that also held onto the emphasis of how to best serve the young people and the families that are entrusted into the care of statutory services.

Methodologically, the limitations of this study are those that arise from any qualitative approach, in terms of objectivity and potential bias of the researcher. My role throughout the process of implementation, documenting the procedures and outcomes of the programme had benefits in terms of being able to understand the enablers and barriers to success and an in-depth, first-hand experience of positive and negative outcomes but also had the potential to influence me in the interpretation of data. Despite my best efforts, it is possible that I may have paid selective attention to particular aspects of an interview which matched my own beliefs of the programme or were of interest to me. While complete objectivity is not achievable, it is my hope that the steps taken to ensure a reasonable level was attained, such as documenting my own subjectivity and experience, my awareness of my own preconceptions and biases and deliberately trying to achieve a balance between the positive statements and critiques made of the programme and the wider system, will be adequate enough for the readers to find the results credible.

Lack of generalisability and an inability to establish cause and effect relationships have also been highlighted as limitations of qualitative research. With regards to this programme, which involved a small group of staff, this project cannot be seen as representative of a wider population. Given that this was the first programme of its kind in New Zealand, a larger participant pool drawn from other services would not have the same insight and knowledge into the processes undertaken. While causal relationships cannot be determined from qualitative data, process evaluations are concerned with how programmes operate to assist in our understanding of the factors which contribute to the success and failures of programmes, rather than exploring linear cause-effect relationships in experimental designs (Patton, 2002). It is also regrettable that the voice of young people and their families could not be included as part of the interviewing process. Due to the transience and chaotic nature of children moving between homes, residential units and even cities, it became operationally difficult to obtain these data. I firmly believe, however, that future research should involve these perspectives as a vital insight into how the services we deliver are received by the targeted population.

Implications and Recommendations

The key findings described above should be examined within the context of this being the first dedicated programme for children who offend in New Zealand. In the introductory chapter, the term 'Crossover Children' was introduced. This group is one that has largely been ignored by children's services in New Zealand because of the complexity of their presentation and the fact that they simultaneously crossover between the Care and Protection and Youth Justice systems but also appear to slip between the cracks between these two systems just as easily.

Until now, as the complexity of these children's mental health, behavioural and environmental needs have become more multifaceted and their offending behaviour more severe, they have been given ever-decreasing numbers of options for their treatment. As time went on, the children involved in this programme met fewer and fewer criteria of available services, had fewer placements available, had fewer physical spaces in their community they were able to go to which did not have a trespass order against them and they were developing a reputation for being 'criminals' and 'problem children'. Ideally, it is the duty of child services to meet the needs of children as opposed to having to require the children to fit into referral criteria, mandates and funding streams. What this all amounts to is that there are not enough services in place for these children and in some ways the staff involved in the programme were fighting a losing battle due to the fact that they had such a high number of complex needs and few resources in place to address these effectively. The question still begs answering: *What can we do for children who offend?*

Staff spoke about needing more time to build on the impressive relational work they had done over the year. They recognised the importance and significance of changing the attitudes young people and their families held towards Child Youth and Family staff and how, in some cases, this allowed for mutual relationships that led to positive outcomes. The change in relationship caused by the programme's principles and case management processes cannot be understated. The experience of families requesting social workers to stay despite being out of area and sadness in response to social workers changing department was a testament to the progress made over the year. These young people and their families received a different experience of statutory care and received a service that would not have been possible without this programme and the team involved.

Despite this, the programme did not meet its goals of changing the trajectory for these children and despite fluctuations over the year there was not a net decrease in offending

behaviour. As a result, it is important to examine the ways in which the programme could be improved, based on what the staff observed. Due to staff responses switching between focusing on the programme and the system these recommendations are presented at programme and system levels.

How Can this Programme Improve?

Considering the relative successes and shortcomings of this programme outlined so far, it is important to explore how it can be adapted to reflect what has been learned from the year. If this programme was to be repeated and we were to learn from what was not successful during this round, the following concepts and conditions must be considered:

1) **Onsite supervision and training**

It is essential that supervision be a core part of the implementation strategy moving forward. Ideally, this supervision needs to be provided by a psychologist on site, due to the issues discussed above. This allows the staff involved in the programme to feel supported and guided in their clinical practice. Trainings should also continue as designed but with a different emphasis; focusing on practical application and issues as well as being refreshed on a regular basis to ensure that information provided is being retained.

2) **Evaluation and psychometric testing being an integrated part of day-to-day operation**

Testing on the cognitive and emotional profile of these children needs to be obtained to better understand their presentation. This could involve collating the tests that are already done as part of referral and assessment procedures and using them to plan interventions, or creating a new battery of tests, given the needs of these children as evidenced by research. In addition to this assisting with targeting interventions more accurately and knowing which services to engage for specific presentations, this would also increase our knowledge of this group in New Zealand. Much of the literature discussed in this report has been from overseas, which is useful but not necessarily generalisable to our society and culture, especially given the overrepresentation of Māori in this group.

3) **Being more structured and clearer in communication with families during early stages of the programme**

When creating initial plans for care it is important that families know what to expect. This was done to a certain extent in the programme but it was not done explicitly. As staff

described, family were confused in early stages as to why social workers were spending more time with them and the purpose of multiple visits. Setting this up in a deliberate way in the initial meetings would allow for engagement and planning accelerating and allow more time for later stages of the programme. Instead, staff experienced a prolonged engagement period which was not merely due to developing trust but confusion about what to expect from staff and what families and young people were expected to do themselves.

4) Collaborating with agencies earlier in the process of implementation

Similar to recommendation (3), outside services that are intended to be contracted to do parts of the intervention should be contacted earlier, rather than just the moment when they are needed. Wraparound processes indicate this is more effectively done in early stages when the care team is being formed rather than waiting to make contact when a young person or family need a specific service. This was not done in the ideal way due to balancing training, working cases that were not part of the programme and a number of other factors. This meant that outside agencies had not invested any resources into the programme at an early stage and were therefore not committed to providing services midway through the year, for example. Understandably, it is difficult to accurately plan into the future what a young person and their family may need, but taking the initiative in contacting the services typically involved and notifying them of a change in process and outlying their potential roles and responsibilities if involved would be useful. Systemic issues come into play here in terms of funding streams, services mandates and how logistically possible it is under these conditions to work collaboratively. These will be discussed in systemic recommendations below.

5) More explicit measurement of offending behaviour and targeting interventions on aspects of offending behaviour that are resistant to change

Behavioural outcomes over the year were intended to be measured using the behavioural tally questionnaire developed by Youth Horizons Trust but this was not completed consistently enough to be used as an accurate and reliable indicator of behaviour change. Instead, behaviour change was reported anecdotally which makes it difficult to draw definitive conclusions from. It is important that if this programme is to continue that changes in antisocial and prosocial behaviour be measured using reliable and validated psychometric tests. This will enable statistical analyses to draw causal links between programme operations and different behavioural outcomes. It will also be intriguing to explore whether relationship and attitude changes observed in this programme do indeed go on to influence behaviour change as the staff hypothesised they would.

How Can the System Improve?

This programme existed under the wider structures of the Care and Protection and Youth Justice systems. Due to the inevitability of systems driving process, it is important that the frontline work is reinforced by systems that emphasise and advocate for the same values. Thus, in order for this programme to exist in the way it needs to, and in order for it to adopt the above recommendations to be effective, it is important that it is supported by structures which complement it. The following recommendations are informed by the expert advisory panels commissioned to improve the services for all children in New Zealand (Ministry of Social Development, 2015) but also use the findings of this study to specifically target services for children who offend.

1) Place children's needs at the centre of all structures and processes

As made clear by this study and many preceding it, children and young people lack a voice at an individual and system level and have little advocacy or ability to enact change to services and systems. This is based on the philosophy that children are subject to risk and present to social services through no fault of their own. They are products of environments and caregivers who were responsible for keeping them safe, providing guidance and empowering them to achieve their potential. For whatever reasons, these circumstances did not eventuate in the ways they ideally should. However, there is also no service or agency that can replace the care a child receives from their family. Therefore, regardless of the relationship with a child's biological parents or wider whānau and hapū, these people are irreplaceable resources that should have some say towards what happens for their child. As part of the advisory panel report, a small group of young people were interviewed about their experiences of services in the care and protection system, with the main themes being: wanting more nurturance and love, wanting a say in what happens to them, wanting to make sense of traumatic experiences, strengthening cultural identity, wanting guidance and nurturing beyond the age of 17 and craving a sense of belonging in a family that cared about them.

In cases where the above is not possible through placements with immediate or extended family, these factors need to be a bottom-line for foster and residential care arrangements. This is essential towards this sense of belonging and the irreplaceable feeling of a place to call 'home'. This, along with facilitating opportunities to hear the voices of the young people and their families (and to do so in a genuine way that is followed through), should be core of future services. Enabling advocacy on individual and systemic levels for a

young person's involvement in the design and governance of programmes is essential to maintaining a collaborative and empowering professional-service user relationship that has their best interests at heart. While this was the main focus of what this programme tried to do, it was not supported by other agencies or the wider Care and Protection structure and was therefore unable to sustain this approach.

2) Adopt a longitudinal, consistent approach for all children that does not isolate or alienate those who offend

It is important to maintain the interventions that target current problem behaviours and risk but also acknowledge the long-term influences on these children and how to change trajectories of these children and their families. This is pertinent to this study with regards to staff perspectives on being restricted by the incident-oriented, short-term focus on safety rather than long-term wellbeing. This change in approach would require comprehensive knowledge of the wellbeing and needs of children and families and risks across their lifetimes, as well as the nature and effectiveness of services that are required to meet these needs. This approach would be one that does not separate children who offend from their peers for the purposes of treatment but rather a unique offending pathway be provided in addition to services that are available for all children who are struggling in various facets of their lives.

Given that the majority of children presenting to social services are of Māori and Pacific descent, it is also important that future services have a strong commitment to these groups under the mandate of investing in all children. This can be done on both family and systemic levels, providing services that are culturally appropriate and relevant to cultural understandings of childhood behaviour problems and family dynamics and also at broader levels of addressing socioeconomic disadvantage and inequality that cause the overrepresentation within statutory services.

3) Adopt a professional practice framework appropriate for the needs of these families

As stated previously, children involved with Child Youth and Family are characterised by histories of high levels of trauma and general adversity in their lives for prolonged, sometimes multi-generational, periods. To my knowledge, there have been no significant, systematic approaches within statutory services to develop evidence-based

interventions and services that address the impact of trauma. This leads to systems that do not meet the needs of the children they serve and staff who are not trained to effectively work with this important aspect of a child's presentation. Being in foster care is also associated with re-traumatisation through removal from their family home, multiple placements with foster parents, group homes, and residential units and, as a result, an ever-changing school environment and peer group (Finkelhor, Ormrod, Turner, & Hamby, 2005; Halfon, Zepeda, & Inkelas, 2006). Although professionals are aware of the rates of trauma, they do not have the clinical experience or theoretical training to have a comprehensive understanding of the impact it has on children's emotional and behavioural response to stress (Taylor & Siegfried, 2005). In youth justice systems, trauma going unaddressed risks an exacerbation of antisocial and risky behaviour which becomes chronic and results in adult criminal justice involvement.

In care and protection settings, it is becoming increasingly vital to evolve into a trauma-informed system. But the mandates of keeping children safe and preventing offending tend to overshadow the importance of long-term mental wellbeing as a precursor to these outcomes. However, being guided by attachment theory (Mennen & O'Keefe, 2005), child welfare services have a duty to protect children from both immediate danger and long-term negative outcomes.

4) Enable strategic collaboration between services to reduce professionals working in silos

Service delivery in its current form, as evidenced by staff perspectives in this study, is not malleable and robust enough to meet the needs of this population. The experience of working in isolation is restrictive, does not allow for creative and innovative strategies and inevitably leads to burnout and risks of unsafe practice due to stress and fatigue. Diffuse responsibilities across multiple systems also impacts on how risk is managed, information is exchanged between services and the ability for joint treatment planning.

The Modernising Child, Youth and Family Panel (2016) proposed a framework that operated on two levels: a system level that underlies the philosophies and engagement of all agencies working with children and families coming to the attention of social services, with shared views on best practice and goals, and a department-level framework that defines agency-specific responsibilities that align with the system-level common set of values and principles.

Conclusion

This research aimed to evaluate processes and procedures of New Zealand's first child offender treatment programme. The findings from this research provide a valuable insight into the experiences of the staff who were responsible for the implementation and operation of the programme as well as the staff whose role was to provide clinical oversight and guidance. Responses covered a range of successes and shortcomings of the programme and the system in which it existed. It highlighted the need for more attention to be paid to this group because of their highly complex needs and the inevitability of poor outcomes if these needs are not addressed. At a programme level, they spoke about the noteworthy relational changes that occurred between staff, young people and families and how this symbolised an opportunity for interventions to be delivered collaboratively. On the other hand, they also noted that these children required more intensive treatment from earlier in their development or for preventative measures to be taken in infancy. At a systemic level, they urged higher levels of management and governance to address resourcing issues by lowering caseloads, providing specific training and ongoing supervision for these difficult roles and responsibilities. These findings have important clinical implications for child offender treatment in New Zealand and it is hoped that this project will form the basis of replicating and tailoring this intervention to become increasingly effective towards reducing offending and improving long-term outcomes for these children and their families.

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