Youth Justice Secure Residences:

A report on the international evidence to guide best practice and service delivery

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MINISTRY OF SOCIAL DEVELOPMENT
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Published May 2016
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ISBN: 978-0-478-32396-2 (online)
ISBN: 978-0-478-32399-3 (print)

Acknowledgements

We would like to thank Nova Salomen, General Manager, Residential, High Needs and Care Services, Monique Tupai, Project Manager, Ken Hand, Principal Analyst, Child, Youth and Family, Principal Youth Court Judge Andrew Becroft, and Professor Angus Macfarlane and Dr Sonja Macfarlane, University of Canterbury, for their assistance in the preparation of this review.

A list of the people who were interviewed and consulted as part of this review is presented in Appendix A.

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In 1999, Ian was awarded the student prize from the Association for the Treatment of Sexual Abusers - ATSA (the largest international organisation for professionals working in the field of sexual offender research and treatment) for his doctoral research on resiliency in male survivors of sexual abuse. In 2001, Ian was the youngest recipient ever to receive the New Zealand Psychological Society Public Interest Award for his longstanding community work with adolescent sexual offenders in New Zealand. In 2006, he was awarded the Ann Ballin Award from the New Zealand Psychological Society for services to clinical psychology in New Zealand. In 2011, Ian was awarded the William Friedrich Memorial Child Sexual Abuse research and treatment award from the American Institute on Violence, Abuse and Trauma for his work on childhood trauma.

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Executive Summary

Young people admitted to Child, Youth and Family's (CYF) youth justice secure residences are some of New Zealand's most vulnerable and challenging. The main function of these residences is to provide a response to when a judge decides that a young person is unsafe to live in the community. Young people may be detained in one of CYF's youth justice secure residences under the following orders of the Youth Court: s235 (Arrest), s238 1(d) (Remand), and s311 (Supervision with Residence) of the Children, Young Persons, and Their Families Act 1989 (CYPF Act). In addition, a minority of young people sentenced by the District or High Court to a term of imprisonment under the Corrections Act 2004 may be placed in a youth justice secure residence on the basis of their age, gender, and assessed vulnerability. Secure residential care is a highly specialised environment at the most intensive and institutional end of the continuum of services available to children and young people in need of CYF intervention.

The four youth justice residences in New Zealand provide secure residential care to young people who are generally aged 14 to 17 years and deemed to require such care. The purpose of these residences is to provide a secure and safe environment for young offenders, support community safety, and, where practical, address drivers of offending behaviour. In addition, there is also a need to address the underlying difficulties and needs of the young person.

This report reviews the international and national evidence-based literature regarding best practice and optimal service delivery in relation to secure residences and the wider continuum of care for the youth justice population in New Zealand. CYF commissioned this report in December 2014 as an input into on-going work to ensure that CYF's youth justice secure residences provide the best possible care that helps improve outcomes for these young people while operating as cost-effectively as possible.

This report is one of two reviews commissioned by CYF regarding the international and national evidence-based literature concerning best practice and service delivery for CYF secure residences in New Zealand; the second report outlines literature and best practice in relation to the care and protection population in secure residential care. Although these reviews are presented as separate reports, given the similar backgrounds, and needs of the care and protection and youth justice populations, there is cross-over in the content presented.

The youth justice population in New Zealand presents with a range of complex needs, and the youth justice system is complex. As such, this report has not set out to provide a comprehensive overview of all aspects regarding this population and its service needs. Instead, this document summarises key conclusions and understandings from the national and international literature and evidence-based practice regarding the youth justice population in secure residential care.

These reviews were written with the philosophy in mind that the population of young people in secure residential care are a vulnerable group that we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care, based on the literature and evidence-based practice presented in this report so that current service provision can be enhanced, thereby promoting the best possible outcomes for this population, their families, and the community.

Terms of Reference

This report is guided by several Terms of Reference. CYF requested a synthesis of the expert and evidence-based literature about current best practice in relation to:

1. When secure residential care is appropriate and necessary for young people with offending needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of young people to similar sorts of secure youth justice residences in other jurisdictions.
2. The right mix of services within youth justice secure residences that would:
    a. improve short and long term outcomes and
    b. ensure a safe and positive residential environment for children/young people and staff.

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

3. The optimal service delivery model for youth justice secure residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes.

We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.

4. Effective social work transitions into and from youth justice secure residences so that young people are well supported when leaving and returning to the community.
5. Whether New Zealand's youth justice secure residences should cater for all those under seventeen years of age who require secure residential care. One issue we wish to consider is whether those aged less than 17 years of age and who are sentenced to the Corrections system should instead be placed in Child, Youth and Family youth justice residential care.

Subsequently, the Terms of Reference were extended to include:

6. Commentary on residences as a "service", as part of a continuum of services.
7. Using the time a young person spends in residence to inform the next steps (i.e., use of assessment and the appropriateness of each assessment model, programmes and interventions).
8. A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry of Social Development. This should include, for example, forensic mental health facilities and examples of other youth justice interventions, such as the Military-style Activity Camp (MAC) programme and community-based programmes. This should include:
    a. The model used
    b. The staffing arrangements
    c. The kinds of clients and their needs
    d. The intervention programme offered
    e. Information on the physical restraint approaches used, and if not used please explain why.

Method of Data Collection

To meet the briefs and objectives for the youth justice residences literature review, information was primarily sought from two sources: (1) national and international literature; and (2) interviews with experts in the field of youth offending and conduct problem behaviour.

1. Literature was searched for using internet search engines (e.g., Google, Google Scholar), electronic databases available through the University of Auckland library (e.g., PsycINFO, ERIC, MEDLINE), and published content from relevant organisations such as the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the U.S, as well as documents and reports from CYF. Publications were restricted to include those published in English.
2. Interviews were conducted with national and international experts in the field of youth offending and conduct problem behaviour. People interviewed or consullted as part of this review are listed in Appendix A.

The reviews were compiled documenting the evidence base, providing an overview of findings from the literature and interviews conducted, and outlining what "works best" with regards to the best practice and optimal service delivery of secure youth justice residences.

Review Structure and Summary

This report is separated into three parts, with each part comprising several chapters:

Part A: The Youth Justice Population and Secure Residential Care in New Zealand

Part A sets the context for the review, and comprises three chapters:

- **Chapter One:** overview of the youth justice population in secure residential care in New Zealand
- **Chapter Two:** overview of the New Zealand youth justice system and governing legislative and regulatory framework in which youth justice secure residences exist
- **Chapter Three:** overview of the youth justice secure residences in New Zealand.

Part A discusses the myriad of difficulties and negative life experiences among the youth justice population in secure residential care. With regards to physical health, the main problems presented among young people residing in CYF secure residences are asthma, skin problems, and sexual and dental health. In addition, those in the youth justice system have a greater prevalence of psychiatric and substance abuse issues compared to their peers in the community. Experience

of trauma, including abuse and neglect, is also common. Furthermore, internationally, young people in residential care are often behind their peers with regards to educational achievement. In New Zealand, many young people in CYF secure residences have left education prior to admission, and 80% of those in CYF care leave school with less than Level 2 NCEA qualifications.

This population are some of the most vulnerable and at-risk young people in New Zealand. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care to best address the needs and improve outcomes for this population, their families, and the community.

Part B: Secure Residential Care: National and International Research and Best Practice

Part B provides an overview of the national and international research and best practice regarding services for the youth justice population, and comprises the following chapters:

- **Chapter Four:** overview of international youth justice systems and continua of care
- **Chapter Five:** frameworks to guide secure residential youth justice services
- **Chapter Six:** models for secure youth justice residential care
- **Chapter Seven:** 'step-down' care models for the youth justice population
- **Chapter Eight:** assessment for the youth justice population in secure residences
- **Chapter Nine:** therapeutic models for the youth justice population in secure residential care
- **Chapter Ten:** cultural models and considerations
- **Chapter Eleven:** education programmes and approaches
- **Chapter Twelve:** crisis management, including de-escalation and non-violent methods of intervention with young people in youth justice residences secure
- **Chapter Thirteen:** addressing the needs of the client types in youth justice secure residences
- **Chapter Fourteen:** transition from youth justice secure residences and aftercare.

Part B classified each framework, model, and rehabilitative programme examined by the report into seven groups, based on their current evidence of effectiveness[1]. The rating scale used to evaluate the evidence of each framework, model, and rehabilitative programme was based on the California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale[2]. The California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale was chosen for this summary review due to its international reputation, ease in usage, and breadth of criteria.

The rating scale (in brief) is as follows:

1. **Well-supported by research evidence**

   These were frameworks, models and/or rehabilitative programmes for which there was strong evidence of efficacy, i.e., two or more published, peer-reviewed rigorous randomised controlled trials (RCTs), with multiple site replication and follow-up (< 1 year post-treatment).

2. **Supported by research evidence**

   These were frameworks, models and/or rehabilitative programmes that had good evidence of efficacy i.e., one published, peer-reviewed rigorous RCT, with multiple site replication and follow-up (< 6 months post-treatment).

3. **Promising research evidence**

   These were frameworks, models and/or rehabilitative programmes that have evidence of efficacy; however, the evidence-base does not include a rigorous RCT, i.e., one published, peer-reviewed study utilising some form of control group.

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1 Please note that a number of models, frameworks and rehabilitative programmes identified in this review are from jurisdictions where sentences in custody are substantially longer than in New Zealand. In New Zealand, young people are detained in secure youth justice residences for a shorter period of time, aligning with the standpoint that young people have limited perspectives on time and consequences. In residence, treatment/rehabilitative options should be made available; however, young people should not receive disproportionate sentences so that they can receive rehabilitative/treatment.

2 More information is available at: www.cebc4cw.org/ratings/scientific-rating-scale

3a. Promising research evidence among comparable youth populations

These were frameworks, models and/or rehabilitative programmes that have good evidence of efficacy i.e., one published, peer-reviewed rigorous RCT among non-youth justice populations who have behavioural and/or mental health difficulties comparable to those of the youth justice population.

4. Evidence fails to demonstrate effect

These were frameworks, models and/or rehabilitative programmes for which there was strong evidence to suggest the practice does not result in improved outcomes, i.e., two or more published, peer-reviewed rigorous randomised controlled trials (RCTs), with multiple site replication and follow-up (< 1 year post-treatment).

5. Concerning practice

These were frameworks, models and/or rehabilitative programmes for which the overall weight of evidence suggests the practice has a negative effect upon clients, including data suggesting risk of harm (that was probably caused by the treatment and the harm was severe or frequent) and/or the practice constitutes a risk of harm to those receiving it.

NR - Not able to be rated

These were frameworks, models and/or rehabilitative programmes for which there was no published, peer-reviewed study using some form of control group, and the practice does not meet criteria for any other level on the rating scale.

On the basis of the current review's rating scale criterion:

Four models and programmes were identified as being *well-supported by research*:

- Risk, Need, Responsivity Framework
- Multi systemic Therapy
- Therapeutic Foster Care (Multidimensional Treatment Foster Care)
- Cognitive Behavioural Therapy Approaches

Two models and programmes were classified as being *supported by research evidence*:

- Positive Peer Culture
- Teaching Family Model

Four models and programmes were classified as having *promising research evidence*:

- Stop-Gap
- Aggression Replacement Training
- Dialectical Behavioural Therapy
- Therapeutic Communities

Three models and programmes were classified as having promising research evidence among *comparable youth populations*:

- Trauma-Focused Cognitive Behavioural Therapy[3]
- Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5
- Positive Behaviour for Learning – School Wide

One programme was classified as having evidence failing to demonstrate effect:

- Alternative Education[4]

One model was classified as having *concerning practice*:

- Behaviour Modification – Token Economy and Point Level System

Thirteen models and programmes were classified as *not able to be rated*:

- Good Lives Model
- Supportive Authority and the Strategy of Choices
- Trauma, Attachment and Neurodevelopment Framework
- Neurosequential Model of Therapeutics
- Cognitive Self-Change
- Seeking Safety
- Meihana Model (was considered a "sustained" programme by the Advisory Group on Conduct Problems (AGCP, 2013))
- Te Pikinga ki Runga (was considered a "sustained" programme by the AGCP (2013))
- Te Hui Whakatika (was considered an "emerging" programme by the AGCP (2013))
- Prevent-Teach-Reinforce
- Non-Violent Crisis Intervention
- Therapeutic Crisis Intervention
- Intensive Aftercare Programme.

Please note that the Advisory Group on Conduct Problems (AGCP) used a different process to classify the effectiveness/efficacy of each programme reviewed in their 2013 report on Conduct Problems: Effective Programmes for Adolescents[5]. An overview of the AGCP's process for classification and how it compares to the scale used in this review is provided in Appendix B.

Part C: What Works Best for the New Zealand Context

Part C summarises the aforementioned literature and best practice for the care and management of the youth justice population, and comprises:

- **Chapter Fifteen:** based on current best practice and evidence-based programmes and models, a summary of what "works best" for youth justice secure residences and the wider continuum of care.

What "works best"

The what "works best" summary is structured to address each of the Terms of Reference that guided this review:

> ***Terms of Reference 1***
> *When secure residential care is appropriate and necessary for young people with offending needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of young people to similar sorts of youth justice residences in other jurisdictions.*

Drawing comparisons between New Zealand and international youth justice systems and the use of secure residential care is difficult due to the differing standards and philosophies regarding the purpose of secure care, age of criminal responsibility, thresholds for remand, and the availability of alternatives to remand.

Internationally, the literature recommends that secure residential care should be reserved only for the most high-needs and at-risk young people, be used as a last resort, and only for a limited amount of time. This is because young people may experience a range of negative impacts while in secure residential care (see Lambie and Randell (2013) for an overview). In addition, there has been a shift internationally toward the use of community-based services as an alternative to secure residential placement, where possible (e.g., Alternatives to Custody for Young Offenders by the British Association for Adoption and Fostering, and the Juvenile Detention Alternatives Initiative; see Chapter Four, Sections 4.3.1 and 4.3.2 respectively).

It is worth noting that a Supervision with Residence order (SwR; s311) places a young person in the custody of the Chief Executive; however, it does not require that the young person be detained in a secure residence. As such, there is potential for other less restrictive residential options for this population. Similarly, young people under a s238 1(d) order (Remand) can be either detained in the custody of the Chief Executive, an iwi social service, or a cultural social service. However, it appears that iwi remand services and cultural social services are not currently available or are very limited. Alternatives to detaining these young people in secure youth justice residences should be investigated.

Community-based and evidence-based models of intervention that can be utilised as an alternative to secure residential care, and as step-down homes (i.e., out-of-home care) that young people from secure residential placement can transition to, include Multidimensional Treatment Foster Care (MTFC) and the Teaching Family Model (TFM; see Chapter Seven, Sections 7.3 and 7.2 respectively). In addition, Multisystemic Therapy (MST; Chapter Seven, Section 7.1) is another efficacious community-based multi-modal treatment used to address serious conduct problems, offending behaviour, and social, emotional and behavioural problems in children and adolescents.

At the time of writing this review, the reviewers were unaware of any clear guidelines regarding the maximum length of time a young person should be detained in secure residential care. However, the Stop-Gap model suggests young people should only be held in residence for up to 150 days (McCurdy & McIntyre, 2004; Zakriski, Wright & Parad, 2006).

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3 Trauma-Focused CBT presents as a particularly promising programme for the youth justice population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

4 Note: concerns regarding Alternative Education, as reported in this review, were identified by the AGCP (2013)

5 See: www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/effective-programmes-for-adolescents.html

Terms of Reference 2 and 7 question what services should be implemented in residence, and request a commentary regarding how to best use the time a young person spends in residence to help inform next steps. Therefore, these TOR are addressed together below.

Terms of Reference 2
The right mix of services within youth justice residences that would:

a. Improve short and long term outcomes, and

b. Ensure a safe and positive residential environment for children/young people and staff.

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

Terms of Reference 7
Using the time a young person spends in residence to inform the next steps (i.e., use of assessment and the appropriateness of each assessment model, programmes, and interventions)

To the best of the authors' knowledge, there is a lack of information regarding what interventions or combination of services help promote the short- and long-term outcomes of young people in youth justice secure residences. However, an overview of the literature and current best practice in relation to the assessment process, framework and model of care, rehabilitative programmes, cultural models and practices, education programmes, vocational skills development, crisis management, and physical environment are provided below, as well as what appears to "work best" in meeting the needs of the various client types seen in youth justice secure residences.

Please note that a number of models, frameworks and rehabilitative programmes identified in this review are from jurisdictions where sentences in custody are substantially longer compared to New Zealand. In New Zealand, young people are detained in youth justice secure residences for a shorter period of time, aligning with the standpoint that young people have limited perspectives on time and consequences. In residence, treatment/rehabilitation options should be made available; however, young people should not receive disproportionate sentences so that they can receive rehabilitation/treatment.

Overarching framework and model of care

Here, a framework is described as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as guiding principles in the assessment and treatment process. A model of care is a therapeutic or rehabilitative model that can be implemented in residential services, and sits underneath the overarching framework. Implementing an overarching framework and model of care may help foster a common understanding between all staff and professionals as to the aims, goals and philosophies of the services provided to young people in residential care, consequently promoting consistency in approach between staff.

It appears that utilising a combined Risk, Need, and Responsivity (RNR) and strengths-based (i.e., Good Lives) framework (see Chapter Five, Sections 5.1 and 5.2, respectively) for guiding the assessment and rehabilitation/intervention of the youth justice population may help reduce recidivism and promote positive outcomes (Singh et al., 2014; Willis, Ward & Levenson, 2014). In addition, secure residential care models such as Positive Peer Culture and Stop-Gap (see Chapter Six, Sections 6.1 and 6.2 respectively) have demonstrated promising research evidence for use among the youth justice population in secure residential care.

Assessment process

Assessment of young people in youth justice secure residences has two purposes: to identify the immediate acute needs of the young person at admission, and to guide the individualised intervention/rehabilitation plan. Assessment should therefore begin when a young person first has contact with CYF services, with reassessment conducted periodically right through to the young person's exit from CYF services.

With regards to the assessment process for the young person's individualised plan, this should involve

standardised identification of a wide range of risk and protective factors of the young person, their family/whānau, and other supports. In addition, each young person should be screened for physical and mental health problems, educational needs, cognitive deficits, substance use, any immediate risks to self (including self-harm or suicidal ideation), risk to others and from others. Such a systemic, holistic and comprehensive assessment acknowledges the childhood experiences and environment that may contribute to the young person's behavioural and mental health difficulties, and aligns with the RNR framework and strengths-based models of practice.

Implementing standardised assessment processes and measures can help facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. Standardised assessment tools identified in Chapter Eight include the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), Novaco Anger Scale and Provocation Inventory, MAYSI-2, and the Substances and Choices Scale.

Utilising a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

Rehabilitative Programmes

To facilitate good outcomes for a young person post-residence to transition, it is important to plan and implement appropriate, individualised and effective interventions which align with the young person's identified strengths and difficulties from assessment, as opposed to a 'one size fits all' approach. This is consistent with the 'risk' principle of the RNR model (Andrews & Bonta, 2010), and parallels practice implemented by the Missouri model and the Kibble Centre (see Chapter Four, Sections 4.4.1 and 4.4.2 respectively) where the level of service a young person receives is determined based on the comprehensive risk and needs assessment.

Implementing multidimensional interventions and rehabilitative programmes, such as educational, mental health, cultural, medical, speech and language, and family-based interventions are important to ensure that the wide array of difficulties the young person may be experiencing are addressed. This is in-line with strategies implemented internationally (e.g., the Missouri model and Kibble Care), and the step-down community-based care models such as MST and MTFC (Chapter Seven, Sections 7.1 and 7.3 respectively). Furthermore, working with family and caregivers, to whom the young person is likely to return post-residence, is accepted as essential to ensure that benefits obtained in residence are maintained in the long term (Caldwell & Van Rybroek, 2013).

Evidence-based rehabilitative programmes identified in this report include Aggression Replacement Training, Trauma-Focused Cognitive Behavioural Therapy, and Dialectical Behavioural Therapy (see Chapter Nine, Sections 9.2.1, 9.2.2 and 9.3 respectively). The use of such evidence-based interventions and therapeutic models within secure residential care has been shown to improve outcomes comparable to those in non-residential out-of-home care (De Swart et al., 2012).

There is tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started while a young person is in a secure residence unless the young person is transitioning back into the community where this intervention can continue with minimal disruption and they see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in secure residential care, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical Behavioural Therapy). Alternatively, rehabilitative programmes could be implemented in a modular-based fashion, where one or several modules are delivered in residence, and the remaining modules post-transition.

Ethnicity and Culture

Māori are significantly over-represented in the youth justice population, and comprise 62% of those admitted to youth justice secure residential care in New Zealand. Therefore, there is a need for services to ensure that they are implementing culturally responsive evidence-based practices for Māori rangatahi, and that their staff are culturally informed and sensitive. Models, such as the Meihana Model (Pitama, Robertson, Cram, Gillies, Huria

& Dallas-Katoa, 2007), provide a framework to guide health professionals in the assessment and intervention of Māori clients and their whānau. Additional kaupapa Māori frameworks and interventions that are recommended in the literature for use with young people include Te Pikinga ki Runga, Te Hui Whakatika, Huakina Mai, and He Awa Whiria, all of which are described within this review (see Chapter Ten). However, these models are currently lacking evidence as to their effectiveness.

Education

Despite the recognised link between low academic achievement and delinquency and that young people in residential care are often behind their peers in the community in regards to educational achievement, there has been limited research examining the effects of education programmes on academic outcomes among this population (see Sander, Patall, Amoscato, Fisher and Funk (2012) for a meta-analysis). It is important that young people in youth justice secure residential care are provided with a comprehensive educational screening assessment, and high-quality educational services tailored to their identified needs to help them re-engage in education and catch-up to their peers. As outlined in Chapter Eleven, some promising education programmes have been developed, such as Positive Behaviour for Learning – School Wide (PB4L-SW). However, this is an area clearly in need of further research.

There appears to be no research or guidelines on the specific mix of professionals required in residential care education settings; however it seems likely that the presence of an educational psychologist, medical support for issues such as hearing loss, and the use of registered teachers would all be beneficial in terms of supporting young people in making the most of educational opportunities while in residence. In addition, given the over-representation of speech, language and communication difficulties present among the care and protection population, it is important to ensure speech-language therapy services are provided (Snow et al., 2015).

Vocational skills

There is a lack of research regarding the benefits of vocational and pre-employment training for young people in the youth justice system and secure residential care. However, the recognised benefits of young people being engaged in education could be generalised to include vocational and pre-employment training, where the acquisition of skills can increase the young person's chance of employment, consequently fostering positive outcomes in the long-term. Transitional staff could help a young person engage in such training programmes in the community post-discharge.

Crisis Management

Although restraint may be necessary as a last resort for the purposes of safety for the young person and staff, in general non-violent methods are both appropriate and necessary as an alternative. Two de-escalation and non-violent models of crisis intervention identified in the literature for use with young people in youth justice secure residences are Non-Violent Crisis Intervention (NVCI) and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Sections 12.1 and 12.2, respectively). However, there has been limited published peer-reviewed research conducted evaluating NVCI and TCI.

Physical Environment

A warm and home-like environment in residence is believed to help support the transition of the young person into residential care and to assist them to cope within the restrictive care environment (Bailey, 2002). Furthermore, providing kitchens, dining areas, lounges and individual bedrooms can ease the young person's transition into residential care and help them feel more 'at home'. Individual bedrooms offer the young person a private space where the young person can feel safe and contained, which can be therapeutic, particularly when living in a group situation (Bailey, 2002). Small facilities that enable 24/7 eyes-on supervision that have a home-like feel are used by Kibble Care and the Missouri model (See Chapter Four, Sections 4.4.2 and 4.4.1 respectively)

Family/whānau are seen as being an integral element of the rehabilitation of the young person. Therefore, to help increase the likelihood of family/whānau involvement in the treatment or intervention process, the young person should be placed in a secure residence that is as close to home as possible.

Addressing the needs of different client types

Distinct client types in the youth justice secure residential population include young people detained on remand, those who have a concurrent care and protection status, young female offenders, and child offenders. An overview of how to best address the needs of these client types is provided in Chapter Thirteen.

Currently, there is limited understanding or knowledge regarding the demographics and characteristics of these client types in youth justice secure residences in New Zealand. It is only with this information that a more thorough examination can be conducted into how the needs of these different client types in youth justice secure residences can be met, in order to establish practice guidelines. However, it appears that due to the vulnerability and complexity of presentation among some female and child offenders, considerations should be made concerning whether female offenders should be separated from male offenders, and child offenders separated from adolescent offenders.

Remand

With regards to the remand population, further information is needed to understand the circumstances in which 238 (1)(d) orders are made, and what alternatives there might be to making such orders. With regards to separating young people on remand from those who have been sentenced, the United Nations Standard Minimum Rules for the Treatment of Prisoners (1977) stipulate that young people on remand should have their cases processed expediently and that every effort should be made to apply alternative measures to avoid detention on remand. Where detention on remand is used, young people should be held for the shortest time possible, be detained separately from convicted youths and have the right to communicate regularly and privately with their legal advisers. The Beijing Rules (i.e., the United Nations Standard Minimum Rules for the Administration of Juvenile Justice) recommend pre-trial detention as a last resort for the shortest time possible. It is acknowledged that this population have a right to due legal process and are not presumed to be guilty, which would then enable rehabilitation/intervention. However, this population may benefit from general psychoeducation programmes, such as Alcohol and other Drugs, and skills from Aggression Replacement Training (see Chapter Nine, Section 9.2.1) and Dialectical Behavioural Therapy (see Chapter Nine, Section 9.3).

Terms of Reference 3
The optimal service delivery model for youth justice residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes. We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.

Professionals in residential care

At the time of this review, the authors were unaware of any research or guidelines regarding the ideal mix of professionals for a secure residential care facility. However, the "best mix" of professionals within youth justice secure residences is likely to include qualified front line staff with extensive training in how to work with young people with offending histories, and mental health and behavioural difficulties. There should be medical and mental health staff on-site, as well as education staff (preferably registered teachers), vocational staff, and at least one cultural advisor per site given the large proportion of Māori young people in secure youth justice residences. With regards to mental health, the presence of a registered psychologist, child psychiatrist, and psychiatric nurses are considered essential within a residential care environment, in order to adequately assess and manage the various mental health, emotional, and behavioural issues present among young people in secure residential care.

Staff attributes, capabilities, and qualifications

Interpersonal skills seen among effective staff who work with at-risk and high-needs young people include prosocial attitudes and behaviour, warmth, effective communication skills, and values aligning with those of the programme model (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000). Furthermore, the characteristics of staff working with young people, including professionalism and the ability to form prosocial relationships, have been found to mediate positive treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm et al., 2011).

Internationally, there has been a shift toward increasing the level of professionalism of staff in residential care (Dekker et al., 2012; Fendrich et al., 2012; Lappi-Seppälä, 2011). In Nordic countries at least 50% of residential care staff have tertiary qualifications (Lappi-Seppälä, 2011), and the Missouri model (see Chapter Four, Section 9.4.1) employs high calibre staff who are motivated, highly trained, and have higher-levels of education.

There appears to be no guidelines concerning the optimal staff-client ratio in secure residences. However, it is likely that having a high staff to young person ratio will help ensure staff are not overworked, consequently reducing staff burn-out and turnover, and an appropriate distribution of tasks across staff.

Training, support and supervision

It is important that staff are highly trained in the framework and model of care that is used within the residence, to ensure consistency in the implementation of the model. The Kibble model and the Missouri model provide their staff with extensive training in how to effectively provide services to young people in residential care. In addition, it is essential that staff are provided with professional development training to develop and extend their skills relating to the effective management and care of young people in secure residences.

Staff that are well-supported, feel appreciated, and are provided with frequent supervision are less likely to experience burn-out, and more likely to stay motivated in delivering a high-level of service to the young people in secure residences. In addition, supervision is essential for intensive and demanding roles in order to assist staff to maintain and develop their rehabilitative work (Lyman & Barry, 2006; Mendel, 2000; Church, 2003).

Social workers

Social workers play a critical role in the care and management of the youth justice population. However, the current training for social workers in New Zealand does not include clinical skills training. Additional training in clinical skills provided to a targeted group of social workers (approximately 40) across New Zealand would be beneficial in order to deliver adequate care and management for the youth justice population.

Management/leadership

To ensure consistency of rehabilitative interventions and a united and motivated team of staff working in secure residences, it is essential that the residential organisation has strong and consistent leadership (Hollin, 2001). In addition, the use of clinical and community advisory groups can be an important support for the management and leadership of the organisation, and can provide informed outsider opinion to ensure that the organisation does not become insulated and "institutionalized" in the way that it operates.

Organisational culture

The best opportunity for effective rehabilitative and therapeutic interactions between staff and young people is within an organisation with a clear therapeutic philosophy, as well as a united vision which all staff are committed to. Organisations which are driven by qualified and committed leadership can improve outcomes for the young people detained in youth justice secure residences. It is important that all staff are highly trained and committed to the model of care and the culture of the organisation, as inconsistent staff behaviour can become counterproductive and may undermine treatment integrity (Hollin, 2001).

Terms of Reference 4
Effective social work transitions into and from youth justice residences so that young people are well supported when leaving and returning to the community.

Transition and aftercare

Evidence suggests that the planning for transition from residence should commence shortly after admission to the residence, for two main reasons. Firstly, the length of stay for a young person is often unknown, and therefore the transition plan should be in place in order to avoid gaps should the young person depart from residential care earlier than expected. Secondly, young people tend to have better outcomes when they have a transition plan in place (Lindqvist, 2011), as this likely reduces uncertainty in their future, allowing them to better focus on their current situation. This can also increase motivation to achieve goals in residence if they are beneficial for their post-residence plan. Furthermore, any positive outcomes gained from time spent in

residential treatment may be lost if transition and post-residence support are not available to the young person (Guterman, Hodges, Blythe & Bronson, 1989).

For all young people transitioning from residence, it is essential that transition planning is inclusive of young people, their families/whānau (where possible) and significant others, and that planning processes are well-coordinated and tailored to the individual needs and circumstances of the young person to promote best possible outcomes.

Given young people often find it difficult to maintain positive gains that they have made in residential care once they have transitioned post-residence, it is important that a young person's transition is well-supported with a continuity of services in place before, during and after transition. Such post-residence support can include aftercare services.

Terms of Reference 5
Whether New Zealand's youth justice residences should cater for all those under seventeen years of age who require secure residential care. One issue we wish to consider is whether those aged under seventeen years of age and who are sentenced to the Corrections system should instead be held in Child, Youth and Family youth justice secure residential care.

Six beds at Korowai Manaaki youth justice secure residence in Auckland are designated Corrections Act 2004 beds for young people aged less than 17 years who have been sentenced to a term of imprisonment by the District or High Court, but for reasons of special circumstances (e.g., age, gender, assessed vulnerability) they are detained in a youth justice secure residence. At this time, the reviewers do not have sufficient information regarding the characteristics and needs of this population, and therefore which agency can best meet these needs (i.e., either CYF or the Department of Corrections). Therefore, to adequately respond to this question in consideration of what is in the best interests of those aged less than 17 years and sentenced to the Correction system, a needs analysis should be conducted to determine the number, characteristics and needs of this group. The best interests of this group should be paramount and held in mind with any decisions made regarding their care and management.

Terms of Reference 6
Commentary on residences as a "service", as part of a continuum of services.

Residential-based services are typically situated within a wider continuum of care that comprises step-down homes (i.e., out-of-home care), multimodal family and community-based interventions, rehabilitative interventions, and interventions aimed at prevention (i.e., young people aged less than 12 years who present with conduct problems). It is important that each part of this continuum of care uses evidence-based models and interventions to help ensure that the needs of these young people and their families are met. Furthermore, having robust and effective resources throughout the continuum of care can help ensure that those who begin to exhibit problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of reoffending and/or being readmitted into a secure residence.

Internationally, the Missouri model and Kibble Education and Care Centre (see Chapter Four, Sections 9.4.1 and 9.4.2 respectively) are well-run and highly-regarded continua of care for the youth justice population. Aspects of these models could be beneficial for implementation in the New Zealand context to strengthen the current youth justice continuum of care. These two models are briefly described below.

The Missouri Model

The United States Missouri model has been highly regarded in the literature. The Missouri model operates a continuum of residential facilities for the youth justice population, with seven secure care facilities, 18 moderate care, and 7 community-based (non-secure) residential group homes (Missouri Department of Social Services, 2013). Diversion, community-based supervision, and dual jurisdiction programmes are also provided. The Missouri model has been found to decrease recidivism after release (Missouri Department of Social Services, 2013), as well as assaults against youth, assaults against staff, and the use of mechanical restraints and isolation (Mendel, 2010). Rates of academic achievement of youth under the Missouri model are also significantly higher than national estimates of young people in confinement in the U.S. (Mendel, 2010).

The Kibble Education and Care Centre (Kibble)

The Kibble Education and Care Centre (Kibble) is a social enterprise in Scotland with the goal of providing a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences, and training to allow them to be successful in independent life. Kibble provides secure care, residential services, day services, intensive fostering, education and training, and transitional support all on-site.

Evaluations have been positive with findings that young people feel cared for and secure, and benefit from having their curriculum tailored to their individual needs (Education Scotland, n.d.). Staff have also been found to be highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.). It is important to note that there has been no external research conducted examining the effectiveness of Kibble.

Terms of Reference 8
A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry. This should include, for example, forensic mental health facilities and examples of other youth justice interventions, such as the Military-style Activity Camp programme and community-based programmes.
This should include:

a. *The model used*
b. *The staffing arrangements*
c. *The kinds of clients and their needs*
d. *The intervention programme offered*
e. *Information on the physical restraint approaches used, and if not used, please explain why.*

Please refer to Chapter Three, Section 3.3, where an overview of the new Youth Forensic Mental Health Unit, Specialist Residential Schools, Barnardos, Spectrum Care, Hohepa Trust, and Disability Support Services' contracted residences is provided.

Part A: The Youth Justice Population and Secure Residential Care in New Zealand

To set the context for this review, this section provides an overview of the youth justice population in secure residential care in New Zealand, the New Zealand youth justice system, and the New Zealand youth justice secure residences.

Chapter One provides a description of the characteristics and needs of the youth justice population in secure residential care, and how these differ across various youth justice client types. Chapter Two provides an overview of the youth justice system, including the governing legislative and regulatory framework in which Child, Youth, and Family youth justice secure residences exist. Chapter Three presents an overview of the youth justice secure residences in New Zealand, including admission criteria and services provided.

Chapter 1: The Current New Zealand Youth Justice Population in Secure Residential Care

To help determine what approach to care may best meet the needs of the youth justice population in secure residential care, it is important to first understand the demographics, characteristics and needs of this population. In this chapter, the characteristics and needs of the general youth justice population in secure residential care are described, followed by an overview of the youth justice client types, namely those who have been sentenced, those detained on remand, those who have a care and protection status, females, and those aged less than 13 years (i.e., child offenders).

1.1 An Overview of the General Youth Justice Population in Secure Residential Care

In 2014 there were a total of 2,082 children and young people charged in court (Statistics New Zealand, 2015), which is the lowest national youth crime rate recorded in over 20 years (Ministry of Justice, 2015). In the past five years, an average of 542 young people were admitted to a secure youth justice residence in New Zealand each year. There was also an average of 202 young people readmitted to youth justice secure residences each year, with readmissions increasing over time (Hand & Tupai, 2015).

The majority of young people in youth justice secure residences are male (84%) and aged between 15 and 16 years old (77%), with an average age of 15 years. Most (62%) of those residing in youth justice secure residences are Māori, while 24% are NZ European, and 11% are Pacific. Seventy-three percent of those admitted to a secure residence were on remand[6]. Young people remanded to a secure youth justice residence stay an average of 46 days, while those on Supervision with Residence (SwR) Orders (s311) stay for a minimum of three months and a maximum of six months, with scope for early release. The average stay in residence for young people in New Zealand on remand is estimated to be 25% longer than those on remand in Australia.

As at 30 June 2012, the main offences committed by young people admitted to secure youth justice residences were violence (64%), property (62%), and dishonesty offences (38%). In 2012/13, other issues at admission included alcohol and drug abuse (68%), absconding, (57%), gang-related behaviour (31%), suicide (25%), intimidation (23%), and harmful sexual behaviour (21%) (Hand & Tupai, 2015).

1.1.1 Physical Health

Research from New Zealand and Australia indicates that young people in secure residences are among the most disadvantaged and vulnerable population of young people, and that they are more likely to reoffend if health care is not provided at critical stages of development (Ogden et al., 2008). In 2009, McKay and Bagshaw investigated the health needs of 94 young people residing in CYF secure residences (Te Au rere a te Tonga youth justice residence, Palmerston North, Te Oranga care and protection residence, Christchurch, and Te Puna Wai o Tuhinapo youth justice residence, Rolleston). With regards to physical health, the main problems among young people in residence were asthma, skin problems, and sexual and dental health. Almost one-half (44%) of young people had poor access to dental health care, while 19% failed a hearing screening test, and 24% failed their vision screening test. Young people's sexual health was also concerning, with 92% disclosing that they have had sex and half (49%) reporting that they had used condoms always or most of the time (McKay & Bagshaw, 2009).

Similarly, the New Zealand Prisoner Health Survey found that asthma and ear infections were prevalent among detained youth (Ministry of Health, 2006), and that their physical health was worse when also taking dental health into account. The most common health issue was injury, which typically involved head injuries. Cases of burns and musculoskeletal injury were also relatively common (Ministry of Health, 2006).

1.1.2 Mental Health, Behavioural Difficulties and Abuse

Internationally, young people involved in the youth justice system have also been shown to have a greater prevalence of psychiatric and substance abuse issues compared to adolescents in the general population (Desai et al., 2006; Fazel, Doll & Langstrom, 2008; Sedlak & McPherson, 2010; Vermeiren, Jespers & Moffitt, 2006). Psychiatric disorders, such as post-traumatic stress disorder, attention-deficit/hyperactivity disorder,

6 Under court orders made under Section 238 1(d) of the Children, Young Persons and their Families Act 1989

and mood and anxiety disorders, are disproportionately higher among young people involved in the youth justice system compared to the general population (Bickel & Campbell, 2002; Kosky & Sawyer, 1996; Teplin et al., 2002). Suicide is of particular concern among young people in the youth justice system (Penn, Esposito, Schaeffer, Fritz & Spirito, 2003), with suicide rates estimated as being four-times higher than for other youth (Abram et al., 2008; Kosky, Sawyer & Gowland, 1989).

The presence of trauma is common among the youth justice population, including experiences of abuse or neglect, accidents, and personal loss (Abram et al., 2004; Ford, Hartman, Hawke & Chapman, 2008). These young people may also present with complex trauma, which can disrupt normal development including attachment patterns (Cook et al., 2005).

The high prevalence of psychiatric disorders, substance abuse, suicidal ideation, and experiences of abuse and trauma found internationally among young people in the youth justice system have also been found among the young people detained in youth justice secure residences in New Zealand (McArdle & Lambie, 2015; McKay & Bagshaw, 2009). McKay and Bagshaw (2009) found 49% of those in secure CYF residences reported 'worrying a lot about things,' 37% had four or more somatic symptoms, 25% reported depressive symptoms, 49% reported feeling anger and irritability, 30% had self-harmed, and 20% had attempted to end their life. Over one-half of boys (56%) and a quarter of girls (26%) reported being physically harmed on more than three occasions in the past year, while 39% had witnessed violence between adults at home on more than three occasions in the past year. The majority (87%) of young people smoked cigarettes daily, 58% drank alcohol at least three days a week, and 49% used cannabis at least once a day.

Similar findings regarding the prevalence of psychological and behavioural problems were found among a sample of 204 young people admitted to youth justice secure residences in New Zealand between July and December 2014 (McArdle & Lambie, 2015). Using the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), which was developed to identify those who are at risk for serious mental, emotional and behavioural difficulties, most young people (66%) were found to have alcohol/drug issues, 38% experienced difficulty with anger/irritability, 30% were depressed/anxious, 30% reported somatic complaints, 24% reported thought disturbance (only among boys), and 17% experienced suicidal ideation. Co-morbidity was prevalent among this population, with half scoring in the non-normal range for two or more mental health or behavioural problems. Finally, young people had experienced approximately two traumatic events (McArdle & Lambie, 2015).

A proportion of those involved in the youth justice system also present with callous-unemotional traits (i.e., lack of guilt, empathy, callous use of others for their own gain). Despite being a small group, these young people can show the most severe patterns of behaviour (Leistico, Salekin, DeCoster & Rogers, 2008), and are often some of the most challenging young people when implementing treatment or intervention (Kimonis, Ogg & Fefer, 2014).

1.1.3 Education

International research has highlighted the prevalence of educational deficits among the youth justice population and the risk such deficits pose to further delinquency. In the United States youth justice system, 61% of young people had been expelled or suspended, with 48% at a grade-level below what was expected for their age (Sedlak & McPherson, 2010). The education youth attend while in custody is not of the same quality as those in the general population, and they do not spend as much time in school (Sedlak & McPherson, 2010). Cognitive and academic testing also suggest that approximately 75% of young people in the youth justice system have impaired functioning, and one-third have numeracy and literacy deficits comparable to those with intellectual disabilities (NSW Department of Juvenile Justice, 2003). In their study of New Zealand CYF secure residences, McKay and Bagshaw (2009) found 70% of young people had left school prior to their admission to residence, and the majority (84% of boys and 100% of girls) had been truant from school.

Further information regarding the educational services provided in CYF youth justice secure residences, as well as the education-related outcomes for this group of young people in New Zealand, is outlined in Chapter Three.

1.1.4 Risk and Protective Factors

There is substantial literature on risk and protective factors for offending behaviour among youth. Risk factors for offending behaviour are variables which predict a high probability of later offending, while protective factors

include strengths of the individual and factors that can reduce or mitigate risk of reoffending (Farrington, Loeber & Ttofi, 2012). Risk factors can also be described as being either 'static' (i.e., unchanging or historical) or 'dynamic' (changeable). Given their association with reoffending and potential to be changed through intervention, dynamic risk factors are primary targets of intervention (Andrews & Bonta, 2010). It is beyond the scope of this review to provide a thorough discussion regarding the literature on risk and protective factors; however, a brief overview is provided below.

Much of the research on risk factors for youth offending has been guided by Andrews and Bonta (2010), whose general personality and social psychological model of criminal behaviour describes the interaction between an individual and their environment as increasing one's risk of engaging in offending behaviour. The likelihood that an individual will engage in offending behaviour is increased by the presence of personal and environmental risk factors (Andrews & Bonta, 2010). Such risk factors have been categorised into the 'big four,' which are the major predictors of engaging in criminal behaviour, and the 'central eight', which have predictive validity incremental to the 'big four.' The 'big four' risk factors are: history of antisocial behaviour, antisocial personality pattern, antisocial cognitions/attitudes, and antisocial peers. Negative parenting and family experiences, education and vocational difficulties, poor use of or involvement in leisure time, and substance abuse are the four additional risk factors which combine with the 'big four' to produce the 'central eight'.

Not all individuals who are at "high-risk" for involvement in criminal behaviour continue to reoffend, and not all young people who have engaged in offending behaviour reoffend despite the presence of risk factors. The question of why these individuals do not engage in criminal behaviour despite their high level of predicted risk has led to research focusing on protective factors for offending behaviour (Losel & Farrington, 2012). It is argued that acknowledging both risk and protective factors is necessary in order to understand the development and maintenance of offending behaviour and to more accurately predict risk (Losel & Bender, 2003). Furthermore, the identification of protective factors associated with reoffending is important for the design of interventions. Protective factors can be described as being either 'direct' (i.e., factors which predict low probability of offending behaviour, not taking into account other factors), or 'buffering' (i.e., predict low probability of offending behaviour in the presence of risk factors) (Losel & Farrington, 2012).

Losel and Farrington (2012) reviewed direct and buffering protective factors of engaging in violence among young people. Identified protective factors from the literature that had been found in at least two longitudinal studies were categorised by the authors into individual, family, school, peer group, and neighbourhood factors. Individual-based protective factors were above-average or high intelligence, prosocial attitudes toward family and school, non-aggression-prone social cognitions and beliefs, low impulsivity and easy temperament, low ADHD, enhanced anxiety and shyness, high heart rate, and high Monoamine oxidase – A (MAO-A) activity. Family-based protective factors included close relationship to at least one parent, intensive parental supervision, parental disapproval of aggressive behaviour, low physical punishment, intensive involvement in family activities, above-average Socio-economic status (SES) of the family, family models of constructive coping, and positive parenting attitudes toward the child's education. School-based protective factors were good school achievement, bonding to school, strong work motivation, reaching higher education, support and supervision by teachers, clear classroom rules, and positive school climate. Peer-based protective factors included non-deviant good friends, peer groups who disapprove of aggression, involvement in religious groups, and being socially isolated. Finally, neighbourhood-based protective factors included living in a non-violent neighbourhood, cohesion, and informal social control (Losel & Farrington, 2012). Many of these variables appeared to have both direct and buffering effects on violence; however, there were too few studies that could analyse the two types of effects. Losel and Farrington (2012) also found that as the number of protective factors increases for an individual, the likelihood of engaging in violence decreases.

One protective factor, resilience, has been identified as a possible factor influencing recidivism among young offenders (Efta-Breitbach & Freeman, 2004). However, as outlined by Fougere, Daffern and Thomas (2015), resiliency is a complex construct with limited research conducted in relation to its association with offending behaviour. In addition, of the research that has been conducted, inconsistent definitions of resilience have been used. In an attempt to address this, Fougere

et al. (2015) used a validated measure of resilience (the Resilience Scale; Wagnild, 2009) to examine the relationship between resilience and recidivism among a sample of young adult offenders (age range 16 to 30 years) in Melbourne, Australia. Contrary to expectations, resilience was not associated with recidivism. The authors reported that the findings of the study suggest that resilience may indeed be unrelated to recidivism among young adult offenders; however, more research is needed to further validate this lack of association (Fougere et al., 2015).

1.1.5 Gang affiliation

As discussed, young people in youth justice secure residences often come from chaotic and dysfunctional family/whānau backgrounds. Youth gang affiliation gives these young people a sense of family/whānau, friendship, identity and belonging that they may not otherwise have had (Becroft, 2006). Affiliation with a youth gang allows these young people to build connections, participate in something bigger than oneself, and provides a space where there are clear boundaries and consequences. In addition, young people whose parents are gang members may be more susceptible to joining a gang themselves (Thornberry, Krohn, Lizotte & Smith, 2003). This is unsurprising given the considerable influence family/whānau has on a young person. It is unclear how many young people in New Zealand belong to a gang, or what the characteristics of these young people are. However, international findings suggests that young gang members contribute to a significant proportion of offending behaviour, including violent and serious offences (Chu, Daffern, Thomas, & Lim, 2012; Krohn & Thornberry, 2008). International research has also established a strong association between gang involvement and offending behaviour (Esbensen, Winfree, He & Taylor, 2001; Esbensen & Weerman, 2005; Gatti, Tremblay, Vitaro & McDuff, 2005; Klein & Maxson, 2006). This is consistent with research on risk factors for offending outlined previously, where having antisocial peers is a major predictor of engaging in offending behaviour.

Information regarding how to mitigate the influence of gang affiliation on these young people in secure residential care is outlined in Chapter Thirteen, Section 13.5.

1.2 Needs of the Youth Justice Population in Secure Residential Care

While the offending behaviour of these young people is one primary concern to be addressed while in secure residential care, these young people present with multiple underlying difficulties and needs that should also be acknowledged given their association with reoffending and the wellbeing of the young person and their family/whānau. The multiple needs of these young people span across individual, peer, family/whānau, education, and community-based domains. For instance, the aforementioned research highlights that youth in secure residential care are functioning at a significantly lower level than other children with respect to their language and literacy development, as well as indicators of health and wellbeing. Further needs among this population may include finding a high-quality and stable placement post-transition from residence, and wraparound services such as day programmes and education to help support the young person and their family/whānau post-residence (Hand & Tupai, 2015). In addition, often these young people in secure residential care have experienced multiple placements with whānau and non-whānau, likely resulting in limited access to, or being excluded from education (Hand & Tupai, 2015).

It is important to note that although there is some information available regarding the difficulties and needs of the youth justice population in secure residential care in New Zealand, full understanding of these needs is restricted due to the limited national and regional aggregated data concerning these young people (as noted in Hand and Tupai, 2015)[7].

7 CYF captures detailed information about an individual client's problems and needs, which is held on CYRAS and/or individual hardcopy case files at a local level. However, at the time of writing, there is no aggregated national or regional information about the needs of clients in CYF's care produced on a regular basis for operational or other reasons. This is due to the complexity of the client information and difficulty aggregating data; such information is not captured by CYRAS in a form that enables reporting (it is captured in free text or in attached documents, not in structured text); nor is there regular collation and reporting of such information by CYF or MSD. Despite this, CYF has a reasonable idea about the problems and needs of clients in residences through day-to-day operations information and a variety of internal reports. However, there is more that could be done in this area.

Figure 1. Maslow's hierarchy of needs

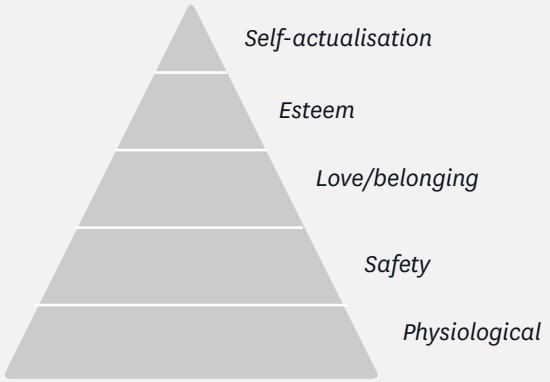
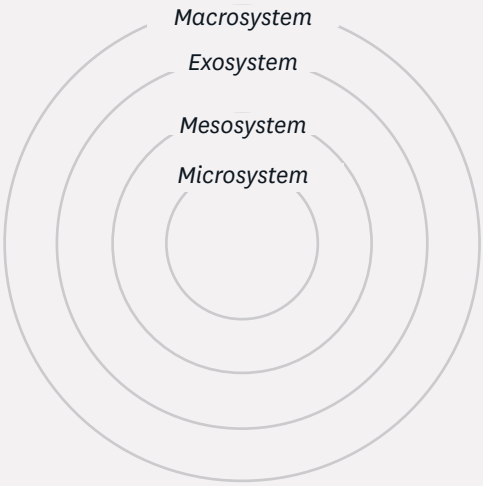


Figure 2. Bronfenbrenner's ecological model



In addition to the difficulties and needs present among the youth justice population in secure residential care, these young people also have essential basic needs that all young people in the general population require. One model to help understand the basic needs of humans is Maslow's Hierarchy of Needs (Maslow, 1970; see Figure 1).Maslow suggested that the most basic needs must be met before higher-level concerns can be addressed. It is at the self-actualisation level, when all bottom four levels of basic need (i.e., physiological, safety, love/belonging, and esteem) have been met, where change can be made (Jones, 2004). Basic human needs can also affect a young person's engagement in treatment and their internal motivation for change (Ryan & Leversee, 2011). For example, when a young person's basic needs aren't being met, this can impair their ability to focus on anything except their own needs.

As conceptualised in Bronfenbrenner's (1979) ecological model, a young person and their family are seen as existing within a broader set of systems which they interact with, impact on, and are impacted by. As shown in Figure 2, according to Bronfenbrenner (1979) there are four nested systems that extend around the young person: the microsystem (the setting the individual has direct contact with; e.g., peers, school, family, church, health services), mesosystem (interactions between microsystems; e.g., interactions between family and teachers), exosystem (system or setting that does not directly involve the individual but still affects them; e.g., parent losing their job), and macrosystem (e.g., culture or subculture in which other systems are nested). When significant difficulties in one or more of these systems arise this can have considerable consequences on the development of the young person. Therefore, it is important to identify such difficulties and provide interventions to adequately address them.

To effectively work with these young people, it is also important to recognise the nature of development that adolescence presents. Core developmental processes for adolescents include belonging and the formation of identity. Adolescents also inevitably face challenges during this life stage related to biological (e.g., puberty), cognitive (e.g., abstract thinking), psychological (e.g., emotional responses, identity), social (e.g., societal and parental expectations), and moral and spiritual domains.

With regards to the needs of the youth justice population, it is important to recognise that there is considerable tension between the need to safeguard the future well-being of the young person and public interest in holding young people accountable for crimes. As stated by Judge Becroft (2006, p.3):

> *Most serious young offenders, in one way or another, bring with them past and/or present care and protection deficits. They present a difficult challenge to the criminal justice system. On the one hand their backgrounds of abuse and environmental dysfunction, categorise them as vulnerable victims in need of help. On the other, their offending demands accountability, creates damaged victims and all too often casts them indeed as "huge and threatening yobs" or worse.*

1.3 Youth Justice Client Types

Although we can examine the characteristics and needs of the young people in youth justice secure residential care in general, it is apparent that within this population there are several client types with distinct needs that are important to recognise. We discuss the demographics, characteristics and needs of these client types below. In Chapters Fourteen and Sixteen, we discuss research and the best practice literature regarding how to best meet the needs of these youth justice client types.

1.3.1 Young People Sentenced to Residence

Young people who receive a Supervision with Residence (SwR) order[8] comprise a small proportion of those admitted to secure youth justice residential care. In Fiscal Year (F) 2014[9], 8.6% of distinct client admissions were those detained under s311/s283 charges. From 2010 to 2014, admissions to youth justice secure residences under s311/s283 orders have remained stable, with an average of 52 admissions each year. Those sentenced to SwR are detained in secure residential care for a minimum of three months and a maximum period of six months, with scope for early release (Hand & Tupai, 2015).

Six beds at Korowai Manaaki youth justice residence in Auckland are designated Corrections Act 2004 beds for young people aged less than 17 years who have been sentenced to a term of imprisonment by the District or High Court, but for reasons of special circumstances (e.g., age, gender, assessed vulnerability) they are detained in a secure youth justice residence. These young people may serve their entire sentence of imprisonment in a youth justice secure residence, or serve part of their sentence in residence with eventual transfer to a Department of Corrections' designated youth unit. The rehabilitative programmes and other interventions for these young people in residence are provided by the Department of Corrections.

Information regarding the demographics, characteristics, and needs of these young people sentenced to Supervision with Residence or sentenced under the Corrections Act 2004 is limited.

However, it is likely that these young people present with a range of mental health, physical heath, behavioural, and educational difficulties. Given these young people are in secure residential care for a period of several months, youth justice secure residences provide a valuable opportunity to address immediate needs and put in place longer-term rehabilitation/intervention plans that extend beyond the young person's stay in residence.

1.3.2 Young People on Remand

The majority of young people (70-80%) detained in secure youth justice secure residences are held on remand, while they await their next appearance in Court[10]. Young people under a s238 1(d) order can be either detained in the custody of the Chief Executive, an iwi social service, or a cultural social service. However, it appears that iwi remand services and cultural social services are not currently available or are very limited. Remand decisions are made against the backdrop of judicial, Police and public expectations about the level of security and public safety required for young people on remand, as well as consideration of the best interests of the young person.

From F2008 to F2012, there has been an increase in the use of remand from 448 distinct client admissions to 552 admissions. The average length of stay for a young person on remand is 46 days. This average length of stay is 25% longer than young people on remand in Australia. A young person's stay in residential care while on remand may last from a few days to several months, often resulting in a highly transient population.

Similar to those who receive a s311/s283 order and those sentenced under the Corrections Act 2004, information regarding the needs of the remand population in youth justice secure residential care is limited. In February 2013, a review of 87 remanded young people's files indicated that 45 were identified as being of risk to the public, 56 were identified as being at risk of absconding, 57 were considered to have mental health or behavioural difficulties, and 79 had known risk factors in their home i.e., domestic violence, abuse and neglect, alcohol/drug abuse issues related to a parent or caregiver (Hand & Tupai, 2015, p.27).

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8 Under Sections 311 and/or 283(n) of the *Children, Young Persons and their Families Act* 1989.

9 i.e, 1 July 2014 to 30 June 2015.

10 Under Section 238 1(d) of the Children, Young Persons and their Families Act 1989.

Therefore, it could be assumed that young people remanded in youth justice secure residences have comparable difficulties and needs to that of the general youth justice population outlined previously, including mental health and behavioural difficulties, and histories of abuse and neglect.

It is likely that the transient nature of the remand population and the uncertainty regarding their length of stay in secure residential care requires considerable resources to manage, and has an impact on the residential environment and on the services provided to the young people who are sentenced to Supervision with Residence (SwR). The high proportion of young people on remand in youth justice secure residences is a longstanding issue.

An additional issue concerning the nature of the remand population is that although they are detained in secure residential care, whether they have committed the offence or not has not been established. Given they are not presumed to be guilty, which would then enable rehabilitation/intervention, this makes it difficult to provide services and rehabilitation. This issue is discussed further in Chapter Thirteen, Section 13.1. More information is needed regarding the characteristics of the remand population, what drives these orders, and whether alternatives to secure residential care could be used for this population.

1.3.3 Care and Protection Status ('Crossover' Youth)

Crossover youth can be defined generally as children who move between child welfare and youth justice systems. This move between systems is typically due to the effects of childhood abuse and/or neglect which are seen to increase the risk of committing crimes (Thornberry, 2008; Widom, 1989). This is especially the case when youth within care and protection services lack a stable home or school environment, supportive relationships, and adequate healthcare (Bilchik & Nash, 2008), consequently increasing their likelihood of crossing over into the youth justice system. Understandably, this subgroup of the youth justice population have more complex needs and require more intensive interventions if they are to avoid long-term involvement within both systems.

In F2014, 12.5% of distinct clients with a Court Directed and Intention to Charge youth justice Family Group Conference were already in the custody of the Chief Executive (i.e., care and protection) at the time of the referral. In F2013 this figure was 11.3%. Of the clients who had a new youth justice Family Group Conference in 2011, less than 20% had previously been in care (Hand & Tupai, 2015, p. 11). It is important to acknowledge that despite not having been in the custody of the Chief Executive prior to admission, many young people in youth justice secure residences have histories of childhood maltreatment (i.e., care and protection-related histories).

1.3.4 Female Offenders

The majority of young people (80-85%) in secure youth justice residences in New Zealand are male, with the number of distinct admissions for males and females being stable from F2010 to F2014. There is limited information regarding the differing demographics, characteristics, and needs between males and females in secure youth justice residences in New Zealand. At the time of this review, the only information known to the reviewers regarding characteristics of the female population in New Zealand CYF residences was from a file review of 37 girls in youth justice and care and protection residences as at 1 July 2012 (Alliston, 2012). Data showed 43% of these females in secure CYF residences had engaged in prostitution, 40% in sexual behaviour with multiple partners, 35% had previously or were currently displaying sexualised behaviour/language, and 11% had engaged in harmful sexual behaviour (Alliston, 2012).

International research can help shed light on some of the likely differences between males and females in secure youth justice facilities. Here, identified needs among the female population are briefly discussed.

While mental health disorders and experiences of abuse are more prevalent among those in the youth justice population than for those in the general population, this is especially so for females. Among those involved with the youth justice system, Shufelt and Cocozza (2006) found that 80% of girls and 67% of boys met criteria for at least one disorder. Shufelt and Cocozza (2006) also found young female offenders were more likely to have anxiety or mood disorders than boys, while rates of disruptive and substance abuse disorders were more comparable between boys and girls. There is evidence to suggest that compared with males, a higher proportion

of young female offenders experience more severe mental health symptoms (22% versus 50%, respectively; Stewart & Trupin, 2003) and have significantly higher rates of comorbidity (41% versus 59%, respectively; Nordness et al., 2002). In addition, female young offenders are more likely to experience suicidal ideation and to have attempted suicide (Odgers & Moretti, 2002).

Young female offenders have more extensive maltreatment histories, with higher rates of physical and sexual abuse than their male counterparts (Abram et al., 2004; Cauffman et al., 1998; Corrado et al., 2000).

1.3.5 Child Offenders

In New Zealand, young people aged between 14 and 16 years who have offended and are deemed to require placement in residential care are detained in youth justice secure residences. Young people aged between 10 and 13 years who have offended and require being detained in residential care may be placed in a care and protection secure residences or in alternative settings, such as group homes or with specialist caregivers. However, those aged between 10 and 13 years who commit indictable offences (ie, murder, manslaughter, rape or serious arson) are detained in youth justice secure residences. In F2014, 42% of young people in youth justice secure residences in New Zealand were aged 16 years, 35% were 15 years, 15% were 14 years, and 7% were aged 17 years. From F2010 to F2014, three young people aged 12 years and nine aged 13 years were admitted to a secure youth justice residence[11] (Hand & Tupai, 2015).

There is limited information regarding the differing demographics, characteristics, and needs between child (i.e., < 13 years) and adolescent offenders (i.e., 13 years and older) in New Zealand secure youth justice residences. Therefore, although there are established developmental differences between children and adolescents that are important to acknowledge, any additional needs of these child offenders are unknown. This information is essential to help identify and understand the needs of these young people and what factors may have contributed to them engaging in offending behaviour, resulting in their admission to a secure residence at a younger age.

One main concern regarding the needs of child and older adolescent offenders is the mixing of these young people in secure residences, resulting in a phenomenon referred to as the 'peer contagion effect'. The peer contagion effect describes the process where delinquent adolescents influence one another, reinforcing each other's behaviours (Dodge, Dishion & Lansford, 2006; Osgood & Briddle, 2006; Warr, 2002). In residence, child offenders are exposed to adolescents who may be more aggressive and have more extensive offending histories.

1.3.6 Disability

It is unknown what proportion of young people in secure youth justice residential care have some form of disability. However, those who are identified as having some form of disability, whether physical, cognitive, sensory, emotional, and/or developmental, have needs that should be identified so appropriate supports can be provided for these young people.

The reviewers of this report acknowledge the importance of meeting the needs of young people in secure youth justice residences who have disabilities. Providing services for young people with disabilities is a specialist area, and as such, the reviewers feel that it is beyond the scope of the report to adequately and comprehensively cover this area.

1.3.7 Ethnicity and Culture

Māori are significantly over-represented in the youth justice population, and comprise 62% of those admitted to secure youth justice residential care in New Zealand. The cultural needs of rangatahi Māori and how these needs can be addressed in residential care are outlined in Chapter Ten.

1.3.8 Serious, violent and chronic young offenders

There appears to be a subgroup of young offenders who commit the greatest number and most violent offences. These young people have been referred to in the literature as 'serious, violent and chronic juvenile offenders' (SVC; Fox, Perez, Cass, Baglivio & Epps, 2015). These young people are comparable to the identified "life course persistent" group of young offenders. Life course persistent offenders display antisocial and aggressive

11 This comprises 0.4% of the total youth justice residential population from F2010 to F2014.

behaviour before they reach adolescence which regularly increases in severity through adolescence (Frick & Viding, 2009). This is in contrast to 'adolescent-limited offenders' whose offending behaviour begins in adolescence and desists in young adulthood (Moffitt, 1993).

It is uncertain what proportion of young people in New Zealand youth justice secure residences could be considered SVC offenders; however, identification of these young people is important given their persistent engagement in severe offending. More information and research concerning this population of young people in New Zealand is needed. Recent research conducted regarding these young SVC offenders in Florida found adverse childhood experiences were highly prevalent among this population (Fox et al., 2015). Furthermore, each additional adverse childhood experience was found to increase that young person's risk of becoming a SVC offender by 35%, when controlling for other risk factors for criminal behaviour. Physical abuse increased the young person's risk of becoming a SVC by 50%, and having an incarcerated household member by 119% (Fox et al., 2015).

Summary

The youth justice population in secure residential care constitute some of the most disadvantaged and vulnerable young people in New Zealand, and present with a range of complex needs. There are also specific subgroups within this population who may be considered more vulnerable and at-risk for negative outcomes, including female offenders, young offenders aged less than 13 years, those with disabilities, 'crossover' youth, and SVC offenders. However, having full understanding of the needs of the general New Zealand youth justice population in secure residential care and these subgroups is limited due to the lack of aggregated data concerning the characteristics of these young people. It is essential that this information is gathered in order to understand the needs of these young people.

The differing levels of need present among these young people in secure residential care, as well as the wide range of risk and protective factors, must be taken into consideration for the care and management of these young people in order to provide them with the greatest chance of successful outcomes.

Chapter 2: The New Zealand Youth Justice System

To understand the context in which youth justice secure residences exist, an understanding of the New Zealand youth justice system and governing legislative and regulatory framework for these residences is required. This chapter will provide an overview of the youth justice system in which youth justice secure residences operate.

Please note that the following is a brief overview of the main legislation in New Zealand concerning the youth justice population, and does not aim to provide an in-depth discussion of the intricacies and complexities of New Zealand's youth justice system.

2.1 Overview and Legislation

The New Zealand youth justice system is governed by the Children, Young Persons and Their Families (CYPF) Act 1989, which applies to children and young people from birth to their 17th birthday[12]. The CYPF Act is legislation relating to children and young persons who are in need of care and protection or who offend against the law. The Act is based on the philosophy that the safety and well-being of children and young people is paramount. In particular, the Act outlines procedures that aim to:

a) Advance the wellbeing of children and young people as members of families, whānau, hapu, iwi, and family groups.

b) Make provision for families to receive assistance in caring for their children and young people.

c) 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.

The youth justice system and CYPF Act attempt to balance the welfare and justice models, with section 4(f) of the Act outlining that young people who commit offences are to be "held accountable" and are encouraged to accept responsibility for their behaviour; however, this should be "dealt with in a way that acknowledges their needs and that will give them the opportunity to develop in responsible, beneficial, and socially acceptable ways" (p.37). Principles of restorative justice are also incorporated in the Act. This includes the young person being encouraged to make amends for harm done, there is a focus on reintegrating offenders, and the offender, victim and wider community all participate in determining the outcome for the offender. As noted in Chapter One, there is tension in balancing the future well-being of these young people and holding these young people accountable for their actions (see Becroft (2006) for a discussion).

The New Zealand youth justice system involves two separate processes for 10-13 year olds and 14-16 year olds. However, under s 272 of the CYPF Act, those aged 12 and 13 years may also come within the Youth Court jurisdiction when offences are serious or the 12 or 13 year old is a previous offender. Although the age of criminal responsibility in New Zealand starts at ten years old, this is limited to charges of murder and manslaughter, and general principles state that criminal procedures should not proceed if there is an alternative way deemed more appropriate in dealing with the issue. In this way, both processes are diversion-focused and emphasise accountability and rehabilitation. When a young person has offended, the police can respond by issuing a warning, arranging a diversionary response, making referrals to Child, Youth and Family for a family group conference, or arresting and laying charges with the Youth Court. The Youth Court is seen as the last resort in New Zealand, and is only to be used if diversion or a family group conference have been unsuccessful. For the most serious young offenders, under s 283(o) the young person may be transferred to the District Court or High Court.

2.1.1 17 Year Olds in the Youth Justice System

As noted above, the New Zealand youth justice system is responsible for addressing the offending of young people under the age of 17 years. Internationally, those under the age of 18 years are considered to be children (United Nations Convention on the Rights of the Child, 1989). Australia (with the exception of Queensland), Canada, England, Wales, and most states in the United States of America (38 of 50) include 17 year olds in their youth justice systems. Therefore, the New Zealand youth justice system is out of step with international practice by excluding 17 year olds from its youth justice jurisdiction. This has been noted by the United Nations Committee on the Rights of the Child, who in 2011 recommended that New Zealand increase the age of criminal majority to 18 years.

12 Note: The CYPF (Vulnerable Children) Amendment Act was passed in 2014.

International approaches and literature on youth justice suggest that the needs of those aged 17 years are better met through the youth justice system as opposed to the adult justice system. In addition, increasing the age of those under the youth justice system to 18 years is in line with neurodevelopmental literature (see Lambie, Ioane & Best, (2014) for an overview). Furthermore, existing literature suggests that better outcomes, such as reduced reoffending, are achieved when young people are involved with the lowest level of the criminal justice system (e.g., Maxwell et al., 2004).

For more on the argument to include 17 year olds in the youth justice system in New Zealand, refer to Lambie, et al. (2014), and Judge Becroft (2009).

2.1.2 The Youth Crime Action Plan

The Youth Crime Action Plan (YCAP) is a 10-year plan introduced in 2013 with the goal to reduce crime by children and young people. It is guided by the three main strategies of partnering with communities and other agencies, reducing escalation of offending and other behaviours by focusing on early intervention before residence, and early and sustainable exits that keep youth from reoffending. This initiative was undertaken in order to hold youth accountable for their actions, but it also recognises them as a vulnerable population. It also acknowledges the unique needs of Māori through collaboration between services and communities in a culturally responsive way.

2.1.3 Roles, Functions and Responsibilities of Child Youth and Family

Child, Youth and Family (CYF) is a service line of the Ministry of Social Development, a New Zealand government department and part of the New Zealand public service. CYF is primarily guided by the Children, Young Persons and their Families Act 1989. CYF's core functions are to:

- Protect children and young people who are 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, and
- Work with young people to manage offending behaviour and reduce re-offending.

CYF has a central role in the management and provision of services for the youth justice population. Such services include residential placement in one of four youth justice secure residences in New Zealand (see Chapter Three), A Fresh Start for young offenders programmes, and the Military-style Activity Camp (MAC) programme implemented in conjunction with the New Zealand Defence Force (see Chapter Three, Section 3.2.1).

CYF's role involves collaborating with wider justice and social development services, as well as recognising the needs and aspirations of Māori with respect to the principles of the Treaty of Waitangi (i.e., protection, participation and partnership) and those of Pacific communities.

The responsibilities of CYF include:

- Receiving, assessing and investigating reports of child abuse and/or neglect
- Receiving referrals from Police about children and young people who have committed offences
- Coordinating Family Group Conferences (FGC) for both care and protection clients and youth justice clients as part of addressing issues and planning the prevention of re-occurrence of abuse, neglect or offending
- Working to implement FGC plans and Court orders
- Providing services that help children, young people and their families to address these issues and improve wellbeing
- Providing care services for young people in the custody of the Chief Executive, including residential services when required
- Taking emergency action when necessary to ensure the safety of young people
- Providing advice, research evaluation and development of operational policies relating to services for children, young people, families, and communities
- Assessing people who wish to adopt, and facilitating the exchange of identifying information for parties to past adoptions
- Undertaking action as directed by the Courts, particularly the Family and Youth Courts.

Summary

The CYPF Act governs the New Zealand youth justice system, which emphasises the importance of holding young people accountable for their actions while acknowledging the range of needs these young people bring with them to the justice system. Similarly, the YCAP aims to further reduce crime among children and young people by holding young people accountable for their actions, while also recognising their vulnerability, and highlights the specific needs of Māori. One key criticism of the New Zealand youth justice system is its exclusion of 17 year olds from its jurisdiction.

CYF are largely responsible for the management and provision of services for the youth justice population, including those residing in one of the four youth justice secure residences in New Zealand. These secure youth justice residences are discussed in further detail in Chapter Three.

Chapter 3: Youth Justice Secure Residential Care in New Zealand

The previous chapter provided an overview of the New Zealand youth justice system in which youth justice secure residences exist. In this chapter, an overview of the current youth justice secure residences in New Zealand is provided. Here, the residential care regulations, the agencies which provide services to young people in secure residential care and what these services and programmes involve is described. In addition, an overview of other residential facilities in New Zealand for other high needs populations of young people in New Zealand is provided.

For the purpose of this review, these youth justice residences are referred to as "youth justice secure residences" to distinguish between these and other (non-secure) residences operating within the continuum of care for the youth justice population (e.g., Supervised Group Homes).

3.1 Youth Justice Secure Residences in New Zealand

Child, Youth and Family's youth justice secure residences are part of the range of services within the youth justice system that respond to youth offending and other harmful behaviours. These services include interventions that comprise the 'A Fresh Start for young offenders' programmes[13], community-based services such as Multisystemic Therapy (see Chapter Seven, Section 7.1) and Multidimensional Treatment Foster Care (see Chapter Seven, Section 7.3), and youth units run by the Department of Corrections.

Youth justice secure residences are locked facilities that provide 24-hour containment and care. Internationally, secure residential facilities are also referred to, for example, as 'youth justice Remand and Detention Centres' (Australia), 'Secure Training Centres', 'Young Offender Institutions', '(Local Authority) Secure Care Homes' (United Kingdom), or 'Youth or Juvenile Detention Centres' (USA).

The purpose of CYF's secure youth justice residences is to provide a secure and safe environment for young offenders, support community safety and, where practical, address the underlying causes of offending behaviour. The main function of CYF's secure youth justice residences is to provide a response to when a judge decides that a young person is unsafe to live in the community. The judge's decision is based on his or her assessment of the underlying risk to the community and the suitability or otherwise of other less restrictive options available to manage the risks and needs of the young person. Young people may be detained in one of CYF's secure youth justice residences under the following orders of the Youth Court: s235 (Arrest), s238 1(d) (Remand), and s311 (Supervision with Residence).

Arrest and Remand orders

Under the Children, Young Persons, and their Families Act 1989, a judge may decide that a young person is to be detained pending hearing only if detention is deemed necessary to fulfil one of following conditions:

- Prevent further offending, and thus not create more victims, and/or
- Prevent the young person from interfering with witnesses or evidence, and/or
- Ensure that the young person appears in Court for a determination of their charge/s.

Supervision with Residence Orders

Supervision with Residence (SwR) may only be ordered if the Court is satisfied that less restrictive options would be inadequate. The SwR order places a young person in the custody of the Chief Executive, but does not require that the young person be detained. Consequently, there is potential for other less restrictive residential options (e.g., iwi social service, or a cultural social service) if the Court is satisfied that they would be sufficient.

Young People Sentenced under the Corrections Act

A minority of young people sentenced by the District or High Court to a term of imprisonment under the Corrections Act 2004 may be placed in a youth justice secure residence on the basis of their age, gender and assessed vulnerability. Six Corrections Act beds are available at CYF's Korowai Manaaki youth justice secure residence in Auckland. Admissions are jointly determined by the Department of Corrections and Child, Youth and Family on a case-by-case basis.

Under Part 4 of the CYPF Act 1989, a young person who has engaged in offending behaviour should be kept in the community as far as that is practicable and consonant

13 For more information see: www.cyf.govt.nz/youth-justice/fresh-start.html

with a need to ensure the safety of the public, and that detention in custody should only be seen as a last resort. Therefore, secure residential care for the youth justice population should be used only when it is determined that other care alternatives within the community or family are inadequate or inappropriate.

In New Zealand there are four youth justice secure residences, with three located in the North Island and one in the South Island. They are: Korowai Manaaki, Auckland (46 beds, of which 40 are youth justice and 6 are Corrections Act beds for custodial sentences), Te Maioha o Parekarangi, Rotorua (30 beds), Te Au rere a te Tonga, Palmerston North (30 beds) and Te Puna Wai o Tuhinapo, Christchurch (30 beds). In total, these residences provide 136 beds nationally. The annual operating budget for secure youth justice residences in New Zealand is around $33 million.

As noted previously, approximately 20-30% of those in secure youth justice residences in New Zealand are on Supervision with Residence orders. The most common order (70-80%) detaining young people in residential care is s238 1(d) (Remand), which is often ordered when continued breaches of bail occur, or oppositions to continuing bail by Police occur. However, this order does not require the young person to be admitted into a secure residence, only that they be placed in the custody of the Chief Executive. Of the 70-80% who are admitted to secure residence for custodial remand, 25% will receive a custodial sentence with the majority returning back to the community.

Children, Young Persons, and Their Families (Residential Care) Regulations 1996

In addition to the legislation outlined in Chapter Two, the services provided by youth justice secure residences are guided by the Children, Young Persons, and Their Families (Residential Care) Regulations (1996). These regulations outline the rights of children and young people in residences, specifically relating to:

- The limitations on punishment and discipline
- The management and inspection of residences
- The boundaries of searches and inspections
- Purposes and conditions of secure care (e.g., contact with others, meals, provided activities)
- The types of records that can be kept.

Information regarding the four youth justice secure residences in New Zealand, based on information outlined in each residence's visitor's pack, is displayed in Table 1.

Table 1. Characteristics of and Services Provided by Youth Justice Secure Residences

Residence	# of beds	# of units	Staffing	Assessment and case planning services	Health services	Education services	Residential programmes
Korowai Manaaki, Auckland	40 beds plus 6 Corrections beds for young people sentenced under the Corrections Act.	Five units. Male only. One secure unit.[14]	126 FTE	Youth justice assessment centre pilot (Korowai Manaaki only). Assessment of welfare, health and education needs. Risk screening including suicide ideation, alcohol and drug issues, psychological distress and mental health issues. Individual Care Plans for each client. May include behaviour management plans. Specialist assessments as required, e.g., psychological assessment. Transition planning from residence to community. Multi-agency teams support assessment and planning processes (comprising CYF residence and local site staff, education and health services, and community-based mental health services).	Primary health care services[15] provided on-site by a general practitioner and nurses. Currently provided by Raukura Hauora o Tainui. Specialist mental health services provided by Auckland District Health Board. Additional health services funded by CYF on a case-by-case basis. These may include medications, eye tests, glasses and orthodontic treatment.	Education services provided on-site by Creative Learning Scheme (contracted alternative education provider). Young people attend for five hours a day. Funded by the Ministry of Education. The Ministry of Education provides additional funding to education providers in the youth justice residences to provide assessments and services during school holiday periods. Literacy and numeracy programmes cater for the varying learning levels of the young people. Programmes support more senior students to gain national qualifications.	A wide range of educational, therapeutic, cultural and recreational programmes are provided by residence staff or the wider MSD and community organisations. Programmes include therapeutic services (eg counselling), life skills, cultural programmes, physical health and activity, sports, arts and music. Examples include: hygiene and fitness, wood carving, kapa haka, driver's licence theory, vegetable gardening, fork-lift certification, cooking, barista training. MSD Service Delivery assists with employment and training opportunities, e.g., the Youth Service.
Te Maioha o Parekarangi, Rotorua	30 beds	Three units. Mixed gender. One secure care unit. A four bed self- care unit.	95 FTE	As above.	As above. Primary health care services provided on-site by a general practitioner and nurses. Currently provided by Rotovegas Youth Health on contract to Lakes DHB. Specialist mental health services provided by Rotovegas through a contract with Lakes Valley DHB.	As above Education services provided on-site by Kingslea School (a specialist state school). Funded by the Ministry of Education.	As above. A 12-week agriculture programme focused on vocational experience for young people serving a Supervision with Residence order. Operates in partnership with the Taratahi Farms. NCEA credits can be gained.

Te Au rere a te Tonga, Palmerston North	40 beds	Three units. Mixed gender. One unit is used as a life-skills unit (see residential programme column for more detail). One secure care unit.	92.5 FTE.	As above.	As above. Primary health care services provided by Manawatu Public Health Authority on contract to MidCentral DHB. Specialist mental health services provided by Te Korowai Whariki – Youth Forensic Service (Capital and Coast DHB Service). Additional services as above. Also includes Whānau Ora.	As above. Education services provided on-site by Central Regional Health School (a specialist state school). Funded by the Ministry of Education.	As above. In addition, Turitea is a life-skills unit. Teaches skills to be used in a flatting environment including cleaning, cooking, budgeting and managing behaviour concerns amongst themselves. 'Hidden Face of Sport' – an eight week sports and character building programme.
Te Puna Wai o Tuhinapo, Rolleston, Christchurch	30 beds	Four units. Two male units, one female unit. One unit used for the Military Activity Camp programme – a joint NZ Defence Force and CYF initiative. One secure unit.	110 FTE	As above.	As above. Primary health care services provided by Pegasus Health. Specialist mental health services provided by CAMHS Canterbury District Health Board.	As above. Education services provided on-site by Kingslea School.	As above. In addition, the Hine Moa programme – a relationship-based life-skills programme for young women.

14 Each residence has a secure care unit, which is referred to as 'secure care' under Section 367 of the Children, Young Persons and their Families Act 1989. Secure care is used as a last resort when a young person is at high risk of harming themselves or others, or of absconding. A young person may only be held in secure care for 24 hours unless otherwise ordered by the court and then only for a maximum of 72 hours.

15 See Ministry of Health, *Health Services for Children and Young People in Child Youth and Family (CYF) Care and Protection and Youth Justice Residences, Tier Level Two Service Specification*, 22 September 2015, http://nsfl.health.govt.nz/service-specifications/current-service-specifications/child-health-service-specifications.

3.1.1 Services provided

An overview of the services provided by youth justice secure residences in New Zealand is provided below.

Assessment framework

Tuituia is the assessment framework used by CYF. The Tuituia framework reflects Māori perspectives of wellbeing, ensuring responsible practice for children and young people, many of whom are Māori. The aims of the framework are to ensure that young people are safe, feel as though they belong, and are healthy, achieving, and participating. Tuituia offers a holistic view of the child/young person, recording areas of need, strength and risk for the child/young person and their parents/caregivers that can then be shared throughout CYF care and protection, youth justice, residential and high needs services. The Tuituia assessment is used from intake to discharge, informing the intervention plan, placement decisions and ongoing work with the child/young person, their family/whānau, caregivers, and other agencies.

The depth and breadth of a Tuituia assessment will vary for a young person depending on the nature of the concerns, purpose of engagement, and the specific circumstances of each child/young person.

The Tuituia assessment covers three dimensions: Mokopuna Ora, Kaitiaki Mokopuna and Te Ao Hurihuri. Mokopuna Ora involves examining the holistic wellbeing of the child/young person, with specific regard to attachments and the degree to which these provide safety and security for the child/young person, health (both emotional and physical), identity and culture, behaviour, friendships and education.

Kaitiaki Mokopuna explores the capacity of the parents/caregivers of the child/young person to undertake the roles, responsibilities and obligations required to nurture and develop the wellbeing of their child/young person and looks specifically at factors impacting on safe parenting (e.g., their mental and physical wellbeing), safe and basic care for their child/young person, their relationship with the child/young person, skill and knowledge regarding how to parent/care for their child/young person, and guidance and supervision given to the child.

Te Ao Hurihuri examines the family/whānau, social, cultural and environmental influences surrounding the child or young person, with specific regard to the availability of networks of support and physical resources (e.g. housing and income), as well as family/whānau/hapu/iwi and wider connectedness of the child/young person and their family. Each dimension and sub-dimension within is scaled, with a high score indicating strengths and protective factors and a low score indicating greater need and highest concern. The scales are used to measure progress and show change over time for practitioners as well as the child/young person and their family/whānau.

While the overarching Tuituia framework is the same for all children/young people, assessment is tailored to the particular circumstances of each child/young person and what has brought them to the attention of CYF. Assessment involves asking why CYF are involved and what the current worries are related to the child/young person. Specific descriptors are available to assess those under the age of 5 years. Assessments completed by other professionals, for example health and education, Gateway, and psychological/psychiatric/cognitive assessments, are also used to inform the Tuituia final report.

The Tuituia final report is completed and kept as a formal record to be used as the assessment summary when completing a child and family assessment or investigation, a report to a family group conference or Court, or when a social work assessment is required.

More information regarding the Tuituia assessment framework can be found on the CYF website at:

www.practicecentre.cyf.govt.nz/policy/assessment-and-decision-making/resources/the-tuituia-assessment-framework-guidelines.html.

Health

As shown in Table 1, primary health care services are provided on-site at residences by District Health Board (DHB) contracted providers. Mental health services are provided by Child, Adolescent and Family Mental Health Services (CAMHS) or Infant, Children, Adolescent and Family Services (ICAFS) of District Health Boards (DHBs).

Education

There are three education providers across New Zealand who deliver education services for young people in the youth justice secure residences. Creative Learning Scheme provides services to Korowai Manaaki youth justice secure residence in Auckland, Kingslea School provides education services for Te Maioha o Parekarangi and Te Puna Wai ō Tuhinapo youth justice secure

residences near Rotorua and Christchurch respectively, and Central Regional Health School provides education services for Te Au rere a te Tonga youth justice secure residence in Palmerston North.

In the 2013 Education Review Office (ERO, 2013) report on the education services provided within the youth justice secure residences, it was concluded the quality of education across most of the schools was "not of a consistently high standard", and that "the quality of education at the residential schools needs to be improved" (ERO, 2013, p. 9). Of the nine residential schools (including CYF's care and protection secure residences and Te Poutama Ārahi Rangatahi[16]) two schools were considered by ERO to be effective, four were considered somewhat effective, and three considered as being of limited effectiveness.

Key features of the two residential schools deemed to be effective were: the strong relationships between staff and students, well-developed curriculum, and good levels of cooperation between teachers and Child, Youth and Family. However, most residential schools were found to require either "moderate or significant improvements in the delivery of the curriculum, the planning and programme design for individual students, and the processes to transition students to further education, training, or employment" (ERO, 2013, p. 1).

As identified in the 2015 interim report of the Expert Advisory Panel[17], among those born in 1990/91, by the age of 22 years those who had some form of contact with CYF were more likely to have left school with few qualifications, and 80% of children and young people who were taken into CYF care left school with less than Level 2 NCEA qualifications (in contrast to 30% of young people who do not have contact with CYF for care and protection reasons).

Ethnicity and Culture

Given many young people in residences are Māori, it is necessary that culturally informed services are provided. Below, the bicultural frameworks used by CYF and Whānau Ora are briefly described. Additional cultural models for the youth justice population are described in Chapter Ten.

CYF Indigenous and Bicultural Framework

The CYF Indigenous and Bicultural Framework for working with Māori establishes principled foundations for practice. The framework has eight guiding principles which are outlined briefly below. These are: *Te Reo Māori, Whakamanawa, Whakapapa, Kaitiakitanga, Manaakitanga, Tikanga, Rangatiratanga* and *Wairuatanga*.

Te Reo Māori is considered to be a life line to Māori culture and so the ability to use Te Reo Māori is central to engaging with Māori practice. Te Reo should be used throughout all dealings in a respectful and deliberate manner and practitioners need to at least have a working knowledge of commonly used Māori terms. Under the *Whakamanawa* principle, emancipation is based on potential that challenges and transforms oppression, and involves reinforcing the values and rights of Māori through participation and protection of cultural knowledge, practices and people.

The principle of *Whakapapa* involves displaying an active implementation of strong meaningful human connections, significant sites of engagement, and the value of relationships with the spiritual dimension. The principle of *Kaitiakitanga* is about the roles, responsibilities and obligations to protect, support and sustain, and ensure that Māori participation is valued, advanced and promoted in a systematic, structured and sustainable way. The principle of *Manaakitanga* is about caring for, and giving service to enhance the mana of others, and involves identifying and enacting roles, responsibilities and obligations in advancing processes that recognise, care and strengthen mana in others. *Tikanga* is the diverse Māori processes that provide balance and stability, safety and integrity for all, and involves championing the voices and aspirations of whānau through modelling and leading the use of diverse Māori cultural practices.

The principle of *Rangatiratanga* is about the distinctive uniqueness of Māori leadership styles and involves using diverse Māori leadership to validate and legitimate inclusive cultural and communal responsiveness. The principle of *Wairuatanga* is about the implicit presence of Māori values, intuitive knowing and critical conceptual

16 Te Poutama Ārahi Rangatahi is a specialist residential treatment facility for young men aged between 12-17 years who have engaged in harmful sexual behaviour located in Christchurch, and contracted to Barnardos by Child, Youth and Family and the Ministry of Education.

17 See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

thinking, and involves grounding all activities that engage with Māori in Māori values, beliefs, theories, ideologies, paradigms, frameworks, perspectives and worldviews.

Whānau Ora

Māori-centred frameworks and initiatives have been developed in New Zealand to enhance the wellbeing and development of Māori. One such framework is Whānau Ora, a whānau-centred approach to Māori wellbeing that aims to empower families. Established in 2009, the Whānau Ora Taskforce developed a framework which requires Government agencies to work with families, rather than separate individual family members. More information regarding Whānau Ora can be found on the Ministry of Social Development's website at: www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whānau-ora/.

Transition planning

Effective transition planning ensures positive and supportive reintegration back into the community, and provides young people with feelings of certainty and control over their future, consequently increasing the likelihood of successful long-term outcomes. The aims of transition planning are to provide seamless transition from residential care to community care, to discuss conditions of the proposed supervision order, to specify the level of supervision, monitoring and additional conditions on the young person, and to ultimately reduce the likelihood of reoffending and readmission to a residence.

Remand

Remand exits are determined by the Youth Court. Prior to the young person appearing in Court for the determination of their charge, their CYF youth justice social worker will develop a plan for the young person post-residence. Typically the planning options are:

- Release without formal youth justice orders
- Bail
- Supported bail
- Electronic monitoring
- Family group conferencing recommendations and planning
- Sentencing to a Supervision with Activity Order.

Following consultation with the child or young person and their family/whānau to determine the best planning option, the Police will also be consulted and their agreement sought. When the young person appears in Court, the judge will consider the plan and make a determination, i.e., approve the plan or request that an alternative plan is developed.

Supervision with Residence orders

Best practice is where the young person's CYF site social worker and the residence staff develop a plan that, amongst other things, outlines the specific actions regarding transition from residence. The young person's family/whānau should also be included in the development of the plan, and be provided with support and strategies to sustain behavioural change. This may involve identifying and resolving issues in the home environment before the young person is discharged from residence. The young person's social worker will prepare a report and plan for the Court, which will then consider the plan and make a determination, i.e., approve the plan or request that an alternative plan is developed.

The plan will outline how transition phases will be prepared and managed for the young person, including where the young person will live (a stable placement option must be secured to ensure a positive transition and outcome), how the transition from residence to a home environment will be managed, any proposed familiarisation visits for the young person in preparation for transition, education, training or employment (supporting what the young person has been doing in residence), and the continuation and/or initiation of rehabilitation/intervention services. In addition, the plan outlines how criminogenic risks can be minimised, what support is required for the young person to complete the plan, the support required by parents/caregivers, key contacts in the community, roles and responsibilities of any community providers post-residence, identification of a key support person (this may be the social worker), identification of who will set-up initial appointments for the young person, details of agreed post-release contact with residential staff, consideration of back-up options, and, where orders are for eight months or more, the objectives of the plan.

Two weeks after the young person has been released from residence, a post-release meeting is held with the purpose of checking that the young person's plan is on track and risk factors are being managed. Those who should attend include the young person, family/whānau, the young person's key person, social worker, supervisor, residential staff member, youth aid, and any additional key providers.

Further information regarding transition and aftercare is also outlined in Chapter Fourteen.

Restraint models

The youth justice secure residences in New Zealand use the Non-Violence Crisis Intervention (NVCI) model (see Chapter Twelve, Section 12.1 for an overview). NVCI is an international licenced de-escalation and physical intervention methodology which emphasises behaviour de-escalation and includes non-harmful physical restraints for use in extreme situations. CYF is currently strengthening the NVCI training for residential staff, and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Section 12.2 for an overview), an alternative to NVCI that is used in Australia, is to be looked into.

3.1.2 Outcomes and Evaluations

There appears to have been no evaluation reports conducted measuring the outcomes of young people post-discharge from youth justice secure residential care. However, monthly CYF governance reports, Office of the Chief Social Worker assessments, residence regulatory inspection reports, Office of Children's Commissioner (OCC) reports, and the Education Review Office (ERO) provide some indicators of performance regarding the youth justice and care and protection secure residences in New Zealand. An overview of ERO's 2013 report is outlined in Chapter Three, as well as education outcomes identified by the interim report of the Expert Advisory Panel. Here, a summary is provided of the OCC's *State of Care 2015* report, outcomes presented by the interim report of the Expert Advisory Panel, and the Office of the Chief Social Worker CYF residential care regulatory inspection reports.

The Office of the Children's Commissioner's *State of Care 2015* report

The Office of the Children's Commissioner's *State of Care 2015* report[18] was a publically published report on the findings from their independent monitoring of CYF in 2014-15. The report outlined a number of key findings. A brief summary of these findings is provided below.

Key Findings

Consistency

Although CYF was generally found to be good at keeping children safe from immediate risk of abuse and neglect and some sites and residences were found to meet or exceed expectations, overall CYF practice was not found to be consistent. Inconsistency with regard to "vision and direction, variable social work and care practice, and insufficient priority given to cultural capability" were found, with "a core issue with workforce capacity and capability" seen to be underpinning this (p.5).

Children at the Centre

It was also found that CYF does not put children at the centre of everything it does and while some children do report positive experiences with CYF, a number report negative and harmful experiences. The report observed that typically, "the longer a child spends in CYF care, the more likely they are to experience harmful negative consequences" (p. 5).

Outcomes of Children in the Care System

Due to a lack of reliable or easily accessible data on the outcomes of children in the care system, it is not clear whether children are better off as a result of state intervention; however what is available regarding "health, education and justice outcomes is concerning" (p. 5). The OCC noted that better collection and analysis of data is essential for CYF to improve its services and for the Government and the public to have confidence in CYF and other state agencies' ability to improve outcomes for vulnerable children.

Focus on Keeping Children Safe, not on

18 This report includes aggregate ratings for four youth justice residences and two care and protection residences. See: www.occ.org.nz/state-of-care/

Improving their Long-term Outcomes

The OCC report found that CYF focuses more on keeping children safe and less on improving their long term-outcomes. This observation was based on their monitoring findings, which found "strong intake and assessment practices in most of the CYF sites we monitored, but poor case management and oversight of young people in specialist care placements" (p. 6).

Recurring Themes

Recurring themes in the OCC's monitoring included that local planning is inconsistent, leading to a lack of clear purpose and direction in many sites and residences; cultural capability is not given sufficient priority; CYF's partnerships and networks with external stakeholders need strengthening; and the quality of social work practice is inconsistent. Finally, the OCC report stated that the capacity for CYF to improve outcomes among children in care is constrained by the following: "limited resources, high caseloads, the organisation's current KPIs which focus on timeliness of front-end work and not on-going support of care placements, and the need to invest in training across the organisation to develop a workforce with the appropriate skillset" (p. 33). In addition, issues consistently raised during visits concerned workforce capability, recruitment, training and retention.

The Voices and Experiences of Children

Children in CYF youth justice residences generally spoke positively about their experiences and indicated that their stay in residence had been of therapeutic and rehabilitative value to them. However, across both care and protection and youth justice systems, children tended to state that they wanted:

- To be told what to expect and what they are entitled to;
- That the people taking care of them (including caregivers, care staff in residences, and CYF social workers) will be qualified for the job, keep them safe, and treat them with care and respect;
- To be supported to maintain positive relationships with their birth family/whānau;
- To have the number of movements between placements that they have to make kept to a minimum; and
- To have a say in decisions about their own care, and for their voice to be listened to.

Children also reported experiencing a high level of uncertainty about planning for transition out of residential care, and little say in decisions around this. Overall "the feedback from the children suggests a system that is not centred on their needs, and does not fully take into account the potential negative consequences of many actions on these children" (p. 38).

Recommendations

The OCC made a total of 53 recommendations for the improvement of services provided by CYF to help promote positive outcomes for these children. The recommendations were aligned with key themes, and were grouped into nine categories: Clarity of purpose, direction, and strategy (nine recommendations), ensuring child-centred practice (eleven recommendations), improving the quality of social work practice across all types of care placement (nine recommendations), building workforce capacity and capability (eight recommendations), building cultural capability (five recommendations), improving integration of services between CYF and other agencies (three recommendations) strengthening partnerships and networks (four recommendations), improving the physical environment in residences (two recommendations), and other recommendations relating to operational systems and processes (eleven recommendations).

The OCC also made seven aggregated, future-oriented recommendations to address current shortcomings and improve children's outcomes:

1. Set clear expectations about CYF's core purpose and the outcomes it needs to achieve;
2. Ensure CYF is fully child-centred in all its activities;
3. Invest more in on-going support for children in all types of care placements;
4. Address capacity and capability issues across the CYF workforce;
5. Improve cultural capability across the organisation;
6. Collect and analyse relevant data to drive improved outcomes for children; and
7. Set clear expectations for other state agencies responsible for improving the outcomes of children in care.

The Interim Report of the Expert Advisory Panel

In 2015, the Expert Advisory Panel[19] released an interim report outlining their initial assessment of the issues and future opportunities for Child, Youth and Family. A brief summary of their key findings is provided below.

Hearing the Voices of Children and Young People

A small group of young people were interviewed about their experiences in the care and protection system. Main themes from this research were:

- We need more nurturing and love
- We want a say in what happens to us
- We have experienced trauma and need help to make sense of what has happened to us
- We crave belonging and being part of a family who bring out the best in us
- We want to strengthen our cultural identity and connection
- We do not stop needing help, support and nurturing just because we turn 17 years old.

Principles

The Panel agreed upon a set of principles[20] to guide their assessment of the current system and consideration of options for the future system. These principles aim to:

1. Place the child or young person at the centre of what we do
2. Support families to care for their children
3. Use evidence-based approaches to get the best results
4. Support the connection of all children, including Māori children, to their family, cultures and communities
5. Have the same high level of aspiration for vulnerable children as we do for all other New Zealand children
6. Help all New Zealanders to make a difference for vulnerable people

Performance of the Current Operating Model

The Panel outlined a number of issues with the current CYF system:

- "The current operating model places a high priority on completion of tasks with narrow responsibility and accountability within and between agencies. Decision-making tends to be focused on managing immediate risk and containing short term costs. This focus has come at the expense of the prevention of re-victimisation, remediation of harm and supporting long term outcomes" (p.10)
- The system is fragmented and lacks common purpose and clear accountabilities
- The system does not place children at the centre
- The system does not reflect a high level of aspiration for vulnerable children
- New Zealanders are not actively engaged in making a difference for vulnerable children
- The system is not effective in supporting families and whānau to care for their children
- The system does not focus on providing earliest opportunities for a loving and stable family
- There is insufficient focus on the recruitment, support and retention of caregivers who are vital to provision of loving and stable families
- There is a lack of evidence-based approaches to achieve results
- The workforce lacks the capabilities and capacity to meet increasingly complex needs of the children and families
- There is more work to do on supporting the connection of children to their cultures and communities
- The use of residences and custodial remand reflects an overly institutional approach to care and youth justice
- Vulnerable young people need and deserve far more support to make a successful transition to adulthood.

19 See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

20 These principles were condensed from the 27 distinct principles outlined in sections 5, 6, 13 and 208 of the CYPF Act.

Life Outcomes

A number of poor life outcomes among children and young people who have contact with CYF were identified by the interim report. Among children born in 1990/91, by age 22 those who had some form of contact with CYF were more likely to have:

- Left school with few qualifications
- Been in receipt of a main benefit (nearly 8 out of 10 of those who had contact with youth justice were on a benefit by age 21)
- Been in receipt of a main benefit with a child
- Been referred to CYF for youth justice reasons
- Received a community or custodial sentence in the adult corrections system.

Using initial data-matching between Child, Youth and Family, the Ministry of Education, and the Ministry of Health (2014)[21], compared to the rest of the population, children in care have lower levels of public health organisation enrolment and high rates of use of mental health services.

Additional findings regarding education outcomes are provided in Section 3.1.1 in this Chapter.

Changes

In response to the aforementioned issues, the Panel outlined a set of important changes to be made in the design and operation of the care and protection and youth justice systems:

- A child-centred system (shift from being primarily centred on the services, processes and administrative convenience of the agencies, to bringing the voice of children, young people and their families to the forefront)
- An investment approach (shift from an event-driven and response-based approach to one focused on evidence and long-term results across the social sector)
- A professional practice framework (shift from a rules, compliance and timeframe-driven practice to professional judgement)
- Engaging all New Zealanders.

CYF Residential Care Regulatory Inspection Reports

CYF's care and protection and youth justice secure residences are assessed each calendar year by the Office of the Chief Social Worker to ensure each residence is compliant with the Children, Young Persons and Their Families (Residential Care) Regulations 1996, and with section 384 of the CYPF Act 1989[22]. In addition, each residence is assessed to ensure that it is providing safe, appropriate care for children and young people.

At the time of writing this report, the inspection reports for all youth justice secure residences were publically available for the 2014 calendar year[23]. Each residence's areas of strength and improvement identified by the inspection reports are summarised below.

Korowai Manaaki

Areas of strength

Korowai Manaaki's strengths included medical assessments being completed in a timely manner, a high standard of medication administration and recording, reviews of placements being completed on time and accurately recorded, both justified and unjustified grievances were discussed by the residence manager with the young people involved, and the secure care register and admission register were well maintained. In addition, Korowai Manaaki's strengths also included individual care plans being completed on time and addressing all the relevant issues as required by the regulations, a positive relationship between residence and education provider staff, and detailed emergency and security management plans.

Areas for improvement

Korowai Manaaki's areas for improvement included ensuring only approved sanctions are applied in the management of children and young people's challenging behaviours, ensuring young people's rights to family

21 Insights MSD (2014) *Outcomes for Children in Care: Initial data-match between Child, Youth and Family, the Ministry of Education and the Ministry of Health*, (unpublished).

22 See: www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/residential-care-inspection-report/

23 ibid.

visits and communications are upheld and that the required detail is recorded in the daily log, and providing training for staff on search processes, including there being appropriate grounds for any searches and the required detail is recorded in the daily logs. In addition, Korowai Manaaki's areas for improvement also included ensuring that young people's rights to send and receive mail are upheld, further strengthening of the compliance monitoring system, ensuring that the required training and monitoring occurs that will support all staff with complying with the Code of Practice standards, and ensuring that approaches taken to managing young people's challenging behaviours involved no more than the minimum amount of physical intervention necessary.

Te Maioha o Parekarangi

Areas of strength

Te Maioha o Parekarangi's area of strength included education services being positive and there was good communication between education staff, the health team and residence staff, individual care plans being completed on time and the young people's families/whānau being included in the development of the plan, a well maintained admission register containing all of the required details, and personal files being orderly and of an exceptionally high standard. In addition, Te Maioha o Parekarangi's strengths also included having comprehensive health services provided and initial medical assessments being generally completed within seven days, an excellent standard of medication administration and recording with daily checks being completed by nursing staff, well-presented emergency management and security management plans, and a wide range of programmes and activities being provided in the open units.

Areas for improvement

Te Maioha o Parekarangi's areas for improvement included ensuring approaches taken to manage young people's challenging behaviours involve no more than the minimum amount of physical intervention necessary, further strengthening of the compliance monitoring system, ensuring only approved sanctions are applied in the management of children and young people's challenging behaviours, and training for staff on search processes, including there being appropriate grounds and that the detail of these are recorded in the daily logs. Te Maioha o Parekarangi's areas for improvement also included ensuring young people's supervised family visits are documented as required in the daily log, ensuring a more robust grievance procedure is developed that meets all the requirements of the schedule, ensuring the required training and monitoring occurs to support all staff complying with the code of practice standards, and the management of secure care processes, including ensuring young people are present and able to participate in their reviews, all reviews are completed in a timely manner, young people are only confined to their rooms in secure care when there are grounds to do so, young people are able to mix freely with others in secure care, and a range of programmes and activities being available.

Te Au rere a te Tonga

Areas of strength

Te Au rere a te Tonga's areas of strength included a senior management team that provided leadership and clear direction to staff, involvement of family and whānau in care planning and delivery, vocational opportunities for young people including working on projects with the Department of Conservation, the management of young people in secure care that ensures they spend the least amount of time possible in the unit, an effective compliance monitoring programme and a commitment by senior management to the development of staff skills in this area, a behaviour management system that is effective in encouraging young people to behave in a positive manner, and the contribution of education services in the case management of young people.

Areas for improvement

Te Au rere a te Tonga's area for improvement concerned the differing views on information sharing between health service staff and residential staff which have impacted on the effectiveness of the multi-agency approach to case management and the operational care of young people.

Te Puna Wai ō Tuhinapo

Areas of strength

Te Puna Wai ō Tuhinapo's areas of strength included well-structured educational provision, a wide range of programmes being available, having young people's involvement in programme development, a well-presented Security Management Plan, well organised Personal Files, and young people's involvement in the development of incentives associated with the Behavioural Management Programme.

Areas for improvement

Te Puna Wai o Tuhinapo's areas for improvement included ensuring consistency of approach when applying sanctions and ensuring that approaches taken to manage young people's challenging behaviour involve no more than the minimum amount of physical intervention necessary, and that the full range of options for managing this behaviour are used, the management of secure care processes, including ensuring appropriate grounds exist for admissions to the secure care unit and that placements are reviewed as required, with the outcomes recorded in the secure care register, and ensuring the management of searches and the recording of such searches. Te Puna Wai o Tuhinapo's areas for improvement also included ensuring care provided is always consistent with the Code of Practice standards and that individual care plans are comprehensive, ensuring the appointment system is sufficiently robust so that it is not necessary to re-schedule young people's health appointments, ensuring the residence manager consistently meets with young people who make a complaint via the grievance process, to discuss findings and actions planned to address the grievance, ensuring trial evacuations are held every three months, and the strengthening the compliance monitoring system.

3.2 Additional programmes

There are a range of programmes available for young people residing in youth justice secure residences. Here, the Military-style Activity Camp, Intensive Wraparound Service, Engaging Challenging Youth Project and Mentoring Youth New Direction are described.

3.2.1 Military-style Activity Camp

The Military-style Activity Camp (MAC) intervention is an intensive wrap-around programme targeted at persistent and serious male youth offenders in New Zealand. Further information regarding the MAC intervention can be found in Polaschek (2010), and the MAC evaluation report (2013) can be accessed through the Ministry of Social Development website.

Overview

The Military-style Activity Camp (MAC) intervention is jointly delivered by CYF and the New Zealand Defence Force (NZDF). It was introduced in New Zealand in 2010 as part of Fresh Start reforms and specifically targets the 40 most persistent and severe male youth offenders each year (Ministry of Social Development, 2013; Polaschek, 2010). These offenders tend to have multiple risk factors and can be characterised as 'life course persistent' offenders (Andrews & Bonta, 2010). Typically they exhibit impulsivity, poor social and interpersonal skills, verbal and physical aggression, and have family problems, deviant peers and difficulties at school. Drug and alcohol use is also common among this population. The programme aims to reduce the frequency and seriousness of reoffending, as well as facilitating community engagement and pro-social development.

Programme model

The MAC programme focuses on structure, treatment and transitions and is largely guided by a risk, needs, responsivity approach (Andrews & Bonta, 2010). In addition to addressing criminogenic risk factors, the intervention also considers broader needs and takes a strengths-based approach to encourage change in behavioural and situational factors through positive reinforcement (Polaschek, 2010). Interventions are individualised and case management designed to address multiple areas of the young person's life.

MAC incorporates three stages: MAC residential placement, transition to community phase and the self-responsibility stage.

MAC Residential placement

The 9-week MAC residential programme is the first stage of the overall intervention and takes place at Te Puna Wai o Tuhinapo (TPW) secure youth justice residence in Christchurch (Ministry of Social Development, 2013). The residential setting fosters a healthy, educational environment with 24-7 managed care, structure, discipline and treatment (Polaschek, 2010). The programme combines military style activities with group therapy, one-to-one alcohol and drug counselling, health care, education and vocational training, and a cultural programme (Ministry of Social Development, 2013). During the second week of the residential programme, the young people participate in a wilderness camp run by the NZDF personnel. The camp is designed to help build trust and encourage team work, as well as helping participants to take self-responsibility and tolerate adversity.

Transition phase

The second stage of the intervention is the transition back into the community under a supervision order. Transition planning begins when the young person first enters the programme, and transition planning meetings are held one month prior to release from the residential programme (Polaschek, 2010). Each participant enters the community with an individualised reintegration plan and a young person's post-residential supervision can last up to 12 months. This component of the intervention aims to support participants to learn and practise new prosocial behaviours in the context of their everyday life. Mentoring, work or education, skills development and parent/caregiver support programmes are key aspects of this stage of the intervention. Dynamic case management and intensive supervision is crucial to support young people to meet the challenges that may arise from practising new skills and behaviours in the community (Polaschek, 2010).

Community integration and self-responsibility

Once the young person has made significant progress in addressing key issues (such as drug and alcohol problems, employment), the intensity of supervision is decreased. The young person is expected to continue practising new skills and behaviours as they reintegrate into the community, although they and their caregiver/s are still supported and mentored.

Before case closure, a final report is discussed with the young person and their caregivers/family to identify ongoing challenges and celebrate progress and successes.

Evidence

An evaluation of the MAC programme was produced in 2013 by the Ministry of Social Development. At the time of this evaluation, only 35 participants had completed the programme and had been back in the community for at least 12 months. Of these 35 participants, 17% (6) had not reoffended, while 83% reduced the frequency and 74% the seriousness of their offending (Ministry of Social Development, 2013). One in five graduates of the programme had successfully transitioned back into the community and either had not offended at all, or only had a single, minor offence.

Latest reoffending data (N= 42) from the MAC programme found 17% had not reoffended within the first 12 months, 83% had reduced their offending frequency and 76% reduced the seriousness of their offending (Ministry of Social Development, 2013). These findings are similar to 172 males sentenced to Supervision with Residence (SwR) who were not involved with MAC, where 11% did not reoffend within the first 12 months; 72% reduced offending frequency, and 77% reduced offending seriousness. It was noted that the difference in sample size and lack of demographic data meant drawing direct comparisons between the groups was inappropriate.

It is important to acknowledge that the aforementioned results have been achieved among some of the most high-risk, challenging and difficult to engage young people in New Zealand. The 2013 evaluation reported that the residential component of the programme was working particularly well and appeared to improve participant motivation to address offending behaviour (Ministry of Social Development, 2013). The involvement of the NZDF was considered vital, with their emphasis on teamwork and structured, routine activities, breaking down barriers, and fostering respect of authority and self-discipline. In addition, appropriately managed and monitored transition back into the community was considered critical to the success of the programme.

The issue of delivering a criminogenic programme was highlighted, with concerns that the nine-week time period is too short, and follow-up community based programmes may be required (Ministry of Social Development, 2013). Additional areas identified as potentially hindering the success of the programme included the integration of different elements of the residential programme, information flow between different agencies and individuals involved, and the single Christchurch based location. Other areas of concern included the referral and selection process, mental health assessment and support, cost of resourcing associated with a single South Island location, and transitioning into the community. Some young people were required to complete their SwR orders in other residences following graduating from MAC, which was identified as needing to be reviewed due to concerns about programme benefits being eroded.

The evaluation authors suggested that while results look promising, the small sample size makes it difficult to ascertain whether programme benefits are greater than standard SwR orders. The evaluation did not use a control group, and the lack of a significant follow-up period used means it is yet to be determined whether these positive results are sustained over time.

Because of a lack of data, the evaluation was unable to report comprehensively on wider outcomes, such as employment or community participation.

The role of the NZDF was found to be crucial to the effectiveness of the programme (Ministry of Social Development, 2013), yet international research regarding the effectiveness of military style interventions is mixed. Two meta-analyses have revealed no overall difference in recidivism rates between participants in boot camp interventions and comparison samples, which included either community supervision or incarceration in a correctional facility (MacKenzie, Wilson & Kider, 2001; Wilson, MacKenzie & Mitchell, 2005). The mean odds-ratio for Wilson et al.'s (2005) meta-analysis was 1.02. A recent meta-analysis that examined multiple types of interventions, revealed that interventions based on a philosophy of discipline (including military style boot camps) were significantly associated with increased recidivism (Lipsey, 2009). While military style activities are only one element of the MAC intervention, findings presented in this literature make further systematic evaluation of the programme's long-term effectiveness imperative.

3.2.2 Intensive Wraparound Service

The Intensive Wraparound Service (IWS) is run by the Ministry of Education and provides a range of intensive support services for young people from years 3 to 10 with highly complex and changing behaviour, and social or educational needs, including those with an intellectual impairment. A young person may be referred to IWS through special education staff or a Resource Teachers: Learning and Behaviour (RTLB). The aim of IWS is to support children and young people to learn new skills and ways of behaving, stay at or return to their local school, behave in a positive and social way, and enjoy a successful home and school life.

Once referred, each young person is assessed by a psychologist. An individualised plan is then developed in conjunction with the young person, their family/whānau, school staff, and/or any other agencies also involved with the young person (e.g., CYF). This plan may include management strategies, resources for the classroom to provide support for the young person, professional development and training for the young person's teacher, and/or the young person being admitted to a residential special school. An overview of these residential schools is provided in Section 3.3.2.

More information about IWS can be found on the Ministry of Education's website at: http://www.education.govt.nz/school/student-support/special-education/intensive-wraparound-service-iws/. More information regarding educational programmes for young people with significant conduct problems is outlined in Chapter Eleven, Section 11.2.

3.2.3 Engaging Challenging Youth Project

CYF's Engaging Challenging Youth Project (ECYP) involves providing intensive social work support for challenging young people engaging in high-risk behaviour. The project was established in June, 2012 due to the high-risk posed by some young people whose needs were not being adequately met. ECYP's vision is 'our young people are engaged, involved, have strong support, and receive best and creative practice from a team with collective responsibility.'

The ECYP team comprises one supervisor and three social workers. As such, there are low caseload numbers and a high-level of contact with young people. The model involves the stabilisation and engagement of the young person, identification of their risks, strengths and needs, development of an individualised plan, implementation and management of the plan, and the reviewing of plans to ensure goals are met. The project aims to reduce each young person's risk, increase their stabilisation, increase the number of young people engaged in work, training and education, and improve their health and wellbeing.

3.2.4 Mentoring Youth New Direction

Mentoring Youth New Direction (MYND) is a community-based programme for young recidivist offenders. MYND is a Foundation for Youth Development (FYD) programme operated under contract by Edge Lifeskills Ltd. MYND aims to promote healthy behaviours and good decision making, support community-based transitions, and provides a multi-modal approach to mitigate ongoing risks. A young person aged 14 to 17 years who is subject to a Court Sanctioned Family Group Conference plan, Supervision Order, or Supervision with Activity order may be referred to MYND. Those subject to an Intensive Supervision order or a Social Workers Plan may be eligible, but admission is determined on a case-by-case basis. Young people with mental health concerns or who are referred for sexual offending may not be accepted.

Young people reside at their place of residence, as stipulated in their court plan or order. Each young person engages with MYND for up to 26 weeks for a minimum of six hours and maximum of 30 hours per week, depending on their plan or order. Within the first four weeks of the programme, each young person has an Individualised Development Plan (IDP) developed that identifies the young person's interests and strengths, determines goals while in the programme, barriers that may prevent the young person from achieving these goals, and strategies to overcome these barriers. An agreement regarding the young person's objectives while engaged in the programme is made with intended outcomes established. The IDP is the young person's 'road map' of intervention.

Staff employed by MYND include youth workers and social workers. Part of the youth worker's role is to increase life skills among the young people. MYND has various life skill topics that are covered: social skills, problem solving through decision making, health and wellbeing, identity development, and self-management. Youth workers all have a minimum of a Level 3 Youth Work qualification, and are enrolled with an Industry Training Organisation (ITO) for further professional development opportunities. Social workers all have a minimum of a Level 6 Social Work qualification. All staff receive Non-violent Crisis Intervention (NVCI) training.

3.2.5 Other programmes

A wide range of programmes are run within the residences by residential staff, community organisations, or the wider Ministry of Social Development. Examples of recent programmes include: kapa haka and other cultural programmes, carving, sports and fitness, driver's licence theory, tyre changing, fork-lift certification, vegetable gardening, personal grooming and hygiene, dental care, cooking programmes, barista training, and agricultural programmes.

3.3 Other residences in New Zealand

While reviewing CYF secure residences, it is important to consider how other secure and non-secure residences for young people in New Zealand currently operate.

Here, the features of some key residences for children and young people are briefly described, although this is not intended to be an exhaustive list. These residences are: the new youth forensic mental health unit; the Ministry of Education's residential special schools; Barnardos' specialist group homes and secure residence for young men with harmful sexual behaviours; Spectrum Care's residential homes and respite services for those with an intellectual disability and/or autism spectrum disorder; Hohepa Trust's residential services for children and youth adults with an intellectual disability; and the Ministry of Health's Disability Support Services' contracted residences for children and young people with disabilities.

3.3.1 Youth Forensic Mental Health Unit

A new 10 bed secure youth forensic unit is currently under construction, and will be opened at the end of April, 2016. This unit will exist alongside the existing 8-bed national secure intellectual disability youth forensic unit and the 13 bed regional youth mental health unit. The aim is for the unit to have a strong link with the youth justice secure residences and regional community youth forensic services.

This new youth forensic mental health unit is expected to cater for young people who are acutely unwell in residential services; however, the population of young people in secure residential care will still present with significantly complex needs.

Admission Criteria

Young people will be involved in the youth justice system and require an in-patient admission for an acute episode of severe mental illness. Typically, these young people will be in a CYF youth justice secure residence on remand or on a Supervision with Residence order, hence the need for admission to a secure youth forensic unit rather than a generic youth mental health unit. They will meet criteria for and be detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992. On rare occasions they may be identified at the youth court by a youth court liaison clinician as requiring an immediate admission.

Further information regarding the access criteria can be found in the Nationwide Service Framework in the youth forensic service specifications at http://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-services-specifications/youth.

Length of stay

Due to the unit being under construction, there is no data on the average length of stay for the young people admitted to the unit. It is expected that the length of stay will be variable (ranging from a few days to a few months), with most staying for between two and six weeks.

Model of care

The unit will be a secure 10 bed hospital and be used for the assessment and treatment of acute episodes of mental illness. When the young people are deemed well enough, they will return to CYF care, with community youth forensic (i.e., RYFS, Hauora, Capital & Coast DHB, and Canterbury DHB) follow-up on site in the residence they transition to. A range of assessment and treatment services will be provided.

A detailed model of care document is in preparation by Capital & Coast DHB in consultation with regional youth forensic services around the country and the Ministry of Health.

Staffing

Staff will include a range of individuals across multiple disciplines, along with specialist Māori and Pasifika staff.

Type of clients and their needs

In addition to the information provided in 3.1.1, the youth forensic client cohort typically has complex needs that span the domains of social and youth justice services, education and health, including treatment for multiple co-existing mental health and Alcohol and other Drug (AoD) difficulties. The youth justice population typically have high levels of challenging behaviour and self-harm.

Tailored service provision requires high levels of interagency collaboration that extends beyond admission to include robust transitional arrangements, a secure and supportive place to live following their stay in the unit, and pro-social adults who provide trustworthy and on-going care and guidance to ensure pro-social development.

Intervention programme/s offered

The service will provide mental health and alcohol and drug treatment, and will involve families when possible and appropriate. Access to specialist assessment/programmes such as sexual offending will also be provided. The service will have a bi-cultural and therapeutic milieu and an on-site school and gymnasium.

The unit will not offer long-term therapeutic programmes. In many cases treatment may be commenced while the young person is in the unit, with follow-up post-discharge in residence by the specialist youth forensic team working on-site in the residence. It is expected that the involvement of youth forensic teams post-discharge will be more extensive than just monitoring, with involvement most weekdays. The community team will also arrange for the continuation of care by community CAMHS or other mental health teams when the young person leaves the residence.

Physical restraint

The unit will seek to reduce the use of physical restraint in accordance with mental health best practice guidelines on restraint minimisation, but details will be part of the CCDHB operating procedures.

Models of transition

Collaborative planning with CYF around stable post-residence placement during the transition stage will be essential so that a young person has a place to live that is stable, safe and prosocial.

3.3.2 Specialist Residential Schools

Three residential Ministry of Education special schools exist: Salisbury School, Halswell Residential College and Westbridge Residential School.

Salisbury School, Richmond

Salisbury School is a school for girls with challenging behaviours and intellectual disabilities. The school operates under its own Board of Trustees.

Halswell Residential College, Christchurch

Halswell is a school for boys with challenging behaviours and intellectual disabilities. The school is able to enrol up to five girls. It operates under a Combined Board of Trustees with Westbridge Residential School.

Westbridge Residential School, West Auckland

Westbridge is a co-educational school for students with challenging behaviours/conduct difficulties that are not related to an intellectual or other disability need. The school operates under a Combined Board of Trustees with Halswell Residential College. Westbridge caters to young people aged from approximately 8 to 14 years, with most young people aged between 9 and 11 years.

The actual enrolments at the schools over the last two years have been significantly below the notional rolls established for the schools. This discrepancy is due to the Intensive Wraparound Service (IWS) increasingly becoming the preferred service option and with prioritisation focussing on the most challenging young people.

Admission Criteria

Each residence provides services for students aged 10 to 14 years on entry.

Criteria for enrolment:

- The referral must demonstrate that all local service options and expertise have been accessed but the student's educational placement, community and family/whānau well-being is still at significant risk.
- Under section 9 of the Education Act, placement in a residential special school must occur through an agreement between the Secretary of Education (delegated to regional managers) and the student's family/whānau/guardians.
- A "home placement" must continue to be available for the student because students return home for school holidays. A residential special school is not an option when CYF or other agencies cannot find a home for a young person.

The referral process:

- Students are identified and prioritised within each of the four Ministry regions.
- The regional prioritisation panel (which is Ministry led but involves principals and Resource Teachers: Learning and Behaviour cluster managers) ensure the student meets the criteria for IWS and then prioritises students on need and according to the number of spaces available in IWS.
- Students are referred through Resource Teachers: Learning and Behaviour or Ministry specialists.
- Referral is for the IWS, the practitioner making the referral must make a commitment to continued involvement with the students.
- Once accepted, the IWS psychologist develops a comprehensive plan for the student, and allocates funding to the student's school to implement the plan. The residential school will be considered as part of the three year intervention plan for the student or if the parent is requesting a residential school.

Length of stay

The average length of stay is twelve months (i.e., four school terms). This may be extended for one term if, for example, a student is due to leave in term four of the last year of primary school and intermediate. Therefore, transition may be deferred until the start of the following year.

Model of care

Residential special school placement is not a standalone intervention. Residential school placement is better regarded as an intervention option within the IWS service. It is expected that the residential school placement focuses on achieving specific goals outlined within the IWS plan. It is expected that the residential and school staff work together so that students experience consistency in approach and care.

Staffing

The schools have a teacher: student ratio of one teacher to five students, benchmarked against schools in CYF facilities, and based on the notional roll for the school.

The principal has overall management and leadership. The manager of residential services and the day school senior teacher report to the principal. Halswell and Westbridge operate a combined ministerially appointed board. Salisbury has its own board. The IWS plan may fund some specific evidence-based interventions for a student or their family/whānau while the student is at the school.

Type of clients and their needs

Clients are girls and boys with challenging behaviours and intellectual disabilities, or young people with challenging behaviours/conduct difficulties that are not related to an intellectual or other disability need.

Intervention programme/s offered

All educational programmes are personalised through an Individual Education Plan. Personalised approaches and interventions occur as part of the IWS plan based on assessment and goals established through the assessment process. Positive participation programmes/experiences, and specific life skills teaching are also personalised through the education plan.

As noted above, the family/whānau/guardians may be offered interventions, such as parenting programmes, while the student is at the residential school. Holiday programmes are also planned to maintain the momentum of the programme beyond term-time.

Physical restraint

Time out/isolation is used in two schools and all staff are trained in Non-Violence Crisis Intervention (NVCI). At one school there is limited knowledge of their approach; however, the school adopts a restorative approach around incidents.

Models of transition

Transition is planned at the outset. The typical pathway if residential school placement occurs is:

- Referral to IWS
- Comprehensive assessment led by an IWS psychologist
- For some students, residential school is identified as part of the plan
- Residential school placement and transition to the school is based on the IWS plan. All parties agree on the key goals and programmes to be implemented while at the school
- IWS remains involved and monitors progress, and the residential school adapt plans as a response to progress made
- IWS leads transition back to home community/school and funds a plan for 12 months post-residential school placement
- The student transitions back to local community supports/services/school.

3.3.3 Barnardos

Barnardos operate a number of specialist group homes located in Auckland, Hamilton and Wellington, for boys aged 10 to 17 years who are in the care of CYF. Three of these group homes are specialist Harmful Sexual Behaviour (HSB) homes, where young males have engaged in any sexual behaviour that is of concern for the CYF social worker. There are a maximum of five boys in each home. Barnardos also operates Te Poutama Ārahi Rangatahi (TPAR), a secure 12-bed residence for male adolescents with high risk HSB.

Admission Criteria

Young males must meet the following admission criteria:

- Young males as defined in the CYPF Act aged 12 to 16 years. With approval of the CYF High and Complex Needs Team, Barnados specialist group homes may accept young people aged 10 to 11 years old.
- Young males must be in the Custody of Child Youth and Family under an s101, s78, or s110 order. Other orders can be discussed with Barnardos.
- Young males must be attending therapy with SAFE, WELLSTOP or STOP and have a current assessment or report that includes a recommendation for the Barnardos Specialist Group Homes Programme.

Length of stay

The average length of stay at a Barnardos home for a young person is around 12-18 months. Length of stay can range from 6 months to 2.5 years. Length of stay depends on the client's progress at SAFE, and whether SAFE deem the young person to require long term or short term care.

Model of care

The model of care used in the home is the Barnardos Journey model. The theoretical underpinning of the journey model combines social learning theory, trauma theory, and attachment theory with an emphasis on supporting therapy for HSB. The model has a cultural base derived from New Zealand's Te Whare Tapu Wha and Fono'fale models. Staff have ongoing training covering all of these areas to ensure informed and up-to-date practice.

The model and its practice is monitored and guided by our residential social workers. Each boy is matched with a journey coach in-house (youth worker). The journey coach works with the boys to set, achieve and review goals from a strengths based perspective. Goals range from small house goals (e.g., making bed daily) to breaking down bigger goals set at their SAFE systems reviews (e.g., building trust with whānau).

A central component of therapy is the need for the boys to engage in 'normal' teenage activities. This enables them to demonstrate the new skills they are learning in a safe and monitored environment.

Staffing

Residential youth workers are well-established, with relatively low turnover over the last few years. Staff work a week-on and week-off system, working 80 hours in one week with seven sleepovers. Pay is commensurate with qualification, skill, experience and longevity. There are four full-time residential youth workers per residence, and a small pool of casuals who assist in covering any shifts. Sick leave is a rarity with this roster system.

Each residence has a qualified and experienced social worker who manages the day-to-day requirements and concerns of the clients. They liaise on a daily basis with clients, family/whanau, CYF, SAFE, schools and associated agencies, and are a critical component of the residence. They do not manage staff, but they direct staff on undertaking models of care and support them with key-working requirements. A team leader manages the residences and provides support and supervision to staff, and ensures the homes are visited and viewed several times a week.

Type of clients and their needs

The clients have all been referred by CYF through their local and/or national hub, and all have displayed some degree of HSB. Academically, a large percentage of clients are significantly behind their peers due to multiple placements, stand downs, exclusions and/or oppositional behaviours. Families are often fractured, unwilling, incapable or unable to cope with the boys' HSB and daily management. Many of the families have had CYF involvement for one or two generations.

Records indicate a higher proportion of Pākehā clients over the last 12 years. However, the ethnic breakdown of these young people needs to be considered in context with other factors, such as Māori and Pacific families preferring to have the young person undertake treatment from a safe extended family placement as an alternative to residence.

Education

Barnardos aims to build good relationships with local schools and alternative education programmes. Their residential social workers are pro-active in networking in this area, and maintain contact with a designated person within the education unit/school to ensure all issues that arise are dealt with immediately and do not, where possible, escalate to unmanageable levels. This support is essential to ensure the boys are positively supported to help them stay in the education system.

Physical restraint

All staff are trained by Barnardos in Non-Violent Crisis Intervention (NVCI) and are required to hold a current certificate. Barnardos have an unwritten policy of 'no restraints' in their specialist family group homes which has been successfully applied over many years. This 'no restraint' policy supports the therapeutic ethos of the homes. Only in extreme circumstances would staff intervene for their or another client's safety. On rare occasions, Police have been called in for support.

Transition

Transition back to family post-residence is the preferred option, but is not always what occurs. For some young people, care to independence is more appropriate and others cannot be re-located back with whānau and have therefore ended up in unsuitable boarding homes in the community. Some young people have remained in boarding situations at schools. CYF hold responsibility to have an adequate transition plan in place, with Barnardos and SAFE assisting where possible. On some occasions, CTI services of Youth Horizons Trust and Dingwall are used for those located in Auckland. While it is acknowledged that CYF are faced with a lack of suitable placements post-residence, the transition planning for these young people could be improved.

3.3.4 Spectrum Care

Spectrum Care operates a number of adult residential homes and a Child, Youth and Respite (CYR) Service in Auckland for individuals with an intellectual disability and/or autism spectrum disorder. The CYR service includes respite and residential care for young people. Each residential home has approximately four people. Several homes also have a separate flat, where individuals may reside in an independent living situation. These flats are monitored by staff. Some people live independently in flats in the community and these people are monitored by staff. Behaviour Support is provided by Explore Specialist Behaviour Advice NZ (Explore).

Admission Criteria

To receive services, a person must have an intellectual disability. All referrals to Spectrum Care are provided through Taikura Trust and/or CYF. Following a referral, Spectrum Care meets with Taikura Trust (or CYF) and the person's family, if appropriate. Current vacancies within Spectrum Care's services are discussed and whether they would be appropriate in meeting the individual's needs.

Length of stay

A person's stay in residential care may be for life. However, some individuals may transition to a supported living environment following an improvement in their skills and capabilities.

Model of Care

All residential services operate on a person-centred model. Spectrum Care also has an 'outcomes' philosophy, and uses Outcomes Brokers. The Outcomes process involves each person setting short- and long-term goals which staff are required to actively support and facilitate the achievement of.

Staffing

Residential services are staffed by Community Support Workers (CSWs), who work alongside people in the home. According to the needs of the people in each home, 24/7 care may be provided. CSWs complete training provided by Spectrum Care, and complete modules within the NZQA system.

CSWs are managed by a service co-ordinator, who is responsible for the operation of approximately three homes. The service co-ordinator oversees the operation of each home, and ensures that Outcome Plans and Behavioural Support Plans are up-to-date.

People and their needs

People who Spectrum Care support include young people and adults with an intellectual disability and/or those with autism spectrum disorder. Typically, adolescents aged 16 years and older are placed in residential services, and children are supported through respite services.

Intervention programme/s offered

Behavioural support is based on the Applied Behavioural Analysis and the Positive Support model. Services also operate on a holistic model of the individual.

Spectrum Care operates Aspiration Services, where people may participate in a day work service (e.g., lawn-mowing crew). Spectrum Care also operates Activity Centres where people can engage in a range of activities.

Young people may be enrolled in schooling up to 21 years of age. The transition co-ordinator may meet with a young person and discusses their dreams, ambitions and what they want to do after the complete school.

Physical Restraint

Spectrum Care staff are trained in Crisis Prevention Intervention (CPI). New staff employed by Spectrum Care are trained in CPI during their induction training. All staff must renew their CPI certification every two years. Spectrum Care adhere to the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.

Restraint may only be used as a last resort if a person is at risk of harm to themselves or others, after all other alternatives have been tried. Among 380 (approx.) people who live in Spectrum Care, approximately 36 have restraint included in their Behavioural Support Plans. Photos and scenarios regarding the restraint process for each individual are included in their plan. For those aged under 17 years, their restraint plan is reviewed every three months, and for those aged over 17 years restraint is reviewed every six months.

There is a list of 10 restraints that have been approved by the risk management group within Spectrum Care, which are individualised for each person. Staff are trained around these restraints, and they are practiced each month during team meetings. Typically, restraint may include escorting the client from one environment to another to help facilitate de-escalation of behaviour.

Restraint is monitored and an incident form is completed each time restraint is used. Spectrum Care has a restraint monitoring group, comprising behavioural advisors and consultants. The restraint monitoring group meet each month and review any new people that may require restraint to be included in their plan.

3.3.5 Hohepa Trust

Hohepa is a charitable organisation (trust) which provides services for children and adults with an intellectual disability. Hohepa provides residential and vocational/day services and a private boarding school for children aged between 7 and 21 years.

The following information regarding Hohepa's residential homes was primarily provided by Hohepa Hawkes Bay.

Admission Criteria

Clients must have a diagnosis of intellectual disability (ID) and receive Ongoing Resourcing Scheme (ORS) funding. For those under the age of 17, clients must have s141 (CYPF Act) Family Group Conference approval/agreement. Children must be compatible with existing

client groups at Hohepa, and require approval by the Ministry of Health (MoH) under the Memorandum of Understanding between MoH and CYF with regards to the s141 process. Before a placement at Hohepa is considered, all other options of support must have been explored.

Length of stay

At the initial Family Group Conference (FGC), it is determined that placement is for 12-months. At 12-months, the FGC is reconvened. Typically, the FGCs agree that placement at Hohepa will continue due to the complex needs of many children that receive Hohepa's services.

Model of care

The model of care can be best described as that of a 'residential boarding school', where the residential care is provided by an 'extended family'. This extended family consists of the house parents (i.e., house managers), a deputy (or assistant), and residential support workers. Hohepa, like many other Rudolf Steiner based organisations for people with disabilities, is often referred to as an 'intentional community'.

Staffing

Residential staff work split shifts, 8 hours per day. Each shift is led by either the house manager, assistant house manager, or a senior support worker. In addition, there is on-call 24/7 support for additional support and advice. There are also "awake" staff who work night shifts from 9pm to 7am. Due to the vulnerability and complexity of presentation of the children, the staff ratio is either 1:1 or 1:2. The role of the residential staff includes "parenting tasks", from personal care or training/teaching of household tasks (e.g., cooking, baking, cleaning, gardening). Staff also engage in recreational activities with the young people in their care. After further training, residential staff become key workers, which involves undertaking specific roles with individual children.

Staff who work within the school include teachers and teacher aides, therapists, and administration and kitchen staff. There is a close liaison between teachers and teacher aides and the residential support staff. Regular review meetings are held to consider the needs and subsequent progress of each child.

People and their needs

Over time, fewer children who have moderate intellectual disabilities have entered residential care; however, there has been a dramatic increase in the admissions of children who have Autism Spectrum Disorder (ASD). Currently, there are 37 residential pupils and one day pupil. Twenty-two children are subject to s141 orders, and one young person subject to a s101 (2) order. Thirty-four children have ID and ASD as primary and secondary diagnosis. The majority of children are severely or profoundly intellectually disabled.

Intervention programme/s offered

All young people have an Individual Education Plan (IEP) at the school and an Individual Developmental Plan (IDP) within the home. School staff and residential staff have input into both the IEP and IDP. The plans are then approved by the school principal and the Director of Services. The young person's family/whānau also have input into the development of the IEP and IDP.

The school receives ORS funding and operates the New Zealand and Waldorf school curriculum. Behaviour support is provided by Explore. The school and residential homes work together on the individual's development as well as the behaviour support programmes. These programmes are generally developed by specialist staff associated with Explore.

The young people's health and mental health support is provided through DHB services, with regular reviews of progress and consultation with staff and families. Young people have access to various therapies, speech and language therapy (including augmentative communication), art-therapy, music therapy, occupational therapy, and nursing therapy.

Physical Restraint

Hohepa uses non-violent intervention methods, namely Team-Teach (see www.team-teach.co.uk/intrudction_Aims.html). Hohepa has one external trainer and a number of in-house staff who have been trained to conduct in-house courses for all staff. The training occurs soon after induction, and refresher courses are held generally every two years.

Hohepa is obliged by its contract with the Ministry of Health to ensure that an ongoing reduction in restraint occurs. Hohepa has a restraint minimisation committee, chaired by the Director of Services. The restraint minimisation committee meets regularly and reviews

all restraints and also issues permission to use restraint for periods of up to three months, when this permission is then reviewed. All restraints are regarded as very serious incidents and are reported in both hard copy and electronically.

Transition

Transition planning commences when the young person turns 18 years of age. However, entry into the adult residential community cannot be guaranteed by Hohepa.

3.3.6 Disability Support Services

The Ministry of Health's Disability Support Services (DSS) contracts a number of community-based residential support services for children and young people with disabilities, including Autism Spectrum Disorder, or intellectual, physical or sensory disabilities. The young people who receive these services are aged between six and twenty years. Under certain guardianship conditions, as notified by the Ministry, the age range may extend to 20 years. However, young people aged 17 years will typically receive adult services.

All DSS funded residential placements for children and young people are approved under s141 of the CYPF Act, 1989. This section applies to any child or young person considered so severely mentally or physically disabled that suitable care for that child or young person can only be provided through the care of an organisation or body approved under s396.

Admission Criteria

Services are provided to children and young people with Autism Spectrum Disorder or an intellectual, physical or sensory disability that have needs that would be best met in a residential service as determined by a Family Group Conference (FGC).

DSS fund Needs Assessment and Service Coordination agencies (NASC) to work with children, young people, and their families to ensure appropriate supports are coordinated to support the child or young person to remain in the family environment. Such involvement may include a multi-agency approach. The NASC will identify whether residential care is the most appropriate option to support the disability needs of the child or young person. To guide the decision of whether an out-of-home placement is required, the NASC will take into consideration a range of factors, including the needs of the child or young person, the sustainability and suitability of the current supports, and access to community supports (both funded and unfunded).

Coordination of an appropriate placement

The NASC process will identify the level of support that is required to safely support the child or young person. This will include staffing levels (e.g., 1:1 or need for 'awake' staff), support required to complete Activities of Daily Living (ADL), and need to access specialist services, including behaviour support.

The NASC will work with the child or young person and their family to identify an appropriate placement with an s396 provider. This includes discussion with providers to ascertain whether a suitable placement is available to meet the individual needs of the young person. Placement allocation will also take into account factors including:

- Compatibility with other children and young people in the house, including consideration of health needs and behavioural difficulties
- Gender and age mixing (in line with the United Nations Convention on the Rights of the Child)
- Ability of the provider to meet the specific disability needs of the young person. The Ministry of Health has responsibility for issuing certificates for all children under s141 to ensure that the provider has the appropriate facilities and staff to meet the disability support needs of the individual (s141(4)).

No out-of-home placements can be agreed or coordinated until a Family Group Conference (FGC) under s145 of the CYPF Act is convened. Prior to the commencement of the FGC, the Ministry of Health approves the funding and placement of the young person.

Length of Stay

When a child or young person has been referred to an out-of-home placement under s141, this typically becomes a permanent arrangement resulting in a home for life into adulthood. The FGC expects that the voluntary out-of-home-placement must be reviewed annually, and a plan implemented for the young person's transition back to their family and region of origin.

Model of Care

There is no one particular model of care for children. Instead, the DSS supports the choice and flexibility of the young person and family to choose the most appropriate

service provider for them. Guidelines for service provision are outlined in the DSS's service specification, s396 approval from CYF, and the best practice standards included in the Safer Organisations Safer Children guideline.

Staffing

The provider is responsible for employing competent staff for adequate hours for the needs of the children or young people to ensure 24-hour service provision. Staff should be experienced to provide a level of service relative to the child or young person's assessed needs. In addition, guidelines outline that providers must provide staff induction training and ongoing professional development, ensure 24-hour back-up and that adequate relief is available to staff, ensure that support and supervision is provided to staff, and monitor the quality of care provided by staff in accordance with the relevant standards and legislation. Staff are provided training in abuse and neglect, fire safety, first-aid and medication management (including PRN).

People and their needs

Those who receive DSS are children and young people with disabilities, including Autism Spectrum Disorder, or intellectual, physical or sensory disabilities. These children and young people have continuous support needs and require out-of-home residential services. Services are also provided to young people with disabilities and experiencing a mental illness if referred by a NASC.

Intervention programme/s offered

The NASC and residential provider have access to the following interventions, funded by the Ministry of Health:

- Specialist Behaviour Support Service
- Equipment and Modification Service
- District Health Board for medical requirements
- Mental Health services.

Once a young person enters residential services, they no longer have access to child development services. Staff have access to specialist clinical input where necessary.

Physical Restraint

Staff are trained in restraint minimisation, risk and safety plans, challenging behaviours, and crisis intervention.

3.4 Effects of Secure Residential Care

This section provides a brief overview of the impacts secure residential care can have on children and young people in the youth justice system. This is not intended to be a thorough overview of the short-, medium-, and long-term effects of secure residential care. Instead, the aim of this section is to highlight research that emphasises the CYPF Act 1989's legislation that detention in custody should only be seen as a last resort (section 4 (f)), and that young people should be placed in the least restrictive environment for the shortest period of time possible.

Young people in secure residential settings are seen to experience a range of negative outcomes, which are suggested to be the by-product of the residential setting itself (Ryan et al., 2008; Lee & McMillen, 2007). In secure residences, youth are exposed to high risk peers, which through the process of socialisation, can subsequently lead to the development of deviant attitudes and behaviours (Ryan et al., 2008), such as substance abuse, academic problems, aggression, and delinquency (Lee & McMillen, 2007), through the process of socialisation. The negative outcomes among incarcerated young people seem to be further exacerbated when ties to family and pro-social peers in the community are severed (Ryan et al., 2008). Research suggests that separating young people from their families and communities makes adapting socially, personally and academically in residence that much more challenging (e.g., Moreno Manso et al., 2011).

Ringle et al. (2012) assessed outcomes among young people 12-months post-discharge from residential care, and found those who left residential care who had received the lowest level of restrictiveness had better outcomes in terms of reintegration into their family home and number of placements following residential care. These low-restriction residences involved the use of the Teaching Family Model (see Chapter Seven, Section 7.2 for an overview).

For those remanded in secure residential care, they face high levels of uncertainty concerning the length of their detention and the outcome of their case (Freeman & Seymour, 2010). For these young people, time becomes "limbo time, a waiting game, a seemingly limitless sentence to unsentenced time" (Neustatter, 2002, p. 52). Freeman and Seymour (2010) interviewed 62 young

people age 16 to 21 years about their experiences of uncertainty while on remand. The findings from their interviews indicated that the uncertainty of being on remand exacerbated the existing difficulties of these young people, with a number of psychological and social effects including high levels of anxiety, a sense of having no control, and feelings of hopelessness. The authors concluded that these young people are being held in custody and exposed to a range of negative effects "at a time when a presumption of innocence is supposed to exist" (Freeman & Seymour, 2010, p. 138).

3.4.1 Recidivism

One of the main purposes of residential youth justice programmes is to reduce youth reoffending. However, there is growing evidence to suggest that detaining youth is generally ineffective and may even increase their levels of antisocial behaviour (Gatti, Tremblay & Vitaro, 2009; Lane et al., 2002). For example, Mendel (2011) found 70-80% of young people who had gone thorough residential programmes for their offending reoffended within a three year period. Research has also shown that majority of young people do not continue engaging in delinquent behaviour, with offending typically desisting before adulthood even among the most serious young offenders (Mulvey, 2011).

Grietens and Hellinckx (2004) conducted a narrative review of five meta-analyses (three from North America and two from Europe) regarding the effects of residential treatment among youth offenders. With regards to recidivism, the overall mean effect size was 0.17, with the treatment of young offenders resulting in a 9% reduction in recidivism. The authors concluded that residential treatment may have beneficial effects. However, these results should be interpreted with the understanding that there was diversity in the studies included in these meta-analyses. Therefore, strong conclusions regarding the effectiveness of residential treatment on youth offending could not be made.

De Swart et al. (2012) conducted a meta-analysis of 27 studies to examine the effectiveness of institutional youth care. The authors compared institutional Evidence-Based Treatment (EBT) with non-institutional EBT, institutional care as usual (e.g. regular group care) with non-institutional care as usual (e.g. foster care), institutional care as usual with non-institutional EBT, and institutional EBT with institutional care as usual. Evidenced-based strategies appear to have common elements of being community-based, family-centred and having wrap-around services involving collaboration between youth justice, mental health, academic and other services (Lambie & Randell, 2013). In addition, evidence-based strategies also appear to target real-world risk factors to help ensure that treatment results have the best possible chance of generalizing beyond residence (Henggeler, 2003). Please see Table C1 (Appendix C) for an overview of the studies included in De Swart et al.'s (2012) meta-analysis.

Results from De Swart et al. (2012) found an overall mean effect size of d=.129, with individual study effect sizes ranging from d=−.690 to d=1.806. The results of the analysis showed that the only significant effect size was when institutional EBT was compared with institutional care as usual (d = .34), suggesting that institutional care can be as effective as non-institutional care, and more favourable outcomes are seen among youth in institutional care when EBT is implemented.

The research outlined above highlights that less restrictive or non-residential programmes should be the most utilised option, when possible. However, institutional programmes that use well-grounded evidence-based approaches can produce good results (e.g., De Swart et al., 2012). The latter is an especially important consideration for the populations of high-risk young people with complex needs for which non-residential treatment may not be appropriate.

Summary

There are four youth justice secure residences in New Zealand. Detainment in one of these residences is used in order to protect the young person from harming themselves or others, to provide a secure and safe environment that is rehabilitative, and for the imprisonment of a minority of young people sentenced under the Corrections Act 2004 by the District or High Court. When determining the course of action for a young person who has engaged in offending behaviour, it is important that such action aligns with the CYPF Act's philosophy of the safety and well-being of children and young people being paramount, and Part 4's statement that detention in custody should only be seen as a last resort. This aligns with the aforementioned research which highlights that less restrictive or non-residential programmes should be the preferred option wherever possible. However, optimal outcomes can be achieved with institutional programs using well-grounded evidence-based approaches.

Part A: Summary

The New Zealand youth justice population in secure residential care present with highly complex needs and a myriad of difficulties. The purpose of secure youth justice residences are to protect these young people from themselves or others, to provide a secure and safe environment that is rehabilitative, and for the imprisonment of a minority of young people sentenced under the Corrections Act 2004 by the District or High Court.

Young people in youth justice secure residences are some of the most vulnerable and at-risk young people in New Zealand. It is a group of young people we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of services in which they exist to best address the needs and improve outcomes for this population, their families, and the community. Part B provides an overview of the national and international research and best practice literature regarding services for the youth justice population.

Part B: Secure Residential Care - National and International Research and Best Practice

Understanding the national and international research and best practice literature regarding the care and management of the youth justice population is important to help guide service provision in New Zealand in order to provide the best level of care and enhance outcomes for this population of young people. Chapters Five to Fifteen describe international youth justice systems and continua of care, frameworks to guide youth justice services, models for secure care and step down care, assessment, rehabilitative models, cultural frameworks, educational programmes, crisis management models, how the needs of different youth justice subpopulations can be met while in secure residential care, and transition and aftercare models.

Chapter 4: International Youth Justice Systems and Residential Care

Examining overseas models and systems for the care and management of the youth justice population can be beneficial to identify aspects that could be implemented for this population in the New Zealand context to enhance outcomes for these young people, their families and the community. This chapter provides an overview of international youth justice systems, comparisons between New Zealand and international youth justice jurisdictions, international initiatives aimed at reducing reliance on the use of secure residential care, and international continua of care.

4.1 Youth Justice International Systems and Residential Care

Here, a brief overview of the youth justice systems of England and Wales, Scotland, the United States, Nordic countries and Australia is provided. Where information was available, an overview of the role of secure residential care for this population in each jurisdiction is also described.

4.1.1 England and Wales

The English and Welsh youth justice systems are governed by the Crime and Disorder Act 1998, specifically Part III. Under section 117(1) of the Act, a young person is a person between the age of 14 and 17 years. Young offenders are dealt with by separate specialist youth courts which are part of the Magistrate's Court. The primary aim of the English and Welsh youth justice systems, as stated in section 37(1) of the Crime and Disorder Act 1998, is to prevent offending by children and young people. Under section 50 of the Children and Young Person's Act 1933, the age of criminal responsibility (i.e., the age at which a person can be convicted of an offence) is 10 years old.

Secure Children's Estate[24]

A sentence, detention, or remand order can be placed on a young person (< 18 years) by the Court. The Youth Justice Board for England and Wales then decides whether the young person is placed in a Secure Children's Home (SCH), a Secure Training Centre (STC), or a Young Offender Institution (YOI). The SCH, STC and YOI comprise the Secure Children's Estate. In England there are 16 SCHs; 15 of which are managed by local authorities and one by a charity (Nugent Care). There is one secure children's home in Wales which is managed by a local authority. There are four STC, eight male YOI, and three dedicated female YOI.

SCHs provide care and accommodation to children and young people who have been detained or sentenced by the Youth Justice Board (YJB) and those who have been remanded to secure local authority (LA) accommodation. They also accommodate and care for children and young people who have been placed there on welfare grounds by LAs and the courts. STCs and YOIs are used for young offenders. More specifically, young people aged 10 to 14 and 15 to 16 year old girls will typically be placed in an SCH or STC. 15 to 17 year old boys and 17 year old girls may be placed in an SCH or STC if the Youth Justice Board and Youth Offending Team agree that it would be in the young person's best interest and they do not pose an unmanageable threat of harm to other young people or staff within those establishment types. Those 15 to 17 year old boys and 17 year old girls not placed into STCs or SCHs will normally be placed in the catchment YOI located closest to their home unless there are good reasons why this may not be appropriate (e.g., co-defendants, rival gang members, unavailability of places).

A child or young person aged 12 to 17 remanded to youth detention accommodation can be placed into an SCH, STC or YOI depending upon their age, risk, needs and individual circumstances. Children aged 12 to 14, or girls aged 15 and 16, would not normally be placed into YOIs.

Under section 73 of the Crime and Disorder Act 1998, young offenders can also be placed under a Detention and Training Order where half of the sentence is served in custody and the other half in the community. This tends to be made for young people who are over the age of 15, but may be ordered if a young person under the age of 15 is a persistent offender, or if the order is necessary to ensure public safety.

The use of 'secure accommodation' is dealt with under section 25 of the Children Act 1989 and the Children (Secure Accommodation) Regulations 1991. Section 25 of the Children Act 1989 states:

24 Information sourced from the Youth Justice Board for England and Wales (2014), from the following website: www.gov.uk/government/publications/placement-information-form-pif-and-guidance.

A child being looked after by a local authority may not be placed, and if placed, may not be kept in a secure accommodation unless it appears:

a. That he/she has a history of absconding and is likely to abscond from anything other than secure accommodation; and

b. If he/she abscond he/she is likely to suffer significant harm (section 25(1)(a));

Or

c. If he/she is kept in anything other than secure accommodation he/she is likely to injure him/herself or other persons (section 25(1)(b)).

4.1.2 Scotland

Children's Hearings Scotland (CHS) is responsible for dealing with children and young people under 16 years who commit offences, or who are in need of care and protection. Children under 18 years may be dealt with by CHS under circumstances where the young person is in the supervision of CHS when he or she reaches 16 years and the supervision requirement is extended, or where their case is remitted to the hearings system for disposal following conviction by a court (The Scottish Parliament, 2011).

Under section 42(1) of the Criminal Procedure (Scotland) Act 1995, no child aged 12 years or more but under 16 years may be prosecuted for any offence except on the instructions of the Lord Advocate. Where bail is not considered appropriate for a young person who appears in court for an offence, they can be remanded in the care of the local authority under section 51 of the Criminal Procedures (Scotland) Act 1995. The local authority is then responsible for placing the young person in secure care. Young people convicted of an offence in court can be sentenced to detention in secure accommodation under section 205 or 208 of the Criminal Procedures (Scotland) Act 1995. The Scottish Ministers are responsible for placing sentenced young people in suitable accommodation.

In Scotland there are 5 secure care establishments which provide approximately 90 beds. Before any young person can be placed in secure accommodation, the children's panel must consider that the young person meets the legal criteria set out in The Children's Hearings (Scotland) Act 2011:

a. The child has previously absconded and likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental, or moral welfare would be at risk;

b. The child is likely to engage in self-harming conduct; or

c. The child is likely to cause injury to another person.

4.1.3 United States

Although specific policies, practices and legislation differ across the various jurisdictions of the United States, all of the states recognise that young people who commit crimes differ from adult offenders. This is acknowledged through the implementation of a separate youth justice system. The primary goal of the United States youth justice system is the rehabilitation of young people who offend (Juvenile Law Center, n.d.). Both community-based and residential options are available to the courts when young people offend.

The age of criminal responsibility ranges from as young as 6 years in North Carolina, to 10 years. In 38 of 50 states, young people under the age of 18 years are included in the youth justice system, while in nine states only those under the age of 17 are included, and in three states only those under the age of 15 are included. Most states allow young people to remain under the supervision of the youth court until the age of 21 years (Juvenile Law Center, n.d.).

Detainment in residential placement is more common in the United States than in many other countries. The Office of Juvenile Justice and Delinquency Prevention (2011) report that one in every five young people who appears before the court is detained. The majority of these young people are detained in secure (locked) settings. In 2006, there were 2,658 juvenile justice residences housing 92,093 young people (Read & O'Cummings, 2010).

4.1.4 Australia

The Australian youth justice system addresses the offending behaviours of young people aged 10 years and older. In all of the Australian states and territories the age of criminal majority is 18 years, wherein an offender is treated as an adult and no longer comes within the youth justice system, with the exception of Queensland where the age of criminal majority is 17 years. While legislation and policy differs between states and territories, the general processes for charging and sentencing young offenders, as well as the types of legal orders available are similar. For instance, diversion is a key principle in all states of Australia.

The wider Australian youth justice system is based on two key principles, both of which are incorporated in state and territory legislation: young people should be detained only as a last resort and for the shortest appropriate period. These principles are consistent with the United Nations Convention on the Rights of the Child and the Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules).

Queensland is the only state to have removed the "last resort" principle from its youth justice legislation. Under Part 9 of the Youth Justice and Other Legislation Amendment Act 2014, a new section (150(5)) has been inserted into the Youth Justice Act 1992 to state that the court must not have regard to any principle that a sentence of imprisonment should be imposed only as a last resort, and that the section overrides any other law or Act in force.

The Australian Institute of Health and Welfare (AIHW) (2015) report states that on an average day in 2013-14 approximately one in 433 young people aged between 10 and 17 were under youth justice supervision in Australia. The majority of young people under supervision in Australia are under community supervision, with 16% in secure detention (AIHW, 2014). Indigenous young people are significantly more likely to be under supervision (15 times more likely) and more specifically detention (24 times more likely), than non-indigenous counterparts (AIHW, 2015).

All states and territories have secure youth justice residences, however, numbers vary with New South Wales having the most with seven residences, while Tasmania, the Australian Capital Territory, and Southern Australia have one each. Attempts were made to make contact with several states of Australia for information regarding the services provided in secure residential care for the youth justice population.

4.1.5 Nordic Countries

The Nordic countries of Norway, Sweden, Finland, and Denmark – are known for having significantly lower imprisonment rates for both adults and adolescents than most other Western countries (Lappi-Seppälä, 2011). Although the legal systems between the four countries differ, multiple commonalities exist. A discussion of the Nordic legal systems (Iceland is omitted due to lack of comparability and language barriers) and apparent reasons for their significantly lower imprisonment rates is presented below.

The age of criminal responsibility in all Nordic countries is 15 years, except for Denmark where the age of criminality is 14 years. Although children under this age can still be subject to a criminal investigation, there can be no legal conviction (Lappi-Seppälä, 2011; Storgaard, 2005). In addition, parents and child welfare authorities must be notified and be present for any interview with a person under 14 years (Lappi-Seppälä, 2011; Storgaard, 2005). Children under the age of 15 years are not allowed to be detained for more than 24 hours or be detained in a jail cell. After 24 hours, the child must be released (Storgaard, 2005).

In all Nordic countries, the principle motivation behind any decisions regarding children who have committed a crime is made in consideration with the child's best interests at the forefront, with no intention of punishing the young person (Storgaard, 2005; Willumsen & Skivenes, 2005). For this reason, all children under the age of 15, and the majority of those aged 15 to 17 years, are referred directly to the Child Welfare Service (Barnevernet) rather than a youth justice-type service. Young people aged 15 to 17 can receive a judicial punishment, or can receive social support. Typically, social support is the most common outcome, with punishments such as confinement only used for the most serious offences or when the social welfare system has been unable to manage the behaviour (Lappi-Seppälä, 2011; Storgaard, 2005).

Both Finland and Sweden have specific youth prisons, while Norway and Denmark do not (Storgaard, 2005). In all Nordic countries, if a young person is detained in a youth or adult prison, every effort is made to have that

young person housed as close to their home as possible in order to best support that young person to remain in contact with their family (Storgaard, 2005).

Similar to New Zealand, young people may be detained in residential care if they pose a serious threat to their own or others safety, usually due to significant behavioural issues and repeated offending, mental health issues, or drug and alcohol abuse (Storgaard, 2005). However, in most Nordic countries, young people in residential care for criminal behaviours are housed with young people placed in residential care for child welfare reasons; though they may have different freedoms and processes in place within the residence (Storgaard, 2005). Although these two populations of young people appear to have many differences, the underlying factors associated with their risk and problematic behaviours are considered to be the same: a history of abuse, neglect, exposure to violence, drug and alcohol abuse, and poverty.

All four Nordic countries favour interdisciplinary collaboration when dealing with these young people, including input from biological parents, social welfare authorities, mental health services, unemployment services, and any other relevant parties that are deemed appropriate to include in discussions regarding the best interests for the young person (Willumsen & Skivenes, 2005).

In Norway, the political climate has created a move away from the use of residential care facilities, and an increase in the use of foster care. However, as is the case in many countries, placement in foster care is limited due to a lack of appropriate available foster families (SOS Children's Villages Norway, 2013).

Current research suggests that the residential care provided in Nordic countries is not significantly more effective in reducing criminal behaviour or improving outcomes for young people who are in care for offending-related behaviour (Lindqvist, 2011). Secure residential youth facilities in Sweden have been widely criticized for providing harsher environments than necessary and inconsistency in provision of treatment or rehabilitation to the young people sentenced (Lappi-Seppälä, 2011). Problems associated with residential care in Sweden appear to be similar to those in New Zealand (Chapter Four, Section 4.1.5), with challenges including young people arriving at residential care without a plan from social services, a lack of involvement and monitoring of care while the young person is in the residential facility, as well as inconsistency in treatment programmes (or lack thereof) (Lappi-Seppälä, 2011; Lindqvist, 2011).

Although the residential care services provided to young people in Nordic countries do not appear to provide better outcomes, significantly lower imprisonment rates are still found among these countries. These lower rates of imprisonment could be attributed to the justice systems in Nordic countries viewing the young person as not fully responsible for their actions, with an aversion to the use of custodial sentences, and the overarching philosophy of having the young person's best interests at the forefront of plans implemented. Interventions implemented are Child Welfare Service-run interventions using a wraparound multidisciplinary approach for these young people.

Summary

Despite variations between international youth justice systems, jurisdictions appear to incorporate elements of both the justice and welfare models into multi-faceted, wrap-around services. Most youth justice systems have goals that are diversionary and emphasise community based programs whenever possible in order to reduce youth crime (Murphy, McGinness & McDermott, 2010).

4.2 Comparisons between New Zealand and International Youth Justice Systems

Drawing comparisons between international jurisdictions in the use of residential care and detainment of young people involved in the youth justice system is difficult due to the differing calculation of rates of young people in care (i.e., number of young people in care per day versus per year), definition of what is considered residential care, and whether out-of-home care is considered a supportive service or coercive measure (Gilbert, 2012). Furthermore, international jurisdictions have different legislation, policy and practice for the care and management of the youth justice population. Given these difficulties in obtaining valid comparisons, the current review did not set out to provide a comprehensive examination of differences across jurisdictions. Here, we present available data across several jurisdictions regarding age of criminal responsibility, inclusion of 17 year olds in the youth justice system, estimated proportion of young people in residential care, and average length of stay (where data are available).

4.2.1 Age of criminal responsibility

The most defining characteristic of youth justice systems are the ages at which young people are considered responsible for criminal actions. Internationally, this ranges from 6 to 18 years old, with an average age of 14 years. The age of criminal responsibility for a number of countries, including New Zealand, is presented in Table 2 below.

Table 2. Age of Criminal Responsibility

Age (years)	Country
10	Australia, England, Wales, United States of America
12	Canada, Greece, Netherlands, Scotland
13	France, Israel
14	Austria, Denmark, Germany, Italy, New Zealand (except for murder and manslaughter in New Zealand which is 10 years old)
15	Finland, Iceland, Norway, Sweden
16	Japan, Portugal, Spain
18	Belgium, Luxembourg

4.2.2 Inclusion of 17 year olds in the Youth Justice System

As outlined in Chapter Two, New Zealand does not include 17 year olds in the youth justice system. This is a well-noted difference between New Zealand and international youth justice systems. Australia (with the exception of Queensland), Canada, England, Wales and most states in the United States of America (38 of 50) include 17 year olds in their youth justice systems. Such inclusion of 17 year olds in the youth justice system is in line with the United Nations Convention on the Rights of the Child 1989 defining children as any person under the age of 18 years, neurodevelopmental literature, and is in line with research showing better outcomes are achieved when young people receive the lowest level of the criminal justice system (Maxwell et al. 2004). For more information regarding the inclusion of 17 year olds in the youth justice system, refer to Lambie, Ioane and Best (2014) and Becroft (2009).

4.2.3 Estimated Percentage and Rates of Young People in Residential Care

Table 3 displays the percentage and rates of young people in residential care across several jurisdictions identified by Ainsworth and Thoburn (2014, p. 17). Please note that these percentages and rates do not distinguish between those who have been detained in residence due to reasons relating to child welfare (i.e., care and protection) and youth justice.

Table 3.Estimated Percentage and Rates of Young People in Residential Care

Percentage of children in residential care	Country	Rates per 10,000 children in total population	Country
0-10	Australia, Ireland	<10	Australia, England, Ireland, USA
11-20	England, USA	10-29	Italy, Japan, Scotland, Spain
21-30	Hungary, Scotland, Spain, Sweden	30-39	Hungary, Israel
31-40	France, Romania	40-49	France, Germany
41-50	Denmark, Italy, Poland, Russian Federation	50-59	Denmark
51-60	Germany Lithuania, Ukraine	60-69	Armenia, Romania
70-95+	Armenia, Czech Republic, Israel, Japan	70-99	Poland
		100+	Czech Republic, Lithuania, Russian Federation, Ukraine

To the best of the authors' knowledge, there are no reported percentages and rates of young people placed in residential care in New Zealand. However, as at 31 March 2015, there were 4,119 children and young people in out-of-home care placements (CYF, 2015).

4.2.4 New Zealand and International Youth Justice Secure Facilities

The number of secure facilities (including secure residences), total number of beds, number of young people detained each year, legal orders resulting in detainment, and average length of stay under the youth justice system across several jurisdictions are presented in Table 4.

Table 4: New Zealand and International Youth Justice Secure Facilities

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legal orders resulting in placement	Average length of stay
New Zealand[a]	Four secure residences (46 beds – 6 are District Court custodial sentences). Three Youth Units managed by the Department of Corrections.	202 distinct client admissions each year. Total of 542 clients admitted each year (average).	s235 (Arrest), s238 1(d) (Remand), and s311 (Supervision with Residence). 20-30% of those in secure youth justice residences in New Zealand have Supervision with Residence orders. The most common order (70-80%) detaining young people in residential care is s238 1(d) (Remand)	The average length of stay for a young person on remand is 46 days. Those under Supervision with Residence orders are detained in secure residential care for a minimum of three months and a maximum period of six months, with scope for early release.
England and Wales	England: 15 secure children's homes managed by Local Authorities (254 places) [c], one secure children's home managed by a charity. Wales: one secure children's home. Of the 16 English homes, 7 provide welfare places only and the remainder provide both welfare and youth justice places. 8 male and 3 female Young Offender Institutions *, and 4 secure training centres (301 places). [d]	Average population in youth secure estate custody in 2013/14 was 1,216 (< 18 years) [b] Average custody population (including 18 year olds) in youth secure estate was 1,318. [b]	Over half (57%) of the average population of young people (under 18) in custody in 2013/14 were serving a Detention and Training Order (DTO). A further 21% were held on remand. The remaining 22% were serving long-term sentences (s90, s91, s226, s228, and s226B). [b] Remand – accounted for 21% of the average custody population 2013/2014. [b]	Average time spent on remand was 51 days in 2013/2014 [b] Time in days spent in custody for young people (under 18): 90 days in 2013/14. For DTOs: 109 days For longer sentences: 409 days. [b]
Scotland [e]	5 secure care establishments (90 beds).	2013-14 average of 74 clients in secure care. Total of 232 admissions between 1 August and 31 July 2014.	Remand: Section 51 of the Criminal Procedures (Scotland) Act 1995.** Sentenced to detention: section 205 or 208 of the Criminal Procedures (Scotland) Act 1995.	In 2014, total population: 16 % - less than one month 17% - 1 to 2 months 17% - 2 to 3 months 28% - 3 to 6 months 11% - 6 months to 1 year 10% 1 year or more.

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legal orders resulting in placement	Average length of stay
United States	2,547 youth facilities (Oct, 2012; Office of Juvenile Justice and Delinquency Prevention). [f] Types of facilities: 696 Detention centres, 142 shelters, 62 reception/diagnostic centre, 417 group homes, 52 ranch/wilderness camps, 184 training schools, and 774 residential treatment centres. [f] Size of facilities range from < 20 residents to 201+. [f]	Of 1,985 facilities that detained youth offenders (< 21 years) in Oct 2012, 57, 190 youth offenders were held in facilities. f Residential placement: approximately 61,000 young people were in residential placement in October 2011. [g]	Residential placement: Young people may be committed to a facility as part of a court-ordered disposition, or they may be detained prior to adjudication or after adjudication while awaiting disposition or placement elsewhere. In addition, a small proportion of juveniles may be admitted voluntarily in lieu of adjudication as part of a diversion agreement. [g] In 2011, 68% were committed to residential placement, while 31% were detained. [g]	Among young people admitted to residential placement at the time of the 2011 and 2013 censuses: [h] Detained: 11.2% - 0 to 1 days 14.1% - 2 to 6 days 16.0% - 7 to 13 days 11.3% - 14 to 20 days 11.0% - 21 to 30 days 14.8% - 31 to 60 days 7.1% - 61 to 90 days 8.9% - 91 to 180 days 3.9% - 181 to 365 days 1.1% - 366 to 545 days 0.6% - over 545. Committed: 2.2% - 0 to 1 days 3.2% - 2 to 6 days 4.4% - 7 to 13 days 3.8% - 14 to 20 days 5.9% - 21 to 30 days 12.1% - 31 to 60 days 11.7% - 61 to 90 days 25.1% - 91 to 180 days 20.3% - 181 to 365 days 6.0% - 366 to 545 days 5.1% - over 545.

Country	Number of secure facilities (# of beds)	Number of young people detained per year	Legal orders resulting in placement	Average length of stay
Australia [i]	Tasmania (one facility; 51 beds). New South Wales (seven facilities; ~ 450 beds). [j] Victoria (three facilities; ~216 beds). [k] Australian Capital Territory (one facility; 40 beds). Queensland (two facilities; ~222 beds). Northern Territory (two facilities; 35 beds). Western Australia (two facilities; ~302 beds). South Australia (one facility; 60 beds).	In 2013-14, 951 young people in detention on an average day. [i]	There are differences in legislation, policy and practice in each State's youth justice system. This includes different types of supervised orders and options for diversion. [i] Nationally, of those in detention in 2013-14, 52% were unsentenced (awaiting the outcome of legal matter or sentencing). [i]	Nationally (2013-14): [i] Sentenced detention: 106 days. Unsentenced detention: 40 days.
Norway	No youth prisons. Young people are held in adult prisons.	0.1% of the prison population (13 March, 2015). [l]	Pursuant to the act relating to Child Welfare Services, sections 4-24 et seq., a juvenile below the age of 18 who has displayed serious behavioural problems either in the form of serious or repeated crime, or of persistent abuse of intoxicating substances, or in other ways, may, as a last resort, be compulsorily placed in an appropriate institution for up to four weeks with the possibility of one renewal up to 12 months.	-

a Hand & Tupai. (2015). Overview of Child, Youth and Family's Secure care and protection and Youth Justice Residences

b Ministry of Justice (2015). Youth Justice Statistics 2013-14 England and Wales. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/399379/youth-justice-annual-stats-13-14.pdf

c Department for Education (2015). Children Accommodated in Secure Children's Homes at 31 March 2015. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/431660/SFR15-2015_Text.pdf

d UK Government (n.d.). Fact Sheet: Secure Colleges. Retrieved from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/322165/fact-sheet-secure-colleges.pdf

e The Scottish Government. (2015). Children's Social Work Statistics Scotland, 2013-14. Retrieved from: www.gov.scot/Resource/0047/00474429.pdf

f Office of Juvenile Justice and Delinquency Prevention (2015). Juvenile residential facility census, 2012: Select findings. Retrieved from: www.ojjdp.gov/pubs/247207.pdf

g Office of Juvenile Justice and Delinquency Prevention (2014). Juveniles in residential placement, 2011. Retrieved from: www.ojjdp.gov/pubs/246826.pdf

h Sickmund, Sladky, Kang & Puzzanchera (2015). Easy access to the census of juveniles in residential placement. Retrieved from: www.ojjdp.gov/ojstatbb/ezacjrp/.

i Australian Government. (2015). Youth Justice in Australia 2013-14. Retrieved from: www.aihw.gov.au/publication-detail/?id=60129550638

j NSW Government. Information about Centres: www.juvenile.justice.nsw.gov.au/Pages/Juvenile%20Justice/aboutdjj/centres_information/centres_information.aspx

k New Zealand Parliament. (2011). Youth Justice in Victoria. Retrieved from: www.parliament.nz/resource/0000177660

l Prison Studies: Norway; obtained from: www.prisonstudies.org/country/norway

* At the time of review, the authors were unable to comment on the capacity of the current YOIs operating.

** At the time of review, the authors were unable to comment on the proportion of remand beds.

Summary

Drawing comparisons between New Zealand and international youth justice systems about the use of secure residential care is difficult due to the differing standards and philosophies regarding the purpose of secure care, age of criminal responsibility, thresholds for remand, and the availability of alternatives to remand. Nevertheless, it is useful to place New Zealand's youth justice system in an international context to see how it aligns with other jurisdictions.

4.3 Reducing Reliance and Use of Secure Residential Care for the Youth Justice Population

In line with the view that community-based treatment is more effective and beneficial and that young people should be detained in the least restrictive environment, international initiatives and projects and youth justice systems have been developed to increase the use of community-based treatment approaches and out-of-home care models (e.g., Teaching Family Model), consequently reducing the number of young people in secure residential facilities. Such international initiatives include: the Alternatives to Custody for Young Offenders by the British Association for Adoption and Fostering, and Juvenile Detention Alternatives Initiative. These two initiatives are described below.

4.3.1 Alternatives to Custody for Young Offenders – The British Association for Adoption and Fostering

The British Association for Adoption and Fostering (BAAF) ran a two-year European project from January 2013 to December 2014 with six agencies across the United Kingdom, Italy, Bulgaria and Hungary to determine a good practice model for implementing intensive fostering services as an alternative to custody for young offenders. The project aimed to provide multi-agency networks with training programmes, including core minimum standards, practice guidelines, national policy guidelines, and information for the young people. The project involved researching 'what works' as identified in the literature and social work practice, qualitative research conducted with service professionals, foster carers, and young offenders and their families, as well as consultations with policy makers.

Findings were presented at the final 'Alternatives to Custody for Young Offenders' conference on 2 December, 2014; however, information regarding the project at present is limited. For more information, refer to the BAAF website at www.baaf.org.uk/ourwork/developing-intensive-and-remand-fostering-programmes , and the Eurochild website at www.eurochild.org/projects/alternatives-to-custody-for-young-offenders.

New Zealand Context

It is recommended that CYF follow-up on the findings and/or results released on this project to determine any guidelines or recommendations that may be applicable for such services in New Zealand.

4.3.2 Juvenile Detention Alternatives Initiative

Recognising that placement in a locked detention centre can have significant negative consequences for young people, the Annie E. Casey Foundation launched the Juvenile Detention Alternatives Initiative (JDAI) project in the early 1990s to reduce reliance on local confinement of court-involved youth. JDAI has now been adopted in approximately 300 counties in the United States.

The JDAI objectives are accomplished through a comprehensive detention reform model, with eight core inter-related elements: *collaboration* (between the court and agencies to implement the detention reform), *collection and utilisation of data* (to identify problems and assess the impact of reforms), *objective admissions screening, new or enhanced non-secure alternative to detention, case processing reforms* (that accelerate the flow of cases through the system, reduce length of stay in custody, increase availability of non-secure programmes), *new court policies and practices to deal with "special" detention cases, persistent and determined attention to combating racial disparities, and intensive monitoring of conditions of confinement*.

JDAI jurisdictions have achieved a reduction in average daily detention population by 43 percent. Of the 112 sites that have reported data, the year prior to implementing JDAI there was an average detention population of 7,426. Daily detention populations in these sites totalled 4,253 in 2011, resulting in a reduction of 3,173 young people per day in detention. Similarly, JDAI jurisdictions have found a decline in the number of young people committed to juvenile correctional facilities, with 5,254 fewer young people committed in 2011 than the year prior to implementing JDAI (12,321 versus 7,067).

4.4 Continuum of Care

A continuum of care is a system which guides clients through services over time, spanning all levels and intensity of care. It is important to take into consideration that secure residences comprise one part of the wider continuum of care that provides services to the youth justice population, and they do not operate in isolation. Here, two international continua of care are described: the Missouri Model of the United States, and Scotland's Kibble Education and Care Centre. These continua of care are models which are seen as providing high quality service for young offenders. Aspects of these models could be beneficial for implementation in the New Zealand context to strengthen the current youth justice continuum of care.

4.4.1 United States: The Missouri Model

The "Missouri Model" refers to the residential programmes for adolescent offenders implemented in Missouri in the United States. Managed by the Missouri Division of Youth Services (DYS), the Missouri model has gained national and international attention and praise. The Missouri model has been regarded as a "guiding light" with its approach to the rehabilitation of young offenders (Mendel, 2010), and as a model youth justice system (Lipsey et al., 2010). In 2008, The Kennedy School of Government at Harvard University named the Missouri DYS the winner of the "Innovations in American Government" award in children and family system reform, and compiled a case study on the model (Scott, 2009).

Detailed information regarding the Missouri model can be found in Mendel (2010), Scott (2009), Huebner (2013), the annual report for the 2013 fiscal year (Missouri Department of Social Services, 2013), and on the DYS Missouri model website (www.missouriapproach.org).

Overview

The restructuring of the youth justice system in Missouri began in the 1960's with the establishment of the dormitory-style W. E. Sears Youth Centre in Poplar Bluff, based on the positive peer culture model (Vorrath & Brendtro, 1985). The Positive Peer Culture model (Chapter Six, Section 6.1) aims to develop a positive prosocial environment to help facilitate and reinforce behaviour change.

The Missouri model currently consists of 32 residential facilities, which provide a total of 710 beds across secure, moderate care, and group home residences (Missouri Department of Social Services, 2013). In addition, diversion, community-based supervision for low risk young offenders, and dual jurisdiction programmes are provided.

The DYS's mission is to "help youth in custody make positive, lasting changes that lead them away from criminality and toward success" (Mendel, 2010, p. 36). In addition, the DYS has several core beliefs, including:

1. All people, including delinquent youth, desire to do well and succeed;
2. With the right kinds of help all youth can (and most will) make lasting behavioural changes and succeed; and
3. The mission of youth corrections must be to provide the right kinds of help, consistent with public safety, so that young people can make needed changes and move on to successful and law-abiding adult lives (Mendel, 2010, p. 36).

To help achieve its purpose and guided by these beliefs and philosophies, the Missouri model has six core elements: (1) small and non-prison-like facilities that are close to home, (2) a focus on individual care within a group treatment model, (3) safety is established through relationships and supervision rather than correctional coercion, (4) the model aims to build skills for success, (5) families are viewed as partners, and (6) there is a focus on aftercare (Mendel, 2010).

Continuum of Care

The Missouri model operates a continuum of residential facilities. Seven facilities are secure care facilities, 18 are moderate care and 7 are community-based (non-secure) residential group homes (Missouri Department of Social Services, 2013). Diversion, community-based supervision, and dual jurisdiction programmes are also provided. The Missouri Model's continuum of care and programmes offered are described below:

Level One: Community-based supervision

Approximately 12% of young people under DYS who have the lowest risk of reoffending are provided community-based supervision. Many attend "day treatment" centres, which are designed to divert lower-risk young people from being sentenced to residential care and services. The day treatment centres run each weekday and consist of education, vocational, and treatment and counselling services. After school the young people may participate in community service, academic tutoring, and individual or family counselling (Mendel, 2010; Missouri Department of Social Services, 2013).

Other young people in community care attend regular schooling, and receive a range of services, including family counselling, support groups, job assistance, life skills training, and supervision and support from mentors based in the community. These community care services are also provided to young people following their release from a residential facility, acting as a step-down service (Mendel, 2010; Missouri Department of Social Services, 2013).

Level Two: Group homes

Young people under DYS who have engaged in limited prior offending, have only committed status offences or misdemeanours, and are considered at low risk of reoffending, are typically referred to one of the non-secure group homes located across various regions of Missouri (Mendel, 2010). Between 10 and 12 youth reside in each group home where they attend education onsite, and are provided individual, group and family counselling. These young people spend substantial time in the community either working or participating in group projects or other activities. Young people typically reside in group homes for between 4 to 6 months (Mendel, 2010).

Level Three: Moderately secure facilities

Young people under DYS who are deemed higher risk and have engaged in more serious prior offending, including felony offences, are often referred to one of the moderately secure facilities (Mendel, 2010). These young people spend some time in the community, participating in community service projects and going on field trips, while under the close supervision of staff. Young people typically stay in moderate care for between 6 to 9 months (Mendel, 2010).

Level Four: Secure care facilities

Young people who have engaged in the most serious offending are typically referred to secure residential facilities (Mendel, 2010). Each residence often contains 30 young people, with a maximum capacity of 36. The residences are surrounded by high perimeter security fences and are locked at all times. Video cameras are set up in each secure facility, which are recorded and monitored by the central office. Although young people who reside in these secure residences participate in fewer activities based in the community, the activities are largely similar to those the young people residing in other residences in the wider continuum of care engage in. Community-based programmes are brought into the

facility, and when the young person has demonstrated progress in treatment, readiness and trustworthiness, they can be gradually reintroduced into the community. Young people typically stay in secure care for between 9 to 12 months. However, residing in a secure care facility can be extended if the young person does not demonstrate progress in treatment or readiness for release.

The Youth, Family and Community Juvenile Court Diversion Programme

The youth, family and community juvenile court diversion programme acts as a prevention programme for at-risk young people. Funded prevention and intervention programmes have accountability supervision, education services, support services, and individual and family counselling (Missouri Department of Social Services, 2013). Approximately $4 million per year is provided to the diversion programme from the DYS (Mendel, 2010).

Dual Jurisdiction Programme

The dual jurisdiction programme addresses the issue of separating young offenders under the age of 17 years from adult prisoners. It is a blending sentencing option, where both juvenile and adult sentences are imposed (Missouri Division of Youth Services, n.d.). The adult sentence is suspended, and the young person is admitted to the DYS dual jurisdiction facility (Mendel, 2010), which is a 40-bed residence located in Montgomery City. The treatment programme is similar to those implemented in other residences. Before the young person's 21st birthday, they must appear in court where a judge will decide to release the young person, sentence them to adult probation, or transfer them to adult prison. A young person aged 21 years and above cannot remain in the care of the DYS.

For more information, refer to the Dual Jurisdiction Statute (211.073 RSMo) and information provided on the Missouri Department of Social Services website at http://dss.mo.gov/dys/djp.htm

Assessment

To determine the level of risk the young person poses and what corresponding appropriate level of care to refer the young person to, the state of Missouri uses the *Missouri Risk and Needs Assessment and Classification System*. The classification system was refined through a risk assessment validation study and two revalidation studies (see Johnson, Wagner & Matthews, 2002; McElfresh, 2011). More information can be found in the manual (Office of State Courts Administrator, 2005), which can be retrieved from: http://www.courts.mo.gov/file.jsp?id=1198. Further information can be found on the Juvenile Offender Classification System Materials website at www.courts.mo.gov/page.jsp?id=1199.

Each young person entering Missouri DYS care takes a standardised test – the Woodcock-Johnson Psycho-Educational Battery-III. This helps measure the young person's progress on educational achievement during their time in residence.

Setting

Providing *small and non-prison-like facilities that are close to home* is a core element of the Missouri model. The number of beds in each facility ranges from ten to fifty, with an average of 20 beds (Huebner, 2013; Scott, 2009). The residences are located across five regions, and each region has an office and administrative staff. The 32 residences are located across a total of 26 campuses.

Emulating the rehabilitative ideal, all residences have a "home-like" feel, based on a small-group, dormitory-style model. Most facilities have recreational activity areas. Living areas have comfortable couches, rugs, posters, and residents' writings and art work. Many residences have live plants, and all have a pet, such as a cat, dog, and chickens. As mentioned previously, secure facilities have high perimeter fences, locked doors and video cameras; however, there are no barred windows, razor wire, or guards. All young people and staff wear casual clothing (Huebner, 2013; Mendel, 2010; Scott, 2009).

To allow active parent participation and maintain familial relationships, the DYS has the aim of placing young people within 50 to 75 miles of their home.

Connection with the community

The Missouri DYS aims to develop and maintain relationships between the residences and the community (Huebner, 2013; Mendel, 2010). These relationships provide valuable opportunities for the young people under DYS both during and after their time in residence. A community liaison council, made up of local leaders, such as county commissioners, business leaders, law enforcement staff, and ministers, supports each DYS facility to help create opportunities for these young people (Mendel, 2010).

Programme Model

Individualised case management

Each young person under DYS custody is allocated a single staff member (service co-ordinator), who is responsible for overseeing the young person's care before, during and after their placement in a DYS residence. The service co-ordinator works in a treatment team that consists of school, treatment service and facility staff, and advocates for the needs of the young person (Huebner, 2013). The pre-release plan is developed by the service co-ordinator in conjunction with the young person and their family. If a suitable environment cannot be provided by the young person's parents or extended family (e.g., grandparents, aunts and uncles etc.), the young person may be released into an independent living programme (Mendel, 2010).

Treatment

Individual care within a group treatment model is a core element of the Missouri model. The Missouri model implements a peer-centred treatment model, which proposes that change does not occur in isolation (Huebner, 2013). The young people stay in a dedicated small group of 10 to 12 individuals throughout their stay. In these groups, they participate in all activities, chores, treatment groups, and eat meals and sleep in the same dorm room together.

There is no specific treatment model, but rather an integrated treatment plan that emphasises group processes. Individualised treatment plans aim to meet the individual, psychosocial, educational, vocational, and health needs of each young person, including engagement in education and gaining vocational skills (Missouri Department of Social Services, 2013). Each evening the young people participate in group therapy. Sessions are facilitated by the team's group leader or an experienced youth specialist. Treatment targets often include communication and social skills, problem solving skills, conflict resolution, substance abuse prevention, establishing healthy relationships, esteem enhancement, and victim empathy enhancement (Missouri Department of Social Services, 2013). More detailed information of content covered in group therapy can be found in Mendel (2010).

The DYS also runs a Jobs Programme and provides medical health care services. More information on these services can be found in the annual report for the 2013 Fiscal Year (Missouri Department of Social Services, 2013).

Throughout the Missouri treatment programme, young people are seen to develop self-awareness and communication skills, progress academically, and are provided with opportunities for hands-on learning in real-world contexts. This reflects the core element of Building skills for success.

Education

Each day is highly structured, beginning with 6 to 8 hours of education in a classroom. The DYS-run school system is accredited and authorised to issue credits and diplomas (Scott, 2009). In each classroom, one certified teacher and a youth specialist, who is often a certified substitute teacher, work with a class of 12 or fewer students (Mendel, 2010). Young people who have been discharged from DYS but feel more comfortable in the education system are able to continue their education in the community with DYS until graduation (Huebner, 2013).

Family engagement

The view of families as partners is a core element of the Missouri model. Family are seen as a central component of the treatment and intervention of these young people. Family are encouraged to attend the regular visiting hours scheduled by each facility. In addition, increased family contact, and in some cases family visits, can help facilitate the re-entry of the young person back into the community (Huebner, 2013).

Indeterminate sentencing

Approximately 80 percent of youth under Missouri DYS care are given indeterminate sentences by a judge. This allows the Missouri DYS to determine how long a young person should be in their care based on their treatment progress and readiness to re-enter the community, what residential programme the young person should be referred to, and when a young person should transition out of the residence and their services (Mendel, 2010). This is in contrast to other states where young people are sentenced for a fixed period of time, and judicial approval must be obtained before they can be released from a facility, and whether they are provided aftercare or are released from state supervision.

This type of sentencing provides an incentive for the young person to engage, participate fully and complete treatment stages to shorten their stay under DYS care. This system also demonstrates the faith the judges in Missouri have in the Missouri model for youth offenders (Mendel, 2010).

Level system

For the young people given an indeterminate sentence, their progress through the treatment programme is tracked using a level system. The process generally has four levels or stages:

1. Orientation – young person adjusts to the DYS procedures and facility environment
2. Self-discovery – young person begins to gain awareness of current problems, behaviours, personal and family history, and takes responsibility for their past offending-related behaviour
3. Integration – the young person applies what they have learnt and adopts a leadership position in their group. The young person is encouraged to communicate positively with their family, and participate in jobs and activities in the community
4. Transition – a post-release plan is developed that sets up the young person for success when they are released into the community

There are no black-and-white guidelines for when a young person should move from level 2 (self-discovery) to level 3 (integration). This is determined by the staff and service co-ordinator, with feedback given from the other youth in the young person's group. A young person cannot leave a DYS residence until they complete these levels. The only exception to this is if the young person 'ages out' of the system.

Intensive Case Monitoring

Focus on aftercare is a core element of the Missouri model. Each young person who is released from a residential placement back into the community is provided intensive case monitoring, which includes 'aftercare.' The aftercare programme implemented by the Missouri DYS is similar to the successful Intensive Aftercare Programme (Altschuler & Armstrong, 1994), where a continuum of service are provided from the time the young person is in residential care to their release back into the community (see Chapter Fourteen).

Correctional coercion versus constant and attentive supervision and leadership

With regards to the core element of safety through relationships and supervision, each group of young people is under constant supervision by at least one youth specialist 24 hours a day, seven days a week. At least two staff members supervise each group in the secure residences (Mendel, 2010). There is zero tolerance for physical aggression or emotional abuse; however, staff treat the young people how they would treat any other - with respect (Mendel, 2010). The staff also aim to facilitate healthy relationships in the residences.

One controversial aspect of the Missouri model with regards to safety is the training of the young people under DYS care on how to restrain another youth when they threaten the safety of others in the group. No programmes that have implemented the Missouri model have incorporated this peer-restraint component into their programmes (Mendel, 2010).

Staff and Training

To achieve the core beliefs and philosophies held by the Missouri model, and to create an environment that is therapeutic and facilitates healthy relationships, staff quality and training are crucial. Staff employed by the DYS are of a high calibre – motivated and highly trained (Mendel, 2010). Youth specialists are the frontline staff who act as facilitators, supervisors and treatment agents in the DYS residences (Scott, 2009). Family therapists are employed by the DYS, and contractors are only used to provide specialised treatment. To apply for a youth specialist position, 60 hours of college experience is required. The majority (84%) of youth specialists have a bachelor's degree or two years of experience working at the DYS and 60 hours of college experience (Mendel, 2010). Educational staff employed have typically worked with young people with diverse education-related difficulties and various backgrounds, and staff are accredited using the same criterion as Missouri public schools (Huebner, 2013).

Youth specialists must complete almost 300 hours of training in their first two years of employment, and 40 hours of training each year subsequent to this to reinforce and build on new techniques and skills (Huebner, 2013; Mendel, 2010). The training curriculum covers youth development, group facilitation, and family systems (Mendel, 2010). In addition, staff are trained in counselling skills, conflict management, group dynamics (e.g., cliques), and to notice changes in facial expressions and body language (Mendel, 2010).

Crisis Management and Restraint

The Missouri model's restraint system is controversial. The Missouri model trains the young people under DYS care how to restrain another youth when they threaten the safety of others in the group. Staff are the only ones who are authorised to request peer-restraint, which involves the group taking the young person's arms and legs and holding the youth on the floor until they gain composure. The group then discusses the events that led up to the incident and how they can recognise and prevent similar occurrences from happening in the future. No programmes that have implemented the Missouri model in their jurisdiction have incorporated this peer-restraint component into their programmes (Mendel, 2010).

Cost

In the 2013 Fiscal Year, the total expenditure for the Missouri DYS was $58.2 million. $52.4 million was allocated to treatment services, $2 million (3.5%) to central and regional offices, and $3.7 million (6%) to juvenile court and diversion (Missouri Department of Social Services, 2013).

Implementation

The Missouri model has been replicated across the United States in Louisiana, New Mexico, Washington DC, and parts of California. Mark Steward, the previous director of the Missouri DYS set up the Missouri Youth Services Institute to help other areas of the country implement the Missouri model. The required cultural change to successfully implement the Missouri model has been identified as being a major reason other areas of the United States have not implemented the model completely (Scott, 2009).

Decker (2011) outlined four key factors identified by the Missouri DYS that are deemed critical in the implementation and maintenance of an effective youth treatment programme: strong organisational leadership, a change in organisational culture (including training and staffing), effective treatment strategies and approaches, and constituency building and buy-in.

Evidence

In the 2013 Fiscal Year, of the 962 young people discharged from the DYS, 834 (86.7%) were considered to have 'satisfactorily' completed the programme, and 88% were considered to have productive involvement in the community (i.e., participation in education and/or employment) (Missouri Department of Social Services, 2013). With regards to recidivism, 87.6% had not returned to DYS care or were not involved with the adult justice system after one year post-discharge, while 65.7% remained 'law-abiding' after three years. Of those who did return to DYS care or had involvement with the adult correctional system within three years post-discharge, 7.4% were recommitted to DYS, 5.2% sentenced to imprisonment, 2.1% sentenced to adult 120-day shock incarceration, and 19.5% sentenced to probation (Missouri Department of Social Services, 2013).

One external evaluation of the Missouri model was funded by the Annie E. Casey Foundation (Mendel, 2010). In comparison with Arizona, Indiana and Maryland, Missouri had a smaller proportion of young people sentenced to adult imprisonment within three years of being discharged from residence (23.4%, 20.8%, 26% and 8.5%, respectively). Similarly low rates of committing a new offence or being sentenced to adult prison or probation were found among those discharged from Missouri in comparison with youth justice systems in Florida, New Jersey, Michigan, and Wisconsin (Mendel, 2010).

According to Mendel (2010), in comparison with 97 facilities in the Council of Juvenile Correctional Administrators' Performance-based Standards project, Missouri facilities have notably fewer assaults against youth, assaults against staff, and the use of mechanical restraints and isolation. No young person in DYS custody has committed suicide in the past 25 years since the closure of the Missouri training schools (Mendel, 2010).

In the 2013 Fiscal Year, 85 DYS students earned their high school diploma, and 85% of those who attempted to obtain a General Educational Development (GED) (n = 414) were successful. At their time of discharge, 40% of those over 16 years of age and 44% of those aged 17 years had graduated with a high school diploma or GED (Missouri Department of Social Services, 2013). In the Fiscal Year 2013, 82% of young people progressed in reading achievement, and 81% in writing and mathematics achievement at an equal or greater rate of growth compared to same age peers (Missouri Department of Social Services, 2013). Three-quarters of young people under DYS care advanced academically on par with students in public school, which is in contrast to national estimates where only 25% of young people in confinement made similar academic progress to typical students (Mendel, 2010).

Limitations

Despite the aforementioned promising recidivism rates of the Missouri model, such findings have come under scrutiny. Some have questioned the reliability of comparing recidivism rates between Missouri and other states, when each state has their own definition of what constitutes 'recidivism' (Scott, 2009). In addition, the Missouri model has not been evaluated using methodologically strong methods, such as randomised clinical trials (RCTs) or quasi-experimental studies (Huebner, 2013). Furthermore, no comparisons have been made between the Missouri model and other youth justice programmes with appropriate comparison groups. Further research is required, including a systematic process evaluation to determine components of the model that are essential for positive outcomes (Huebner, 2013).

Another limitation of the Missouri model relates to its ability to be replicated in other jurisdictions. Despite more than 25 states visiting Missouri to observe the model, only a few States have implemented the model. This was attributed to the huge cultural shift required to implement the model, which requires a great deal of commitment (Scott, 2009).

Recently, Mae Quinn, a Professor of Law and Director of the Juvenile Law and Justice Clinic at the Washington University School of Law, outlined several wider issues with the Missouri youth justice system. In her review, Quinn (2013) noted that the Missouri model operates beside failing state education, a conflicted court structure, and lack of free representation. In addition, nearly 2,000 young offenders are currently serving imprisonment in Missouri's adult prisons, with 84 serving mandatory life without parole prison sentences. Such sentences are now deemed unlawful by the Supreme Court of the United States. Thus, although the Missouri model is demonstrating much success in the care and rehabilitation of youth offenders, there are issues in the wider Missouri youth justice system that need to be acknowledged and improved to provide better outcomes for such young vulnerable people.

4.4.2 Scotland: Kibble Education and Care Centre

Kibble Education and Care Centre (Kibble) is an independent, charitable service in Paisley, Scotland (Kibble, 2015). It is run as a social enterprise where any financial surplus made is reinvested back into the organisation. Kibble caters to young people aged between 5 and 25 years with significant social, emotional and behavioural needs.

Kibble's purpose is to provide a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences and training to allow them to be successful in independent life. Key values include safety, structure, stability and success. A strong emphasis throughout the various programmes and interventions provided by Kibble is that these young people are vulnerable and in need of care and protection.

Continuum of Care

Kibble provides secure care, residential services, day services, intensive fostering, education and training, and transitional support. All services aside from secure care are intended as preventative alternatives to secure accommodation.

Secure services

Where a secure placement is required, this is available at one of three secure residences located within the Kibble 'Safe Centre'. At any one time up to 18 young people may be in secure care. These secure services provide a safe and secure environment for young people aged between 12 and 18 who are at risk of harming themselves or others, or who are considered as being at a point of crisis. Young people are referred to the secure service by either the Children's Panel or by a court order. Kibble has three units each of which house a maximum of six young people.

The secure services are integrated with all of Kibble's other services ensuring that those in secure care can still benefit from a care plan integrated with their education, access to specialist intervention services, a supported transition to their next stage and access to employment and training services.

Residential services

Kibble also provides residential services for looked after young people, both girls and boys, who have been referred by local authorities around Scotland. Residential care is available for up to 64 young people with a maximum of 8 beds per unit. Kibble has 10 units which cater to young people with a range of difficulties including severely traumatised young people, young people who exhibit extremely challenging behaviour and who need stability in their lives, those who display high risk behaviour requiring ongoing support and intervention, young people with a history of disruption, and those who generally need extra support. There are also smaller units with 2 or 4 beds for young people who have difficulty coping with larger groups and those who struggle with group living. One unit, Clyde, is specifically designed as a direct alternative or step down from secure care and is for young people who exhibit a range of harmful and inappropriate behaviours.

Three additional residences are also available to support young people leaving Kibble to return to the community. In these, young people are helped to prepare and adjust to life beyond school and residential campus living and are offered support when ultimately moving into independent living.

Day services

Kibble also provides day services with three day units. These are an alternative way for young people in their local community to access Kibble's education services. These young people often have a history of failed educational placements and disrupted learning, and some have learning difficulties such as dyslexia, as well as Autistic Spectrum Disorders and established patterns of offending behaviour.

Each young person who is enrolled in the day service has their own key worker who works closely with them and teaching staff to overcome barriers to learning. Young people work with their key worker to formulate plans and are updated regularly on their progress. In recognition of the trauma experiences of many of these young people, the day units are designed as spaces where young people can relax and have fun. This includes areas designed specifically as a calm space to be used during times of crisis. Holiday programmes are also available which involve activities and residential trips across the United Kingdom.

Intensive day services are also available as an alternative to residential care. This is intended to provide the young person with extra support outside of normal day service hours. This may include evening and weekend work (may involve hobbies/activities or extra time with key worker), family work (where the key worker spends time rebuilding relationships) and wrap around on call service for young people and their families.

Intensive Fostering

The Kibble fostering service provides homes for vulnerable young people (aged between 5 and 25 years) where foster care is considered the best alternative to living with their families. Two services are currently available and one will be opening in 2015. These are: Intensive Fostering Services (for those aged 12-18 years offering continuity of care), Adult Placement Services (allowing young people to continue living in their foster family home until they are 25), and Merton House Care Home (opening 2015: a care home for up to five children aged between 5 and 12 years with the aim of easing the transition to foster care).

Education and Youth Training

Kibble provides education services, both primary and secondary level, for young people who have difficulty staying engaged in learning. Each class has a maximum of five young people. The syllabus is flexible and includes practical activities, vocational training and qualifications, and academic qualifications. Additional opportunities are also available such as participating in the Duke of Edinburgh Awards or the Young Enterprise Scotland project. A peer mentoring system is also in place.

Kibble offers supported employment within KibbleWorks (a collection of small social enterprises) for young people aged between 16 and 25 years who face barriers to employment.

Framework and Programmes

All services are provided internally at Kibble with integrated care and education, in order to best enable young people to fulfil their potential. Within Kibble, young people are able to have their educational, mental health, physical health and social needs all met on site.

Staff undergo a high level of training which includes training in areas related, but not limited, to trauma, emotional regulation, anxiety regulation, harmful sexual behaviour, social skills training and self-harm and suicide. There is an awareness of both the importance and prevalence of previous trauma experiences faced by many of the young people at Kibble.

Kibble's in-house Specialist Intervention Services (SIS) offer young people access to a team of forensic psychologists, social workers, family and programme workers. The Psychological Team delivers full forensic psychological assessments and therapies. The Programme Team delivers numerous evidence-based programmes and individually tailored interventions. The Family Service offers both group and individual family work.

There are two levels of psychological assessment available at Kibble. Within the first 72 hours at Kibble all young people are given the opportunity to undergo a psychological assessment. The aim of this is to screen for any acute mental health issues, substance abuse or suicidal/self-harm behaviour, as well as to identify any potential supports and the nature of any further specialist intervention services. The results of this first level psychological assessment are reviewed every 6 weeks. A second level psychological assessment is also available where necessary and is completed within 6-8 weeks. Such an assessment will only be completed if it is considered in the best interests of the young person and the public, and if it is proportional to the psychological needs of the young person.

A range of interventions are available at Kibble to support the needs of young people. Some of the programmes offered are outlined below.

Kibble implements The Ross Programme which is a cognitive skills development course addressing difficult and anti-social behaviour. The course aims to teach skills and values that promote social behaviour. The programme has been found to be successful at reducing the risk of re-offending and improving behavioural, and specifically conduct, difficulties (Curran & Bull, 2009). Kibble also implements the Substance Misuse programme which aims to reduce harmful substance abuse in young people.

The Offending is not the Only Choice programme addresses criminal behaviour with a focus on morality, victim awareness and consequential thinking. This programme has been found to reduce offending and seriousness of offending, and to be sustained over time (Glasgow Youth Justice Programmes Team, 2008). The Violence is not the Only Choice programme aims to reduce aggressive and violent behaviour by promoting calming techniques, conflict resolution and self -management. Kibble also implements the Keeping Cool, Thinking Smart: Managing Anger programme which aims to assist young people to control their anger with a focus on understanding the consequences of uncontrolled anger.

Short programmes on offer, typically used in a stand-alone or introductory setting, include motivational sessions, Eye Max (teaches young people to express their emotions to the maximum) and Anger Management Programme: Turn Down the Volume.

Tailored interventions provided by Kibble include Cognitive Behavioural Therapy, Eye Movement Desensitisation and Reprocessing (for use with individuals with severe trauma histories), Treating Problem Behaviours: A Trauma Informed Approach, Talking it over counselling service, Young Person's Family Work Programme and the Safer Lives Model.

Kibble also provides support to the families of young people. All families are offered general advice and support when their young person is placed within Kibble services. A group work programme named Handling Teenage Behaviour, carried out over 12 sessions, is available which allows families to share their experiences with other families. Interventions are also provided where necessary for the caregivers of young people with behavioural problems or the whole family.

Evaluation

In their "How good is our school?" evaluation of Kibble, Education Scotland reported that the young people were provided with a wide range of programmes and courses and that they benefited from having their curriculum tailored to their needs (Education Scotland, n.d.). Staff were reportedly highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.).

In their own evaluation of their interventions and programmes, the Kibble team reported that 100% of young people felt respected in sessions and 96% felt safe. In addition, 82% said that they had learned new skills (Kibble Education and Care Centre, 2015).

In a Care Service Inspectorate Report, the inspector reported that young people were actively involved in the making of decisions relevant to them and that they felt cared for, and that staff were working closely with young people to support their health and wellbeing (Care Inspectorate, 2013).

Limitations

Kibble has not been evaluated using strong methodology, such as RCTs or quasi-experimental studies. Furthermore, no comparisons have been made between Kibble and other jurisdictions with appropriate comparison groups. Further research is required, including a systematic evaluation to determine components of the model that are essential for positive outcomes.

Summary

Investigating what international models and systems of care and management are implemented for the youth justice population is useful for the consideration of what elements or aspects of these systems could be implemented in the New Zealand context to enhance current service provision. As outlined, international initiatives and projects have been implemented which increase the use of community-based treatment approaches and out-of-home care models to reduce the number of young people in secure residential facilities. Aspects of international continua of care, such as the Missouri model and Kibble Care, could be considered for possible implemenation in the New Zealand context. Due to limited data, few comparisons can be drawn between New Zealand and international youth justice systems. However, one notable difference between New Zealand and international jurisdictions is the exclusion of 17 year olds in the New Zealand youth justice system.

Chapter 5: Frameworks to Guide Secure Residential Youth Justice Services

A framework is as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as principles to guide the assessment and treatment process. Using a unified vision and framework can provide a structure to help ensure all agencies operating within the residential facility are encompassing the same philosophy and values, and are working toward the same aims. This chapter provides an overview of frameworks that can be implemented to guide services provided in secure residences for young people who have engaged in offending behaviour.

When interpreting the evidence-base for each framework, it is important to note that Randomised Control Trials (RCTs)[25] are considered the 'gold standard' of clinical trials, providing the most robust form of clinical evidence. RCTs provide strong foundations for drawing inferences about the effectiveness of frameworks for the youth justice population. Meta-analyses also provide useful estimates of the direction and magnitude of effects through statistically combining findings from independent studies. Therefore, for each framework, an outline of RCTs and/or meta-analyses conducted is provided. Where there is a lack of robust evidence, findings from studies using alternative study designs will then be discussed (e.g., pre-test/post-test, quasi-experimental designs); however, conclusions regarding the framework's effectiveness from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as "significant" are those that are statistically significant at the $p<.05$ level.

5.1 Risk, Need and Responsivity Model

The Risk, Need and Responsivity (RNR) model (Andrews & Bonta, 2010) is the prominent overarching model used for guiding assessment and intervention of the offending population in New Zealand and overseas.

The RNR model has three principles: risk, need and responsivity (Andrews & Bonta, 2010). According to the risk principle, risk of reoffending can be predicted, and the intervention and management of an offender should appropriately match the level of risk posed.

Risk of reoffending is assessed through static (i.e., stable) and dynamic (i.e., changeable) risk factors. According to the need principle, dynamic risk factors (also called criminogenic needs) should be the main target of intervention, given their association with reoffending. The responsivity principle states that intervention should match the characteristics of the offender, such as their learning style and capability (Andrews & Bonta, 2010).

To align with the RNR model, assessment tools should examine a range of factors found to be associated with risk, while also taking into account the developmental stage of the young person (Borum, Bartel & Forth, 2005). One such assessment tool, the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), is widely used as a risk assessment and case management tool, which provides assistance in the planning of intervention and risk management. The YLS/CMI aligns with the RNR principles, and has strong predictive validity among male and female young offenders (Olver et al., 2009; Luong & Wormith, 2011; Vitopoulos et al., 2012), including among New Zealand young offenders (Mooney, 2010).

To also align with the RNR model, interventions should be individualised according to the young person's identified risk, needs and capabilities (Trupin, 2007; Vieira, Skilling & Peterson-Badali, 2009), and use empirically-validated treatment approaches (Crites & Taxman, 2013; Jeglic, Maile & Calkins-Mercado, 2011). More information on how the RNR model can be applied to the youth justice system can be found in Brogan, Haney-Caron, NeMoyer and DeMatteo (2015).

Evidence and Limitations

The RNR model is considered a best practice framework for the assessment and treatment of adolescent and adult offenders (Crime & Justice Institute at Community Resources for Justice, 2009). Although the RNR model has predominantly been developed and researched in the adult offending population, two meta-analyses have indicated that the RNR model is also effective when applied to adolescent offenders (Dowden & Andrews, 1999; Koehler, Losel, Akoensi & Humphreys, 2013). These two meta-analyses are described below.

25 RCTs involve random allocation of participants to one of several interventions.

Dowden and Andrews (1999)

Dowden and Andrews (1999) conducted a meta-analysis of 229 tests concerning effectiveness of correctional treatment from 134 primary studies. Findings indicated that adherence to the RNR principles was associated with a reduction in reoffending. With regards to the risk principle, a larger mean effect size was found among interventions delivered to high risk (+.12) versus low risk offenders (+.03, p< .01). With regards to responsivity, the mean effect size for behavioural programmes was significantly larger than that for non-behavioural programmes (+.24 versus +.04, p< .0001). Finally, programmes that targeted criminogenic needs had a larger mean effect size than programmes that did not (.22 versus -.01, p<.0001).

Koehler et al. (2013)

Koehler et al. (2013) conducted a meta-analysis of 21 studies to examine the effectiveness of young offender rehabilitation programmes in Europe. Four studies used RCT and 8 studies used 'strong statistical control' methods, where groups were matched according to key variables. Findings indicated that programmes adhering to the three principles of the RNR model revealed the strongest mean effect (1.90), with a substantial difference in recidivism rates between treatment and non-treatment groups (16%). In addition, programmes were most effective when they addressed high-risk offenders (effect size = 1.63, p <.05), targeted multiple criminogenic needs (effect size for those "high" on addressing this =1.59, p <.05), and followed the principle of specific responsivity (effect size for those "high" in responsivity = 1.64, p <.05). A specific concern noted by the authors was the limited number of studies reviewed (7 of 25) that closely and strictly adhered to the RNR principles. No differences were found on outcomes between voluntary and mandatory programme participation.

Applying the RNR framework to the youth justice population is still in progress (Singh, Desmarais, Sellers, Hylton, Tirotti & Van Dom, 2014). Nonetheless, the RNR provides a well-established framework for guiding the assessment and treatment of adolescent offenders to help reduce recidivism and promote positive outcomes.

5.2 Strengths-based Approaches

Strengths-based approaches are premised on the belief that genuine change is much more likely if people are actively engaged in the process of goal identification and planning, rather than being subjected to treatment goals and plans made by others (Barton, 2006). As opposed to a strict focus on risk assessment or problem diagnosis, they look more broadly to also identify strengths and resources specific to the individual and their family/ wider community, and work to flexibly integrate these into a treatment or rehabilitation plan.

The Good Lives model (Ward, 2002; Ward & Brown, 2004), and Supportive Authority (Bush & Harris, 2010; Harris, Attrill & Bush, 2005) are two strengths-based models used with offender populations. While they are currently the two most relevant models to youth justice settings, it is important to note that strengths-based approaches were used with adolescents prior to their development.

5.2.1 Good Lives Model

The Good Lives Model (GLM) aims to help offenders develop internal and external resources that enable them to live a life that is personally meaningful, socially acceptable and free from criminal activity (Ward & Brown, 2004; Ward, Yates, & Willis, 2012). GLM has two interconnected, overarching goals: reducing and managing risk; and improving psychological wellbeing and attaining a good life (Ward & Brown, 2004). It is argued that the integration of GLM with the RNR model of offender rehabilitation offers a more comprehensive approach to offender rehabilitation (Wilson and Yates, 2009; Willis, Yates, Gannon, & Ward, 2013). While managing risk remains a priority, the GLM offers a strength-based framework that acknowledges the need to help offenders improve their psychological well-being and work toward a better life, for their own sake as well as for community safety.

The model assumes that all humans build their lives around their core values and follow some sort of implicit plan to achieve a 'good life' (Ward & Willis, 2013). It also assumes that universally, humans pursue legitimate, innately beneficial experiences, circumstances and states of mind that are referred to as primary human goods (Ward & Brown, 2004). The means to achieving these primary goods are referred to as secondary or instrumental goods. Under the GLM, antisocial behaviour is conceptualised as stemming from flaws

in an individual's good life plan, and either directly or indirectly related to the pursuit of primary human goods (Willis & Ward, 2013). It is posited that the primary goods a person values most highly are often linked directly to either their offending, or to the experiences occurring at the time of their offending.

A key component of assessment under GLM is to understand what primary goods are most important to the individual. Treatment is based on the construction of an explicit good lives plan, which takes into account the person's strengths, weaknesses and the wider ecological factors that impact on the achievement of this plan. Focus is placed on building internal and external capacities for achieving this good life through pro-social means, rather than targeting specific criminogenic needs to be 'fixed' or eradicated. Criminogenic needs are considered barriers to the achievement of a good life through pro-social means (Willis, Ward, & Levenson, 2014). Approach goals are prioritised with the focus on motivating offenders to change their criminal behaviour because of what is important to them (Ward et al., 2012). GLM also places explicit importance on the therapeutic relationship (Ward & Brown, 2004), which has been well-documented as essential to treatment success (Messer & Wampold, 2002).

Evidence and Limitations

With adult offending populations there is evidence that integration of the GLM is associated with increased engagement in the treatment process and higher completion rates (Gannon, King, Miles, Lockerbie, & Willis, 2011; Harkins, Flak, Beech, & Woodhams, 2012; Simons, McCullar, & Tyler, 2006; Willis, Ward, & Levenson, 2014). Preliminary evidence also suggests that clinicians like the GLM (Harkins et al., 2012; Willis, Ward & Levenson, 2014), which is important given therapist buy-in is a significant predictor of treatment success (Messer & Wampold, 2002).

Although the GLM was developed primarily for adult populations, it has started to be used in some adolescent programmes (e.g., G-map for adolescents who engage in harmful sexual behaviour, see Print (2013)); however evidence of effectiveness in these settings is currently unavailable. Research using sound methodology (i.e., RCTs) is needed to draw strong conclusions regarding the efficacy of the GLM model among the youth justice population in secure residential care.

5.2.2 Supportive Authority and The Strategy of Choices

Treatment resistance is often strongest from highly antisocial and very serious youth offenders (Florsheim et al., 2000). It has been suggested that coercing very anti-social or psychopathic offenders into treatment may lead to feelings of being controlled or manipulated, consequently leading to attempts to exert their own influence and power (Hemphill & Hart, 2002) - a process disruptive to both their own progress and wider group dynamics. The Supportive Authority approach respects offenders' right to choice and self-determination, while still prioritising public safety (Bush & Harris, 2010; Harris, Attril & Bush, 2005). A Supportive Authority or 'strategy of choice' approach has been offered as a way to tap into the need for power and control among some offenders, and has been used to aid therapeutic change (Hemphill & Hart, 2002).

The underlying principle of Supportive Authority is that change only occurs if a person chooses it and is actively engaged with the process (Harris et al., 2005; Bush & Harris, 2010). It is proposed that offenders often need two types of experiences to be in a position to change. Firstly, the opportunity to learn and practice skills that will help them observe how long-term, engrained patterns of thinking and behaving may have actually limited them and resulted in less self-autonomy; and secondly, the opportunity to choose to learn and practice skills that will help them understand and experience potential benefits of pro-social behaviours and cognitions. Over time, Supportive Authority aims to help offenders to create a realistic picture of what benefits potential change may bring, rather than assuming they will be motivated to change for the sake of benefits they have not yet experienced or are even able to imagine (Harris et al., 2005). Offenders are asked to make a series of choices – to actively opt in or out of learning successive skills before deciding if they see a benefit in change or not.

Instead of an adversarial relationship between facilitators and offenders, the aim is to challenge offenders' common perception that treatment is a restriction, and rather position treatment and interactions with authority as opportunities to enhance autonomy (Bush, 1995).

A key role of the facilitator is to carefully and transparently communicate the rules of participation, and the consequences of choosing not to participate. Rules are positioned as conditions under which people work together on their goals, rather than a tool in a power struggle (Harris et al., 2005; Bush & Harris, 2010). Offenders are required to make a conscious choice between accepting conditions and participating, or not accepting and not participating. Along with teaching skills, offenders are also constantly challenged to use these skills pro-socially, or alternatively, accept the consequences of using them anti-socially. The consequences of not participating or behaving antisocially are often related to the imposition of increased risk-management restrictions. In a way, this approach offers offenders a genuine opportunity to choose between self-managed risk reduction or external risk management (Harris et al. 2005).

Within this framework, the facilitator clearly communicates that they have no intention of trying to force change on anyone. Instead, the facilitator's role is presented as being to there to support individuals to learn skills that can help them make change or help them to make an active decision about change (Bush, 1995; Harris et al., 2005). This approach is intended to clearly demonstrate respect for participants' autonomy and freedom of choice. To genuinely adhere to this approach, facilitators must be comfortable with non-judgmentally respecting a participant's choice to not participate or to behave antisocially (Harris et al., 2005). However, it is equally important that authority is exercised and the consequences of this are carried out.

Evidence and Limitations

There appears to have been no research conducted examining the Supportive Authority and The Strategy of Choices among youth offenders. However, proponents of this approach argue it is consistent with both RNR and GLM intervention frameworks, which require individuals to make choices about changing parts of their life that are related to offending (Harris et al., 2005). Furthermore, in regard to treatment, there is a strong emphasis on dynamic risk factors, while the approach also specifically attempts to tap into the GLM primary good of 'sense of autonomy'. It has been suggested that fostering agency does play an important role in desistance within this population (McNeil, 2006; Walker, Bowen & Brown, 2013).

5.3 Trauma, Attachment and Neurodevelopment

Many young people in the youth justice system have been exposed to trauma. In one large study in the United States (n= 898), 92.5% of recently arrested and detained youth aged 10 to 18 years had experienced at least one trauma – with a mean of 14.6 and median of 6 separate incidents each (Abram et al., 2004). Childhood trauma is associated with developmental delays, depressive and anxious symptoms, suicide attempts, antisocial and violent behaviour, and substance misuse (Colquhoun 2009, Kaplow & Widom, 2007; Lansford et al., 2007; Mersky & Reynolds, 2007; Yampolskaya, Mowery & Dollard, 2014). Unsurprisingly, Post-Traumatic Stress Disorder (PTSD) is common among this population (Abram et al., 2004; Dixon, Howie & Starling, 2005). However, in young people, trauma symptoms stretch far beyond those encapsulated in a PTSD diagnosis and can include conduct problems, symptoms of depression and anxiety, and impulsive, aggressive or sexualized behaviours. Conduct problems and impulsive, aggressive behaviours are commonly seen in youth offenders and often directly relate to their offending. Neurodevelopmental and attachment theories offer useful insight into why trauma has such long lasting, significant effects on children, and support a case for the inclusion of trauma-focused interventions (Kinniburgh, Blaustein, Spinazzola & Van der Kolk, 2005; Perry, 2006; Vela, 2014; Yampolskaya et al., 2014).

There is growing recognition that the link between childhood maltreatment and subsequent negative outcomes is mediated by biological consequences of trauma on the developing brain (Nemeroff & Binder, 2014). It has been suggested that the negative effect of trauma is so fundamental and serious, that it be considered acquired brain damage (Gralton et al., 2008). This has been influenced by advances in neuroimaging, and a more sophisticated understanding of neuro-development and brain plasticity. The development of the brain is complex and susceptible to influence from environmental factors, especially during sensitive periods such as infancy and early childhood (Perry, 2006). Extreme and chronic stress, such as that caused by abuse and neglect, has a durable, detrimental influence on development (De Bellis, 2005; Vela, 2014). As brain function develops sequentially (from most basic to most sophisticated), interruption at early stages of development can have a flow on effect, causing

long lasting developmental delays as manifesting as attachment problems, difficulties with self-regulation, maladaptive behaviours, negative emotional states and psychological difficulties.

Attachment theory is also useful in considering the link between childhood trauma and youth offending. It is based on the premise that forming attachment to a primary caregiver is a key developmental task, and that caregiver-child attachment significantly impacts identity, emotional regulation and interpersonal/relationship skills (Bowlby 1969, 1991). It is posited that early attachment interactions form mental representations of the self, others and relationships that become templates for how the child perceives themselves and interacts with others throughout their lifetime. If a caregiver provides consistent nurturing in a safe environment, a child is likely to develop secure attachment. Secure attachment is associated with children being easily comforted, age appropriate interpersonal skills and positive long-term outcomes (Ainsworth, Blehar, Waters & Wall, 1978; Mennen & O'Keefe, 2005).

However, young children who are neglected, abused or receive inconsistent nurturing from their primary caregivers often develop anxious/avoidant, anxious ambivalent or disoriented/disorganised forms of insecure attachment (Ainsworth, et al., 1978; Main & Solomon, 1990). In order to survive their adverse environment, maltreated infants are required to use primitive coping strategies of avoidance, aggression or dissociation. They are also likely deprived of the opportunity to develop more emotionally mature strategies that are primarily learnt through positive caregiver-child interactions (Kinniburgh et al., 2005). As the child grows up, these behaviours may become increasingly inappropriate and dysfunctional, and increase the risk of other developmental and social problems (Mennen & O'Keefe, 2005).

There is overlap between neurodevelopmental and attachment perspectives. For example, the neural systems primarily responsible for threat perception and arousal are primarily located in the lower brain and the limbic system (Gralton, Muchatuta, Morey-Canellas & Lopez, 2008). These are basic areas of the brain that develop rapidly in infancy and early childhood. Infants are dependent on their primary caregivers to provide a safe, secure environment to regulate their affect because their undeveloped limbic systems are not yet able to do this (Jonsson & Jonsson, 2009). The amygdala, part of the limbic system, plays a crucial role in modulating vigilance levels and generating negative emotional states. Secure infant-caregiver attachment relationships encourage the limbic system to develop affect regulation as part of normal development. However, trauma in early life can cause deregulation of the amygdala, therefore playing an important role in the subsequent development of arousal problems and hyper vigilance, which are often seen in people with serious conduct issues and antisocial behavioural patterns (Donegan et al., 2003).

Both neurodevelopmental and attachment theory perspectives argue that the trauma induced developmental interruptions or delays must be addressed to effectively treat young people with trauma histories. Attachment focused interventions emphasise the importance of facilitating a structured, predictable environment and the promotion of positive attachment relationships in the young person's life (Kinniburgh et al., 2005). Creating stability and encouraging feelings of safety is considered the foundation for subsequent work on self-regulation and developmental competencies. Likewise, neurodevelopmental-trauma focused interventions propose that clients must be assessed on a range of developmental domains (e.g. emotional, communication) to guide appropriate nature and timing of therapeutic activities (Perry, 2006). Both attachment and neurodevelopmental approaches emphasise the importance of repetition to create new positive attachment relationships and to 'rewire' brain systems respectively. More conventional therapeutic approaches such as cognitive behavioural therapy (CBT) are still considered useful from these approaches, but only once the young person feels safe enough, is more emotionally regulated, or has caught up developmentally to be able to take advantage of positive developmental experiences offered by school or therapy (Kinniburgh et al., 2005; Perry, 2006; Vela, 2014).

Evidence and Limitations

The reviewers are unaware of research examining the trauma, attachment and neurodevelopmental framework among the youth justice population in secure residential care. However, given the relevance of trauma, attachment and neurodevelopment for this population as mentioned above, there is likely to be some benefit gained from utilising components of this framework to address these needs.

5.3.1 Neurosequential Model of Therapeutics

Aligned with the aforementioned trauma, attachment and neurodevelopmental framework, the Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive and neurobiologically informed approach to clinical work. Core principles of neurodevelopment and traumatology are integrated into a comprehensive approach to the young person, family, and their broader community. NMT is not a specific therapeutic technique or intervention; it is a framework which helps organise the young person's history and current functioning to optimally inform the therapeutic process.

More information regarding NMT can be found in Perry (2006, 2009) and Perry and Hambrick (2008), and on the Child Trauma Academy website at: childtrauma.org/nmt-model. There are reportedly over 50 organisations using the NMT as part of standard clinical practice (Perry & Dobson, 2013).

Programme Model

NMT has three key components: training/capacity building, an assessment of insults, stressors and challenges, and a set of recommendations for intervention and enrichment (Perry, 2006; 2009). Two assumptions underlie the NMT. The first is that therapeutic and educational efforts are most effective when they are provided in a sequential manner that replicates neural organisation and development. The second is that therapeutic interventions must provide adequate patterns and frequency of experiences that will activate and influence the areas of the brain mediating the dysfunction. The NMT process involves identification of the young person's strengths and vulnerabilities across key domains of functioning (sensory integration, self-regulation, relational and cognitive) and areas in the brain, which have been impacted by adverse developmental experiences. Based on this information, a selection and sequence of interventions and activities are identified and implemented.

NMT Assessment: Where the child has been

NMT assessment begins with a review of the key insults, stressors, and challenges, present during the young person's development. Assessment reviews the timing, nature and severity of developmental challenges and scores these to determine a developmental "load". This is then use to estimate which networks and functions have been impacted by developmental insults or trauma. The developmental history also includes a review of the relational history of the young person during development (Perry, 2009).

NMT Functional Review: Where the child is

The second component of the NMT process is a review of current functioning. This allows for estimates to be made concerning which neural systems and areas of the brain are involved in the individual's neuropsychiatric symptoms, as well as their key strengths. A visual map is developed during this stage that shows developmental status across various domains of functioning. This allows for discussion around trauma, brain development and the rationale for recommendations as it allows progress to be tracked. Interdisciplinary staffing is required for the success of this component, in addition to a working knowledge of neural organisation and functioning.

NMT Recommendations: Where the child should go

The third component of NMT involves providing specific recommendations for therapeutic, enrichment and educational activities. Recommendations and subsequent interventions and enrichments are not constrained by conventional limits of mental health symptoms. The NMT mapping process enables the development of a unique sequence of developmentally appropriate interventions and enrichments that aim to help the young person re-approximate a more normal developmental trajectory. Interventions should start with the lowest underdeveloped/abnormally functioning set of problems in the brain and move sequentially up the brain as improvements are seen. Problems with self-regulation will need to be addressed before therapeutic work can address relational problems, and relational problems will need to be addressed before therapeutic work can move to verbal and insight oriented interventions.

Recommendations for co-therapeutic activities where parents and children can engage and receive mutually beneficial services are also common.

Evidence

Evidence supporting the use of the NMT can be found for very young children with emotional and behaviour problems. Barfield, Gaskill, Dobson and Perry (2012) conducted two studies to examine the use of the NMT on social-emotional development and behaviour among 28 children. The first study was a pretest- posttest

design with multiple time series measures, and the second study included a quasi-experimental, multiple time series design, with pre-test/post-test measures to examine changes in behaviour. Findings showed that inclusion of the NMT assessment and recommended interventions into therapeutic preschool programmes facilitated social and emotional development among high risk and traumatised children, as well as significant growth in nearly every area of socio-emotional development. In addition, gains made from participation in the programme were maintained at both 6- and 12-month follow-ups (Barfield et al. 2012).

Individual case study data suggests NMT may be successful among older children (Perry & Dobson, 2013); however there appears to be no current empirical evaluations available examining the NMT.

Limitations

Research using sound methodology (i.e., RCTs) is needed to draw strong conclusions regarding the efficacy of the NMT among the youth justice population in secure residential care.

Implementation of the NMT requires highly skilled senior clinicians to lead the process with a unique combination of clinical and preclinical skills and knowledge of child development, clinical traumatology and developmental neuroscience, and requires considerable training for staff (Perry, 2009; Perry & Dobson, 2013). A lack of resources to follow through with the NMT recommendations has also been reported (Perry & Dobson, 2013). Furthermore, NMT intervention outcomes may be poor where the young person's relational environment is chaotic, impoverished or impermanent (e.g., in foster care) (Perry, 2009).

New Zealand Context

NMT was integrated into the services in Puketai care and protection secure residence under the previous Team Leader of Clinical Practice, Sean Twomey. In New Zealand, other practitioners trained in the NMT model include Brendan Ward (CYF, Rotorua) and Kathryn Berkett (Brainwave Trust; www.kbkonsulting.co.nz).

Summary

Implementing a framework in residential facilities can help ensure those providing services within the facility are working toward the same philosophy and aims. As outlined, frameworks that could be implemented to guide services provided in youth justice secure residences include the RNR model, strengths-based approaches of the Good Lives Model and Supportive Authority and The Strategy of Choices, and the trauma, attachment and neurodevelopmental framework. At this time, the RNR framework appears to have the strongest evidence for reducing recidivism rates among young offenders. However, each framework described here highlights an important perspective or philosophy in the intervention and care of young people in the youth justice population to help address the complex needs of this population.

Chapter 6: Models for Secure Youth Justice Residential Care

A model of care is a therapeutic or rehabilitative model that can be implemented in residential services, and sits underneath the overarching framework (see Chapter Five). Similar to implementing a framework in youth justice secure residences, having a model of care can provide a structure to help ensure all agencies are working toward the same philosophy and aims, consequently leading to a greater level of consistency in approach. Secure residential care models discussed in this chapter were identified through the California Evidence-based Clearinghouse for Child Welfare, reviews of treatment models for group homes and residential care (e.g., James, 2011), and searches via internet search engines and electronic databases (e.g., should be PsycINFO). The final secure care models were selected due to their promising evidence-base for use in secure youth justice residential care and/or their current use in secure residences in New Zealand or internationally.

It is important to note that when interpreting the evidence for each model of care presented in this chapter, studies that do not use RCTs provide a weaker foundation for drawing inferences about the effectiveness of the model. In such cases, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as "significant" are those that are statistically significant at the $p<.05$ level.

6.1 Positive Peer Culture

Positive Peer Culture (PPC), developed by Vorrath and Brendtro (1985), is a peer-helping group-based treatment model for use in residential care among children and young people aged 12 to 17 years with similar difficulties. PPC was developed to help effectively counteract the "peer contagion effect" that is often seen among groups of troubled youth in treatment interventions. The peer contagion effect refers to the consolidation of antisocial behaviour when delinquent young people are grouped together (Dodge, Dishion & Lansford, 2006; Warr, 2002). The PPC model aims to replace this negative social environment with a positive peer culture, and through the teaching and modelling of prosocial values such as altruism, responsibility, self-worth, autonomy, and acceptance, a range of prosocial behaviours and attitudes are developed (Vorrath & Brendtro, 1985).

Vorrath and Brendtro (1985) state that PPC's central position is "that young people can develop self-worth, significance, dignity and responsibility only as they become committed to the positive values of helping and caring for others" (p.XI). The overall goals of PPC are:

1. To meet the universal growth needs of youth for affiliation, achievement, autonomy and altruism
2. Improve social competence
3. Cultivate strengths in troubled and troubling youth
4. Convert negative peer influence into care and concern for others
5. Develop social interest through leadership and guidance from trained adults

Further information regarding PPC can be found in Vorrath and Brentro (1985), on the California Evidence-based Clearinghouse for Child Welfare website at www.cebc4cw.org/program/positive-peer-culture/detailed, and in James (2011).

Programme Model

PPC treatment is value-based and process-oriented. The young people are essentially responsible for the majority of their treatment, under the supervision of adult staff (Vorrath & Brendtro, 1985). Thus, adult authority is largely de-emphasised.

The four treatment components are: (i) building group responsibility, (ii) group meeting, (iii) service learning and (iv) team work primacy. In the first component of building group responsibility, the members learn to keep each other out of trouble. The second component highlights the importance of the group meeting as a medium through which problem-solving and helping other group members is facilitated. The group meetings are structured, and include problem reporting, problem solving, and group leader's summary. The third component of service learning is where the young people participate in community projects to help reinforce the PPC value of caring for and helping others. The last component is teamwork primacy, which is a programme management model that prioritises teamwork.

The recommended PPC group size is between 8 and 12 young people, with treatment being implemented over 6 to 9 months. The group meetings are recommended to be run for 90 minutes, 5 days per week. PPC has a programme manual, and training is available through The Academy for Positive Peer Culture. Adequate training is essential to guide the group process.

Evidence

The PPC model has been used in various sites in Canada and the Netherlands, and is implemented in the highly regarded Missouri model (see Chapter Four, Section 4.4.1). PPC has been recognised by the California Evidence-based Clearinghouse for Child Welfare as being "supported by research evidence" for young children placed in higher level placements[26].

Studies evaluating PPC include an experimental design (McVicar, 1991), a quasi-experimental study (Sherer, 1985), and two one-group pre-test/post-test design studies (Ryan, 2006; Steinebach & Steinebach, 2009). Findings from these studies are outlined below.

McVicar (1991) found significant positive treatment effects of the PPC model in an experimental design study, including advanced moral reasoning, reduced antisocial and disruptive behaviour, and a healthier institutional climate. Similarly, among street-corner gangs using a quasi-experimental design study, Sherer (1985) found significantly improved moral development and increased resistance to temptation.

Ryan (2006) examined PPC in a one group pre-test/post-test design among young people released from a residential programme that employed the PPC model. Findings showed 41% of young people were arrested post-release from residential care, which Ryan (2006) reported were comparable to those found in the delinquency literature. However, victims of physical abuse and neglect were found to be at higher risk for arrest following PPC intervention (50% versus 37%). Ryan (2006) concluded that PPC programmes may not be the most effective strategy for youth in the youth justice system with histories of maltreatment.

Steinebach and Steinebach (2009) conducted a one group pre-test/post-test design to evaluate PPC among adolescent males in a residential treatment facility who exhibited behavioural problems and delinquency. Over a three-year period, a reduction in violence and increase in prosocial behaviour and self-esteem were found; however, actual rates were not reported. Limitations of this study included no randomisation of participants, and a lack of control or comparison group.

Further studies examining PPC among youth in residential treatment have evaluated an adapted PPC programme – EQUIP. Findings from these studies are outlined below.

EQUIP

EQUIP (Gibbs, Potter & Goldstein, 1995) is an adaptation of PPC (see Chapter Six, Section 6.1) which also incorporates components from Aggression Replacement Training (ART; see Chapter Nine, Section 9.2.1). In the Netherlands, five studies have examined the effectiveness of EQUIP among young offenders – one RCT (Leeman, Gibbs and Fuller 1993), two quasi-experimental pre-test/post-test design studies (Brugman & Bink, 2011; Nas, Brugman & Koops, 2005), and two quasi-experimental designed studies which included measures of programme integrity (Helmond, Overbeek & Brugman, 2012, 2015). Overall, research evaluating EQUIP has found mixed results for young offenders. An overview of this research is provided below.

Leeman et al. (1993) conducted a RCT and found EQUIP to be effective in increasing social skills and reducing recidivism 12-months post-release for male youth at a medium-security correctional facility (15% recidivism rate among EQUIP group, 40.5% among control group), but no significant differences in moral judgement were found between groups.

Nas et al. (2005) evaluated EQUIP among male young offenders in a high-security correctional facility using a quasi-experimental pre-test/post-test study. The matched control group of young people were from two facilities that offered care as usual. Those who completed EQUIP had significantly greater reductions in cognitive distortions compared to the control group (total effect size, d = .27). However, no differences were found on moral judgement, social skills and social information processing.

Brugman and Bink (2011) used a quasi-experimental pre-test/post-test design with a control group to examine EQUIP among youth offenders in high-security youth correctional facilities. A significant reduction in cognitive distortions among the EQUIP group was found, but no differences were found in speed or seriousness of offending post-release (Brugman & Bink, 2011).

26 The Clearinghouse defines 'higher levels of placement' as group, residential, and community treatment facilities. More information on the different levels can be found at the following website: www.childsworld.ca.gov/res/pdf/OverviewClassificationLvls.pdf

Helmond et al. (2012) investigated programme integrity and effectiveness of EQUIP in six youth correctional facilities in the Netherlands and Flanders using a quasi-experimental study. Those who received EQUIP had stable social skills and moral value evaluation scores from pre- to post-intervention, while those in the control group exhibited a decrease in these scores. EQUIP was not found to improve moral judgement or reduce cognitive distortions. The treatment integrity was found to be 'low to moderate' across the facilities; however, programme integrity was not found to moderate the effectiveness of EQUIP.

Helmond et al. (2015) used a quasi-experimental study design to examine programme integrity and effectiveness of EQUIP on recidivism among a sample of 133 incarcerated youth in the Netherlands. Overall the EQUIP programme was implemented with low-to-moderate levels of programme integrity. No differences between the experimental and control groups were found in the prevalence, frequency and severity of recidivism, and high levels of programme integrity in the low-to-moderate-range did not improve effectiveness of EQUIP on recidivism for the experimental group.

Limitations

The aforementioned research has indicated mixed outcomes of PPC among young offenders. Further research using sound methodology (i.e., RCTs) is needed in order to draw strong conclusions regarding the efficacy of PPC among the youth justice population in secure residential care.

Some limitations of the PPC model have been identified in the literature. Brugman and Bink (2011) found no differences between the EQUIP treatment group and the control group on speed or seriousness of reoffending, while Ryan (2006) noted that PPC may be limited for young people in the youth justice system who have experienced maltreatment. In addition, a qualitative study of young people who had completed a PPC programme found the young people were critical of the group process (Kapp, 2000). Furthermore, studies have shown EQUIP is typically implemented with low-to-moderate integrity (Helmond et al. 2012, 2015), suggesting that the programme may pose a high bar of implementation requirements.

As noted by Quigley (2004), the PPC has been "misunderstood, misused and improperly implemented" (p. 136).

6.2 Stop-Gap

Stop-Gap is a secure residential model for children with emotional and behavioural disorders developed by the Devereux Centre for Effective Schools in Pennsylvania (McCurdy & McIntyre, 2004). The Stop-Gap model emphasises short-term confinement in residential care to stabilise the young person with emotional and behavioural disorders, providing "a stop-gap for children and youth caught in a downward spiral of increasingly disruptive and antisocial behaviour" (McCurdy & McIntyre, 2004, p. 141). The young person ideally remains in the residence for less than 150 days, with duration dependant on the young person's needs (Zakriski, Wright & Parad, 2006). While the young person is in residence, Stop Gap also prepares the young person and their family for positive outcomes in community-based care (McCurdy & McIntyre, 2004). Further information regarding the Stop-Gap model can be found in McCurdy and McIntyre (2004) and James (2011).

Programme Model

The programme model has three tiers of intervention: (i) Environment-based, (ii) Intensive, and (iii) Discharge-related intervention. McCurdy and McIntyre (2004) state that for a residential facility to implement the Stop-Gap model it should provide services across these three tiers of care. Each tier is described briefly below.

Environment-based intervention

The purpose of the first tier of environment-based intervention is to provide an environment which produces a decrease in behaviour to a level which enables the young person to be discharged to community-based care and intervention. Services and programmes provided to young people at this level include token economy, academic intervention, social skill intervention, anger management skills training, and problem solving skills training. It is believed that acquiring these skills and adaptive behaviours will help facilitate sustained behavioural change (McCurdy & McIntyre, 2004).

Intensive intervention

It is proposed that the first tier of Stop-Gap, the environment-based intervention, should be sufficient for most young people entering residential treatment in reducing their problematic behaviour to a level where they can begin to re-integrate into the community.

However, a young person with serious problematic behaviour which either does not improve or intensifies will be provided more intensive services (McCurdy & McIntyre, 2004). Intensive services include a functional behavioural assessment (FBA) and behaviour support plans.

The Naturalistic Functional Assessment (NFA; Repp, 1999; Repp & Karsh, 1994) is the FBA recommended by Stop-Gap to identify behavioural function and conditional probabilities in a residential setting. Information from the NFA and interviews with team leaders is used to develop behavioural support and individualised crisis management plans.

Discharge-related intervention

The last tier concerns the preparation of the young person and their family for discharge back into the community. The aim of discharge intervention is to maintain and generalise the skills obtained while the young person is in residence (McCurdy & McIntyre, 2004). Discharge-related interventions begin as soon as the young person is admitted to the residence, and extends through to discharge and follow-up. To help overcome typical difficulties associated with residential facilities of minimal family involvement, decision-making in treatment process, and lack of community involvement and access for the young people residing in residences, Stop-Gap incorporates intensive case management, parent management training, and community reintegration (see McCurdy and McIntyre (2004) for an overview of these services). If the young person is unable to return to the care of their immediate family, then a family relative, foster care or treatment foster care placement is provided (McCurdy & McIntyre, 2004).

Evidence

Stop-Gap model was recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements. The Stop-Gap model is believed to be advantageous in several ways. Stop-Gap is considered to be in-line with the stance of placing children and youth in the least restrictive and community-based forms of treatment; however, Stop-Gap still recognises the need for secure facilities to be available for the most at-risk young people (McCurdy & McIntyre, 2004; Zakriski, Wright & Parad, 2006). In addition, the treatment components recommended (e.g., parent management training) are typically manualised and have strong empirical-evidence among young people with complex needs.

One non-randomised control study by McCurdy and McIntyre (2004) evaluated the effectiveness of Stop-Gap on reducing the use of therapeutic holds (i.e., therapeutic restraint). Two residential treatment centres were compared; one treatment centre which had implemented the environment-based intervention of the Stop-Gap model, while the comparison group provided traditional residential treatment centre services. Both groups were matched on population number, gender and disability. After 12 months, the environment-based intervention had a decline in use of therapeutic holds, while the comparison group had an increase in use (McCurdy &McIntyre, 2004). No other studies have evaluated the Stop-Gap model.

Limitations

Although Stop-Gap has demonstrated promise, there is a lack of empirical evidence on programmes implementing the full model. Research using sound methodology (i.e., RCTs) is needed in order to draw strong conclusions regarding the efficacy of Stop-Gap among the youth justice population in secure residential care.

6.3 Behaviour Modification

Behaviour modification is a treatment approach based on learning theory and operant conditioning which posits that behaviour can be altered or maintained by the consequence of ones' actions. Behaviour modification uses reinforcement (either positive or negative) to increase desired behaviours, and punishment (either positive or negative) to decrease problematic behaviours. Token economy and point level systems are behaviour modification strategies that are frequently implemented in residential settings for young people. Token economy and point level systems are often combined and employed together.

Token Economy

The token economy is described as a reinforcement system, where desired behaviour (or absence of problematic behaviour) is reinforced through tokens, such as coins, that are exchanged for back-up reinforcers (Rodriguez, Montesinos & Preciado, 2005). Back-up reinforcers are objects, privileges or activities that are appealing to the young person to motivate them to engage in desired behaviours to earn tokens toward

earning the reinforcer. Elements of a token economy include: identifying the target behaviour, identifying what back-up reinforcers to use and the token value of each reinforcer, determining how tokens will be earned and spent to access the back-up reinforcers, gathering baseline information on the current behaviour of the young person, and consistent implementation by staff. The development of the token economy has been credited to Montrose Wolf (Risley, 1997) and was introduced for use in a therapeutic setting by Ayllon and Azrin (1968).

Point Level Systems

Point Level Systems typically take the form of young people either advancing or dropping "levels" based on set contingencies (Hagopian, Rush, Richman, Kurtz, Contrucci & Crossland, 2002). These contingencies may include young people not engaging in inappropriate behaviours (e.g., swearing). Young people often start in the most restrictive level, and after displaying desired behaviour for a set amount of time, they advance to higher levels. Advancing to the next level often means the young person has less restrictions and more access to privileges (Hagopian et al., 2002).

More information on the components of token economy and point level systems can be found in Ayllon and Azrin (1968), Doll, McLaughlin and Barretto (2013), Hagopian et al. (2002), and Kazdin (1977).

Evidence

Early implementation of token economies produced positive results across a range of settings. However, no recent research has been conducted examining token economies or point-level systems using sound methodology (i.e., RCTs) among young offending populations. An overview of research examining token economies or point-level systems is provided below.

In a reversal experimental design, Phillips, Phillips, Fixsen and Wolf (1971) found token reinforcement positively modified pre-delinquent behaviours among six boys, including promptness at the evening meal, room-cleaning behaviour, saving money and accuracy of answers on a news quiz. Milan and McKee (1976) implemented the token economy in an adult male prison system also using reversal design experiments and found improvement in observed behaviours (e.g., arising at a determined time, making the bed, cleaning, maintaining a well-groomed personal appearance). Similarly, point level systems was found to be effective in managing the shaping of appropriate behaviours and decreasing behavioural excesses in a children's psychiatric unit using a non-experimental study design (Jones, Downing, Latkowski & Ferre, 1992). Furthermore, level systems demonstrated improvement in disruptive behaviours (e.g., decrease in disruptive and off-task behaviours, increase in task completion) in a classroom setting in a reversal design study (Mastropieri, Jenne & Scruggs, 1988).

Behaviour modification approaches are also incorporated in the empirically-validated Teaching Family Model (see Chapter Seven, Section 7.2) and Multi-dimensional Treatment Foster Care models (see Chapter Seven, Section 7.3) for conduct problem behaviour.

Limitations

The token economy and point and level systems strategies have been strongly critiqued in the literature (see Mohr, Martin, Olson, Pumariega & Branca, 2009; Mohr & Pumariega, 2004; Tompkins-Rosenblatt & VanderVen, 2005; VanderVen, 1995, 2000). These behaviour modification strategies have not been evaluated by recent research implementing RCTs, and the assumptions upon which these programmes are based do not stand up to empirical scrutiny or theoretical validity (Mohr et al., 2009). In addition, the point and level systems strategies are considered counterproductive and non-client centred in that they neglect individual differences among children (Mohr et al., 2009). Furthermore, such approaches are punitive and require children to earn things that could be argued are the essence of treatment (e.g., activities) (Mohr et al., 2009). The American Association of Children's Residential Centres (2014) recommended the removal of point and level systems, particularly for children and young people with severe trauma. Mohr and colleagues (2009) suggest these behavioural modification strategies should be replaced with client-centred approaches.

New Zealand Context

Token economy and level systems are currently used in youth justice secure residential facilities in New Zealand. Other residential facilities in New Zealand, including Odyssey House's youth services residential programme, also implement these behaviour modification strategies. However, there appears to have been no evaluation conducted on the current behaviour modification programmes implemented in New Zealand secure residential facilities for young people.

Summary

Implementing an overarching model of care in youth justice secure residences can help create structure, and ensure a consistent vision and philosophy of care by the agencies working in these facilities. Here, Positive Peer Culture (PPC), Stop-Gap, and token economy and point level systems were described. At this stage, PPC has had mixed results, and RCTs examining the model among the youth justice population in residential care are needed. Although Stop-Gap has a lack of empirical evidence, this model is in line with the philosophy of placing children and youth in residence for the shortest amount of time, recommends the use of evidence-based programmes, and emphasises the need for more community-based forms of treatment. Finally, token economy and point and level systems have been strongly critiqued as being non-client centred, and have not been examined by recent research using sound methodology.

Chapter 7: 'Step-down' Care Models

The aforementioned treatment models are evidence-based and/or highly regarded internationally for providing residential-based services for the youth justice population. The following is an overview of evidence-based models that can be implemented as an alternative to residential or institutional services, either while the young person resides with family or in out-of-home care, such as foster care and group homes. This aligns with the philosophy of providing services for these young people via the least restrictive medium, ideally within the community and incorporating their family in the treatment and reintegration process.

Here, models that can be implemented for the youth justice population are described, including their programme model and evidence-base. These secure residential care models were identified through the California Evidence-based Clearinghouse for Child Welfare, reviews of treatment models for group homes and residential care (e.g., James, 2011), and searches via internet search engines and electronic databases (e.g., PsycINFO).

It is important to note that RCTs provide strong foundations for drawing inferences about the effectiveness of 'stepdown' care models. In addition, meta-analyses provide useful estimates of the combined size and direction of effects across independent studies. Here, an outline of RCTs and/or meta-analyses for each 'stepdown' care model is provided. Where there is a lack of robust evidence, findings from studies using alternative study designs (e.g., pre-test/post-test) will then be discussed; however, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as "significant" are those that are statistically significant at the $p<.05$ level.

7.1 Multisystemic Therapy

Multisystemic Therapy (MST), developed by Henggeler and colleagues, is a multimodal family and community-based treatment for addressing serious conduct problems, offending behaviour, and social, emotional and behavioural problems in children and adolescents.

MST is based on Bronfrenbrenner's (1979) social-ecological theory, where an individual's development and behaviour is influenced by their social ecology. Therefore, MST promotes behavioural change by addressing the systems that are believed to maintain conduct problem behaviours among young people, namely their family, peers, school and community. In particular, MST views the family and/or caregivers as the primary source of change and aims to empower them to facilitate change in the young person's social ecology (Hennggeler & Sheidow, 2012). MST is implemented for youth aged 12 to 17 years for a typical duration of three to five months.

MST is an individualised intervention, with nine treatment principles that provide a framework for intervention:

1. The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context.
2. Therapeutic contacts emphasize the positives and use systemic strengths as levers for change.
3. Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behaviour within and between multiple systems that maintain the identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

(Henggeler, 2012, p. 184)

Further information regarding MST can be found in several clinical volumes (Henggeler, Schoenwald, Rowland & Cunningham, 2002; Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 2009), in a review of treatment models for conduct problem behaviour

and delinquency (Henggeler & Sheidow, 2012), on the blueprints website at www.blueprintsprograms.com, and on the MST website at www.mstservices.com.

Programme Model

Guided by the nine treatment principles, MST is implemented in the family home and other locations in the community. An individualised treatment plan for each young person is developed integrating evidence-based interventions. Such flexibility and individualised intervention is in line with the RNR model of addressing recidivism risk factors and matching interventions to the needs and capabilities of the individual (Andrews & Bonta, 2010).

Interventions at the family level include structural family therapy, strategic family therapy, and behavioural parent training (Henggeler et al., 2009). Interventions at the peer level aim to decrease associations with antisocial peers, while interventions in the school domain include increasing positive communication between caregivers and teachers, and restructuring the young person's activities after school to facilitate school performance. At the community level, the young person is encouraged to engage in prosocial recreational and social activities. Individual-based interventions are also implemented for the young person, including cognitive behavioural therapy (Henggeler et al., 2009). If an intervention is deemed successful, then a plan is employed to facilitate continued outcomes. If an intervention is not successful then the MST team identifies the cause of failure and subsequently implements new interventions (Henggeler & Sheidow, 2012).

Interventions in each domain are integrated into the broader MST model and quality assurance and improvement system (Henggeler, 2012). The quality assurance and improvement system includes three components: training, organisational support and implementation and reporting to help maintain the reliability and sustainability of the MST programme.

The MST team consists of 2 to 4 full time masters-level therapists and a half-time doctoral or advanced masters-level supervisor (Henggeler & Sheidow, 2012). Each therapist has a caseload of 4 to 6 families. Therapists rotate on an on-call schedule so one therapist is available for families 24 hours a day, 7 days a week.

Implementation

MST has been disseminated in fourteen countries (MST Services Inc., 2010), including in over 30 states in the U.S, Norway, Australia, Canada, Denmark, Ireland, England, Sweden, Switzerland, the Netherlands, and New Zealand.

Evidence

MST is one of the most extensively validated and highly regarded treatment models for children and adolescents exhibiting offending and problematic behaviours. MST is included on the Blueprints for Violence Prevention database, is considered to be "well-supported" by research by The California Evidence-Based Clearinghouse for Child Welfare, and is recognised as an "effective" intervention by the Office of the Juvenile Justice and Delinquency Prevention (OJJDP) and National Institute of Justice for serious/violent offenders and young offenders.

Van der Stouwe, Asscher, Stams, Dekovic, and van der Laan (2014) identified fifty-one studies (22 independent samples) conducted on MST that targeted antisocial, conduct disordered, and/or delinquent youth. These studies had been conducted across the Netherlands, U.S., United Kingdom, Canada, Sweden and Norway, using RCTs and quasi-experimental designs. In their meta-analysis, van der Stouwe et al. (2014) found small significant effects of MST on delinquency (d = .201), psychopathology (d = .268), substance use (d = .291), family factors (i.e., family functioning, parenting skills, mental health) (d = .143), out-of-home placement (d = .267) and peer factors (d = .213).

Van der Stouwe et al. (2014) found moderators of the effectiveness of MST to include the study (e.g., country, research design etc.), treatment (e.g., duration), sample (e.g., offenders, sex offenders), and outcome characteristics (i.e., delinquency type). Specifically, van der Stouwe et al. (2014) found MST was most effective when implemented with young people aged less than 15 years (delinquency: d = .421; psychopathology: d = .4; family factors: d =.253), and in studies including a larger proportion of Caucasian youth offenders (delinquency: d = .291). In addition, positive treatment effects were found to be more prominent among those aged over 15 years when treatment targeted peer relationships and risk and protective factors at the school-level (van der Stouwe et al., 2014).

Research on MST has been implemented by several independent research teams and in real-world community settings. In addition, research has found positive treatment effects among samples of youth sex offenders (Letourneau, Henggeler, Borduin, Schewe, McCart, Chapman & Saldana, 2009), violent and chronic youth offenders (Henggeler, Melton, Brondino, Scherer & Hanley, 1997), youth justice-involved young people with substance abuse or dependence (Henggeler, Halliday-Boykins, Cunningham, Randall, Shapiro & Chapman, 2006), and general population youth justice-involved young people (Timmons-Mitchell, Bender, Kishna & Mitchell, 2006).

Dopp, Borduin, Wagner and Sawyer (2014) calculated that for every one dollar spent on MST treatment, MST returned $5.04 in savings to taxpayers and crime victims 25 years post-treatment. For serious and violent youth offenders, Klietz, Borduin and Schaeffer (2010) found MST retuned $9.51 to $23.59 in savings for every dollar spent on treatment.

Limitations

Implementation of MST is intensive, requiring a high workload and demand for MST therapists and supervisors. In addition, the replication of MST in Sweden did not reproduce findings similar to those found by the developers of MST (Sundell, Hansson, Lofholm, Olsson, Gustle & Kadesio, 2008). However, this was attributed to low treatment fidelity by MST therapists, and the strength of intervention provided to the Sweden comparison group relative to that provided to comparison groups in the U.S.

New Zealand Context

Currently there are six teams in New Zealand across Auckland, Wellington, Christchurch and Hawkes Bay who are trained in and deliver MST.

Curtis, Ronan, Heiblum and Crellin (2009) examined the effectiveness of MST for the treatment of adolescent offenders in New Zealand using a pre-test/post-test design with 6- and 12-month follow-up periods. A significant decrease in offending behaviours (pre-treatment: 51%; post-treatment: 41%; 6-month follow-up: 35%; 12-month follow-up: 27%), and an increase in youth compliance and youth and family functioning were found. In addition, reductions in the frequency (d = .23) and severity (d = .16) of offending were found between pre- and post-treatment, which were maintained at 6- and 12-month follow-up. The effect sizes found post-treatment were comparable to those of international MST studies, with ultimate and instrumental outcomes (d = .53) being clinically equivalent to the treatment benchmark (dB = .32). However, gains in school attendance and out-of-home placements reduced across the follow-up periods. In addition, Curtis et al. (2009) found the therapist and supervisor attrition rate was 42%, possibly reflecting the intensive workload and demand of implementing MST.

7.2 Teaching Family Model

The Teaching Family Model (TFM) is a model used with young people who are at risk of escalating criminal behaviour, self-injurious behaviour, or emotional disturbance, and with families who are known by social welfare authorities and are at risk of having their children removed from their care. This model may be used either as an adjunct to help prevent the child needing to be detained in secure residential care (step-down), or as a transitional option for young people coming out of residential care before they return to their biological family or transition to independence.

TFM is a group home scenario, where up to eight young people, up to the age of 17 years, are housed together in a home (as opposed to a residential facility) where they are cared for by Teaching Parents, who are often a married couple (Fixsen, Blasé, Timbers & Wolf, 2007; McLean, Price-Robertson & Robinson, 2011). The Teaching Parents are carefully selected and highly trained in the use of appropriate interactions, positive support and skill acquisition (McLean et al., 2011). They are also supported through on-call professional consultation, and are thoroughly evaluated on a regular basis.

The goals of TFM include that it is humane, effective, individualized, satisfactory to stakeholders, cost efficient, replicable, and integrated. Further discussion of these goals can be found in Fixsen et al. (2007).

There is an emphasis on the environment being based on family style living, which is considered essential in terms of allowing the young people to learn in a caring, consistent and normalized environment, which assists them in transitioning back to living with their biological family (Fixsen et al., 2007; James, 2011). Important aspects of the model include the teaching parents'

proactive efforts in assisting the young people to learn interpersonal relationship skills and life skills, and the use of a therapeutic community style peer leadership format (Fixsen et al., 2007; James, 2011). The use of a token economy and high levels of positive reinforcement are further essential components of the model (Lee & Thompson, 2008).

TFM is usually used in group home settings but can also be applied to foster care and treatment foster care settings, as well as schools and psychiatric care settings (Fixsen et al., 2007; James, 2011). TFM is manualised and professional training is available.

Evidence

TFM has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements.

Several studies have been conducted evaluating the effectiveness of TFM among young people with conduct problem behaviour and offending behaviour. TFM has been evaluated using one RCT (Lewis, 2005), one quasi-experimental study with a matched comparison group (Thompson, Smith, Osgood, Dowd, Friman & Daly, 1996), four quasi-experimental studies with non-matched comparison groups (Bedlington, Braukmann, Ramp & Wolf, 1988; Kirigin, Braukman, Atwater & Wolf, 1982; Slot, Jagers & Dangel, 1992), three pre-test/post-test studies (Jones & Timbers, 2003; Larzelere, Daly, Davis, Chmelka & Handwerk, 2004; Slot et al. 1992), and one retrospective study using propensity matching (Lee & Thompson, 2008). An overview of these studies is provided below.

Using a RCT, Lewis (2005) examined an adapted version of TFM for use in the family home (called the Families First Intervention) for young people referred by the school or youth court due to serious problems in functioning. Those in the Families First intervention showed significant improvement on family functioning, child behaviour problems, physical care and resources, and parental effectiveness from pre- to post-test. The only non-significant difference between the treatment and control groups was for parent effectiveness/parent-child relationships from pre-test to follow-up. The author reported that the latter finding may have been due to the control group's improved score over time (Lewis, 2005).

Thompson et al. (1996) examined Boys Town, an updated adaptation of the TFM (see Daly and Dowd, 1992) among young people admitted to the residential programme by referral from social services. The follow-up period for this quasi-experimental study was approximately four years post-discharge. Those placed in Boy's Town had significantly higher grade point averages, completed more years of school, and had a higher rate of high school graduation than those in the control group (83% completed high school/GED versus 69% of controls) (Thompson et al. 1996).

Among court adjudicated youth using a non-equivalent comparison group design study, Bedlington et al. (1988) found that compared to those in non-TFM homes, those in a TFM home scored significantly higher on staff-youth relationships and interactions, staff teaching activities and disapproval of deviance, pleasantness, and prosocial behaviour.

Kirigin et al. (1982) compared court assigned youth in TFM homes and non-TFM on offence and institutionalised rates at one year post-discharge in a non-matched comparison group design study. Compared to the comparison group, fewer young people in the TFM group had engaged in offending and were institutionalised one year post-discharge. However, differences between groups were not statistically significant.

Slot et al. (1992) conducted three studies to determine the effectiveness of cross-cultural replication of TFM in the Netherlands. The first study was a pretest-posttest design, and the second and third studies were quasi-experimental designs with non-matched comparison groups. Most youth in the TFM sample had been detained in care by a youth court judge. In study one, pre- and post-treatment scores indicated significant improvement in overall adjustment, family adjustment, relationship with parents, social competence, offence rates, problems at home, and ability for relationships outside family were found. However, no significant improvement in academic and vocational aspirations was found. In study two, the offending patterns of the Dutch youth who completed treatment in the TFM were compared to those of a non-treatment group from Canada. At six months post-treatment, analyses found a reduction in the number of Dutch youth considered frequent offenders (a 68% decrease) and an increase in the number of youth considered non-offenders (94.1% increase). When compared to the non-treatment group from Canada, the Dutch sample showed a considerable trend toward less serious offending (73% versus 20%), while the Canadian youth showed a trend toward more serious

offending (24% versus 3%; Slot et al. 1992). Finally, in study three, the effects and costs of placement in a TFM were compared to those of placement in a Dutch State Correctional Institute. No differences were found between groups on measures of problems (e.g., overall adjustment, adjustment within family, relation with parents, offences etc.), abilities for relationships outside family, and community participation. Costs of TFM were one-fourth that of placement in a state institution (Slot et al. 1992).

Jones and Timbers (2003) examined TFM's effectiveness in reducing physical restraint, seclusion and negative incidence reports in a pretest-posttest design of two facilities in the United States that employed the TFM (Barium Springs and Bridgehouse). Barium Springs demonstrated a 40% reduction in restraints and 80% reduction in negative incident reports. Bridgehouse had a 75% reduction in restraints and seclusion. All findings, except for Barium Springs' restraint level, reached statistical significance (Jones & Timbers, 2003).

Larzelere et al. (2004) evaluated the Boys Town family programme in a pretest-posttest study design with a three month follow-up. Young people discharged from TFM had been referred by youth justice (34%), social services (21%), mental health (17%), family/self (17%), or other (11%). Both boys and girls showed significant improvement on all outcome scores (Child Behaviour Checklist (CBCL), Diagnostic Interview Schedule for Children (DISC), and Restrictiveness of Living Environment scale), except for scores among boys on the CBCL 'social problems' narrow-band scale. The percentage of young people with diagnosable psychiatric disorders decreased from 60% to 25% from admission to 12-months later. Between discharge and follow-up 9.8% of girls and 9.4% of boys were arrested, whereas prior to admission, 59% of girls and 67.9% of boys had been arrested. At three months post-discharge, the young people were functioning at comparable rates to national norms for being in school or having graduated (93% versus 90%), being neither in school nor working (8.1% versus 8%), and being employed (52.9% versus 58.4%) (Larzelere et al. 2004).

Finally, Lee and Thompson (2008) compared outcomes between young people in TFM and MTFC (see Chapter Seven, Section 7.3) in a retrospective study using propensity matching. Those in TFM were more likely to be favourably discharged, more likely to return home, and less likely to experience a subsequent formal placement than those in MTFC. No differences were found between groups for legal involvement or the likelihood of living in a homelike setting 6 months post-discharge. These findings suggest that placement in a group home, such as TFM, can be more or just as effective as MTFC for some youth (Lee & Thompson, 2008).

Limitations

Of the research that is currently available, findings regarding TFM are promising. However, more research utilising RCTs and follow-up periods are needed before strong conclusions can be made regarding the efficacy of TFM for the youth justice population. Therefore, conclusions that can be drawn from the available research are provisional.

New Zealand Context

Youth Horizons runs four residential therapeutic homes for adolescents with significant emotional and behavioural difficulties and/or involvement with youth justice, three of which are in Auckland, and one in Hamilton. The residential therapeutic home run by Youth Horizons based in Waikato and functioning as a TFM, is Hamilton House. Two treatment foster care programmes run by Youth Horizons also implement the TFM model.

7.3 Therapeutic Foster Care (Multidimensional Treatment Foster Care)

Therapeutic Foster Care (Multidimensional Treatment Foster Care; MTFC) is a foster care intervention model for young people exhibiting severe behavioural and emotional difficulties who are in need of an out-of-home intervention. MTFC is seen as an alternative model to secure residential care. MTFC, also referred to as the Oregon Treatment Foster Care and Treatment Foster Care, was developed by Chamberlain (2003).

MTFC is based on social learning theory, and utilises behavioural therapy and cognitive-behavioural therapy approaches. The model emphasises the role of the foster parent on providing supervision, monitoring, and the promotion of prosocial behaviours. The overall goal of MTFC is to reunite the young person and their family, and to promote long-term successful outcomes (Chamberlain, 2003). The philosophy of MTFC is to provide the young person with reinforcement and encouragement from prosocial adults in a naturalistic setting. MTFC is implemented for youth aged 12 to

18 years; however, a preschool version (MTFC-P) is also available for young children aged 3 to 6 years (e.g., Fisher, Gunnar, Chamberlain & Reid, 2000). Implementation of MTFC is recommended over a minimum of six months before the young person is transitioned back to their family environment.

Further information regarding MTFC can be found in Chamberlain (2003), Henggeler and Sheidow (2012), on the multidimensional therapeutic foster care website at www.mtfc.com, and on the blueprints website at www.blueprintsprograms.com.

Programme Model

MTFC treatment is individualised, with the young person placed in a one-on-one foster care environment, with foster parents who are part of a treatment team. The treatment team includes a range of specialists, including a therapist, behaviour support specialist, family therapist, psychiatrist, and team supervisors.

A highly structured behavioural management plan is implemented, which aims to surround the young person with positive, encouraging adults who provide a highly structured and supervised context. In addition, the aim is to reduce or eliminate associations with antisocial peers, and to increase engagement with prosocial peers and activities. Clear rules and contingencies are established, and the young person's behaviour is closely monitored.

Individual therapy is provided to the young person, a skills trainer offers real-world opportunities to the young person, and a family therapist works with the young person's family. Services are provided both in the foster home, in the family home, and in the community.

Evidence

Multi-dimensional Treatment Foster Care (MTFC) is the only established evidence-based foster care intervention. MTFC is included on the Blueprints for Violence Prevention database, is considered to be "well-supported" by research by The California Evidence-Based Clearinghouse for Child Welfare (referred to as 'Treatment Foster Care Oregon – Adolescents'), and an "effective" programme model by the OJJDP and National Institute of Justice. MTFC sites have been implemented in the United States and across Europe, including Norway, Denmark, the UK, Ireland, and the Netherlands.

Multiple RCTs have been conducted examining MTFC (e.g., Chamberlain & Reid, 1991, 1998; Chamberlain, Leve, & DeGarmo, 2007; Eddy & Chamberlain, 2000; Eddy, Whaley & Chamberlain, 2004; Leve, Chamberlain & Reid, 2005; Leve & Chamberlain, 2007). RCTs have evaluated MTFC across a range of adolescent populations, including those involved in the youth justice system (e.g., see Fisher & Chamberlain (2000) for an overview), referred from a state mental hospital (Chamberlain & Reid, 1991), young people in social services (e.g., Westermark, Hansson & Olsson, 2010), and youth justice and/or high-risk girls (e.g., Chamberlain et al., 2007; Leve et al. 2005; Leve & Chamberlain, 2007; Smith, Chamberlain & Eddy, 2010).

Studies using RCTs to evaluate the effectiveness of MTFC among youth offenders have found MTFC to decrease the number of violent offences post-treatment (Eddy et al. 2004), decrease the number of criminal referrals, number of days in locked settings, and self-reported delinquency (Chamberlain et al. 2007), reduce self-reported tobacco, marijuana and other drug use (Smith et al. 2010), reduce the number of days spent in locked settings, and increase school attendance and homework completion (Leve et al. 2005; Leve & Chamberlain, 2007). Among studies using quasi-experimental designs, MTFC has been shown to improve rates of offending (d = .76 to .90), violence (d = .24 to .26), risky sexual behaviour (d = .28), self-harm (d = .42 to .65) and school activities (d = .37 to .48) (Rhoades, Chamberlain, Roberts & Leve, 2013), as well as reduce duration of post-treatment incarceration (Chamberlain, 1990). Aos, Phipps, Barnoski & Lieb (2001) found MTFC to be very cost effective, with every dollar spent on treatment MTFC returning $43.70 in benefits.

Limitations

Training in MTFC is complex, and the set-up and implementation of MTFC can be time consuming. In a study of implementation of MTFC across 51 countries, Chamberlain, Brown, and Saldana (2011) found that several sites failed in the pre-implementation phase.

New Zealand Context

MTFC is provided by Youth Horizons Trust in Auckland. Youth Horizons provides MTFC for young people aged 12 to 16 years old who exhibit significant behavioural problems. More information can be found at www.youthhorizons.org.nz.

Summary

Given the detrimental effects of secure residential care for young people in the youth justice population, where possible, services should ideally be provided to these young people via the least restrictive medium, with emphasis on community-based services. This chapter provided an overview of three such community-based models that can be implemented for the youth justice population: Multisystemic Therapy, Teaching Family Model, and Multi-dimensional Treatment Foster Care. All three models have demonstrated beneficial outcomes for young people in the youth justice population. As such, these models could be used in New Zealand as alternatives to residential services for the youth justice population, either while the young person resides with their family or where the young person is in an out-of-home care placement.

Chapter 8: Assessment

The assessment process of a young person can help identify which interventions may be most appropriate to target their identified needs, and what considerations should be made regarding the intensity and/or frequency of treatment and level of intervention (e.g., out-of-home care). CYF's assessment framework, Tuituia, is briefly described in Chapter Three, Section 3.1.1

In this chapter, a brief overview is provided of what the assessment of young people in secure youth justice residences should entail, including evidence-based assessment tools for this population. Please note that this chapter does not aim to provide a comprehensive overview or guideline of how assessment should be conducted for the youth justice population in secure residential care. Further guidelines regarding the assessment of mental health and alcohol and other drugs among the youth justice population is outlined in the 2009 literature review by The Werry Centre.

8.1 Assessment of the Youth Justice Population in Secure Residential Care

Effective assessment allows for tailored and appropriate intervention, and helps agencies to assign young people to appropriate levels of treatment and intervention with necessary levels of intensity and security (Vincent, 2012; Youth Justice Board for England and Wales, 2013). In addition, assessment helps to ensure scarce resources are allocated in the most appropriate way to benefit the young person (Vincent, 2012). Assessment should begin when a young person first has contact with CYF services to identify any immediate needs, with reassessment conducted periodically right through to the young person's exit from CYF services. Reassessment is important given a young person's needs and circumstances may change over time, including their developmental and psychosocial needs.

When a young person is first admitted into a secure youth justice residence, an initial assessment should be conducted to identify the immediate acute needs of the young person to help ensure these needs are addressed. This initial assessment may also help to identify factors that need to be taken into account in order to provide adequate care and management of the young person while in residence. The assessment may include screening for physical and mental health needs, substance use, and any imminent risk to self, to others and from others, including self-harm or suicidal ideation. Assessment should be conducted in a space where the child/young person can feel comfortable, private and secure (Substance Abuse and Mental Health Services Administration, 2012).

A further comprehensive assessment of each young person should be conducted to help inform the young person's individualised rehabilitation plan. This assessment should cover physical and mental health problems, education needs or issues, cognitive difficulties, substance use, and risks to self, to others and from others. The young person's strengths (i.e., protective factors) should also be identified. Such a comprehensive assessment aligns with the Risk, Need, and Responsivity and strengths-based models (see Chapter Five, Section 5.1). Comparable assessments for each young person are implemented by the Missouri model and Kibble Education and Care Centre. The assessment should also involve identification of a wide range of risk and protective factors of the young person's family and other supports. This systemic and holistic approach to assessment is in line with the understanding that behavioural and mental health issues are often caused or contributed to by the young person's childhood, and environment, including their family, peers and community. Assessment should be informed by a range of sources, including self-reported information from the child/young person, the views of parents/caregivers and relevant information from other agencies involved with the child/young person (e.g., health, education, justice) (youth justice Board for England and Wales, 2013).

As outlined in Chapter Four, Section 4.4.1, the Missouri model has a standardised assessment system - the Missouri Risk and Needs Assessment and Classification System - and also utilises a standardised education test called the Woodcock-Johnson Psycho-Educational Battery-III. Having a standardised assessment process and measures can facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. A brief overview of some assessment tools that can be used for this population is provided below.

8.1.1 Assessment tools for the youth justice population

There is a considerable range of assessment tools that could be used for the youth justice population in secure residential care. It is beyond the scope of this review to provide an overview of the range of assessment measures, and their validity and reliability for this population. Here, a description is provided of nine assessment tools that can be used to assess risk, protective factors, and the range of needs and presenting difficulties among the youth justice population.

The Youth Level of Service/Case Management Inventory (YLS/CMI)

The Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), is widely used as a risk assessment and case management tool, which provides assistance in the planning of intervention and risk management. The YLS/CMI aligns with the RNR principles, and has strong predictive validity among male and female young offenders (Olver et al., 2009; Luong & Wormith, 2011; Vitopoulos et al., 2012) including among New Zealand young offenders (Mooney, 2010).

The YLS/CMI could be used among young people detained in secure youth justice residences who have committed non-violent or mixed offences, to identify their criminogenic risk and needs.

Structured Assessment of Violence Risk in Youth (SAVRY)

The Structured Assessment of Violence Risk in Youth (SAVRY; Bartel, Borum & Forth, 2000; Borum, Bartel & Forth, 2002) comprises 24-items in three risk domains: historical risk factors, social/contextual risk factors, and individual/clinical factors. Protective factors are also identified. The SAVRY has shown good predictive validity for re-offending among young people in North America (e.g., Schmidt, Campbell, & Houlding, 2011), Europe (Singh, Grann, & Fazel, 2011), and Australia (Shepherd, Leubbers, Ogloff, Fullam & Dolan, 2014).

For young people who have committed a violent offence, use of the SAVRY could be considered to identify their risk and needs. Administrators of the SAVRY should have experience in individual assessment and knowledge of child and adolescent development.

Novaco Anger Scale and Provocation Inventory (NAS-PI)

Novaco Anger Scale and Provocation Inventory (NAS-PI) is a 60-item self-report measure that assesses cognitive, arousal and behavioural domains of anger. Although the NAS-PI has not been validated in New Zealand, the measure has demonstrated good predictive validity of violence (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey & Banks, 2001) and discriminating between aggressive patients and non-clinical controls (Jones, Thomas-Peter & Trout, 1999).

Structured Assessment of Protective Factors for Violence Risk – Youth Version (SAPROF-YV)

The Structured Assessment of Protective Factors for Violence Risk – Youth Version (SAPROF-YV) is an assessment tool designed for the assessment of protective factors for violence risk among young people. The adult version, SAPROF, has been successfully implemented in a range of settings and in multiple countries. The SAPROF-YV assesses 16 dynamic protective factors. Validation studies are currently being conducted in the Netherlands, Spain, UK, US, Canada and Singapore. More information regarding the SAPROF-YV can be found at the following website: www.saprof.com/saprof-youth-version.

Inventory of Callous-Unemotional Traits (ICU)

The Inventory of Callous-Unemotional Traits (ICU) is a 24-item questionnaire designed to assess callous-unemotional traits. Young people with callous-unemotional traits are at risk for severe, aggressive and stable conduct problems. The ICU has three subscales: callousness, uncaring, and unemotional. Research has found evidence for its validity among adolescent offenders (e.g., Kimonis, Frick, Skeem, Marsee, Cruise, Munoz, et al. 2008).

The Massachusetts Youth Screening Instrument – Second edition (MAYSI-2)

The Massachusetts Youth Screening Instrument second edition (MAYSI-2) was developed by Grisso et al. (2001) to identify individuals who are at risk for serious mental, emotional and behavioural difficulties. The MAYSI-2 is a 52-item screening tool, comprising seven scales: alcohol/drug use, anger/irritability, depression/anxiety, somatic complaints, suicide ideation, thought disturbance, and traumatic experiences. Administration takes between 10 and 15 minutes. As outlined in McArdle and Lambie

(2015), the MAYSI-2 is the most commonly used mental health screening tool in youth justice settings (Cruise, Marsee, Dandreaux, & DePrato, 2007). The MAYSI-2 has good internal consistency (e.g., see Ford, Chapman, Pearson, Borum, & Wolpaw, 2008) and test-retest reliability (e.g., see Grisso & Barnum, 2006).

Substances and Choices Scale (SACS)

The Substances and Choices Scale (SACS) is a self-reporting measure for assessing and monitoring substance use among young people. The SACS is a one-page form comprising three sections: frequency of occasions of use (past month for a range of substances); alcohol and drug taking behaviour, symptoms and impacts/consequences (past month); and frequency of tobacco use (past month). The SACS has demonstrated sound reliability, congruent validity, and predictive ability in New Zealand (e.g., Christie et al., 2007).

CAGE Questionnaire - Substance Abuse Screening Tool

The CAGE is a self-report measure for assessing problem drinking and potential alcohol problems. The CAGE is a widely used tool to assess alcohol use among individuals in primary care settings and general population surveys. The CAGE is a short screening tool comprising only four questions. The CAGE has demonstrated sound test-retest reliability (0.80-0.95) and adequate correlations with other screening instruments (0.48-0.70) (Dhalla and Kopec, 2007). The CAGE is a valid tool for detecting alcohol abuse and dependence, particularly in medical and surgical inpatients, ambulatory medical patients and psychiatric inpatients (average sensitivity and specificity: 0.71 and 0.90, respectively) (Dhalla and Kopec, 2007).

Kessler Scales – Non-specific Psychological Distress

The Kessler screening tools are self-report measures of non-specific psychological distress (i.e., risk of an anxiety or depressive disorder). The Kessler scales consist of 6-item (Kessler-6; K6) and 10-item (Kessler-10; K10) scales, which have been extensively used in a range of population and community surveys in New Zealand (New Zealand Health Survey, New Zealand Mental Health Survey) and internationally. The K6 has demonstrated good measurement precision in the New Zealand context (Krynen, Osborne, Duck, Houkamau & Sibley, 2013), and is seen to perform as well as the K10 (Kessler et al., 2010).

Summary

A comprehensive assessment is essential in order to guide the most effective intervention approach that best meets the young person's identified needs and risks. As outlined, a comprehensive assessment should include the identification of the young person's strengths, and any difficulties or issues related to their physical and mental health, educational needs, cognitive abilities, and substance use, in addition to any risk to self, to others, and from others. The assessment should also identify risk and protective factors of the young person's wider environment, including their family/whānau and other supports. The assessment of each young person in CYF care should be standardised and incorporate assessment tools to facilitate objectivity and ensure consistency between practitioners. Using a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

Chapter 9: Rehabilitative Programmes

Young people in secure youth justice residences present with a variety of complex needs, including mental health and behavioural difficulties. It is important, therefore, that a range of evidence-based interventions are available for these young people to help address their needs. In this chapter, meta-analytic studies on the effects of youth offender treatment and rehabilitation are described, followed by an overview of cognitive-behavioural treatment approaches, dialectical behavioural therapy (DBT), and alcohol and other drug programmes.

Meta-analyses provide useful estimates of the combined size and direction of effects across independent studies. RCTs also provide strong foundations for drawing inferences about the effectiveness of rehabilitative programmes. For each rehabilitative programme presented in this chapter, an outline of meta-analyses and RCTs are provided. Where there is a lack of robust evidence, findings from studies using alternative study designs (e.g., pre-test/post-test) will then be discussed; however, conclusions made from these studies can only be considered provisional. Please also note that when discussing empirical evidence, we have adopted the convention that results described as "significant" are those that are statistically significant at the $p<.05$ level.

9.1 Meta-analytic studies: Effects of youth offender treatment

Several meta-analytic studies have been conducted regarding the effects of youth offender treatment, providing insight into what programmes may or may not be effective among this population. Here, findings from meta-analyses by Koehler et al. (2013), Lipsey (2009), and De Swart et al. (2012) are provided.

9.1.1 Koehler, Lösel, Akoensi and Humphreys (2013)

Koehler et al. (2013) conducted a meta-analysis of 21 studies with 25 discrete comparisons between treatment and control groups to examine the effectiveness of young offender rehabilitation programmes in Europe. Very few systematic reviews had previously addressed young offender treatment in Europe. The analysis examined three categories of offender treatment: Cognitive-Behavioural and Behavioural treatment (thinking skills programmes, social skills and problem solving approaches), Intensive Supervision and Deterrence-Based interventions (boot camps without educational/ therapeutic elements and purely control base supervision) and Non-Behavioural treatment (included a range of educational and vocational skills training, mentoring programmes, restorative justice and intensive probation support) (Koehler et al., 2013). Please see Table C2 (Appendix C) for an overview of the studies included in Koehler et al.'s (2013) meta-analysis.

Behavioural and cognitive-behavioural treatments had the largest effect size of 1.73 (Odds Ratio), which corresponded to a 13% reduction in recidivism in the treatment group when compared to the control group. Non-behavioural treatments reported a smaller non-significant mean effect with the direction in favour of treatment (effect size = 1.23). Intensive supervision and deterrence-based treatments reported non-significant criminogenic effects, favouring the control condition (effect size = 0.85). Within non-behavioural treatments, educational and vocational training programmes appeared the most promising (effect size = 1.69) however this was, as mentioned, a non-significant result. The finding that cognitive behavioural and behavioural treatments showed the largest effect was consistent with the North American literature discussed in the review (Koehler et al., 2013).

The analysis by Koehler et al. (2013) also showed that programmes adhering to the three principles of the RNR model revealed the strongest mean effect (1.90), with a substantial difference in recidivism rates between treatment and non-treatment groups (16%). Further information regarding the RNR model can be found in Chapter Five, Section 5.1.

9.1.2 Lipsey (2009)

Lipsey (2009) investigated data from a previous meta-analysis to identify general principles and intervention types associated with the greatest reductions in recidivism among youth offenders. Seven intervention philosophies were identified: Surveillance (based on idea that close monitoring will inhibit offending e.g. intensive probation or parole), Deterrence (attempt to deter by dramatising negative consequences of behaviour e.g. "Scared Straight" programmes), Discipline (e.g. boot camps), Restorative Programs (which aim to repair harm done e.g. restitution or mediation), Counselling and its variants (e.g. individual counselling, family counselling, peer programmes), Skill Building Programs (which aim to teach young people skills to prevent future offending, e.g., cognitive behaviour therapy or social skills training), and Multiple Coordinated Services.

The only significant difference found between intervention types was between discipline and other intervention approaches, with discipline having notably smaller recidivism effects. Counselling interventions had the largest effect on recidivism (13% reduction) followed by multiple coordinated services (12% reduction), skill-building programmes (12% reduction), restorative programs (10% reduction), surveillance (6% reduction), deterrence (2% increase) and discipline (8% increase). When other variables were controlled, few differences were found with regards to the effectiveness of the various therapeutic interventions (Lipsey, 2009).

Lipsey (2009) grouped counselling, skill-building, restorative interventions and multiple services as "therapeutic interventions," while surveillance, deterrence and discipline were grouped as "non-therapeutic interventions." A "therapeutic" intervention philosophy, serving high risk offenders, and quality of implementation were the only three factors to emerge as major correlates of programme effectiveness. With regards to risk level, interventions for high-risk adolescents typically produce larger reductions in recidivism than those among low-risk adolescents, while a therapeutic philosophy and approach to intervention produce better outcomes than interventions focused on control (e.g., surveillance, scared straight programmes, and boot camps). With regards to the implementation of the treatment model, when the model was implemented to a high quality this produced better outcomes than those that were implemented poorly (Lipsey, 2009).

9.1.3 De Swart et al. (2012)

In De Swart et al.'s (2012) meta-analysis of effectiveness of institutional youth care (see Table C1, Appendix C), the authors coded treatment programmes as either: Social Skills Training (e.g. transitional living programmes, Moral Reconation Therapy, Peer counselling, Family Preservation Programmes), Cognitive Behaviour Therapy (e.g. Decompression Treatment, Reasoning and Rehabilitation, Enhanced Thinking Skills, Dialectical Behaviour Therapy) or Care as Usual.

Only Cognitive Behavioural Therapy (CBT) showed a significant medium effect (effect size 0.5, $p<.05$), while Social Skills Training and Care as Usual showed no effect. The authors were not surprised by this finding as other meta-analyses (e.g. Ang & Hughes, 2001; Cook et al., 2008; Durlack, Weissberg & Pachan, 2010; Losel & Beelmann, 2003; Schneider, 1992; Quinn, Kavale Mathur, Rutherford & Forness, 1999) had previously reported only small to medium effects for social skills training and these effects did not tend to persist long after interventions ended. Finally, the authors did not find the results to be influenced by age, gender, type of outcome measure (e.g., delinquency, skills, problem behaviour etc.) or study design characteristics (randomised, matched or non-matched controls).

Summary

"Therapeutic" interventions (i.e., cognitive behaviour and behavioural approaches, counselling, skills training, restorative interventions, multiple services) tend to have greater positive effects than "non-therapeutic" interventions (i.e., surveillance, deterrence and discipline). In addition, interventions that are highly responsive, target high risk young people, target multiple criminogenic needs and are implemented to a high quality, have greater positive outcomes.

With regards to therapeutic interventions, cognitive behavioural and behavioural approaches, as well as counselling appear to have the largest effect on recidivism, while skills training interventions tend only to have small to medium effects at best. Application of the Risk Needs Responsivity model also shows positive effects.

We are unable to robustly determine "what works" for the youth justice population based on current research. More well-controlled studies are needed to further identify what interventions works best for whom and under what circumstances (e.g., institutionalised versus noninstitutionalised care). However, the meta-analyses summarised here provide some indication as to what treatments are effective for the youth offending population. In addition, it is possible to draw conclusions from the adult offending literature regarding what rehabilitative strategies could be considered for intervention among youth offenders.

9.2 Cognitive Behavioural Therapy Approaches

Young people in residential care tend to share a commonality in their propensity to experience negative core beliefs, schemas, and cognitive distortions (Lipsey, Chapman & Landenberger, 2001). The most common treatment or intervention implemented to assist people with these kinds of difficulties is Cognitive Behavioural Therapy (CBT), which is used to identify and then correct negative core beliefs, schemas, assumptions and cognitive distortions, through the use of both cognitive and behavioural techniques (Raftery, Steinke & Nickerson, 2010). When used with young people in residential care, CBT may focus on anger and behavioural difficulties if used in a youth justice population. Currie, Wood, Williams and Bates (2012) assert that any programme for young people that aims to change aggressive and antisocial behaviour must include CBT in order to address both the cognitive and behavioural aspects of these behaviours, and these CBT programmes are thought to be the most effective in reducing these behaviours.

As mentioned above, meta-analyses have indicated the relatively beneficial effects of CBT-based programmes on recidivism in comparison with other intervention types (De Swart et al., 2012; Koehler et al., 2013; Lipsey, 2009). Lipsey (2009), for example, found that cognitive-behavioural approaches to treatment of youth offenders were more effective in reducing recidivism than behavioural, social skills, challenge (i.e., opportunities for experiential learning by mastering difficult tasks), academic, and job-related interventions, with a 26% reduction in recidivism.

The three forms of CBT described below are: Aggression Replacement Training (ART), Trauma-Focused CBT (TF-CBT), and Cognitive Self-Change, all of which have been evaluated among the youth justice population. Further CBT-based programmes for offenders include the Reasoning and Rehabilitation programme and Moral Reconation Therapy; however these are not discussed within this report due to a lack of research evidence for their use with children and adolescents (Lipsey et al., 2001).

9.2.1 Aggression Replacement Training

Aggression Replacement Training (ART) is a CBT-based intervention for young people who experience difficulty with anger and violence. It aims to develop their awareness of what to do in triggering situations, how to control their anger, and how to develop an ability to see situations from other people's perspective (Currie, Wood, Williams & Bates 2012). Further information regarding ART can be found in Amendola and Oliver (2013).

ART is a programme that is delivered over 10 weeks to groups of five to eight young people, with three classes each week in the three components that are part of the programme: Structured Learning Training/ Skillstreaming[27], Moral Reasoning Training, and Anger Control Training (Gunderson & Svartdal, 2006). The young people are generally grouped together based on age and similarity of problems (Gunderson & Svartdal, 2006). Participation in the programme is preferably voluntary, and can be utilised by young people up to the age of 17 (Gunderson & Svartdal, 2006).

Within the Structured Learning Training/Skillstreaming component, young people learn social skills through the use of modelling, role playing, feedback, and homework (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001). During the Anger Control Training component, the young people learn about triggers and cues for their anger reactions, as well as anger reducers, self-talk, self-evaluation and consequential thinking (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001). Finally, the Moral Reasoning Training component involves learning how to view the world differently, and in particular the ability to see a situation from the other person's standpoint and make appropriate and socially acceptable decisions based on this reasoning (Amendola & Oliver, 2013; Gunderson & Svartdal, 2006; Reddy & Goldstein, 2001).

Evidence

ART is currently a model programme for the United States Office of the Juvenile Justice and Delinquency Prevention (OJJDP), and is recognised as an "effective" intervention by the OJJDP and National Institute of Justice for serious/violent offenders and young offenders. ART has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements. Furthermore, in their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found ART to be the third most commonly implemented programme, with 13 of the 75 agencies using ART.

Multiple studies using various methodological designs have evaluated the effectiveness of ART among young people exhibiting aggressive and offending behaviour, including those residing in youth justice facilities. However, no RCTs have been conducted. An overview of the current research on ART is provided below. Nugent, Bruley and Allen (1999) used an interrupted time series design study to evaluate an adapted version of ART among 522 boys and girls in a runaway shelter over a 21-day period. The results indicated that ART led to a significant decrease in antisocial behaviour among males and females (14% and 29.4% decrease, respectively). Limitations of this study included a lack of control or comparison group, and concerns regarding how agency staff recorded male antisocial behaviour incidents in case files.

The Washington State Institute for Public Policy (WSIPP) conducted an outcome evaluation to examine the effectiveness of the ART program among a group of 704 medium- and high-risk youth offenders. Findings were compared with a control group of 525 youth offenders who received Youth Justice Court services (treatment as usual). ART was associated with a 24% reduction in 18-month felony recidivism comparative to the control group (Barnoski, 2004). To the best of the authors' knowledge, this study has not been published in a peer-reviewed journal.

Perseus House, a residential program for male and females in Pennsylvania, conducted a quasi-experimental evaluation for both community-based and residential programming (Neal, 2012). Findings demonstrated significant increases in Skillstreaming skills scores, achievement, and staff ratings of youth's overall psychological and social functioning, and significant decreases in aggression scores and thinking errors. Among 1127 young people in the Collaborative Intensive Community Treatment Program, the recidivism

27 Skillstreaming is an intervention which teaches a range of prosocial behaviours and skills to children and adolescents.

rate one-year post-discharge was 10.5%. Among 853 young people in the Residential Program, the recidivism rate one-year post-discharge was 7%. Limitations of this research include a lack of control or comparison group. To the best of the authors' knowledge, this study has not been published in a peer-reviewed journal. Gunderson and Svartdal (2006) conducted a non-equivalent control group design to examine the effectiveness of ART among 65 children and young people with varying degrees of behavioural problems. ART intervention resulted in improvements in both social skills and behavioural problems from pre- to post-intervention, compared to the control group.

Currie et al. (2012) examined ART among twenty aggressive youth offenders in Australia using a pre-test/post-test design, with 6- and 24-month follow-up. Participants reported significant reductions in aggressive behaviours and thoughts, cognitive distortions, and impulsivity and some improvement in social problem-solving skills at treatment-end. These treatment effects were maintained at the 24-month follow-up.

In a non-randomised design study, Holmqvist, Hill and Lang (2009) evaluated ART and token economy within two treatment units, and compared these findings with two units that used a treatment programme based on an object-relational and developmental treatment model. There were multiple limitations to this study, including a limited number of young people participating from two of the residential units (i.e., 6 and 7 young people), and lack of programme integrity. Findings showed no differences between the treatment models on sentences and police suspicion reports post-discharge.

Hornsveld, Kraaimaat, Muris, Zwets and Kanters (2014) examined ART using a pre-test/post-test design among young people convicted by the court for a violent offence who were referred to a forensic psychiatric outpatient setting. Comparing pre- and post-intervention measures, ART was associated with a significant reduction in self-reported physical aggression (d = .28) and social anxiety (d = .31). A trend of reduction in hostility (p = .056; d = .25), aggression (p = 0.50; d = .21) and anger (p = .058; p = .21) were also found. Overall, these results provide some support for ART among young violent males receiving treatment in forensic psychiatric outpatient settings.

A review of ART by Reddy and Goldstein (2001) reported that the programme can be easily replicated and evaluated in youth justice settings and residential care (Reddy & Goldstein, 2001). In addition, Amendola and Oliver (2013) suggest that the use of ART should be paired with Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) (see Chapter Nine, Section 9.2.2) in order to increase the effectiveness of both interventions.

EQUIP

EQUIP (Gibbs et al. 1995) is an adaptation of PCC (see Chapter Six, Section 6.1) with components from ART. Research evaluating EQUIP has found mixed results for young offenders. An overview of this research is provided in Chapter Six, Section 6.1.

Limitations

Despite some research demonstrating the benefits of ART among the youth justice population, including studies using control-group designs, findings are mixed. In addition, no RCT examining the ART programme has been conducted; however, Leeman et al (1993) examined EQUIP using a RCT (see Chapter Six, Section 6.1). Further research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of ART for the youth justice population.

9.2.2 Trauma-Focused Cognitive Behavioural Therapy

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a form of CBT often used in care and protection residences to assist young people in dealing with the traumatic experiences that are often underlying the behavioural and mental health issues that have resulted in them ending up in secure care (Holstead & Dalton, 2013). In particular, TF-CBT addresses symptoms of post-traumatic stress disorder (PTSD), and incorporates attachment, humanistic, and family therapy models in order to do this (Holstead & Dalton, 2013).

Within secure youth justice residences, there are a high number of young people who have experienced significant trauma, and these trauma experiences contribute to the issues that these children present with, including mental health diagnoses such as PTSD, aggression, trust and attachment issues, and developmental delays (Brown, McCauley Navalta, & Saxe, 2013; Holstead & Dalton, 2013). These young people often have neurobiological changes that result in sleeping

difficulties, and issues with concentration, physical symptoms, and regulating emotion (Cohen, Mannarino & Murray, 2011).

TF-CBT uses cognitive and behaviour strategies to assist young people in care with coping skills, relaxation and in-vivo strategies[28], affective modulation[29], and cognitive processing of trauma experiences (Cohen et al., 2011; Holstead & Dalton, 2013). In addition, the young person develops a trauma narrative which assists with the processing of the traumatic experiences, and the inclusion of parents or caregivers is essential in the treatment process (Cohen at al., 2011; Holstead & Dalton, 2013).

A particular difficulty when working with traumatised youth in residences is that the experience of being in a residence can, in itself, be traumatic due to change of environment, being confined, and being placed with other young people who may exhibit disturbing behaviours. For this reason TF-CBT works to assist the young person to differentiate between a genuine current danger versus a reminder of historical trauma (Cohen et al., 2011).

Evidence

TF-CBT is currently a model programme for the United States Office of the Juvenile Justice and Delinquency Prevention (OJJDP), and is recognised as an "effective" intervention by the OJJDP and National Institute of Justice for victims of crime and children exposed to violence. TF-CBT has been recognised by the California Evidence-based Clearinghouse for Child Welfare as being "well-supported by research evidence" for young children placed in higher level placements. In their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found TF-CBT to be the second most commonly implemented programme, with 26 of the 75 agencies using TF-CBT.

Numerous RCTs have been conducted on TF-CBT for young people or children with trauma and/or PTSD (e.g., Black, Woodworth, Tremblay & Carpenter, 2012; Cohen & Mannarino, 1996; Cohen, Mannarino, & Iyengar, 2011; Deblinger, Lippmann & Steer, 1996; Deblinger, Mannarino, Cohen, Runyon, & Steer 2011; Deblinger, Steer & Lippmann, 1999; King, Tonge, Mullen, Myserson, Heyene, Rollings et al., 2000) with findings demonstrating significantly reduced PTSD symptoms and behavioural problems post-treatment.

Holstead and Dalton (2013) assert that there is strong evidence for the use of TF-CBT in treating young people who are experiencing PTSD symptoms. In addition, in their systematic review of evidence-based treatments for children exposed to childhood maltreatment, Leenarts, Diehle, Doreleijers, Jansma and Lindauer (2013) found TF-CBT to be the best-supported treatment. Of the five studies evaluating TF-CBT included in Leenarts et al.'s (2013) systematic review, the between group effect sizes ranged from 0.22 to 0.70. Furthermore, in their review of TF-CBT research, Ramirez de Arellano, Lyman, Jobe-Shields, George, Dougherty, Daniels et al. (2014) found TF-CBT demonstrated significant decreases in PTSD symptoms, with medium-range effect sizes. However, there were inconsistent findings for TF-CBT in reducing depressive symptoms and behaviour problems (e.g., sexual behaviour, aggression) (Ramirez de Arellano et al. 2014).

There is no empirical evidence examining TF-CBT among the youth justice population in secure residential care. From 2011 to June 2014, Cohen and Mannarino began conducting a RCT of two delivery strategies for TF-CBT among young people in 10 residential treatment facilities in New England. The reviewers are unaware of any published results from this study. It is strongly recommended that CYF follow-up on the findings of this project to determine the efficacy of TF-CBT among the youth justice population in secure residential care.

Limitations

Although there is strong empirical evidence for TF-CBT for young people exposed to childhood maltreatment, at this stage the reviewers are unaware of any empirical evidence evaluating TF-CBT among the youth justice population. However, given the prevalence of maltreatment experienced among these young people, it is likely that such an approach would provide some benefit for this population. As stated above, it is recommended that CYF follow-up the findings of Cohen and Mannarino's research regarding TF-CBT among the youth justice population in residential facilities.

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28 This refers to the graded exposure to trauma reminders in the young person's environment (i.e., triggers) so they learn to manage their emotional responses, and reduce avoidance behaviours.

29 This refers to the identification and modulation of affective states, including problem solving and anger management.

9.2.3 Cognitive Self-Change

Cognitive Self-Change is a CBT-based intervention used among youth and adult offenders to help them bring automatic thoughts under conscious control (Powell, Bush & Bilodeau, 2001). The process of cognitive self-change occurs through awareness of antisocial thoughts and cognitions, and learning and practicing of prosocial thinking skills (Bush & Harris, 2010). The offenders are seen as responsible for their own motivation to change their behaviours, and controlling their own risk of reoffending through the process of Cognitive Self-Change (Bush, 1995).

The Cognitive Self-Change treatment model comprises four steps. Firstly, the individual learns to become aware of, and be objective toward, their thinking process. Next, the individual learns to connect their offending behaviours to their thinking patterns. The individual is then required to come up with alternative ways of thinking that lead them away from offending behaviours and are meaningful and realistic. Finally, the individual practices the new way of thinking in real situations. The individual is not allowed to move on to the next skill until the first one has been mastered, and so on (Henning & Frueh, 1996). Offenders also learn strategies to assist in preventing new cognitive distortions and maladaptive thinking processes developing in the future, including cognitive re-direction and behavioural strategies (Henning & Frueh, 1996).

Evidence

There is limited evidence on the effectiveness of Cognitive Self-Change. In a non-randomised study with a comparison group, Henning and Frueh (1996) found that adult offenders who had completed the full Cognitive Self-Change programme had significantly lower rates of recidivism over 24 months than the control group (50% versus 70.8%). Post discharge, those who completed Cognitive Self-Change had a 75% chance of not receiving a new charge in the first year, 62% chance at two years, and 54% at three years. In contrast, the control group had a 54% chance of not receiving a new charge in the first year, 33% chance at two years, and 25% chance at three years (Henning & Frueh, 1996).

Limitations

Few studies have been conducted on the Cognitive Self-Change programme, and no RCT has been conducted. The reviewers are unaware of any empirical evidence examining the Cognitive Self-Change model among youth offenders or those exhibiting problematic behaviour (e.g., conduct). Research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of the Cognitive Self-Change programme for the youth justice population.

The last step of the Cognitive Self-Change process involves the offender practicing their new ways of thinking in real life, however for young people in secure residences, this may be difficult until after they leave the residential environment.

New Zealand Context

The Mauri Toa Rangatahi (The Power of Youth) programme run by the Department of Corrections uses Cognitive Self-Change as one of its treatment approaches.

9.3 Dialectical Behavioural Therapy

Dialectical Behavioural Therapy (DBT) was developed by Marsha Linehan (1993) for the treatment of Borderline Personality Disorder, chronic suicidal behaviour, and emotional problems. DBT is helpful in obtaining skills in distress tolerance, emotional regulation, interpersonal conflict, and mindfulness. As such, DBT has been shown to be effective in addressing difficulties that young people in residential care often present with, namely self-harming behaviour, suicidal ideation, emotional problems, and anger.

DBT combines cognitive-behavioural, skills-building techniques, mindfulness, and acceptance and change techniques based on Buddhist principles (Shelton, Kesten, Zhang & Trestman, 2011). Treatment targets include life-threatening behaviours, therapy-interfering behaviours, quality of life, and skills acquisition. DBT aims to replace ineffective, maladaptive emotional and behavioural responses with more effective, skilful responses.

DBT has four modules: interpersonal effectiveness, emotional regulation, distress tolerance, and mindfulness (Linehan, 1993). Within these four modules, adolescents are taught skills, such as being intentional in the moment (i.e., mindfulness), how to distract

themselves from unpleasant emotions (i.e., distress tolerance), and coping with interpersonal conflict (i.e., interpersonal effectiveness).

DBT has been adapted for adolescents (DBT-A; Rathus & Miller, 2002) and children (Perepletchikova, Axelrod, Kaufman, Rounsaville, Douglas-Palumberi & Miller, 2011). In addition, a manual is currently being developed to apply DBT to school settings (Mazza, Dexter-Mazza, Murphy, Miller & Rathus, in press).

Further information regarding DBT can be found in Linehan (1993), Linehan and Dimeff (2001), the 2011 report by the California Department of Corrections and Rehabilitation (Office of Research, Juvenile Justice Research Branch, Carr, Fitzgerald & Skonovd, 2011), and on the DBT New Zealand website at www.dbtnz.co.nz.

Evidence

In their national survey of evidence-based practices in residential care settings in the United States, James et al. (2015) found DBT to be the most commonly implemented programme, with 29 of the 75 agencies utilising DBT.

No RCTs have been conducted examining the effectiveness of DBT among young offenders. However, two prettest-posttest studies have evaluated DBT among youth offenders in correctional facilities (Trupin, Stewart, Beach & Boesky, 2002; Shelton et al. 2011), and one pilot study has evaluated DBT among youth offenders with mental health difficulties residing in state institutions (Drake & Barnoski, 2006). An overview of the current research on DBT for the youth offending population is provided below.

Trupin et al. (2002) used a prettest-posttest study design with a comparison group to examine the effects of DBT among a sample of incarcerated female youth offenders, Trupin et al. (2002) found DBT was associated with significant reductions in serious behaviour problems during the 10-month period of treatment. In addition, although not statistically significant, reductions in suicidal acts, aggressive behaviours and class disruption following DBT were found (Trupin et al., 2002). Similarly, Shelton et al. (2011) conducted a one-group pre-test/post-test design study evaluating a 16-week DBT course among male incarcerated adolescents, and found a significant reduction in aggression, the number of disciplinary tickets, and using distancing as a coping strategy. Shelton et al. (2011) also found improved scores for negative affect and self-control, however these were not significant.

The Washington State Institute for Public Policy piloted DBT to examine its effect on recidivism among youth offenders who have mental health issues and reside in a state institution (Drake & Barnoski, 2006). Using a posttest design study with a comparison group, findings indicated that 40% of the DBT group and 46% of the comparison group was reconvicted with a new felony within 36 months post-release, which represented a 15% reduction. In addition, 19% of the DBT group had been reconvicted with a violent offence, while 21% of the comparison group had been reconvicted, representing a 9% reduction (Drake & Barnoski, 2006).

Research investigating outcomes of DBT treatment among non-offending adolescents is beginning to accumulate. Adaptations of DBT for the adolescent population have indicated positive results among a sample in an inpatient hospital setting, including reduced behavioural incidents during admission, para-suicidal behaviour, depressive symptoms, and suicidal ideation in one pre-test/post-test study with a comparison group (Katz, Cox, Gunasekara & Miller, 2004). In a recent RCT conducted among adolescents at an outpatient adolescent psychiatric clinic, the DBT-A group had reduced self-harm, suicidal ideation and depressive symptoms in comparison with the enhanced usual care control group (Mehlum, Tormoen, Ramberg, Haga, Diep, Laberg, et al., 2014). See Groves, Backer, van den Bosch and Miller (2012) for a review on adaptations of DBT among adolescents.

DBT has been adapted for children, with significant reductions in depressive symptoms and suicidal ideation found in one one-group pre-test/post-test design study (Perepletchikova et al. 2011). Research has also found evidence for a 4-week skills group intervention based on DBT principles for adolescents, with significant reductions in behavioural distress found comparative to a matched control group of students (Ricard, Lerma & Heard, 2013). Implementing DBT skills groups in school settings was also found to produce positive outcomes, including reduced externalising and internalising symptoms, as well as increasing positive behaviours, in one pre-test/post-test design study among non-suicidal oppositional defiant adolescents (Nelson-Gray, Keane, Hurst, Mitchell, Warburton, Chok & Cobb, 2006).

Limitations

Research is still in emerging phases regarding the positive outcomes of DBT among young offenders. To date, there has been no RCT conducted examining DBT for this population. Further research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of DBT for the youth justice population. Nonetheless, implementing DBT among young people is an emerging area and could offer a new direction of treatment for the youth justice population in New Zealand.

New Zealand Context

The feasibility of researching DBT among adolescents with self-injuring behaviour was assessed in New Zealand in 2010 (Cooney, Davis, Thompson, Wharewera-Mika & Stewart, 2010). The study used a RCT, and included 29 adolescents who had engaged in self-injurious and suicidal behaviour. Fourteen adolescents received 6 months of DBT, and 15 received treatment as usual. Results found that DBT was 'acceptable' to the young people, their families, and clinicians, with a 93% completion and attendance rate.

In 2009, Te Pou assessed the feasibility of future service development using DBT in mental health services in New Zealand. The report identified that DBT has strong evidence in treating complex and high-risk problems, is strongly supported among district health boards, consumer advisors, and DBT leaders and clinicians, and that there is a small group of specialist DBT trainers in New Zealand (i.e., DBTNZ). However, noted barriers to extending DBT services in New Zealand included the cost, access to training, and the expertise of knowledge required to do so. This report can be found on the Te Pou website at www.tepou.co.nz.

9.4 Alcohol and other Drugs

Research indicates that a high percentage of young people in youth justice secure residential care facilities in New Zealand misuse alcohol and drugs (McArdle & Lambie, 2015; McKay & Bagshaw, 2009). This is thought to be due to a variety of factors including increased incidence of mental health issues, trauma experiences, and family of origin modelling (Kepper, Monshouwer, van Dorsselaer & Volleburgh, 2011). Young people in residence with co-occurring mental health and substance use disorders present as a particularly difficult challenge in regards to treatment, and are known to experience poor outcomes (Hawkins, 2009).

There are two main avenues of treatment for substance use disorders in dual diagnosis adolescents. The first is serial treatment, which entails treatment for one disorder (usually substance use treatment first), followed by treatment for whatever other mental health issues they have. The second is parallel treatment, where treatment for both disorders occurs concurrently. The latter is the treatment avenue that would most likely suit secure youth justice residences, as a substance use treatment modality could be incorporated into the wider therapeutic model and suite of interventions.

A national survey of substance abuse treatment for youth offenders across 141 youth institutional and community corrections facilities in the United States was conducted by Young, Dembo and Henderson (2007). The most common types of substance abuse services were alcohol and drug education, with substance abuse treatment more prevalent in larger state-funded residential facilities compared to local detention centres and community correctional facilities (Young et al., 2007).

There appears to be very limited research directly examining treatment models for young people in secure youth justice residences; however two promising outpatient treatments could likely be modified for use within the residential setting: Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5 and Seeking Safety. These two programmes are described below. The following also outlines the Therapeutic Community model, which is the most common intensive residential treatment for drug and alcohol misuse.

9.4.1 Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5

Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5 (MET/CBT5) is a five session motivational enhancement and CBT therapy programme. MET/CBT5 consists of two individual MET sessions, followed by three sessions of group CBT (Hawkins, 2009). The first two MET sessions are intended to progress the young person through the stages of change (Hawkins, 2009), given lack of motivation to change behaviours can be a huge barrier to treatment for substance use disorders. The CBT sessions are intended to assist the young person to learn and practice coping skills to avoid relapse upon encountering high risk situations (Hawkins, 2009).

Evidence

MET/CBT5 has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements.

Among adolescents, MET/CBT5 has been evaluated by two RCTs (Dennis, Godley, Diamond, Tims, Babor, Donaldson & Funk, 2004; Godley, Garner, Passetti, Funk, Dennis & Godley, 2010), one non-randomised comparison study (Mason & Posner, 2009), and one quasi-experimental study (Ramchand, Griffin, Suttorp, Harris & Morral, 2011). An overview of this research is provided below.

Dennis et al. (2004) conducted a RCT to evaluate MET/CBT5 among outpatient adolescents with cannabis use disorders. MET/CBT5 was compared with a 12-session regimen of MET and CBT (MET/CBT12), another that included family education and therapy components (Family Support Network [FSN), the Adolescent Community Reinforcement Approach (A-CRA) and Multidimensional Family Therapy (MDFT). All interventions produced significant improvements for days of abstinence and the proportion of adolescents in recovery at the end of the study. When controlling for initial severity, MET/CBT5, MET/CBT12 and ACRA were the most cost-effective interventions (Dennis et al., 2004).

The sample included in Dennis et al.'s (2004) study comprised adolescents with co-occurring disorders with 53% having conduct disorder, 38% having ADHD, 23% generalised anxiety, 18% depression, and 14% traumatic stress disorders. This cohort also had 83% of young people with some form of justice system involvement, suggesting that the MET/CBT5 model can be effective with the youth justice population.

Mason and Posner (2009) conducted a non-randomised comparison study examining MET/CBT5 among adolescents in an urban community setting enrolled in a substance abuse treatment programme. Findings indicated that MET/CBT5 had significantly reduced adolescent alcohol use, in comparison with the control group.

Godley et al. (2010) used an RCT to evaluate a seven-session version, MET/CBT7, among adolescents with substance use disorders. The study used a cross-treatment design and compared MET/CBT7 to a control condition, with and without Assertive Continuing Care (ACC), a home-based continuing care approach for adolescents discharged from residential treatment. Most of the sample had been involved in the youth justice system (73%). Adolescents who received MET/CBT7 had somewhat lower increases in the percentage of days abstinent over the 12-month follow-up, although the effect sizes were small. However, a cost effectiveness analysis showed that MET/CBT7 without ACC was a most cost-effective intervention (Godley et al., 2010).

Ramchand et al. (2011) compared MET/CBT5 with three outpatient treatment programmes for substance abuse among adolescents in a quasi-experimental design. Findings suggested that the MET/CBT5 group had significantly reduced substance use frequency and problems, and illegal behaviours (as measured by the Illegal Activities Scale; Dennis et al., 2010) 12-months post-treatment. No significant differences were found between groups regarding emotional problems, institutionalisation rates, or achieving 'recovery' status at 12 months (Ramchand et al., 2011).

Limitations

Although the samples in Dennis et al. (2004) and Godley et al. (2010) included adolescents who had involvement with the justice system, to the best of the authors' knowledge, MET/CBT5 has not been evaluated using RCTs among young people involved in the youth justice system and in secure residential care.

9.4.2 Seeking Safety

The Seeking Safety programme (Najavits, 2007) was developed in the 1990s for use with people who have a dual diagnosis of a substance use disorder and PTSD. At its roots, Seeking Safety is a CBT intervention, but also includes interpersonal case management aspects (Hawkins, 2009). There are five principles that are part of the intervention:

- Safety as a priority
- Integrated treatment of both disorders
- A focus on ideals, which is intended to counteract the loss of ideals experienced in both PTSD and substance use disorders
- Content areas include cognitive, behavioural, interpersonal, and case management
- A focus on therapist processes.

The Seeking Safety programme is very flexible, consisting of 25 topics that can be presented separately from each other, either individually or in groups, and in a customisable form which can be modified to suit the population it is being used with (Hawkins, 2009).

Evidence

Seeking Safety has been recognised by the California Evidence-based Clearinghouse for Child Welfare as having "promising research evidence" for young children placed in higher level placements.

One RCT has been conducted evaluating the Seeking Safety programme among adolescent females who met criteria for PTSD and substance use disorder (Najavits, Gallop, & Weiss, 2006). Findings indicated a reduction in substance use, trauma-related problems, and cognitions related to both PTSD and substance use (Najavits et al., 2006).

The Seeking Safety programme has been evaluated among adults in a variety of settings and has produced positive results, including a reduction in substance use, reduction in PTSD and other mental health symptoms, and improvements in social adjustment (e.g., Hien et al., 2004; Najavits et al., 1998; Zlotnick et al., 2003).

Limitations

To the best of the authors' knowledge, the Seeking Safety programme has not been evaluated among young people in a residential environment, those in the youth justice population, or among those exhibiting problematic behaviour (e.g., conduct problems). Research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of Seeking Safety for the youth justice population.

9.4.3 Therapeutic Communities

Therapeutic community (TC) is a milieu therapy model most often used to treat drug and alcohol use, through self-help and mutual support (Magor-Blatch, Bhullar, Thomson & Thorsteinsson, 2014). The essential elements of a TC include the requirement that the participants live together as a community, preferably isolated from most external influences. This is important in order to ensure that the community develops a sense of social togetherness and a sense of community and prosocial values (Abdel-Salam & Gunter, 2013; Fortune, Ward & Polaschek, 2014). Other aspects include a confrontational approach in which participants are made aware by staff and peers of aspects of themselves or their behaviour that are detrimental to their recovery and to the community, and democratisation, where decision making is shared by the community (Abdel-Salam & Gunter, 2013; Fortune et al., 2014).

When used with adult clients, a TC will normally have a progressive system of 'levels' that participants can attain through achieving certain social and personal goals (Molloy, Sarver & Butters, 2012). As the participants move through these levels they are given more responsibility within the programme, to the point where they are responsible for large aspects of the day to day running of the programme, and assisting newer participants with issues, while staff focus on therapeutic aspects. With adolescents, there can be difficulties with managing some of the responsibilities that adults in TCs are afforded, particularly in situations where the adolescent is quite young and emotionally immature. For this reason, adolescent TCs are normally referred to as "modified TC". Modified TC for adolescents may include having more staff involvement as opposed to using senior participants, and more restrictions on the movements and decision making capabilities of the participants. TCs are considered to be an intensive form of treatment and duration is typically between 6 and 12 months (Molloy et al., 2012).

Evidence

TC has been evaluated using various methodological designs. However, no RCTs have been conducted among young people in residential care. An overview of the current research on TC among adolescents is provided below. Gordon et al. (2000) used a non-randomised design with matched control group to examine TC among adolescents who had been convicted of a Felony 1 or 2 offence. The comparison group comprised young people from a youth justice detention centre in Ohio. The authors found that adolescents in the TC group were less likely to receive a reconviction or be recommitted post-treatment than the comparison group (for both reconvictions and recommitments: TC group: 26% (Caucasian), 39% (ethnic minority); Comparison group: 37% (Caucasian), 52% (ethnic minority)) (Gordon et al., 2000).

Hawke et al. (2000) examined drug use, criminal and HIV risk behaviour in a one-year post-treatment outcome study among adolescent amphetamine users and non-users in the United States and Canada one-year post-

treatment in a TC. Findings showed significant reduction for regular drug use, criminal involvement, drug offences, property offences, violent offences, and having sex while high. Amphetamine use was not associated with treatment outcomes (Hawke et al., 2000).

In a 5-year post-treatment outcome study, Jainchill, Hawke, and Messina (2005) examined The Recovery House (RH) programme, a therapeutic approach that integrates TC for drug and alcohol use, among adolescents admitted to a residential therapeutic community in the United States. The RH program focuses on the antisocial behaviours of these young people, as well as the substance use. With the exception of alcohol use, no significant differences were found in the number of young people reporting substance use pre- to post-treatment for marijuana, cocaine and opiate use. However, the use of drugs, other than marijuana and alcohol, was infrequent. With regards to criminal activity post-treatment, drug possession, drug sales, violent crimes and property damage, there were significant decreases in involvement. An increase in the number of young people involved in "hustles" (e.g., prostitution, forgery) was found, and the number of weapon offences did not change post-treatment (Jainchill et al., 2005).

Similar to the aforementioned studies, Morral, McCaffrey, and Ridgeway (2004) found significantly lower substance use rates and improved psychological functioning among a group of adolescent probationers who underwent TC treatment in a 12-month outcome study using a case-mix adjustment approach. Compared to a matched control group (alternative probation disposition), the TC group demonstrated a significant reduction in past month substance problems (d = -.27), substance use density (d = -.25), substance involvement (past 90 days; d = -.24), somatic symptoms (d = -.32), and anxiety symptoms (d = -.29). No differences were found between groups on crime outcomes (i.e., arrests, property offences, violent offences, drug offences etc. in the previous 90 days) (Morral et al. 2004).

In an exploratory study using quantitative and qualitative data, Perry and Duroy (2004) compared young heroin users with non-heroin users admitted to a TC at 12-month follow-up on substance use, psychosocial and criminal justice measures. Findings indicated that both heroin and non-heroin young adults in TC achieved positive outcomes following TC treatment, including reduced substance use (e.g., days used any drugs (past 90 days)), behavioural complexity, general mental distress and improved general social support. Property crime, interpersonal crime and drug crime also reduced for both groups post-treatment.

There is also benefit in using TC with clients who have experienced trauma and attachment issues, due to the use of a pro-social community model, and the inclusion of staff as part of the community. This can assist these attachment disordered clients to form secure attachments, and can allow staff time to engage in appropriate therapeutic work (Haigh, 2013).

Limitations

The research above suggests there is promising evidence for the use of TC among adolescents involved in the youth justice system. However, further research using sound methodology (e.g., RCTs) is needed to draw strong conclusions regarding the efficacy of TC for this population.

The main limitation of the TC model is that it is designed specifically and is most effective for treatment of drug and alcohol addiction (Fortune et al., 2014). The use of TC models for youth justice populations may be limited due to the time young people typically spend in residential care compared to the six to nine months required for TC treatment, and the range of presenting problems among these populations, some of which may not be compatible with the use of a TC model. However, the RH programme examined by Jainchill et al. (2005) could be a suitable alternative for the youth justice population.

Finally, the operation of a TC requires an organisation that runs effectively and is staffed by caring, knowledgeable and experienced staff, as negative experiences can re-traumatise clients who are already suffering from the after effects of childhood trauma (Cross, 2012). TC staff need to ensure consistency, and have the ability to regulate emotions under stress, and to avoid transference and counter-transference as much as possible while still maintaining the therapeutic alliance (Cross, 2012). It would be wise if implementing a TC to first analyse the organisational culture and staff mix and qualifications in order to determine whether a TC could be operated effectively.

Summary

Given the youth justice population in secure residential care present with a range of complex needs, a suite of evidence-based interventions should be available in order to help address these needs. Here, Aggression Replacement Training (ART), Trauma-Focused-Cognitive-Behavioural Therapy (TF-CBT), Cognitive-Self-Change, Dialectical Behavioural Therapy (DBT), and a range of programmes to address alcohol and other drug difficulties were outlined. At this time, ART, TF-CBT, DBT, Motivational Enhancement Treatment/ Cognitive Behaviour Therapy 5, and Seeking Safety have demonstrated promising research findings that suggest implementation among the youth justice population in New Zealand could provide positive outcomes. For secure youth justice residences in New Zealand, any interventions implemented should be complementary to the therapeutic environment the residences are seeking to create.

It is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started in secure residence unless a young person is transitioning back into the community where this intervention can continue with minimal disruption and they continue to see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in residence, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical-Behavioural Treatment). Alternatively, rehabilitative programmes could be implemented in a modular-based manner, where one or several modules are delivered in residence, and the remaining modules after release from residence.

Chapter 10: Ethnicity and Culture

As noted earlier, Māori are over-represented in the youth justice population, including those residing in residential care. There is evidence to suggest that disparities between Māori and non-Māori in the justice system may be attributed to colonisation and its subsequent impact on socioeconomic status, loss of cultural identity, and educational underachievement among Māori (Becroft, 2009; Macfarlane, Webber, Cookson-Cox & McRae, 2014; Quince, 2007). Scholars, including Mason Durie, suggest that creating contexts that enable Māori to develop a secure and more positive cultural identity is one important component in the goal of addressing issues that create a cycle of poverty, truancy, and offending (Durie, 2005; Jackson, 1988). Longitudinal research has also indicated that having a strong cultural identity and a connection with culture are protective factors against engaging in offending for Māori (Marie, Fergusson & Boden, 2009). Therefore, it appears vital not only to implement interventions that are responsive to challenging behaviours that are presented by rangatahi Māori, but to also invest in culturally responsive evidence-based practices that help strengthen cultural identity, address cultural needs, and consequently promote positive cultural, educational, and socio-economic outcomes. Furthermore, cultural safety and cultural competency are performance requirements of health practitioners in all professional health regulatory bodies, as outlined in The Health Practitioners Competency Assurance Act (2003).

As outlined in Chapter Three, Section 3.1.1, CYF residences use the indigenous and bicultural framework for working with Māori. In addition, Māori-centred frameworks and initiatives have been developed in New Zealand, including Whānau Ora – a whānau-centred approach to Māori wellbeing that aims to empower families.

A comprehensive overview of a te ao Māori perspective on conduct problems among adolescents, core elements of kaupapa Māori programmes, and the range of kaupapa Māori programmes that are currently available to address conduct problem behaviours are outlined in the 2011 and 2013 Advisory Group on Conduct Problems (AGCP) reports (see: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/effective-programmes-for-adolescents.html). Here, an overview is provided of three kaupapa Māori programmes deemed to be the most intensive in the AGCP (2013) report, and therefore the most appropriate to implement among rangatahi Māori residing in youth justice residential care. These programmes are: The Meihana Model, Te Pikinga ki Runga, and Te Hui Whakatika. In addition, a promising kaupapa Māori school-wide approach, Huakina Mai, is also described. Finally, an overview of how cultural needs are met in other youth justice jurisdictions is provided.

10.1 Kaupapa Māori programmes

10.1.1 The Meihana Model

The Meihana Model (Pitama, Robertson, Cram, Gillies, Huria & Dallas-Katoa, 2007) provides a framework and practice model for health professionals in the assessment and intervention of Māori clients and their whānau. The model is an extension of the Te Whare Tapa Whā (Durie, 1985), and includes six components – whānau (family), wairua (beliefs, connectedness and spirituality), tinana (physical health), hinengaro (psychological and emotional wellbeing), taiao (physical environment) and iwi katoa (support services and systems in the health environment) – which are overlaid with the core concept of 'Māori Beliefs, Values and Experiences' (Pitama et al., 2007). The six components interconnect to form a multi-dimensional assessment tool, which enables a comprehensive picture to be formed of the context in which the client's difficulties are occurring (Pitama et al., 2007). The individual is therefore seen as existing within a collective, which should be engaged with and utilised in the assessment and intervention process. Using this framework, a more thorough assessment and intervention programme can be developed. It is believed that such a framework validates the beliefs, values and experiences of Māori in a clinical setting (Pitama et al., 2007).

The Meihana Model is used within the Indigenous Health Framework utilised in the training of medical students at the University of Otago, based in Christchurch (Pitama, Huria & Lacey, 2014). This framework also comprises the Hui Process (Lacey, Huria, Beckert, Gillies & Pitama, 2011), which helps to facilitate an enhanced relationship between the doctor and Māori client from the initial meeting to the end of the session (see Pitama et al. (2014) for an overview).

The Meihana Model is considered to be a 'sustained' kaupapa Māori programme (AGCP, 2013). Increased interactions between health practitioners and Māori clients and whānau have been found when using the Meihana Model (Lacey et al., 2011; Pitama et al., 2007; Pitama, 2012). More information on the Meihana Model can be found in Pitama et al. (2007) and Pitama et al. (2014).

10.1.2 Te Pikinga ki Runga

Te Pikinga ki Runga: Raising Possibilities (Macfarlane, 2009) is a framework for the assessment and programme planning of Māori exhibiting problematic behaviours in educational settings. The framework is based on the three Treaty of Waitangi human-rights principles – partnership, protection and participation (Macfarlane, 2009). Under the principle of partnership, engaging with and building effective partnerships with whānau are essential. Under the principle of protection, meeting the needs (i.e., wellbeing, identity and self-concept) of the young person in a strengths-based and holistic manner is vital. Such a holistic approach is based on four domains: hononga (relational), hinengaro (psychological), tinana (physical), and mana motuhake (self-concept), each of which comprises three subdimensions. The 12 subdimensions are presented in a grid, along with reflective questions, to assist the practitioner in implementing the framework. Finally, under the principle of participation, it is important that the presence, participation and learning of the young person is supported and enhanced within the learning context (Macfarlane, 2009). Te Pikinga ki Runga is considered a 'sustained' kaupapa Māori programme (AGCP, 2013). More information on the Te Pikinga ki Runga can be found in Macfarlane (2009).

10.1.3 Te Hui Whakatika

Te Hui Whakatika (Hooper, Winslade, Drewery, Monk & Macfarlane, 1999) is based on the traditional hui (assembly, gathering), where a culturally-grounded space is created to provide support and to seek and achieve resolution, consequently restoring harmony. In essence, Te Hui Whakatika promotes concepts that now underpin restorative justice. The Hui Whakatika process has four phases: preparing the groundwork, the hui proper (the hui phase), forming/consolidating the plan, and follow-up and review. Te Hui Whakatika has been implemented in several primary and secondary schools across the Waikato, Bay of Plenty and Canterbury regions.

Te Hui Whakatika is considered an 'emerging' programme (AGCP, 2013). More information on the Te Hui Whakatika model can be found in Hooper et al. (1999), Bateman and Berryman (2008), and Berryman and Macfarlane (2011).

10.2 Kaupapa Māori school-wide approach: Huakina Mai

Huakina Mai ("opening doors") was developed by the Ministry of Education, University of Canterbury and Te Runanga o Ngāi Tahu. Huakina Mai aims to facilitate positive outcomes for Māori students and their whānau by promoting a positive school culture that is developed through collaboration between whānau, schools and Iwi. Huakina Mai is based on five principles: whanaungatanga (relationships), kotahitanga (unity), rangatiratanga (leadership), manaakitanga (ethic of caring), and pūmanawatanga (centrality of te ao Māori) (Savage, Macfarlane, Macfarlane, Fickel & Te Hēmi, 2014). Huakina Mai is currently being trialled in two Canterbury schools in 2014-2015. More information on Huakina Mai can be found on the Te Kete Ipurangi website at http://pb4l.tki.org.nz/Kaupapa-Māori/Huakina-Mai, and in Savage et al. (2014).

10.3 He Awa Whiria: "Braided Rivers"

Although evidence on kaupapa Māori programmes appears to be accumulating, there is limited information on how to effectively and appropriately combine Western science and kaupapa Māori perspectives concerning programme effectiveness. In an attempt to integrate these two perspectives, Macfarlane proposed the concept of a braided river (he Awa whiria) (AGCP, 2011). The model firstly recognises that these two knowledge perspectives (i.e., two main streams) are distinct; however, the two streams interconnect with knowledge from one perspective helping to inform the development of programmes of the other perspective, and vice versa. In addition, the methodologies used to evaluate programmes from the Western science stream can be utilised by kaupapa Māori research, and vice versa. Thus, the streams connect through minor tributaries. The two streams finally converge, with the perspective that a programme is considered effective when it is accepted as having evidence from both streams.

10.4 Cultural Needs of the Youth Justice Population in International Jurisdictions

Here, the cultural needs of young people in the youth justice population in Australia and the United States are discussed, including how these cultural needs are met and addressed.

10.4.1 Australia

Aboriginal young people are over-represented in the youth justice population, and are more likely to experience supervision when aged between 10 and 17 years (Australian Institute of Health and Welfare, 2015). A range of culturally appropriate programmes are available for youth in contact with the youth justice system. These include the Intensive Supervision Program and Our Journey to Respect Program in New South Wales, the Koori Youth Justice Program and the Koori Early School Leavers and Youth Employment Program in Victoria, the Woorabinda Early Intervention Coordination Panel Service and The Youth Opportunity Program in Queensland, the Aboriginal Youth Diversion Service, the Halo day program and the Regional Youth Justice Services in Western Australia, and the Baluni Foundation, Elders Visiting Program and The Northern and Central Australian Aboriginal Legal Services in the Northern Territory. While most operate in the community, there are a few that serve those young people in custody.

In New South Wales, Dthina yuwali ("tracking footprints") is a culturally appropriate alcohol and drugs programme targeted at young Aboriginal and Torres Strait Islander offenders in custody, delivered by Aboriginal and non-Aboriginal staff with regular input from Elders. The programme promotes awareness and respect for culture and looks at the impact on individuals, the community, families and culture of offending and alcohol and drug use. The programme is heavily influenced by Elders and involves the use of Aboriginal symbols and tools such as a message stick, demonstrating respect for storytelling. The programme won the New South Wales Juvenile Justice's Aboriginal and Torres Strait Islander Recognition Award in 2011. In Tasmania, young people who are on remand or serving a sentence of detention are eligible to take part in the Lungtalanana residency programme. Young people who take part live on Lungtalanana (also known as Clarke Island) and participate in culturally appropriate activities. The aim of the programme is to divert youths at risk away from at risk lifestyles.

10.4.2 United States

American Indian and Alaska Native young people are disproportionately represented in the youth justice system (Caringi & Lawson, 2014). There is very limited information available on treatment and interventions that are culturally tailored to meet the needs of Native American Indian and Alaska Native young people in residences. At best, cultural needs are incorporated into mainstream practice as one of a long list of considerations. Care and protection and youth justice matters can be dealt with within tribal and community systems, which is considered by some to be the preferred approach (Caringi & Lawson, 2014), with some tribes having their own secure youth justice residences (Arya & Rolnick, 2005).

Summary

Any programmes implemented for rangatahi Māori should use well recognised and culturally grounded frameworks, such as those outlined above, to ensure that an ecological perspective that is culturally informed is provided. Furthermore, it is important to continue investigating and attempting to understand what the causes of offending are among Māori, and what approaches need to be implemented to facilitate the best outcomes for rangatahi Māori who are in the youth justice system. Conversely, strengths-based approaches that report on the key (cultural) indicators for rangatahi Māori who have succeeded at school and beyond must be considered.

Chapter 11: Education

Youth in residential care often perform at a lower level academically than their peers, have fewer qualifications than other young people their age, and progress through the education system at a slower rate (Gharabaghi, 2011; Zeller & Köngeter, 2012). Poor educational achievement can affect the young person later in life, leading to unemployment and sometimes homelessness (Gharbaghi, 2011). Furthermore, education and vocational difficulties are risk factors for offending behaviour (Andrews & Bonta, 2010). Therefore, it is essential that intensive educational services by skilled professionals are offered to help these young people catch up to their peers. As outlined in Chapter Three, Section 3.1.1 there are three education providers in New Zealand who deliver education services for youth justice secure residences.

The following provides an overview of a recent meta-analysis of the effect of youth delinquency interventions on academic outcomes, and three educational approaches that can be implemented among young people with significant conduct problems: Positive Behaviour for Learning (PB4L), Alternative Education, and Prevent-Teach-Reinforce.

11.1 Meta-analytic study: Effects of youth offender treatment on academic outcomes

Sander, Patall, Amoscato, Fisher and Funk (2012) conducted a meta-analysis of 15 studies to investigate the effects of youth delinquency interventions on academic outcomes. While the link between low academic achievement and youth delinquency is well established, the meta-analysis revealed that there is very limited research examining youth delinquency interventions on academic outcomes. Of 250 reports originally found, only 15 met the inclusion criteria for the study. It was noted that in the five years prior to the study being conducted, no new reports had been produced in the area.

The results of the meta-analysis suggested that youth delinquency interventions are generally ineffective in improving academic outcomes, even in cases where delinquency programmes have an academic component. The unadjusted effects of programme on academic achievement varied between d = -.57 and +.66, and the adjusted effects of programme on achievement between d = -.48 and +1.12.

The most encouraging finding from the meta-analysis was that youth delinquency programmes may have a positive effect on school attendance among older youth delinquents aged between 15 and 18; however this is not the case for younger delinquents. The authors noted however, that this conclusion was tentative.

11.2 Educational approaches for young people with problematic behaviour

The following outlines the Positive Behaviour for Learning (PB4L), Alternative Education, and Prevent-Teach-Reinforce educational approaches for young people with significant conduct problems.

11.2.1 Positive Behaviour for Learning

Positive Behaviour for Learning (PB4L) is an initiative developed from the 2009 Taumata Whanonga in response to concerns about the effects of problematic behaviours on the educational achievement and overall wellbeing of young people. PB4L is led by the Ministry of Education in a joint initiative between several education sector organisations. The aim of the PB4L initiative is to plan and support programmes that are able to intervene early in the young person's life, are evidence-based, can be delivered with fidelity, be consistent in quality across New Zealand, and can be sustained over the long-term.

PB4L comprises ten evidence-based programmes currently aimed at enabling parents, teachers and schools to address problematic behaviour and to promote positive outcomes for these young people. Programmes to support schools include the School-Wide framework, Wellbeing@school, Behaviour Crisis Response Service and Intensive Wraparound Service (IWS; see Chapter Three, Section 3.2.2, for more on this service). A programme to support teachers includes the Incredible Years: Teacher programme, and for parents the Incredible Years: Parent programme. In addition, Kaupapa Māori programmes, such as Huakina Mai (see Chapter Ten, Section 10.2), are being trialled. Further information regarding PB4L can be found on the Ministry of Education website at:

www.minedu.govt.nz/theMinistry/EducationInitiatives/PositiveBehaviourForLearning.aspx.

The Positive Behaviour for Learning – School Wide (PB4L-SW) is a whole-school approach to addressing problematic behaviours being introduced in New Zealand. This programme is described briefly below.

Positive Behaviour for Learning – School Wide

Positive Behaviour for Learning – School Wide (PB4L-SW), also known as Positive Behaviour Support (PBS), School Wide Positive Behaviour for Learning (SWPB4L), or Positive Behavioural Interventions and Supports (PBIS), is one of the cornerstone programmes for the PB4L initiative. PB4L-SW is a whole school approach that emphasises the readjustment of environments, teaching of replacement behaviours, and a continuum of consequences to reduce or eliminate problematic behaviour (Horner et al., 2005; Spaulding et al., 2010).

The PB4L-SW framework models the School-Wide Positive Behaviour Support (SWPBS) developed by the Office of Special Education Programs – Centre on Positive Behaviour Interventions and Supports (see www.pbis.com) in the United States. PB4L-SW originates from Applied Behaviour Analysis, and extends on behavioural principles to include the familial and interpersonal contexts for the young person with problematic behaviours. PB4L-SW is a three tier programme to manage challenging behaviour. The goal of PB4L-SW is to increase positive behaviour and academic achievement through the promotion of a prosocial and positive climate (Horner & Sugai, 2000).

Further information regarding PB4L – School Wide can be found in Savage, Lewis and Colless (2011), on the Te Kete Ipurangi website at http://pb4l.tki.org.nz/PB4L-School-Wide, Ministry of Education website at www.education.govt.nz, and in the 2014 evaluation report to the Ministry of Education (Boyd, Dingle, Herdina and the New Zealand Council for Educational Research, 2014).

Programme Model

PB4L-SW has three levels of prevention and intervention (Flannery, Sugai, & Anderson, 2009; Sugai & Horner, 1999, 2006). The primary level interventions are designed for all students in the school and include teaching of behavioural expectations and reinforcement. Secondary level interventions are designed for up to approximately 15% of students who have more intensive behaviour and learning support needs and include small group social skills training, behavioural expectations, and reinforcement. Tertiary level interventions are for those who exhibit severe and challenging behaviour, and include individualised specialised behaviour interventions (Flannery, et al., 2009; Sugai & Horner, 1999, 2006).

Evidence

The PB4L-SW programme itself has not been subject to empirical testing; however, the US programme on which it is based (SWPBS) has been examined in several studies, including RCTs (e.g., Bradshaw, Mitchell & Leaf, 2010; Horner, Sugai, Smolkowski, Eher, Nakasato, Todd & Esperanza, 2009). An overview of these findings is provided below.

In a five-year longitudinal RCT, Bradshaw et al. (2010) examined the effectiveness of PB4L-SW implemented in 21 elementary schools in the United States. Over the course of the study, schools that had implemented PB4L-SW showed a significant reduction in the percentage of children with a major or minor office discipline referral (from 18.8% to 18.1%, d = .08), and the number of major and minor discipline referrals per student (d = .12). In addition, Bradshaw et al. (2010) found a significant reduction in the number of suspensions over time (d = .27). Although non-significant, PB4L-SW schools also showed greater gains in fifth-grade math scores compared to comparison schools (d = .54).

Horner et al. (2009) conducted a randomised, wait-list controlled effectiveness trial of PB4L-SW in elementary schools in the United States. Findings showed that schools that implemented PB4L-SW were significantly more likely to be perceived as a safer environment, and associated with significant increases in third-grade reading performance. The study also found low rates of office discipline referrals among the PB4L-SW schools compared to those reported by a national database; however, due to no pre-PB4L-SW data being available, this finding could not be attributed to PB4L-SW.

Several studies using a range of alternative methodological designs to that of RCTs have also examined the effects of implementing PB4L-SW on a range of outcomes (e.g., Lane, Wehby, Robertson, & Rogers, 2007; Lassen, Steele & Sailor, 2006; McIntosh, Bennett, & Price, 2011). These studies are briefly described below.

Lane et al. (2007) used a repeated-measures design study to compare the effects of PB4L-SW across different groups of high school students, namely those with externalising behaviours, internalising behaviours,

co-morbid behaviours (i.e., both internalising and externalising characteristics), those with typical behaviours (i.e., no externalising or internalising behaviours), and high-incidence disabilities (i.e., students who had specific learning disabilities, other health impaired, or speech/language impairments). Results from this study indicated that these five groups of students responded differently to PB4L-SW. Over time, the internalising group showed the greatest improvements in GPA (d = 0.39) in comparison with the externalising (d = .22), co-morbid (d = -.12), high-incidence (d = -.06) and typical (d = .03) groups. All groups, except for the co-morbid group, showed decreases in unexcused lateness to class (internalising: d = -.60; typical: d = -.72; co-morbid: d = .36; high-incidence: d = -.46; externalising: d = -.17). With regards to suspensions, all groups had some decrease in the rates of suspension (internalising: d = -.27; typical: d = -.21; co-morbid: d = -.05; high-incidence: d = -.16; externalising: d = -.04). However, the externalising and co-morbid groups were least responsive. The typical group were the only group to show a decrease in disciplinary contracts (d = -.25). Overall, the findings suggest that the internalising group were most responsive to PB4L-SW, while co-morbid students were the least responsive (Lane et al. 2007).

Lassen et al. (2006) examined the effect of PB4L-SW in an urban, inner-city middle school in a 3-year longitudinal study. Over time, PB4L-SW was associated with significant reductions in the average number of office disciplinary referrals per student, average number of long-term suspensions per student, and an increase in standardised math and reading scores. In addition, analyses found that treatment adherence was significantly correlated with a reduction in problem behaviours (Lassen et al. 2006).

An outcome and fidelity of implementation study was conducted by McIntosh et al. (2011) examining PB4L-SW across eleven elementary schools and one secondary school in Canada. Findings showed that in comparison with PB4L-SW low implementing schools and other districts and provincial schools, moderate to high fidelity PB4L-SW schools had decreases in office disciplinary referrals, number of students at risk for significant behaviour challenges, increased academic achievement (as measured by the percentage of students meeting or exceeding standards on an achievement test), and student perceptions of school safety (McIntosh et al. 2011).

A pre-test/post-test comparison group design by Nelson, Martella and Marchand-Martella (2002) and an outcome study by Muscott, Mann and LeBrun (2008) found comparable findings to those outlined above, including reduced disciplinary actions and improved academic performance among schools implementing PB4L-SW.

Implementation

PB4L-SW has been implemented in over 10,000 schools in the United States. Several reports have documented the process for successful implementation of PB4L-SW (e.g., Bohannon Fenning, Borgmeier, Flannery & Malloy, 2009; Chitiyo & Wheeler, 2009; Flannery, et al., 2009). A study conducted in New Zealand found that the key elements of successful implementation were schools' readiness, student empowerment, community input, professional learning and evidence-based decision making (Savage, Lewis & Colless, 2011). Lassen et al. (2006) found an inverse relationship between PB4L-SW implementation and disruptive behaviour, highlighting the importance of adherence to the PB4L-SW features to achieve outcomes.

New Zealand Context

PB4L-SW is currently implemented in over 500 schools in New Zealand, and is on track to meet the target of 828 schools using the programme by 2017. In 2013, the New Zealand Council of Education Research (NZCER) began evaluations of the PB4L-School Wide service. The 2013 School-Wide Indicator Report analysed data from 87 PB4L-SW schools in New Zealand from 2009 to 2011, and found stand-down rates had reduced when compared with non- PB4L-SW schools and the gap between student retention rates in PB4L-SW schools and comparison schools had reduced. In addition, improvements have been found in student retention until age 17 years and NCEA Level 1 achievement for 15-year olds in PB4L-SW since 2009. The PB4L-SW is currently being trialled in New Zealand by Kingslea school in a secure youth justice residence.

Limitations

Despite strong research evidence, including the use of RCTs, and implementation in over 10,000 schools in the United States, there is limited information available describing PB4L-SW in its applicability to the youth justice population in residential care. Further research

using sound methodology is needed in order to draw strong conclusions regarding the efficacy of PB4L-SW among the youth justice population in secure residential care.

11.2.2 Alternative Education

For young people with emotional and behavioural problems, mainstream schools and conventional classrooms can be difficult to manage, and many of these young people end up falling behind their peers academically, or are suspended and excluded from school, leaving them to miss out on education. The use of alternative education programmes is intended to offer these young people a place where they can re-engage with the education system and be treated compassionately, while also having their behaviour managed in a more appropriate setting for them (Smyth, McInerney & Fish, 2013). Alternative education programmes often focus on vocational training as opposed to the mainstream educational curriculum, and where the mainstream curriculum is used, it is often at a lower level than would be offered in a mainstream school. Importantly, alternative education programmes are not required to employ registered teachers, and do not have to offer NCEA qualifications, which are the mainstream educational standard for high school students in New Zealand (Nairn & Higgins, 2011). Many alternative education programmes are run by community providers with 20 students or less and are not standardised, and therefore it is not possible to offer a specific programme overview.

Evidence

In a review of the literature regarding alternative educational programmes, Gutherson, Davies and Daszkiewicz (2010) found evidence to suggest that alternative education programmes are associated with improvements in academic achievement, school attendance, reduction in offending behaviours, reductions in disruptive and/or violent behaviours and exclusions, reductions in suspensions, improved sense of direction, self-esteem, confidence and motivation.

Limitations

Despite the review by Gutherson et al. (2010) indicating beneficial outcomes of alternative education for young people, a review by Kilma, Miller and Nunlist (2009) concluded that there was no research to indicate that alternative education has an impact on school attendance, achievement or programme completion.

The AGCP (2013) noted that these different conclusions regarding the effectiveness of alternative education may have been due to differences in the definition of alternative education used. Given the limited information regarding benefits of alternative education, the AGCP (2013) classified this education programme as having "inconclusive" evidence for addressing conduct problems. Further research using sound methodology, including RCTs, is needed to examine the efficacy of alternative education programmes for the youth justice population.

Smyth, McInerney and Fish (2013) note that the curriculum and vocational training at alternative education programmes is at a lower level than necessary for young people to benefit from compared with what can be achieved in mainstream schooling. It is suggested that young people in alternative education still require challenging education, and should be pushed to achieve at the same level as their mainstream school peers, with supports in place to assist them to learn effectively (Smyth et al., 2013). Unfortunately, alternative education programmes also appear to lack access to educational materials on par with mainstream schools, and often lack sufficient funding necessary to provide a mainstream level education to these young people (Nairn & Higgins, 2011).

New Zealand Context

There is a lack of New Zealand-based research examining alternative education programmes. In New Zealand, Nairn and Higgins (2011) found that young people in an alternative education programme felt that their alienation from mainstream education was reinforced by their participation in alternative education. However, the young people perceived the alternative education educators more positively and felt that they had a greater sense of control over their actions (Nairn & Higgins, 2011).

11.2.3 Prevent-Teach-Reinforce

Prevent-Teach-Reinforce (PTR) is a manualised behaviourally informed programme that is designed to assist young people with significant conduct problems to meet educational needs (Dunlap, Iovannone, Wilson, Kincaid & Strain, 2010). The components of the programme are all known to be important for the education of young people with ongoing and serious

conduct problems (AGCP, 2013).

There are four components to the PTR programme:

- Undertake a functional assessment in order to determine the factors that are currently maintaining antisocial behaviours.
- Prevent or remove the factors that are triggering and maintaining antisocial behaviours
- Teach prosocial replacement behaviours and skills
- Reinforce by implementing motivational rewards for achievements like attendance, engagement, and progress towards goals.

A more detailed description and explanation of the components of the programme can be found in the AGCP report (2013).

Further important aspects of the programme include the moving of young people onto tasks and curriculum that are suited to their level of ability and learning style. In addition, it is important to use teaching methods which have an evidence base for use with conduct disordered individuals (Johnson & Layng, 1992).

Evidence

One RCT has been implemented examining the PTR programme (Iovannone, Greenbaum, Wang, Kincaid, Dunlap & Strain, 2009). Among 5 to 13 year old students in the United States, Iovannone et al. (2009) found that those who participated in the PTR programme had significantly higher social skills (Hedges' g = .52), academic engagement (Hedges' g = .51), and reduced levels of problem behaviours (Hedges' g = .44) compared to students in the control group.

Limitations

Research investigating the efficacy of PTR is still emerging. Only one RCT has been implemented, and there is no information regarding the feasibility of its use among the youth justice population in secure residential care. Further research using sound methodology (i.e., RCTs) is needed to draw strong conclusions regarding the effectiveness of PTR among this population.

Summary

Comparative to their peers, young people in youth justice secure residences perform at a significantly lower level in regards to their education. In addition, education and vocational difficulties are associated with an increased risk for offending behaviour. Therefore, it is important that young people in youth justice secure residential care are provided with high-quality educational opportunities to re-engage in education and catch-up to their peers. Several promising education programmes have been developed that might be suitable for young people in residential care; however, they have not yet been tested among this population. Any education programme that is implemented in CYF residences should be complementary to the therapeutic environment the residences are seeking to create.

Chapter 12: Crisis Management

Given the complex behaviours and needs of young people in secure youth justice residences, there will inevitably be times where de-escalation needs to occur to ensure the safety of both the young person and those around them. Non-violent methods (i.e. non-restraint) are the preferred method of addressing such behaviours over violent/restraint methods. This is due to physical restraint being found to demoralise, humiliate, frighten, anger, traumatise and re-traumatise young people who experience it (Smith & Bowman, 2009; Steckley, 2010). The use of physical restraint, in particular where pain is involved, can also seriously damage the therapeutic relationship between young people and staff (Paterson et al., 2003). When implemented incorrectly or in a manner that is not developmentally appropriate, there is also a risk of injury and harm to both the young person and staff, and in the most serious cases, death may result (Paterson et al., 2003).

Restraint is allowed under the Children, Young Persons and their Families Act 1989. Section 384 under the Act states that the chief executive may, in relation to any child or young person detained in a residence established under section 364, use such means to discipline the child or young person, as are both reasonable and within the limits permitted by regulations made under this Act.

Two models prevalent in the literature with regard to de-escalation and non-violent methods of intervening with young people in residential care are: Non-Violent Crisis Intervention and Therapeutic Crisis Intervention. These two models are outlined below.

12.1 Non-Violent Crisis Intervention

Non-Violent Crisis Intervention (NVCI) was created by the Crisis Prevention Institute, an institution focused on developing strategies for safely resolving situations involving anxious or violent behaviour, while also protecting therapeutic relationships (Crisis Prevention Institute, 2015). NVCI is a safe, non-harmful behaviour management system for early intervention and de-escalation. Further information regarding NVCI can be found on the Crisis Prevention Institute website at www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention.

Programme Model

NVCI is based on the philosophy of providing the best care, welfare, and security for staff and clients in crisis situations. The programme focuses on the prevention of disruptive behaviour through respectful communication with young people and overarching concern for their wellbeing. Therefore, NVCI aims to deal with crises in a way that is not traumatic for those involved. The key elements of NVCI are prevention, de-escalation, personal safety and physical intervention.

NVCI focuses on early intervention at a stage before behavioural triggers and underlying emotional or psychological issues evolve into violent behaviour. NVCI training provides staff with the skills to safely and effectively respond to situations early, and with the use of non-physical methods for preventing or managing disruptive behaviour.

The NVCI model involves an understanding of how a crises develops, non-verbal behaviours and how they affect the behaviour of others, para-verbal communication, the importance and use of verbal intervention (including how to control violent outbursts before they turn physical), how to recognise precipitating factors, understanding of staff fear and anxiety and how these may escalate crisis situations, and personal safety techniques for staff.

Physical intervention is only to be used as a last resort when the young person presents an imminent danger to themselves and to others. Any physical intervention must be designed to be non-harmful, non-invasive, and the young person's dignity must be maintained. Physical intervention is never to be used as a form of punishment. Extensive debriefing is also required after any physical intervention.

Evidence

No RCTs have been conducted examining the effectiveness of NVCI. However, findings from two residential treatment programmes implementing NVCI are available (Crisis Prevention Institute, 2015), as well as findings from two one group pre-test/post-test design studies (Jonikas, Cook, Rosen, Laris & Kim, 2004; Ryan, Peterson, Tetreault & Van der Hagen, 2007). An overview of this research is provided below.

NVCI has been used at the Boys Town Specialised Treatment Group Homes for young people aged 10 to 18 years, for whom lower levels of care have been

unsuccessful (Crisis Prevention Institute, 2015). An evaluation of this found that safety holds had decreased significantly over a three year period, which in turn reduced the risk of injuries for both staff and young people[30].

Teaching Family Homes of Upper Michigan, who provide a range of care services including foster care, residential programmes, education, counselling, juvenile justice diversion, and reintegration alternatives, use NVCI. Reports suggest that compared to the average number of incidents involving physical restraint in the two years prior to implementation, in the two years post-implementation the annual rate had decreased significantly from 250 incidents to 127 incidents (Crisis Prevention Institute, 2015). In a one-group prettest-posttest design study, NVCI was associated with reductions in restraint among adolescents admitted to a psychiatric ward (98% decrease two-quarters post-training; Jonikas et al. 2004), and a reduction in the use of seclusion timeout (39.4%). In addition, a reduction of restraint procedures (17.6%) was found in a one group prettest-posttest design study among at-risk students in a K-12 special day school (Ryan et al., 2007). Limitations There is limited published, peer-reviewed research evaluating NVCI, including a lack of studies using sound methodology (i.e., RCTs). Due to this, the California Evidence-Based Clearinghouse for Child Welfare could not rate the strength of empirical support for NVCI. Further research is needed in order to draw strong conclusions regarding the efficacy of NVCI among the youth justice population in secure residential care.

New Zealand Context

NVCI is used in the secure youth justice residences in New Zealand. The Ministry of Social Development have outlined in their delivery and guidelines standards for organisations providing youth justice programmes, that in order to ensure the safety of young people, staff are to attend NVCI training (Ministry of Social Development, n.d.). Staff working in CYF residential facilities are to be trained in NVCI and must attend regular refresher trainings.

12.2 Therapeutic Crisis Intervention

Therapeutic Crisis Intervention (TCI) is a prevention and intervention model, developed by the Family Life Development Center at Cornell University. TCI was developed in response to evidence of neglect and incidents of abuse resulting from poor management and unmonitored disciplinary measures in child care agencies (Cornell University, 2015). Further information regarding TCI can be found in The Residential Child Care Project's information bulletin (2010)[31] and on their website at rccp.cornell.edu.

Programme Model

TCI is based on the assumption that the successful resolution of a young person's crisis is dependent on an adult staff member's ability to respond in the most therapeutic and developmentally appropriate manner. The physical safety of the young person is the key consideration at all times. A central element of TCI is the understanding that young people's aggressive and violent behaviours are an expression of needs and must be treated as such.

The goals of TCI are to prevent crises from occurring through de-escalation, effectively manage acute crises, reduce potential and actual injury to young people and staff, teach constructive ways to handle stressful situations, and develop a learning circle within the organisation. TCI aims to do all of this while maintaining the dignity of all relevant parties.

Staff trained in the TCI model learn to interpret young people's aggressive behaviours as an expression of needs, and learn to reduce the likelihood of responding with their own counter-aggression. Staff must aim to help the young person gain self-control and to later use the experience as an opportunity for learning and growth. Under TCI, the goal is for young people to learn more constructive ways of dealing with negative emotions and pain, and coping with distress. Staff under the TCI model use strategies including active listening, caring gestures, and managing the environment in an attempt to verbally de-escalate a situation.

30 Details regarding these findings were presented on the Crisis Prevention Institute website at http://www.crisisprevention.com/Resources/Success-Stories/nonviolent-crisis-intervention-training/Youth-Juvenile-Services. To the best of the authors' knowledge, there is limited information regarding the methodology of this research.

31 See: http://rccp.cornell.edu/assets/TCI_SYSTBULLETIN.pdf

Under TCI, physical restraint should only be used in situations where there is clear indication of danger to the young person or others. Safe, evidence-based methods of physical restraint are provided under the model.

Evidence

No RCTs have been conducted examining the effectiveness of TCI. However, findings from residential treatment programmes implementing TCI are available (Cornell University, 2015), as well as findings of a one-group pre-test/post-test design study (Nunno, Holden & Leidy, 2003). An overview of this research is provided below.

The Registration Council for Clinical Psychologists have conducted evaluations of TCI in residential treatment settings in both the United States and the United Kingdom (Cornell University, 2015) [32]. Data was collected through records of critical incidents, pre/post- tests and surveys and interviews with both staff and young people in the residential settings. Results indicated a decrease in physical restraints, fighting incidents, physical assaults, runaways and verbal threats. Reports of increased staff confidence in their ability to manage crisis situations were also found, as well as reduced fear in handling crisis situations.

Similar results were found in an earlier study conducted by Nunno et al. (2003), who used a one group prettest-posttest design study to evaluate the implementation of TCI in a medium sized facility catering to a variety of young people aged 5 to 18 years referred by child welfare agencies or the courts. A large increase in staff knowledge was found, as well as consistency and confidence around managing crisis situations, a reduction in critical incidents, and significantly fewer physical restraint incidents (by 66%) in one of the four units.

Limitations

There is limited published, peer-reviewed research evaluating TCI, including a lack of studies using sound methodology (i.e., RCTs). Due to this, the California Evidence-Based Clearinghouse for Child Welfare could not rate the strength of empirical support for TCI. Further research is needed in order to draw strong conclusions regarding the efficacy of TCI among the youth justice population in secure residential care. Staff in Nunno et al.'s (2003) study reported that in some instances there is not time to implement all of the recommended pre-crisis intervention strategies.

32 Details regarding these findings were presented on the Cornell University website at http://rccp.cornell.edu/tcimainpage.html. To the best of the authors' knowledge, there is limited information regarding the methodology of this research.

Summary

It is inevitable that crises will occur and de-escalation will be required in secure youth justice residences to ensure the safety of the young person and those around them. However, it is important that methods of de-escalation and crisis management are non-violent due to the risk of demoralising and re-traumatising the young person when using physical restraint. Two non-violent methods of crisis management are NVCI and TCI. Despite these interventions providing alternatives to the use of force and restraint, there is a significant lack of peer-reviewed research on their efficacy. When considering which model of non-violent crisis management to use, as with any model implemented in a secure residential facility, the model should complement the therapeutic environment the residences are seeking to create.

Chapter 13: Addressing the Needs of the Client Types in Youth Justice Secure Residential Care

As outlined in Chapter One, there are a range of client types among the youth justice population in secure residential care in New Zealand. These client types include young people who have been detained on remand, those who have a dual youth justice and care and protection status, females, and those aged less than 13 years (i.e., child offenders). It is important that the distinct needs of these client types are recognised and addressed in order to promote the best possible outcomes for these young people. In a 2013 Child, Youth, and Family-led workshop, it was acknowledged that any reconfiguration of the youth justice secure residences should consider the different models of care required for meeting the needs of these client types in residences (Hand & Tupai, 2015). In this chapter, a brief overview is provided of how the needs of these client types can be best met within secure youth justice residences. In addition, information regarding how to mitigate the influence of gang affiliation on young people in secure residential care is provided.

It is important to note that there is a lack of aggregated data concerning the demographics and characteristics of the general youth justice population in secure residential care and the aforementioned client types. As such, understanding of the needs of these young people, and consequently how we can best meet these needs, is limited.

Information regarding what "works best" for the general youth justice population in secure residential care based on literature and national and international best practice is outlined in Chapter Fifteen.

13.1 Addressing the Needs of the Remand Population

As outlined in Chapter One, the remand population comprise the majority (70-80%) of young people detained in secure youth justice residences in New Zealand. The average length of stay for this population is highly variable (average = 46 days), and it is suspected that these young people have comparable difficulties and needs to those of the general youth justice population, such as mental health and behavioural difficulties and histories of maltreatment. The transient nature of this population likely requires considerable resources to effectively manage. Furthermore, given the guilt or innocence of those remanded to secure residential care has not been established, this creates a barrier for agencies to intervene and provide services to this group of young people. Due to the complexities presented by the remand population, it is important to understand how to effectively manage these young people in secure residential care.

There is limited information regarding the characteristics and needs of the remand population in youth justice secure residences in New Zealand, circumstances in which 238 (1)(d) orders are made, and what alternatives there might be from making such orders. It is essential that this information is obtained in order to guide the appropriate management and care of this population. With regards to understanding and developing alternatives to remand, this is a key strategy outlined in the Youth Crime Action Plan. Alternatives to remand may include iwi remand services, cultural social services, electronic bail, regional remand homes, and semi-secure family homes. The feasibility of these options needs to be investigated as a suite of alternative short-term bail options for the remand population.

The United Nations Standard Minimum Rules for the Treatment of Prisoners (1977) stipulate that young people on remand have their cases processed expediently and that every effort is made to apply alternative measures to avoid detention on remand. Where detention on remand is used, young people should be held for the shortest time possible, be detained separately from convicted youths and have the right to communicate regularly and privately with their legal advisers. The Beijing Rules (i.e., the United Nations Standard Minimum Rules for the Administration of Juvenile Justice) set-out broad principles for the governance of juvenile justice. Specifically, they recommend pre-trial detention as a last resort for the shortest time possible, warning of 'the danger to juveniles of "criminal contamination" while in detention pending trial' (Part 2 No. 13). There is limited information regarding best practice for separating those on remand from those who are sentenced in secure residential facilities. However, separating these young people from the sentenced population and providing alternatives for those on remand in the community should be seriously considered as a first step.

It is acknowledged that this population have a right to due legal process and are not presumed to be guilty, which would then enable treatment/intervention. However, this population may benefit from general psychoeducation programmes, such as Alcohol and other Drugs, and skills from Aggression Replacement Training (see Chapter Nine, Section 9.2.1) and Dialectical Behavioural Therapy (see Chapter Nine, Section 9.3).

13.2 Addressing the Needs of the 'Crossover' Youth (i.e those with a concurrent care and protection status)

As outlined in Chapter One, a proportion of young people admitted to youth justice secure residences are already in the custody of the Chief Executive. In addition, although the majority of young people in youth justice secure residences do not have a concurrent care and protection status, many have histories of childhood maltreatment and family dysfunction.

In acknowledgement of the childhood maltreatment histories prevalent among this population, and emotion regulation difficulties that can result from such maltreatment, programmes such as Trauma-Informed Cognitive Behavioural Therapy (TF-CBT; see Chapter Nine, Section 9.2.2), and skills from Dialectical Behavioural Therapy (DBT; see Chapter Nine, Section 9.3) could be implemented in secure residential care and/or post-transition from residence.

Further information on the psychosocial, mental health and other needs of this group is required to understand how secure youth justice residences can best address the needs of those with a concurrent care and protection status and histories of childhood maltreatment and family dysfunction.

13.3 Addressing the Needs of the Female Population

Given the majority of young people in secure youth justice residences both nationally and internationally are male, current models and guidelines for secure youth justice residences are likely to be predominantly based on "what works" for males. However, female young offenders are seen to have more extensive maltreatment histories and a higher prevalence of mental health disorders than their male counterparts. In addition, there are concerns of sexual and physical safety of young females in residences when placed with young males who may exhibit aggressive behaviours. Therefore, it is essential to consider how the needs of the female population can be best met while in secure youth justice residences. Over the past two decades, the United States have attempted to reform their youth justice system to better meet the needs of young females who come in contact with the justice system. The Juvenile Justice and Delinquency Prevention Act requires states to assess how the youth justice programmes serve females, and how they can implement gender-responsive plans to better meet their needs. In 1998, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) reported the reform efforts of 25 states, and presented the following guidelines:

- Programmes should be all female wherever possible;
- Girls should be treated in the least restrictive environment wherever possible;
- Programmes should be close to their homes in order to maintain family relationships;
- Programmes should be consistent with female development and stress the role of relationships between staff members and girls; and
- Programmes should address the needs of parenting and pregnant teens.

Since 1998 there have been no comprehensive publications concerning "what works" for female youth offenders. However, some guidelines concerning services for female youth offenders have been provided. For example, The National Mental Health Association (2004) suggest programmes that foster positive gender identity development, address relationship issues (especially where violence and conflict in dating relationships are involved), coping strategies, competency building and empowerment strategies would all greatly benefit female young offenders. In addition, in a literature review regarding girls' delinquency by Zahn, Agnew, Fishbein, Miller, Winn, Dakoff et al. (2010) for the OJJDP, addressing physical maltreatment (including sexual abuse and assault) and mental health difficulties were identified as being integral components required for programmes for females. Furthermore, it is suggested that restraint and seclusion be avoided where possible with female young offenders. This is due to these practices being more likely to exacerbate feelings of loss of control and increase the risk of re-traumatisation and subsequent engagement in harmful behaviours among females than males (McCabe et al., 2002; National Mental Health Association, 2004).

At the time of writing this review, the reviewers were unaware of any published guidelines concerning best practice in relation to the separation of male and females in youth justice secure residences. Due to sexual and physical safety concerns and vulnerability of the female population, gender separation in residence may be

considered. However, it is acknowledged that separating female and male young people can result in a number of system issues, including more females being admitted into youth justice secure residences than there are allocated spaces for, resulting in males being transferred to other residences that may be further away from their home and community. Such factors need to be taken into consideration when considering the service provision for females in secure youth justice residences. Furthermore, with regards to the vulnerability of, and complexity of presentation among some female young offenders, it should be questioned whether the youth justice secure residential care environment is the most appropriate setting in which these young people can have their needs met. Alternative community-based services may need to be considered for this population. How to best meet the needs of the female youth offending population in youth justice secure residences in New Zealand is an area in need of further research.

13.4 Addressing the Needs of Child Offenders

Due to the lack of national aggregated data regarding child offenders (i.e., < 13 years) admitted to youth justice secure residences, there is limited understanding concerning the differing needs of child and adolescent offenders beyond the developmental differences between the two groups. However, as outlined in Chapter One, one significant concern identified regarding this population concerns the mixing of child and adolescent offenders in residence, resulting in the 'peer contagion effect' (Dodge, Dishion & Lansford, 2006; Osgood & Briddle, 2006; Warr, 2002). Indeed, child offenders may be exposed to older offenders in residence who can present as being more aggressive and having more extensive offending histories. Therefore, as a preventative measure, separating child and adolescent offenders in secure residences could be considered. Further research concerning how to best meet the needs of child offenders in youth justice secure residences is needed.

13.5 Addressing Gang Affiliation

Although it is unclear what proportion of young people in youth justice secure residences in New Zealand are affiliated with a gang, the influence of gang involvement is strongly associated with offending behaviour (e.g., see Esbensen, Winfree, He & Taylor, 2001; Esbensen & Weerman, 2005; Gatti, Tremblay, Vitaro & McDuff, 2005; Klein & Maxson, 2006). Therefore, mitigating the influence of gang affiliation among these young people in secure residential care may help diminish their risk of engaging in future offending behaviour. Interventions that have the most promising outcomes on reducing gang involvement focus on educational deficits, vocational skills, interpersonal and social skills development, and drug abuse/use values and behaviour change and treatment (Howell, 2000). Such interventions are called "focused deterrence strategies" (Braga & Weisburd, 2012). These interventions offer young people the opportunity to develop their skills and knowledge so that upon release from residence they are better equipped with the tools and self-esteem to deter from illegal activities, and an increased perception that the costs of engaging in criminal activities outweigh the benefits. In a recent systematic review, Braga and Weisburd (2012) found that focused deterrent strategies targeting gangs and criminally active groups produced significant reductions in crime.

Programmes targeting gang affiliation also need to include aftercare and transition elements due to the risk of young people retuning to active gang involvement after time in a secure youth justice residence, in many cases with their reputations enhanced due to incarceration. One such programme, the Lifeskills 95 programme in California, was found to reduce frequent gang contact among young people post-release from the California Youth Authority (8% frequent contact versus 27% in a control group; Josi & Sechrest, 1999).

13.6 The Importance of Staff

Frontline staff are the catalysts for change in young people in residence. In addition, staff attributes, including professionalism, education, training, and the ability to form prosocial relationships, have been found to moderate treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm, Boekee, Stams, & Vander Laan, 2011). Therefore, it is important that staff working in youth justice secure residences have a thorough understanding of the needs of the general youth justice population in residential care and each client group, and have the training and personal attributes required for working with these young people. There are limited guidelines regarding what attributes staff working with at-risk and high-needs

young people should possess; however, some literature suggests that prosocial attitudes and behaviours, warmth, communication skills, and values aligning with the programme model, are attributes seen among effective staff working with these vulnerable young people (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000).

Summary

There are several distinct client types in the youth justice secure residential population who have unique needs that should be recognised and addressed to help promote the best possible outcomes. These client types include young people who have been detained on remand, those who have a care and protection status, female young offenders, and those aged less than 13 years (defined as 'child offenders'). Additional factors, such as gang affiliation, also need to be addressed in the intervention of these young people. Currently, there is limited understanding and knowledge regarding the demographics and characteristics of the various client types in New Zealand youth justice secure residences. Obtaining such information is essential in order to provide a more thorough review of how the needs of these different client types in youth justice secure residences can be met, and to subsequently establish practice guidelines.

Chapter 14: Transition and Aftercare

Young people transitioning back into the community from residence, either into independent care, a new caregiving environment or into the care of their family, experience changes in physical living arrangements accompanied by various psychological processes. Three psychological phases were identified by Van Ryzin, Mills, Kelban, Vars and Chamberlain (2011) that describe the loss, acceptance, uncomfortability, confusion, chaos, anxiety and development of new identity that is experienced by young people when they transition.

Young people who are transitioning from out-of-home care to independent living or to an unfamiliar caregiver are particularly vulnerable groups. The transition to adulthood will likely be difficult for all young people; however this will be particularly so for those transitioning from out-of-home care given they will likely be doing so without familial support. Young people transitioning from out-of-home care are more likely to experience negative life outcomes including homelessness, unemployment, lower educational attainment and early parenthood (Courtney & Dworsky, 2006; Courtney, Piliavin, Grogan-Kaylor & Nesmith, 1998), and have been found to be at a higher risk for arrest (Cusick, Courtney, Havlicek & Hess, 2010).

Several studies have found that among the youth offending population released from secure residential care, only 30-40% gain employment one-year post-release (Bullis & Yovanoff, 2006; Chung, Schubert, & Mulvey, 2007). Given engagement in education or employment in early adulthood is associated with desistance of severe offending behaviours (Stouthamer-Loeber, Wei, Loeber, & Masten, 2004), it is essential for the youth justice population in secure residential care to be engaged in educational and learning opportunities in residence and post-transition. In addition, for all young people transitioning from residence, it is important that transition planning is inclusive of young people, their families (where possible) and significant others, and that planning processes are well coordinated and tailored to the individual needs and circumstances of the young person to promote the best possible outcomes.

Comprehensive and well-planned transitions may also help generalise any treatment gains from residence when the young person is transitioned back into the community. In New Zealand, young children in CYF youth justice and care and protection systems interviewed in the Office of the Children's Commissioner 2015 *State of Care report* [33] stated that they wanted to have the number of movements between placements kept to a minimum. Similarly, one theme identified from young people interviewed in the interim report of the Expert Advisory Panel[34] concerned them requiring help, support and nurturing beyond the age of 17 years[35]. In their interim report, the Expert Advisory Panel concluded that vulnerable young people need and deserve far more support to make a successful transition to adulthood. The transition planning process for young people in CYF youth justice secure residences in New Zealand is outlined in Chapter Three, Section, 3.1.1.

Following transition from residential care back into the community, aftercare is another essential part of the residential care framework to help maintain and sometimes improve on positive outcomes gained from residential treatment. One important aspect of successful aftercare programmes is the ability to fit support to the needs of the young person (Fontanella et al., 2008; Trout et al., 2010). In addition, a meta-analytic review of aftercare programmes for youth and young audlt offenders found the effect size for aftercare programmes was small (d = .12); however, aftercare programmes were seen to be most effective if they had been well-implemented, consisted of individual treatment (as opposed to group treatment), and aimed at older and high-risk youth (James, Stams, Asscher, De Roo & van der Laan, 2013). In addition, more intensive aftercare programmes were associated with lower recidivism rates (James et al. 2013).

Few intensive models for transition and aftercare have been developed and validated. One programme, the Intensive Aftercare Program for Serious, Violent Juvenile Offenders, is outlined below.

33 See: www.occ.org.nz/state-of-care/

34 See: www.msd.govt.nz/about-msd-and-our-work/work-programmes/cyf-modernisation/

35 In New Zealand, young people remain in formal State care until the age of 17 years. Consequently, young care leavers fall into a 'no-man's land' between care and full independence.

14.1 Intensive Aftercare Programme

The Intensive Aftercare Programme for Serious, Violent Juvenile Offenders (IAP) was developed by Altschler and Armstrong (1994) and funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). IAP was designed for use with those institutionalised young people who pose the greatest risk of repeat offending on return to the community.

Programme Model

The overall aim of IAP is to identify and help high risk young offenders make a gradual transition from secure care into the community and independent living in order to decrease the likelihood of reoffending.

The IAP model is based on five key principles for reintegration. These are: preparing youth for progressively increased responsibility and freedom in the community, facilitating youth-community interaction and involvement, working with both the young offender and community support systems on qualities needed for constructive interaction and the young person's successful return to the community, developing new resources and supports where needed, and monitoring and testing the young person's and the community's ability to work productively together (Altschuler & Armstrong, 1994).

Aftercare planning begins when a young person first enters the youth justice system and involves cooperation between institutional staff, community aftercare staff and community service providers. In addition, Wiebush et al. (2005) talk of the importance of building a family perspective into aftercare planning. Under the IAP model, successful reintegration requires intensive supervision services after release from incarceration, as well as a focus on reintegration while incarcerated (Wiebush et al., 2005). Aftercare plans include information on the young person's living arrangements, educational needs, medical/mental health needs and job skills.

Evidence

The National Council on Crime and Delinquency published a report presenting findings from a 5-year multisite evaluation of IAP (Wiebush, Wagner, McNulty, Wang & Le, 2005). Youth were randomly assigned to either the experimental or control group. Findings suggested that in each site there was no difference between IAP and controls with regards to recidivism.

Limitations

There has been limited research conducted examining the effectiveness of IAP. IAP and intensive aftercare generally tends not to be successful with young offenders who are at low risk for reoffending (Altschler & Armstrong 1994). Risk-screening devices are required to determine which young offenders would benefit from IAP. Implementation of these may be time and resource costly while only providing benefit to a small group of the youth justice population.

Summary

Comprehensive transition planning is important for the successful reintegration of the young person back into their community or into an out-of-home residence from secure residence. There appears to be no clear guidelines about how to promote the successful transition of young people from secure care back into the community. Here, the Intensive Aftercare Programme was outlined; however, there is a lack of research evaluating this programme. For more discussion regarding transition planning for these young people, see Chapter Fifteen (what 'works best" for secure residential care for the youth justice population).

Part B: Summary

Part B has provided an overview of the international youth justice systems and continua of care, frameworks to guide youth justice services, models for secure care and stepdown care, assessment, rehabilitative models, cultural frameworks, educational programmes, crisis management models, how the needs of different youth justice client types can be met while in secure residential care, and transition and aftercare models. Having an understanding of the national and international research and best practice literature regarding services for the youth justice population is essential to help guide service delivery in New Zealand and enhance current service provision.

In an attempt to summarise the effectiveness of each model and intervention presented in Part B, a classification system was implemented whereby each model and intervention was assigned a rating of effectiveness based on their research evidence. This classification system of research evidence is outlined below, and the rating of each model and intervention is presented in Table 5.

The classification of models and interventions

The frameworks, models of care and range of rehabilitative interventions outlined in this chapter were classified into seven groups, depending on the evidence for their effectiveness among the youth justice population in secure residential care[36]. The rating scale used to evaluate each model and intervention on the available research evidence was based on the California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale[37]. The California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale was chosen for this summary review due to its international reputation, ease in usage, and breadth of criteria.

The rating scale is as follows:

1. Well-supported by research evidence

Criteria:

1. Multiple Site Replication and Follow-up:
    a. At least two rigorous randomised controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice.
    b. In at least one of these RCTs, the practice has shown to have a sustained effect at least one year beyond the end of treatment, when compared to a control group.
    c. The RCTs have been reported in published, peer-reviewed literature.

2. Supported by research evidence

Criteria:

1. Randomized Controlled Trial and Follow-up:
    a. At least one rigorous RCT in usual care or a practice setting has found the practice to be superior to an appropriate comparison practice.
    b. In that same RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
    c. That same RCT has been reported in published, peer-reviewed literature.

3. Promising research evidence

Criteria:

1. At least one study using some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.

36 Please note that a number of models, frameworks and rehabilitative programmes identified in this review are from jurisdictions where sentences in custody are substantially longer comparative to New Zealand. In New Zealand, young people are detained in secure youth justice residences for a shorter period of time, aligning with the standpoint that young people have limited perspectives on time and consequences. In residence, treatment/rehabilitative options should be made available; however, young people should not receive disproportionate sentences so that they can receive rehabilitative/treatment.

37 More information is available at: www.cebc4cw.org/ratings/scientific-rating-scale

3a. Promising research evidence among comparable youth populations

1. The current review also classified models and programmes as having "promising research evidence" (3a) where at least one rigorous RCT has been conducted and found the practice to be superior to an appropriate comparison practice among non-youth justice populations who have behavioural and/or mental health difficulties comparable to those of the youth justice population.

4. Evidence fails to demonstrate effect

Criteria:

1. Two or more RCTs have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.
2. If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice. The overall weight of evidence is based on the preponderance of published, peer-reviewed studies, and not a systematic review or meta-analysis. For example, if there have been three published RCTs and two of them showed the programme did not have the desired effect, then the programme would be rated a "4 - Evidence Fails to Demonstrate Effect".

5. Concerning practice

Criteria:

1. If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
2. There is case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent; and/or
3. There is a legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR - Not able to be rated

Criteria:

1. There is no case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent.
2. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
3. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it.
4. The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.
5. The practice does not have any published, peer-reviewed study using some form of control (e.g., untreated group, placebo group, matched wait list study) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.
6. The practice does not meet criteria for any other level on the rating scale.

Additional criteria

For a programme to be classified as a being well-supported by research evidence (1), supported by research evidence (2), or promising research evidence (3) the following criteria must also be met:

1. There is no case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent.
2. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
3. The practice has a book, manual, and/or other available writings that specify components of the service and describe how to administer it.
4. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
5. If multiple outcome studies have been published, the overall weight of the evidence supports the benefit of the practice.

Please note that the Advisory Group on Conduct Problems (AGCP) uses a different process to classify the effectiveness/efficacy of each programme reviewed in their 2013 report. An overview of the AGCP's process for classification and how it compares to the scale used in this review is provided in Appendix B.

Table 5. Summary of Evidence for Frameworks, Secure Care, Stepdown Care, Rehabilitation, Culture, Education, Crisis Management, and Transition and Aftercare Models for the Youth Justice Population

Type	Intervention/Framework name	Evidence[1]
Frameworks	Risk, Need, Responsivity	1
	Good Lives Model	NR
	Supportive Authority and the Strategy of Choices	NR
	Trauma, Attachment and Neurodevelopment	NR
	Neurosequential Model of Therapeutics (NMT)	NR
Secure Care Models	Positive Peer Culture	2
	Stop-Gap	3
	Behaviour Modification – Token Economy and Point Level System	5
Stepdown Care Models	Multisystemic Therapy	1
	Teaching Family Model	2
	Therapeutic Foster Care (Multidimensional Treatment Foster Care)	1
Rehabilitative Programmes	Cognitive-Behavioural Therapy Approaches	1
	Aggression Replacement Training	3
	Trauma-Focused CBT[38]	3a
	Cognitive Self-Change	NR
	Dialectical Behavioural Therapy	3
	Alcohol and other Drugs	
	Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5	3a
	Seeking Safety	NR
	Therapeutic Communities	3
Culture	Meihana Model	NR (S)*
	Te Pikinga ki Runga	NR (S)*
	Te Hui Whakatika	NR (E)**
Education	Positive Behaviour for Learning – School Wide	3a
	Alternative education[39]	4
	Prevent-Teach-Reinforce	NR
Crisis Management	Non-Violent Crisis Intervention	NR
	Therapeutic Crisis Intervention	NR
Transition and Aftercare	Intensive Aftercare Programme	NR

1 The California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale, for the youth justice population in New Zealand.

38 Trauma-Focused CBT presents as a particularly promising programme for the youth justice population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

39 Note: concerns regarding Alternative Education, as reported in this review, were identified by the Advisory Group on Conduct Problems (2013).

Note: * These models have limited empirical evidence; however, they were considered a "sustained" programme by the AGCP (2013), ie, they have been continued over a period of time, met user expectations and received endorsement from Māori, overcome constraints (e.g., funding), and accessed on-going support from national or regional resources (p. 47).

** This model has limited empirical evidence and was considered an "emerging" programme by the AGCP (2013), ie, they were recently developed and gained initial support from local communities and whānau, they expanded and refined content, method and supporting resources, they were yet to be reproduced in other sites or may be unique to local needs and opportunities, and they were seeking wider endorsement from Māori (p.47).

Conclusion

The youth justice population in secure residential care present with a variety of complex needs. Evidence-based frameworks and models that have demonstrated positive outcomes among this population should be used to enhance the care and management of this at-risk and high-needs population while in secure residential care and post-transition. In line with holding a holistic view of a young person, multimodal interventions that involve family/whānau are essential for appropriately addressing the needs of these young people across multiple domains and systems.

As summarised here, the current research evidence suggests that the frameworks and secure care models which have demonstrated positive effects among the youth justice population include the Risk, Need, Responsivity model and Positive Peer Culture. Models designed as an alternative to residential care and rehabilitative programmes that have also demonstrated positive effects include Multisystemic Therapy, Teaching Family Model, Therapeutic Foster Care (MTFC), and Cognitive-Behavioural Therapy. Secure care models and programmes that show promising research evidence for the youth justice population include Stop-Gap, Aggression Replacement Training, Trauma-Focused CBT[40], Dialectical Behavioural Therapy, Motivational Enhancement Treatment/Cognitive Behavioural Therapy 5, and Therapeutic Communities. Positive Behaviour for Learning – School Wide is a school-based intervention which has also shown promising research evidence. For secure youth justice residences in New Zealand, any interventions implemented should be complementary to the therapeutic environment the residences are seeking to create.

As outlined in Chapter Nine, it is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in secure residence for the shortest period of time possible. Only when interventions can continue with minimal disruption and with the same therapist/clinician post-residence should therapeutic and rehabilitative models be started when the young person is in a secure youth justice residence. For young people who have identified needs and/or risks that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for post-residence implementation. It is likely, however, that providing skills related to anger management (e.g., ART) and emotion regulation (e.g., DBT) while in secure youth justice residences would provide some benefit for these young people. Alternatively, rehabilitative programmes could be implemented in a modular-based manner, where one or several modules are delivered in residence, and the remaining modules post-release.

40 Trauma-Focused CBT presents as a particularly promising programme for the youth justice population in secure residential care, given the high rates of trauma and maltreatment experienced among this population.

Part C: What "Works Best"

Thus far, this report has outlined the national and international research and best practice literature in relation to the care and management of the youth justice population. Drawing from this literature, this section summarises what appears to "work best" regarding the services provided to the youth justice population to help promote the best outcomes for these young people, their families, and the community. In this section, emphasis will be placed on the services provided to the youth justice population in secure residential care. However, it is important to take into consideration that secure residences do not operate in isolation and comprise one part of the wider continuum of care that provides services to the youth justice population. Therefore, commentary is also made regarding what "works best" in relation to the wider continuum of care for this population.

Chapter 15: What "Works Best" for Secure Residential Care for the Youth Justice Population

Young people in youth justice secure residences present with a complex array of risk and needs. Therefore, the continuum of services provided to this population should be aimed at minimising risk to themselves and to the community, and maximising positive and long-lasting outcomes. This continuum of services includes secure youth justice residences, step-down services, and preventive interventions for young people exhibiting early signs of behavioural difficulties. Based on the current research, best practice, and communication with experts in the field of youth offending and conduct problem behaviour, this section outlines what "works best" regarding the care and management of the youth justice population. This chapter is structured to address each of the Terms of Reference that guided this review.

The New Zealand youth justice secure residences are operated by CYF and governed by the CYPF Act 1989 and the Children, Young Persons, and Their Families (Residential Care) Regulations (1996). It is important that all services and programmes are implemented with the interests of the young people (i.e., child-centred)[41] and community at the forefront, and are delivered in a culturally safe manner. Furthermore, services should be implemented based on the following set of philosophies:

1. The safety and well-being of children and young people is paramount (CYPF Act 1989).
2. Detention in custody should only be seen as a last resort (CYPF Act 1989, Section 4(f)).
3. Intervention ideally should be community-based, using evidence-based strategies.
4. Family/whānau should always be seen as a central part of any residential placement.
5. The physical environment should help facilitate therapeutic and rehabilitative work.
6. Staff are viewed as prosocial adults.
7. Young people who engage in criminal or other risky and disruptive behaviours should not be viewed as 'naughty kids', but rather as a product of their background, environment, and their experiences of past trauma.

Terms of Reference 1
When secure residential care is appropriate and necessary for young people with offending needs. We would like, if possible, to understand the age, gender, needs, conditions and/or criteria for admission of young people to similar sorts of youth justice residences in other jurisdictions.

In New Zealand, the purpose of youth justice secure residences are to provide a secure and safe environment for young offenders, protect these young people from themselves or others, support community safety, and, where practical, address drivers of offending behaviour. In addition, a minority of young people sentenced by the District or High Court to a term of imprisonment under the Corrections Act 2004 may be placed in a youth justice secure residence on the basis of their age[42], gender, and assessed vulnerability[43]. Drawing comparisons between New Zealand and international youth justice systems and the use of secure residential care is difficult due to the differing standards and philosophies regarding the purpose of secure care, age of criminal responsibility, thresholds for remand, and the availability of alternatives to remand.

Internationally, the literature recommends that secure residential care should be reserved only for the most high-needs and at-risk young people, be used as a last resort, and only for a limited amount of time. This is because young people may experience a range of negative impacts while in secure residential care. These negative impacts include increased levels of antisocial

41 Please refer to page 48 of the Modernising Child, Youth and Family Expert Panel: Interim Report regarding their expectations of a child-centred child protection and youth justice system.

42 It is important to note that age does not necessarily equate with maturation for this group. Maturation should be considered, among a range of other factors, when making decisions regarding the most appropriate placement type, rehabilitative/treatment programmes to be provided, length of time a young person should reside in secure care, and expectations regarding outcomes post-transition.

43 Young people may be deemed 'vulnerable' for a range of reasons, including mental health difficulties, intellectual and/or developmental disabilities, and developmental maturation.

behaviour due to exposure to other high-risk peers (i.e., the peer contagion effect; Dishion & Dodge, 2005; Dodge, Dishion, & Lansford, 2006; Warr, 2002), and difficulty in adapting to the residential environment due to being separated from their families and communities (see Lambie and Randell (2013) for an overview). The latter is particularly applicable to the New Zealand context with only four youth justice secure residences nationwide, consequently resulting in many young people being placed away from their families and support networks. This is likely to impact on the amount of family work that can be implemented, which is essential to generalising treatment gains when the young person transitions back into the community.

In light of this literature, there has been a shift internationally toward the increased use of community-based services as an alternative to secure residential placement, where possible. These initiatives include the Alternatives to Custody for Young Offenders by the British Association for Adoption and Fostering, and the Juvenile Detention Alternatives Initiative (see Chapter Four, Sections 4.3.1 and 4.3.2 respectively). The use of less restrictive step-down residential care, such as TFM, has been shown to demonstrate better outcomes than those in more restrictive secure facilities (i.e., successful reintegration into their family home and number of placements following residential care; Ringle et al., 2012).

It is worth noting that a Supervision with Residence order (SwR; s311), under the CYPF Act 1989, places a young person in the custody of the Chief Executive; however, it does not require that the young person be detained. As such, there is potential for other less restrictive residential options for this population. Similarly, young people under a s238 1(d) order (Remand) can be either detained in the custody of the Chief Executive, an iwi social service, or a cultural social service. However, it appears that iwi remand services and cultural social services are not currently available or are very limited. Alternatives to detaining these young people under s311 and s238 1(d) orders in secure youth justice residences should be investigated.

Community-based and evidence-based models of care that can be used as an alternative to secure residential care and as step-down homes (i.e., out-of-home care) that young people from secure residential placement can transition to include Multidimensional Treatment Foster Care (MTFC) and the Teaching Family Model (TFM; see Chapter Seven, Sections 7.3 and 7.2, respectively). In addition, Multi Systemic Therapy (MST; Chapter Seven, Section 7.1) is an efficacious community-based multimodal treatment used to address serious conduct problems, offending behaviour, and social, emotional and behavioural problems in children and adolescents. These community-based models are cost-effective, with every one dollar spent on MST and MTFC treatment returning $5.04 and $43.70 in benefits (e.g., savings to taxpayers and crime victims 25-years post-treatment) respectively.

Reprioritisation of resources into evidence- and community-based services can help strengthen the robustness and effectiveness of resources provided to the youth justice population throughout the continuum of care. This can help ensure that those who exhibit early signs of conduct problems and other problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of reoffending and being re-admitted into a secure residence.

Length of Time in Secure Residential Care

At the time of writing this review, the reviewers were unaware of any clear and empirically-based guidelines regarding the maximum length of time a young person should be detained in secure residential care. However, the Stop-Gap model (see Chapter Six, Section 6.2) suggests young people should only be held in residence for up to 150 days.

Terms of Reference 2 and 7 question what services should be implemented in residence, and request a commentary regarding how to use the time a young person spends in residence to help inform next steps. Therefore, these TOR are addressed together below.

Terms of Reference 2
The right mix of services within Youth Justice residences that would:

a. *Improve short and long term outcomes*

b. *Ensure a safe and positive residential environment for children/young people and staff.*

This should include, but is not limited to, the kinds of physical environment that should be provided, assessment, planning, therapeutic and other treatment services (e.g., behaviour modification), life skills, education, physical and mental health services, cultural, recreation, vocational training, pre-employment services and crisis management services.

Terms of Reference 7
Using the time a young person spends in residence to inform the next steps (i.e., use of assessment and the appropriateness of each assessment model, programmes, and interventions)

As previously mentioned, secure residential care for the youth justice population should be used as a last resort. Furthermore, as outlined by the Stop-Gap model of care (see Chapter Six, Section 6.2), the time a young person is detained in residential care should be limited, with focus on stabilisation, assessment of needs, and transition back into community care within a 150 day time period (McCurdy & McIntyre, 2004; Zakriski et al., 2006).

Based on the literature and current best practice, what "works best" in relation to the assessment process, framework and model of care for secure residences, cultural models and practices, education programmes, vocational development, crisis management, and physical environment are outlined below. In addition, a brief summary is provided of what appears to "work best" in meeting the differing needs of the variety of client types seen in youth justice secure residences (i.e., those detained on remand, females, child offenders; see Chapter One and Chapter Fifteen).

To the best of the authors' knowledge, there is a lack of information regarding what interventions or combination of services help promote the short- and long-term outcomes of young people in secure youth justice residences. In addition, please note that a number of models, frameworks and rehabilitative programmes identified in this review are from jurisdictions where sentences in custody are substantially longer comparative to New Zealand. In New Zealand, young people are detained in secure youth justice residences for a shorter period of time, aligning with the standpoint that young people have limited perspectives on time and consequences. In residence, treatment/rehabilitative options should be made available; however, young people should not receive disproportionate sentences so that they can receive rehabilitative/treatment.

Overarching Framework and Model of Care

The benefits of implementing an overarching framework and model of care include the fostering of a common understanding between all staff and professionals as to the aims, goals and philosophies of their services provided to young people in residential care, consequently promoting consistency in approach between staff. Here, a framework is described as an overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as principles to guide the assessment and treatment of individuals. A model of care is a therapeutic or rehabilitative model implemented in residential services, and sits underneath the overarching framework.

It appears that utilising a combined RNR and strengths-based (i.e., Good Lives) framework for guiding assessment and rehabilitation/intervention of the youth justice population may help reduce recidivism and promote positive outcomes (Singh et al., 2014; Willis, Ward & Levenson, 2014). In addition, secure care models such as Positive Peer Culture and Stop-Gap (see Chapter Six, Sections 6.1 and 6.2 respectively) have demonstrated promising research evidence for use among the youth justice population in secure residential care. As outlined in Chapter Four, Section 4.4.1, the Missouri model's treatment programme is based the Positive Peer Culture (PPC) model, where group treatment is delivered each week-night in conjunction with individualised treatment when necessary.

Assessment process

Assessment of young people in secure youth justice residences has two purposes: to identify the immediate acute needs of the young person at admission, and to guide the individualised intervention/rehabilitation plan. Assessment should therefore begin when a young person first has contact with CYF services, with reassessment conducted periodically right through to the young person's exit from CYF services. Reassessment is important given a young person's needs and circumstances change over time.

With regards to the assessment process for the young person's individualised plan, this should involve standardised identification of a wide range of risk and protective factors of the young person, their family/whānau, and other supports. This systemic and holistic approach to assessment is in line with the understanding that behavioural and mental health issues are often contributed to by the young person's childhood experiences and environment, including their family/whānau, peers and community; therefore, assessment should identify such factors that may need to be addressed through intervention. This includes family/whānau intervention.

As part of the assessment, each young person should be screened for physical and mental health problems, educational needs, cognitive deficits, substance use, any immediate risks to self (including self-harm or suicidal ideation), and risks to others and from others. Conducting a comprehensive assessment, including identification of a range of risk and protective factors mentioned above, aligns with the RNR framework and strengths-based models. Comparable risk and needs assessments for each young person are also conducted by the Missouri model and Kibble Education and Care Centre. Guidelines regarding the assessment of mental health and alcohol and other drugs among the youth justice population are outlined in the 2009 literature review by The Werry Centre[44]. As noted by the Royal Australasian College of Physicians (2011) there appears to be no guidelines outlining the recommended standards for healthcare among incarcerated adolescents in New Zealand.

Many models of care have an assessment component included; however research examining such components is scarce. The Stop-Gap model employs the use of a functional assessment in order to determine the basis of the young person's ongoing issues (The Naturalistic Functional Assessment; Repp, 1999; Repp & Karsh, 1994). In addition, the Missouri model has a standardised assessment system (i.e., the Missouri Risk and Needs Assessment and Classification System), and also uses a standardised education test called the Woodcock-Johnson Psycho-Educational Battery-III.

Standardised assessment tools are those that have been designed to measure an individual's abilities comparative to those of others their age (i.e., based on normative data established from large samples of individuals). Having a standardised assessment process and measures can help facilitate objectivity from the practitioner during assessment, and increase consistency in the assessments conducted. Standardised assessment tools identified in Chapter Eight included the Novaco Anger Scale and Provocation Inventory, MAYSI-2, and the Substances and Choices Scale.

For young people detained in youth justice secure residences, the assessment should also include identification of criminogenic risk and needs. One such standardised assessment tool, the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2002), is widely used as a risk assessment and case management tool, which provides assistance in the planning of intervention and risk management. The YLS/CMI aligns with the RNR principles, and has strong predictive validity among male and female young offenders (Olver et al., 2009; Luong & Wormith, 2011; Vitopoulos et al., 2012), including among New Zealand young offenders (Mooney, 2010).

Using a battery of assessment tools, which screen for strengths and difficulties across a broad range of domains, can help achieve a comprehensive assessment process that holds a holistic viewpoint of the young person.

44 www.werrycentre.org.nz/sites/default/files/Youth_Forensic_Lit_ReviewFeb09.pdf

Rehabilitative Programmes

To facilitate good outcomes for a young person post-residence, it is important to plan and implement appropriate, individualised and effective interventions which align with the young person's identified strengths and difficulties from assessment, as opposed to a 'one size fits all' approach. This is consistent with the 'risk' principle of the RNR model (Andrews & Bonta, 2010), and parallels practice implemented by the Missouri model and Kibble Centre where the level of service a young person receives is determined based on the comprehensive risk and needs assessment. Furthermore, the importance of follow-through of practice from assessment to intervention has been highlighted by research, where the appropriate matching of interventions with the individual's identified difficulties is associated with enhanced outcomes (Luong & Wormith, 2011; Vieira et al., 2009).

In light of the fact that childhood experiences and environmental factors contribute to the development of problematic behaviour and mental health issues (Caldwell & Van Rybroek, 2013), interventions should not only target the behaviours of the young person, but also their social and environmental context. Therefore, multimodal approaches, including educational, mental health, cultural, medical, speech and language, and family-based interventions, are important to ensure that the wide array of difficulties the young person may experience are addressed. This is in line with strategies implemented by the Missouri model, Kibble, and Stop-Gap in residence, and models such as Multisystemic Therapy and Multidimensional Treatment Foster Care in step-down community-based care. Furthermore, working with the young person's family/whānau and caregivers, to whom the young person is likely to return post-residence, is seen as essential to ensure that any rehabilitative gains obtained in residence (or community-based out-of-home care) are maintained in the long term (Caldwell & Van Rybroek, 2013).

Kibble and the Stop-Gap residential model offer a suite of evidence-based programmes to target the range of difficulties young people in residence often present with. Evidence-based rehabilitative programmes identified in this report include Aggression Replacement Training, Trauma-Focused CBT, and Dialectical Behavioural Therapy (see Chapter Nine, Sections 9.2.1, 9.2.2 and 9.3, respectively). ART is a group-based programme, TF-CBT is an individual (i.e., one-on-one) programme, and DBT has both individual and group components. The use of evidence-based interventions and rehabilitative models within residential secure care has been shown to improve the outcomes comparable to those in non-residential out of home care (De Wart et al., 2012), and aligns with the RNR framework. In addition, the use of evidence-based models ensures access to empirical data from other implementations of the model, and also facilitates ease of evaluation of the model (Caldwell & Van Rybroek, 2013).

Several meta-analyses (De Swart et al. 2012; Koehler et al. 2013; Lipsey, 2009) have offered insight into what intervention types and core elements of intervention programmes promote the best outcomes for the youth justice population. "Therapeutic" interventions (i.e., cognitive behaviour and behavioural approaches, counselling, skills training, restorative interventions, multiple services) were found to have the greater positive effects (e.g., recidivism) than "non-therapeutic" interventions (i.e., surveillance, deterrence and discipline. In addition, interventions that were highly responsive, targeted high risk young people, targeted multiple criminogenic needs, and were implemented to a high quality, had greater positive outcomes. With regards to the implementation of the treatment model, when the model was implemented to a high quality this had better outcomes than those implemented poorly (Lipsey, 2009). Therefore, it is important that providers are trained and supervised to a high standard.

The ongoing monitoring and evaluation of rehabilitative outcomes for each young person is essential in order to provide a tailored rehabilitative service. This ensures that clinical staff can modify interventions which are ineffective (Caldwell & Van Rybroek, 2013). In support of this, the literature suggests that regular multidisciplinary meetings are conducted and daily progress monitored via some form of rating system, which is then reviewed by senior clinical and leadership staff (Caldwell et al., 2008).

It is important to acknowledge the tension between providing rehabilitative programmes that may require several weeks or months to deliver with the philosophy of detaining young people in residence for the shortest period of time possible. Therapeutic and rehabilitative work that requires long-term delivery should not be started in secure residence unless a young person is transitioning back into the community where this intervention can continue with minimal disruption and

they see the same therapist/clinician. For young people who have needs and/or risks identified from assessment that require intervention, rehabilitative programmes that target such needs should be incorporated into their individualised plan for implementation post-residence. However, while in secure residence, young people are likely to benefit from attaining skills related to anger management (e.g., Aggression Replacement Training) and emotion regulation (e.g., Dialectical-Behavioural Treatment). Alternatively, rehabilitative programmes could be implemented in a modular-based fashion, where one or several modules are delivered in residence, and the remaining modules post-release.

Based on current research, determining "what works" in relation to rehabilitative programmes for the youth justice population is limited. Further research using sound methodology, such as RCTs, are needed to help identify what interventions work best for whom and under what circumstances (e.g., institutionalised versus non-institutionalised care). However, good outcomes are likely to be achieved when interventions are implemented that target identified risks and needs from the young person's assessment.

Ethnicity and Culture

Māori are significantly over-represented in the youth justice population, and comprise 62% of those admitted to secure youth justice residential care in New Zealand. Given that a significant proportion of young people are Māori, there is a need for services to ensure that they are implementing culturally responsive evidence-based practices for Māori rangatahi, and that their staff are culturally informed and sensitive. All agencies should align their practices in a manner that is consistent with and upholds the Treaty of Waitangi's principles of partnership, protection and participation. In addition, cultural competency and safety is a requirement of all health practitioners and professional regulatory bodies, as outlined in the Health Practitioners Competency Assurance Act (2003). Cultural responsiveness may include the incorporation of Māori beliefs and customs into all services, such as karakia, mihimihi, pepeha, and waiata, among others (AGCP, 2013). This will help to provide a smoother transition into residential care for Māori rangatahi, and a learning environment for non-Māori (AGCP, 2013).

Cultural models, such as the Meihana Model (Pitama, Robertson, Cram, Gillies, Huria & Dallas-Katoa, 2007), provide a useful framework to guide health professionals in the assessment of and intervention with Māori clients and their whānau. Additional kaupapa Māori frameworks and interventions that are recommended in the literature for use with young people include Te Pikinga ki Runga, Te Hui Whakatika, Huakina Mai, and He Awa Whiria, all of which are described within this review (see Chapter Ten). However, at the time of writing, these models are lacking evidence as to their effectiveness.

Education

Young people in residential care are often behind in their educational achievement compared with their peers in the community, likely due to disruption of education by breakdown of placements, cognitive deficits, medical issues (e.g., hearing loss), and behavioural and mental health difficulties that make it a challenge to learn in a conventional environment. Research indicates that educational success and school attainment are protective factors for engaging in offending-related behaviours (Andrews & Bonta, 2010; Gottfredson, 2001; Maughan, 1994; Sprott et al., 2000), and that facilitating engagement in high quality education is important to reduce risk of reoffending among this population (Sutherland, 2011; Stouthamer-Loeber, Wei, Loeber & Masten, 2004). Therefore, it is important that young people in youth justice secure residential care are provided with a comprehensive educational screening assessment and high-quality educational opportunities tailored to their identified needs to help them re-engage in education and catch-up to their peers. Access to education, vocational training, or structured learning activities is a requirement outlined in the CYPF (Residential Care) Regulations (1996).

Despite a recognised link between low academic achievement and delinquency, there has been limited research examining the effects of education programmes on academic outcomes among the youth justice population (see Sander et al. (2012) for a meta-analysis). Of those that have been implemented, findings suggest that programmes implemented for this population tend to be ineffective at improving academic outcomes (Sander et al., 2012). As outlined in Chapter Eleven, some promising education programmes have been developed, such as Positive Behaviour for Learning – School Wide (PB4L-SW). However, this is an area clearly in need of further research.

There appears to be no research or guidelines on the specific mix of professionals required in residential care education settings; however it seems likely that

the presence of an educational psychologist, medical support for issues such as hearing loss, and the use of registered teachers would all be beneficial in terms of supporting young people in making the most of educational opportunities while in residence. In addition, given the overrepresentation of speech, language and communication difficulties present among the care and protection population, it is important to ensure speech-language therapy services are provided (Snow et al., 2015). The Missouri model employ staff who have worked with young people with diverse education-related difficulties and various backgrounds, and staff are accredited using the same criterion as Missouri public schools (Huebner, 2013).

With regards to class size, there is limited research or guidelines on the optimal number of children per classroom to achieve positive outcomes. However, Leone (2006) found that having small class sizes, year-round operation of the school, and curriculum aligned with state standards were common characteristics among the most effective education programmes for young people who have engaged in offending behaviour.

The use of Dialectical Behavioural Therapy (DBT) among adolescents is well researched, and incorporating DBT in the school setting has been recommended to help reduce levels of aggression, distress intolerance, and interpersonal conflict (Mazza, Dexter-Mazza, Murphy, Miller & Rathus, in press). This addition of DBT to the education curriculum could enable young people to receive further benefits from their time in education during residential care.

Vocational Skills

Both the Missouri model and Kibble Centre offer employment programmes. In addition, each residence in the Missouri model has a community liaison group consisting of community leaders to actively facilitate the development of connections to training programmes and opportunities.

There is a lack of research regarding the benefits of vocational and pre-employment training for young people in the youth justice system and secure residential care. However, the recognised benefits of young people being engaged in education could be generalised to include vocational and pre-employment training, where the acquisition of real world skills can increase the young person's chance of employment, consequently fostering positive outcomes in the long-term. Transitional staff could help a young person engage in such training programmes (e.g., building, plumbing, electrician etc.) in the community post-discharge. A community liaison group consisting of community leaders could actively facilitate the development of connections to training programmes.

Crisis Management

Although restraint may be necessary in rare instances to ensure the safety of the young person and staff, in general non-violent methods are both appropriate and necessary as an alternative. This is because physical restraint has been found to demoralise, humiliate, traumatise and re-traumatise the young people who experience it (Smith & Bowman, 2009; Steckley, 2010). Furthermore, the use of restraint or other violent methods of de-escalation may serve to damage the therapeutic relationship between staff and young people (Paterson et al., 2003).

There are two de-escalation and non-violent models of crisis intervention that could be used for intervening with young people in youth justice secure residences. These are: Non-Violent Crisis Intervention (NVCI) and Therapeutic Crisis Intervention (TCI; see Chapter Twelve, Sections 12.1 and 12.2, respectively). However, there has been limited published peer-reviewed research conducted evaluating NVCI and TCI.

Physical Environment

Based on the philosophy that if young people are treated like a typical young person and less like a criminal, then the less likely they will feel and act like a criminal (Mendel, 2010), the Missouri model's facilities have a home-like feel, with rooms and facilities decorated with personal touches, comfortable furniture, and many have live plants and pets. Such an environment helps normalise the experience of the young person in residential care, and emulates the rehabilitative ideal. Research has supported this practice of providing a warm and home-like environment in residence, which helps support the transition of the young person into residential care and to assist them to cope within the restrictive care environment (Bailey, 2002). Furthermore, providing kitchens, dining areas, lounges and individual bedrooms can ease the young person's transition into residential care and help them feel more "normal." Individual bedrooms offer the young person a private space where the young person can feel safe and contained, which can be therapeutic, particularly when living in a group situation (Bailey, 2002).

Similar to Missouri, Kibble has small residential facilities with a maximum of six young people residing in one residence. Having small facilities allows for 24/7 eyes-on supervision, provision of specialist attention, and the formation of one-on-one relationships between young people and staff (Mendel, 2010).

Family/whānau are seen as being an integral element of the rehabilitation of the young person. Therefore, to help increase the likelihood of family/whānau involvement in the treatment or intervention process, the young person should be placed in a secure residence that is as close to their home as possible. Family/whānau involvement in therapy or intervention programmes may allow for any identified issues in the young person's family and community environment to be addressed, which can help to maximise the generalisability of rehabilitative gains post-transition into the community. Being detained in a secure residence close to home can also allow the young person to develop and maintain relationships with their family and community. Developing and maintaining relationships between residences and the community using Community Liaison Groups, similar to the Missouri model, can provide valuable opportunities for young people in the community during and after their time in residence.

Addressing the Needs of Different Client Types

There are several distinct client types in the youth justice secure residential population: young people detained on remand, those who have a concurrent care and protection status, females, and child offenders (i.e., < 13 years). An overview of how to best address the needs of these client types is provided in Chapter Thirteen.

Currently, there is limited understanding or knowledge regarding the demographics and characteristics of these client types in youth justice secure residences in New Zealand. Only with this information could a more thorough review be undertaken into the needs of these different client types in youth justice secure residences can be met, to subsequently establish practice guidelines. However, it appears that due to the vulnerability of, and complexity of some female and child offenders, considerations should be made concerning whether females should be separated from male offenders, and child offenders separated from adolescent offenders.

Remand

With regards to the remand population, further information is needed to understand the circumstances in which 238 (1)(d) orders are made, and what alternatives there might be to making such orders. With regards to understanding and developing alternatives to remand, this is a key strategy outlined in the Youth Crime Action Plan. Alternatives to remand may include iwi remand services, cultural social services, electronic bail, regional remand homes, and semi-secure family homes. The feasibility of these options needs to be investigated as a suite of alternative short-term bail options for the remand population.

With regards to separating young people on remand from those who have been sentenced, the United Nations Standard Minimum Rules for the Treatment of Prisoners (1977) stipulate that young people on remand should have their cases processed expediently and that every effort should be made to apply alternative measures to avoid detention on remand. Where detention on remand is used, young people should be held for the shortest time possible, be detained separately from convicted youths and have the right to communicate regularly and privately with their legal advisers. The Beijing Rules (i.e., the United Nations Standard Minimum Rules for the Administration of Juvenile Justice) set out broad principles for the governance of juvenile justice. Specifically, they recommend pre-trial detention as a last resort for the shortest time possible, warning of 'the danger to juveniles of "criminal contamination" while in detention pending trial' (Part 2, No. 13). It is acknowledged that this population have a right to due legal process and are not presumed to be guilty, which would then enable rehabilitation/intervention. However, this population may benefit from general psycho-education programmes, such as Alcohol and other Drugs, and skills from Aggression Replacement Training (see Chapter Nine, Section 9.2.1) and Dialectical Behavioural Therapy (see Chapter Nine, Section 9.3).

Terms of Reference 3
The optimal service delivery model for youth justice residences. By this we mean what is the best mix of professionals in residential care to achieve improvements in short and long term outcomes. We are interested in what the national and international evidence tells us about what works best, compared with our current model. This includes the right staff attributes, capabilities and qualifications.

Professionals in Residential Care

At the time of writing this review, the reviewers were unaware of any research or guidelines concerning the ideal mix of professionals for a secure residential care facility. However, the "best mix" of professionals within youth justice secure residences is likely to include qualified front-line staff with extensive training in how to work with young people with offending histories, and mental health and behavioural difficulties. In terms of specific roles, there should be medical and mental health staff on-site, as well as education staff (preferably registered teachers), vocational staff, and at least one cultural advisor per site given the high numbers of Māori young people in secure youth justice residences. With regards to physical health, a GP, dentist, hearing specialist and optometrist are considered core professionals for meeting the physical health needs of the young people. With regards to mental health, the presence of a registered psychologist, child psychiatrist, and psychiatric nurses are considered essential within a residential care environment, in order to adequately assess and manage the various mental health, emotional, and behavioural issues present among young people in secure residential care.

Staff Attributes, Capabilities, and Qualifications

It is important to remember that staff, and particularly frontline staff, are the catalysts for change among the young people in secure residence. Staff can provide positive attachment figures and undertake effective therapeutic interactions, if they are skilled and are trained to do so. Interpersonal skills seen among effective staff who work with at-risk and high-needs young people include prosocial attitudes and behaviour, warmth, communication skills, and values aligning with those of the programme model (Bullock, 2000; Church, 2003; McLaren, 2004a, b; Singh & White, 2000). Furthermore, characteristics of staff working with young people, including professionalism, education, training, and the ability to form prosocial relationships, have been found to mediate positive treatment outcomes (e.g. Bickman et al., 2004; Duncan, Miller, Wampold, & Hubble, 2009; Knorth, Harder, Huyghen, Kalverboer & Zandberg, 2010; Van der Helm, Boekee, Stams, & Vander Laan, 2011).

Internationally, there has been a shift toward increasing the level of professionalism of staff in residential care (Dekker et al., 2012; Fendrich et al., 2012; Lappi-Seppälä, 2011). In Nordic countries at least 50% of residential care staff have tertiary qualifications (Lappi-Seppälä, 2011), and the Missouri model employs high calibre staff who are motivated, highly trained, and have higher-levels of education. Although voluntary and unqualified staff can do excellent work, may have relevant life experience, and be extremely motivated, they may have a lack of understanding of how to manage and care for difficult clients.

To the best of the authors' knowledge, there appears to be no guidelines concerning the optimal staff-client ratio in secure residences. However, it is likely that having a high staff to young person ratio will help ensure staff are not overworked, consequently reducing staff burn-out and turnover, and an appropriate distribution of tasks across staff.

Training, Support and Supervision

Staff employed by the Kibble Centre and the Missouri model are provided with extensive training in how to effectively provide services to young people in residential care. Kibble provides a useful model for training staff in secure residences. Staff undergo a high level of training related to trauma, emotion regulation, harmful sexual behaviour, social skills training, and self-harm and suicide. Similarly, staff employed in the Missouri model are highly trained in in counselling skills, conflict management, group dynamics (e.g., cliques), and to notice changes in facial expressions and body language (Mendel, 2010). In addition, youth specialists employed by the Missouri model are required to undergo hundreds of hours of training in their first two years of employment (Huebner, 2013; Mendel, 2010).

It is also important that staff are highly trained in the framework and rehabilitative model that is used within the residence, to ensure consistency in the implementation of the model. Staff should also have a belief in, and ongoing training in the use of, group care as a rehabilitative intervention (Bullock, 2000; Church, 2003; McLaren, 2004; Miskimins, 1990; Singh & White, 2000). Furthermore, it is essential that staff are provided professional development training to extend and develop their skills for the effective management and care of young people in secure residences. The Department of Corrections psychologists and programme facilitators are highly trained, and are a valuable resource that could be used to help implement well-run evidence-based programmes for young people in secure youth justice residences. In addition, Corrections psychologists and programme facilitators could be used to help train frontline and escort staff in therapeutic skills.

Staff employed in youth justice secure residential care should also have ongoing training in how to work with Māori and Pasifika young people, in order to provide culturally appropriate services.

Supervision and oversight of implemented practice by experienced programme leaders and management, including consultation and mentoring, is essential to ensure the programme is being delivered with fidelity, and that assessment and programme delivery are standardised across all staff.

Staff that are well-supported, feel appreciated, and are provided with frequent supervision are less likely to experience burn-out, and are more likely to stay motivated in delivering a high-level of service to the young people in residence. A high-level of staff turnover due to burnout can exacerbate the attachment issues prevalent among the youth justice population in secure residential care, and cause disruptions to consistency in care and rehabilitative work. In addition, supervision is essential for intensive and demanding roles in order to assist staff to maintain and develop their rehabilitative work (Lyman & Barry, 2006; Mendel, 2000; Church, 2003). Therefore, supervision should be offered to all staff on a regular basis, including individual and peer supervision.

Social Workers

Social workers play a critical role in the care and management of the youth justice population. However, the current training for social workers in New Zealand does not include clinical skills training. It is felt that additional training in clinical skills provided to a targeted group of social workers (approximately 40) across New Zealand would be beneficial in order to deliver adequate care and management for the youth justice population.

This group of social workers should be trained in: family therapy (e.g., Functional Family Therapy adapted model), behaviour management and skills teaching (i.e., practical application of social learning theory), basic CBT and DBT, motivational interviewing, transference and countertransference, supervision and personal development, how to engage youth and their families, how to work in a trauma-informed manner, how to administer and score psychometrics, and DSM-5 criteria. In addition, these social workers should have a basic understanding of research and applying knowledge, be trained in understanding the complex aetiology of behaviour problems, including neurodevelopmental/ brain related issues, attachment/relationships with significant others, complex trauma, social context and learning, and how to use this knowledge to support parents/caregivers and other adults working with the youth justice population.

Management and Leadership

To ensure consistency of rehabilitative interventions and a united and motivated team of staff working in secure residences, it is essential that the residential organisation has strong and consistent leadership (Hollin, 2001). In addition, the use of clinical and community advisory groups can be an important support for the management and leadership of the organisation, and can provide informed outsider opinion to ensure that the organisation does not become insulated and "institutionalized" in the way that it operates.

Organisational Culture

The best opportunity for effective rehabilitative and therapeutic interactions between staff and young people is within an organisation with a clear therapeutic philosophy, as well as a united vision which all staff are committed to. Organisations with a clear culture, and one which is driven by qualified and committed leadership, can improve outcomes for the young people detained in secure youth justice residences. It is important that all staff are qualified and committed to the model of care and the culture of the organisation, as inconsistent staff behaviour can become counterproductive and may undermine treatment integrity (Hollin, 2001).

Terms of Reference 4
Effective social work transitions into and from youth justice residences so that young people are well supported when leaving and returning to the community.

Transition and Aftercare

Transitions in and out of residence can be a difficult and unsettling experience, and young people coming into residence often have backgrounds that include abuse, neglect, and other trauma that can render the move into a restrictive and unfamiliar setting a challenging process. If there is a lack of engagement within the residential facility for the young person, then they may find it very

difficult to adjust to the residential care setting, which consequently limits their ability to engage and gain benefits from the rehabilitative interventions provided (Moreno Manso et al., 2011). For this reason the smooth transition of young people into residence is deemed to be a priority.

In addition, there is evidence to suggest that the planning for transition from residence should commence shortly after admission to the residence, for two main reasons. Firstly, the length of stay for a young person is often unknown at the outset, and therefore the transition plan should be in place as early as possible in order to avoid gaps should the young person depart from residential care earlier than expected. Secondly, young people tend to have better outcomes when they have a clear transition plan in place (Lindqvist, 2011), as this likely reduces uncertainty about their future, allowing them to better focus on their current situation. This can also increase motivation to achieve goals in residence if they are beneficial for their post-residence plan. Planning for transition as soon as the young person enters residence is an element of the Stop-Gap model.

For all young people transitioning from residence, it is essential that transition planning is inclusive of young people, their families (where possible) and significant others, and that planning processes are well-coordinated and tailored to the individual needs and circumstances of the young person to promote best possible outcomes. If possible, transition plans should involve the young person returning home to their biological family/whānau if appropriate, or to a foster family or appropriate caregiver. These options are known to result in better outcomes than transition to living independently, or in other types of care, where the young person may struggle to remain in school or employment, and lack necessary support (Bruil & Mesman Schultz, 1991; Bullock et al., 1998; Embry et al., 2000).

Young people often find it difficult to maintain positive gains that they have made in residential care once they have transitioned back into their home environment (Narendorf, Fedoravicius, McMillen, McNelly & Robinson, 2012). Therefore, it is important that a young person's transition from residence be well-supported with a continuity of services in place before, during, and after transition to allow for successful implementation of their individualised intervention/rehabilitation plan. In addition, movement between placements should be kept to a minimum. The transition plan should be regularly reviewed before, during and after transition, and if the needs of the young person and/or their family change then services should also be adjusted accordingly.

Given the importance of smooth transitions both in and out of residential care, the employment of staff who are dedicated solely to facilitating the young person's transition could improve outcomes post-discharge. A young person's transition plan could be monitored by one person with clinical knowledge to ensure all services are working together collaboratively, with the young person and their family's best interests at the forefront. It may also be beneficial for the young people leaving a secure residence if they can maintain a connection with staff from the residence that they have developed an attachment to. This may help avoid exposing the young person to what may feel like further rejection in a life which may have been marred by attachment issues and rejection by parents and foster parents (Ward, 2009).

Following transition from residential care back into the community, aftercare is another essential part of the residential care framework. As previously noted, any positive outcomes gained from time spent in residential treatment may be lost if transition and post-residence support are not available to the young people (Guterman, Hodges, Blythe & Bronson, 1989). Aftercare services have been shown to maintain and sometimes improve on positive outcomes from residential treatment, likely by extending the effects of evidence-based treatment models (De Swart et al., 2012; Harder, Kalverboer & Knorth, 2011; James, Stams, Assher, De Roo & de Laan, 2012). An important aspect of successful aftercare programmes is the ability to fit support to the needs of the young person (Fontanella et al., 2008; Trout et al., 2010).

Terms of Reference 5
Whether New Zealand's youth justice residences should cater for all those under seventeen years of age who require secure residential care. One issue we wish to consider is whether those aged under 17 years of age and who are sentenced to the Corrections system should instead be held in Child, Youth and Family Youth Justice residential care.

Internationally, those under the age of 18 years are considered children. In addition, neurodevelopmental literature shows that young people under 18 years are very different to adults (e.g., prefrontal cortex

development), and as such have different needs to the adult population. Furthermore, better outcomes (e.g., reduced recidivism) are achieved when young people are involved with the lowest level of the criminal justice system. Based on this information, placing all young people under 17 years in secure youth justice residences is a consideration which should be further investigated.

In New Zealand, six beds at Korowai Manaaki youth justice residence in Auckland are designated Corrections Act 2004 beds for young people aged less than 17 years who have been sentenced to a term of imprisonment by the District or High Court, but for reasons of special circumstances (e.g., age, gender, assessed vulnerability) they are detained in a secure youth justice residence. At this time, the reviewers do not have adequate information regarding the characteristics and needs of these young people, and consequently which agency can best meet their needs (i.e., either the Department of Corrections or CYF). Therefore, to adequately respond to this question in consideration of what is in the best interests of these young people sentenced to imprisonment, a needs analysis should be conducted to determine the number, characteristics and needs of this group. The best interests of this group should be paramount and held in mind with any decisions made regarding their care and management.

Terms of Reference 6
Commentary on residences as a "service", as part of a continuum of services.

Residential-based services are typically situated within a wider continuum of care that comprises step-down homes (i.e., out-of-home care), multimodal family and community-based interventions (e.g., Multisystemic Therapy; MST), rehabilitative interventions (e.g., cognitive-behavioural therapy, Aggression Replacement Training, Dialectical-Behavioural Therapy etc.), and interventions aimed at prevention (i.e., young people aged less than 12 years who present with conduct problems). As outlined in Chapter Three, the New Zealand youth justice continuum of care comprises the Fresh Start for Youth Offenders Initiative, community-based services (e.g., MST), and youth units run by the Department of Corrections. It is important that each part of this continuum of care uses evidence-based models and interventions ranging from preventive work to those sentenced on a Supervision with Residence order or term of imprisonment under the Corrections Act 2004, to help ensure the needs of these young people and their families are met. Furthermore, having robust and effective resources throughout the continuum of care can help ensure that those who begin to exhibit problematic behaviours are offered intervention services before they require more intensive (and potentially residential-based) services, and those transitioning from secure residence are well-supported to reduce their likelihood of reoffending and/or being re-admitted into a secure residence.

Internationally, the Missouri model and Kibble Education and Care Centre (See Chapter Four, Sections 4.4.1 and 4.4.2 respectively) are well-run and highly-regarded continua of care for the youth justice population. Aspects of these models could be beneficial for implementation in the New Zealand context to strengthen the current youth justice continuum of care. These two models are briefly described below.

The Missouri Model

The United States Missouri model has been highly regarded in the literature. The Missouri model operates a continuum of residential facilities for the youth justice population, with seven secure care facilities, 18 moderate care, and 7 community-based (non-secure) residential group homes (Missouri Department of Social Services, 2013). Diversion, community-based supervision, and dual jurisdiction programmes are also provided. The Missouri model has been found to decrease recidivism after release (Missouri Department of Social Services, 2013), as well as assaults against youth, assaults against staff, and the use of mechanical restraints and isolation (Mendel, 2010). Rates of academic achievement of youth under the Missouri model are also significantly higher than national estimates of young people in confinement (Mendel, 2010).

The Kibble Education and Care Centre (Kibble)

Kibble is a social enterprise in Scotland with the goal of providing a stable, safe and happy environment for young people considered high risk and disadvantaged, and to provide these young people with the skills, experiences, and training to allow them to be successful in independent life. Kibble provides secure care, residential services, day services, intensive fostering, education and training, and transitional support all on-site. Evaluations have been positive with findings that

young people feel cared for and secure, and benefit from having their curriculum tailored to their individual needs (Education Scotland, n.d.). Staff have also been found to be highly effective at assisting young people to overcome their barriers to learning (Education Scotland, n.d.).

Terms of Reference 8
A summary of what other residential care facilities exist in New Zealand outside the ones provided by the Ministry. This should include, for example, forensic mental health facilities and examples of other youth justice interventions, such as the MAC programme and community-based programmes. This should include:

14.2 The model used

14.3 The staffing arrangements

14.4 The kinds of clients and their needs

14.5 The intervention programme offered

14.6 Information on the physical restraint approaches used, and if not used, please explain why.

Please refer to Chapter 3, Section 3.3 where an overview of the new Youth Forensic Mental Health Unit, Ministry of Education, Barnardos, Spectrum Care, Hohepa Trust, and the Ministry of Health's Disability Support Services' contracted residences was provided.

Summary

The youth justice population in secure residential care exhibit multiple difficulties that require a multi-pronged response to their care and management. The overarching framework, model of care, and rehabilitative programmes for secure residence need to be evidence-based, culturally appropriate, implemented by highly trained professional staff, and located within a continuum of care so that pre- and post-residential placements are planned for systematically. This larger continuum of care should provide evidence-based resources for the youth justice population, including alternatives to residence and step down services (e.g., MTFC, Teaching Family Model), as well as preventive interventions for young people presenting with early signs of conduct problems (e.g., Functional Family Therapy, MST, Parent-Child Interaction Therapy). Multimodal interventions which involve family/whānau are essential for appropriately addressing the needs of these young people across multiple domains and systems.

These reviews were written with the philosophy in mind that the population of young people in youth justice secure residential care is a vulnerable group that we all have a collective responsibility for. Therefore, it is important to consider what changes could be made to these residences and the wider continuum of care based on the literature and evidence-based practice presented in this review so that current service provision can be enhanced, consequently promoting best possible outcomes for this population, their families, and the community.

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Appendix A: People interviewed or consulted

People interviewed and/or consulted with as part of this project:

Nova Salomen – General Manager, Residential, High Needs and Care Services, CYF

Chris Polaschek – General Manager, Youth Justice Support, CYF

Bernadine Mackenzie – Deputy Chief Executive, CYF

Denise Tapper – Manager Clinical Services, CYF

Phil Dinham – Manager Youth Justice Support, CYF

Jean MacDonald – Manager High Needs Services, CYF

Sharon Thom – Regional Director, Auckland Region, CYF

Ana Su'a Hawkins – Manager Operation Support, Residential, High Needs and Care Services, CYF

Andrew Beattie – Manager Social Work Quality Assurance, CYF

Rebecca Barson – Lead Strategic Advisor, CYF

Ken Hand – Principal Analyst, CYF

Jo Smith – Manager, Engaging Challenging Youth Team, CYF

Sean Twomey – Practice Leader, Southern Rural, CYF

Judge Andrew Becroft – Principal Youth Court Judge

Dr John Church – Department of Psychology, University of Canterbury

Professor David Fergusson –Professor of Psychology, University of Otago, Christchurch; Christchurch Health and Development Study

Professor Angus McFarlane – Faculty of Education, University of Canterbury

Dr Sonja McFarlane – School of Health Sciences, University of Canterbury

Dr Louise Webster – Child and Adolescent Psychiatrist and Paediatrician, Starship Hospital, Auckland

Jemma Stephens – Team Leader, Regional Youth Forensic Servuice and Taiohi Tu Taiohi Ora

Dr Julia Ioane – Clinical Psychologist, Regional Youth Forensic Service

Clinical Team – Regional Youth Forensic Service, Kari Centre

Sarah Bramhall – Principal psychologist, Department of Corrections

Suzanne Lee – Psychologist, Department of Corrections

Belinda Seymour-Wright – Clinical Director, Youth Horizons Trust

Colin Hamlin – Principal Advisor, Ministry of Health

Pamela Greenlee – Contract Relationship Manager, Disability Support Services, Ministry of Health

Brian Coffey – Group Manager Special Education Strategy and Service Improvement, Ministry of Education

Karina Phillips – Professional Teaching Fellow, Psychology Department, University of Auckland

Bernie Holden – Barnardos Residential Services Manager, Wellington

Paul Deacon – Barnardos Residential Team Leader

Spectrum Care

Hohepa Services Ltd

Stephen Boxer – Edge Lifeskills Ltd Director, MYND programme and 4C Fitness

Miller Matangi – Behaviour Support Manager, Te Roopu Taurima O Manukau Trust

Barry Dunh – Paukura Hauora o Tainui

Anita Balhorn – Manager, Ivita Health Services Ltd

Hazel Audain – Team Leader, AoD Practitioner, Primary Care Services

Betty Anderson – Principal, Creative Learning Scheme

Tina Lomax – Principal, Kingslea school

Mark Stephenson – Operations and Team Leader (Transitions), Creative Learning Scheme

International Experts:

A range of experts from the United States, United Kingdom, Scotland, and Australia were consulted.

Kibble Education and Care Centre:

Dan Johnson – Psychology Manager

Claire McCartney – Specialist Interventions Service Manager

Jennifer Copley – Psychology Team Member

Claire Reilly – Psychology Team Member

Appendix B: Classification System of the Advisory Group on Conduct Problems

The Advisory Group on Conduct Problems' (AGCP) classification of programmes process is outlined in their Conduct Problems: Effective Programmes for Adolescents 2013 report (see pages 8 to 10).[45] To provide context for comparison with the scale used in this report, the AGCP's four-fold classification system is outlined below.

Recommended Programmes

These were programmes for which there was generally strong evidence of programme efficacy and which met all of the following inclusion criteria:

- The intervention was founded on a clearly articulated theoretical model and the protocol for implementation of the intervention had been manualised.
- The intervention had been evaluated by multiple randomised trials and/or single case experiments, with the majority of these showing evidence of efficacy.
- The intervention was widely regarded in the literature as being an effective treatment for antisocial behaviour.
- After reviewing the evidence, members of the AGCP were unanimously of the opinion that the intervention should be recommended as a method for treating and managing conduct problems in adolescence.

Promising Programmes

These were programmes for which there was substantial evidence of programme efficacy for children under 13, with these programmes meeting all the criteria for recommended programmes. However, for these programmes, the evidence of the efficacy of the programme for adolescent population was limited and not sufficient for the AGCP to classify these programmes as recommended. Programmes classified as "Promising" met all of the following criteria:

- The intervention was founded on a clearly articulated theoretical model and the protocol for the implementation of the programme had been manualised.
- The efficacy of the intervention had been evaluated by multiple randomised trials and/or single case experiments on children under 13 and had been shown to be effective for this population.
- There was limited evidence available to show that the intervention could be successfully applied to 13–17 year olds.
- After reviewing the evidence, members of the AGCP were unanimously of the opinion that the approach should be classified as a "Promising" rather than "Recommended" approach to addressing adolescent conduct problems.

Programmes for which the Evidence was Inconclusive

These were programmes or interventions for which there was evidence of programme efficacy on the basis of randomised trials or quasi-experimental designs, but for which the evidence was not conclusive for any one of a number of reasons, including:

- The intervention had not been manualised, making translation of the programme to a new context difficult.
- There was substantial heterogeneity in the way that intervention had been applied in terms of methods of programme delivery, target population or outcome measures.
- Evidence on programme efficacy was variable, with some studies showing positive effects and others failing to find such effects.
- There was not wide agreement in the literature that the intervention was effective for the treatment and management of conduct problems and antisocial behaviours in adolescence.
- There were concerns that the evidence of the efficacy of the intervention may have been influenced by other interventions which were delivered at the same time.
- After considering the evidence, the AGCP was of the view that the evidence on programme efficacy was not sufficiently strong to recommend the programme, nor was the evidence sufficiently strong to conclude that the programme was ineffective.

45 See: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/effective-programmes-for-adolescents.html

Not Recommended

These were interventions for which there was strong and consistent evidence to suggest that the programme was either ineffective or harmful. Interventions classified as "Not recommended" met all of the following criteria:

- The intervention had been evaluated in multiple randomised trials, with the majority of these trials finding that the intervention was ineffective or potentially harmful.
- There was general agreement in the literature that the approach was either ineffective or increased antisocial behaviour.
- After reviewing the available evidence, the AGCP was of the view that the programme could not be recommended as an effective or safe intervention for the management of conduct problems and antisocial behaviour in adolescence.

Comparison between the AGCP's Classification of Programmes and the California Evidence-Based Clearinghouse's Rating Scale

California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale is similar to the AGCP's classification system, as follows:

- AGCP's '*recommended programmes*' is comparable with Clearinghouse's rating 1 (well-supported by research evidence).
- AGCP's '*promising programmes*' is comparable with Clearinghouse's ratings 2 and 3 (supported by research evidence and promising research evidence, respectively).
- AGCP's '*not recommended*' is comparable with the Clearinghouse's rating 4 (evidence fails to demonstrate effect).

The Clearinghouse's rating 5 (concerning practice) and Not able to be Rated (NR) are not equivalent with any of the AGCP's classifications. In addition, the Clearinghouse does not have a comparable rating to the AGCP's 'evidence inconclusive'.

Appendix C: Meta-Analyses

Table C-1: De Swart et al. (2012) Meta-Analysis

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Cohen's d)[1]
Abrams, Shannon & Sangalang (2008).	83 incarcerated young offenders.	Transitional living program.	Six weeks.	No significant difference in recidivism outcomes for participants in the programme at 1 year follow up.	-0.563
Armstrong (2003).	257 male young offenders who were incarcerated in a county jail in Maryland.	Moral Reconation Therapy (Primary goal of treatment is the moral development of treatment client). Developed by Little & Robinson (1988).	On average, participants exposed to three sessions lasting 1 to 1.5 hours per week. The mean treatment length was 77 days (high implementation group was minimum of 30 days).	No statistical differences found for recidivism rates between treatment group and control group, nor between those in high implementation treatment group and control group.	0.005
Brugman et al. (2007).	This paper was not in English.				-0.083
Caldwell & Van Rybroeck (2001).	30 highly disruptive and aggressive incarcerated juvenile offenders: 10 received decompression treatment, 10 receive mental health treatment services, 10 received assessment only.	Decompression Treatment. Developed by Monroe, Van Rybroek, & Maier (1988).	Not reported.	Decompression therapy and mental health treatment participants were significantly less likely to reoffend in 2 year follow up than those who only received mental health assessment and usual juvenile corrections rehabilitation services (10%, 20% and 70% respectively).	0.537
Caldwell & Van Rybroeck (2005).	Serious and violent offenders 101 treated youth and 147 comparison youth.	Intensive institutional treatment programme based in part on the Decompression Treatment model.	Mean treatment duration was 354.1 days.	Untreated comparison group twice as likely to commit violence offences as treated group. Treated group also had significantly lower hazard ratios for recidivism in the community than comparison group.	1.806
Cann, Falshaw & Friendship (2005).	Young offender population in England and Wales 1,534 who participated in treatment during custodial sentence and 1,534 who had not.	Prison based Cognitive Skills programmes – Either Reasoning and Rehabilitation (R&R) (developed by Ross & Fabiano 1985) or Enhanced Thinking Skills (ETS) (adapted version of R&R and used with lower risk offenders).	R&R delivered over 36 two hour sessions. ETS is delivered over 20 two hour sessions.	No statistically significant reductions in reconviction rates found among programme participants at 2 years follow-up. However, when those who dropped out of treatment were excluded, the one year reconviction rate for programme completers was statistically significantly lower than those who did not begin treatment.	0.113

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Cohen's d)[1]
Gordon et al. (2000).	254 young offenders at Paint Creek Centre in structured programme and 226 young offenders in comparison traditional detention facility.	Institute programme integrating family, cognitive behavioural and social learning perspectives.	Not reported.	Residential treatment group had lower percentage of reconvictions and recommitments than comparison group.	0.260
Guerra & Slaby (1990).	120 male and female adolescents, aged 15 to 18, incarcerated for aggression offences. Participated in either the cognitive mediation training program, an attention control group, or a no-treatment group.	Short-term cognitive mediation training - designed to remediate both those social-cognitive skills involved in the process of solving specific social problems, and those generalized social beliefs about supporting the use of aggression. Developed by Slaby & Guerra (1988).	12 sessions over 12 weeks.	When compared to the control group, those in the treatment group had increased skills in solving social problems, decreased endorsement of beliefs supporting aggression, and decreased aggressive, impulsive, and inflexible behaviours, as rated by staff. Post-test aggression was directly related to change in cognitive factors. No group differences were detected for number of parole violators up to 24 months after release.	0.345
Hawkins et al. (1991).	141 incarcerated juvenile delinquents (69 in the experimental group and 72 in control group).	Cognitive-behavioural skills training program.	Phase 1 (preparation for community re-entry) duration was 10 weeks with skills training conducted in groups twice weekly for 2 hours. Phase 2 (aftercare) duration was 6 months	Those in the treatment/experimental group had significantly higher drug and alcohol avoidance, social and problem solving performance, and self-control performance than did the randomly assigned untreated control subjects.	0.610
Katz et al. (2004)	62 adolescents in one of two child and adolescent psychiatric inpatient units One unit used a DBT protocol and the other unit relied on treatment as usual.	Dialectical Behaviour Therapy (DBT) with modifications by authors. Adolescent DBT model used in this study developed by Miller et al. (1997).	2 weeks: comprised 10 daily, manualised DBT skills training sessions, as well as 2 individual DBT psychotherapy sessions per week. Also participated in a DBT milieu.	When compared to treatment as usual, DBT significantly reduced behavioural incidents during admission.	0.410

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Cohen's d)[1]
Kolko et al. (1990).	56 inpatients in a child psychiatric unit. 36 assigned to a social-cognitive skills training (SCST) group and 20 participated in a social activity group (SA).	Social-cognitive skills training.	15 hourly sessions.	Significantly greater pre-post improvements for the SCST than the SA group in child reported loneliness, staff sociometric ratings, role-play performances, and in vivo behavioural observations of individual social skills.	-0.317
Leeman et al. (1993)	57 male juvenile offenders aged 15-18 who were incarcerated at a medium-security correctional facility. Participants assigned to either EQUIP or one of two control groups.	Preliminary version of "Equipping Youth to Help One Another". Developed by Gibbs & Potter (1987)	EQUIP groups met daily during weekdays for 1 to 1.5 hours, 5days per week. No overall duration reported.	When compared to the control group, those in the EQUIP group demonstrated significant improvements in institutional conduct and recidivism rates, reflecting, to some extent, gains in social skills.	0.629
Moody (1997).	14 incarcerated juvenile offenders with emotional problems (7 pairs).	Pair counselling.	10 weeks. On average each session was 1 hour.	Qualitative results presented in case studies provided support for improvement in peer relationships Overall, pair counselling did not stimulate moral reasoning for the majority of participants, and it did not have an impact on recidivism.	0.266
Rohde et al. (2004).	76 male adolescents incarcerated at a youth correctional facility. Participants were randomly assigned to either the Coping Course (n = 46) or usual care (n = 30).	Coping Course (A cognitive-behavioural group intervention) . The basis for the Coping Course intervention was the Adolescent Coping With Depression course (Clarke et al., 1990).	Sixteen treatment sessions over an 8-week period.	Significant changes were found among the treatment group, including reduced externalising problems, reduced suicide proneness, increased self-esteem, and increased sharing of feelings with staff.	0.469
Scholte & Van der Ploeg (2003)	Unable to locate study.				

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Cohen's d)[1]
Thompson et al. (1996)	503 participants in a residential program comprised the treatment group, comparison group did not enter the program (84).	Residential programme.	Average stay in the programme was 20 months.	Treatment group had significantly greater improvements in both school performance and attitudes during placement.	0.375
Wilmshurst (2002)	Youth with severe emotional and behavioural disorders randomly assigned for 3 months of intensive treatment to a 5-day residential program (5DR Program) or a community-based alternative, family preservation program (FP Program).	Family Preservation program.	12 weeks.	At 1 year follow-up, a significantly higher proportion of youth from the FP Program demonstrated a reduction in clinical symptoms for ADHD, general anxiety and depression. A significant proportion of youth from the 5DR Program demonstrated clinical deterioration and increased symptoms of anxiety and depression.	-0.338

1 In line with generally accepted principles for the interpretation of effect sizes, an effect size of d=.20 is considered small, an effect size of d=.50 is considered medium, and an effect size of .80 is considered large (Cohen, 1988).

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Odds Ratios)
Bottoms (1995).	Unable to locate study.				Comparison A:1.392 Comparison B:0.844
Cann, Falshaw & Friendship (2005).	Young offender population in England and Wales. 1,534 who participated in treatment during custodial sentence and 1,534 who had not.	Prison based Cognitive Skills programmes – Either Reasoning and Rehabilitation (R&R) (developed by Ross & Fabiano 1985) or Enhanced Thinking Skills (ETS) (adapted version of R&R and used with lower risk offenders).	R&R delivered over 36 two hour sessions. ETS is delivered over 20 two hour sessions.	No statistically significant reductions in reconviction rates found among programme participants at 2 years follow-up. However, when those who dropped out of treatment were excluded, the one year reconviction rate for programme completers was statistically significantly lower than those who did not begin treatment.	1.203
Curran, Kilpatrick, Young & Wilson (1995).	592 male juvenile offenders sentenced to secure and open forms of residential custody in Northern Ireland training schools.	Secure vs open forms of residential custody.	Not clearly reported.	7-15% of those in secure care were reconvicted. Shorter lengths of stay were associated with lower levels of reconviction.	0.739
Farrington et al. (2002).	HIT: 176 young offenders under HIT regime compared with 127 control young offenders MCTC: 61 young offenders under HIT regime compared with 97 control young offenders.	Boot camp deterrent regimes. Thorn Cross High Intensity Training – HIT – Centre. Colchester Military Corrective Training Centre – MCTC.	HIT: 25 weeks. MCTC: Between 18 and 26 weeks.	HIT: HIT young offenders were significantly less likely to be reconvicted within one year than were controls. Although HIT young offenders were not less likely to be reconvicted within two years than controls, they desisted from reoffending for longer and committed fewer offences during the follow-up period. MCTC: Results showed no significant differences between MCTC young offenders and controls on reconviction rates at 1 and 2 year follow-up.	Comparison A: 2.130 Comparison B: 1.119
Kruissink (1990).	Unable to locate study.				5.087

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Odds Ratios)
Kury (1989)	Young offenders in the Freiburg pre-trial detention institute receiving treatment were compared with young offenders in two other retrial detention institutes (control groups) where treatment was not implemented.	Pre-trial detention treatment programme consisting of counselling therapy (client-centred psychotherapy and behaviour therapy).	Average length of treatment was 26 hours for both treatment types.	Comparisons within the treatment group showed that only counselling therapy resulted in significant change. Differences in recidivism between the treatment and control groups were not significant.	1.341
Little, Kogan, Bullock, & van der Laan (2004)	592 juvenile offenders - Candidates were randomly assigned to ISSP or one of two control groups.	Intensive Support and Supervision Programme (ISSP) (Multisystemic intervention).	Not clearly reported.	Reconviction rates were unaffected by the intervention but there was a 30 to 50 per cent reduction in the number of arrests by ISSP participants. No particular aspect of the programme was associated with success suggesting a general placebo effect of participation.	0.714
Lobley & Smith (2007).	Unable to locate study in the review timeframe.				Comparison A: 2.071 Comparison B: 0.774
Lösel & Pomplun (1998)	This paper was not in English.				0.901
McMurran & Boyle (1990).	Forty-five male young offenders who drink were selected from the population of a Young Offenders Centre. Allocated to one of three conditions: no intervention; minimal intervention (given a behavioural self-help manual to read alone); and group intervention (manual read aloud in groups).	Group intervention – manual read aloud in groups.	Not clearly reported.	At 15-month follow-up, there were no significant differences in reconviction rates in the three conditions.	Comparison A: 1.00 Comparison B: 0.582

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Odds Ratios)
Mitchell & Palmer (2004).	Juvenile offenders in an English prison who completed the program (n = 31) were compared with a group of offenders who did not receive the program (n = 31).	Reasoning and Rehabilitation programme. Ross, Fabiano, & Ewles (1988).	The program is comprised of 35-38 two-hour group sessions.	No significant differences were found for reconviction rates during the first eighteen months after release and re-imprisonment rates.	1.341
Newburn & Shiner (2005).	Unable to locate study in the review timeframe.				0.642
Ogden & Hagen (2006).	75 adolescents were randomly assigned to either MST or Regular Child Welfare Services	Multi-Systemic Treatment.	Average treatment time was 24.3 weeks ranging from 7 to 38 weeks.	MST was more effective than RS in reducing out of home placement and behavioural problems.	2.722
Ogden, Hagen & Andersen (2007).	55 youths were referred to MST in the programme's second year of operation (MST2), and 50 youths were included in the RCT the first year in which 30 were randomly assigned to MST (MST1) and 20 to regular services (RS).	Multi-Systemic Treatment.	Treatment lasts between three and six months but is terminated earlier if the goals of the individual treatment plan are reached.	At two project sites, MST clinical outcomes in the second year of programme operation matched and, for key indices of anti-social behaviour, surpassed those achieved during the first year. MST treatment delivered in the second year was more effective than regular child welfare services in preventing out of home placement and reducing internalising and externalising behaviour. No group differences were found for social competence.	3.605
Raynor & Vanstone (1997).	Unable to locate study.				1.604
Scholte & Smit (1988).	71 juveniles in programme made up experimental group, 71 in control group.	Prejop Programme (A preventive social welfare intervention programme).	Not clearly reported.	Programme reduced family malfunctioning, delinquent behaviour and the amount of returns to police notice for Dutch juveniles. Recidivism rate was 12% for Prejop juveniles and 31% in comparison group. Positive effect for ethnic minorities found only in family dysfunction measure.	1.482
Shapland et al. (2008).	Unable to locate study.				1.558

Study	Sample Information	Therapy	Duration	Outcome	Effect Size (Odds Ratios)
Slot (1983).	Youth at the Ambulatorium van het Paedologisch Institute in Amsterdam who were living in an experimental cottage receiving SST were compared with two control groups living in cottages where no SST programme had been implemented.	Social Skills Training (SST).	Effects were limited to the first 6 months.	The SST programme yielded most of its success after 6 months. At follow up, significant differences favouring the SST group were found for overall improvement, the level of social skills in contacts with peers, teachers and employers, and the number of months in which the youth had a job or attended a school.	2.176
Slot & Bartels (1983).	29 youths from the Ambulatorium van het Paedologisch Institute in Amsterdam. Also, a control group of 29 youth.	Social Skills Training (SST).	Sessions between 15 minutes and 3 hours, between once and four times a week.	Significant differences found in favour of the social skills training group on measures of recidivism, referral to a correctional institute, serious behaviour problems at home, number of months worked during follow up, overall functioning in home or residence, progress, association with caregivers and association skills.	6.984
St. James-Roberts, Greenlaw, Simon & Hurry (2005).	4 projects targeted groups of Black minority ethnic young people and young people with literacy and numeracy needs who had offended, or were at risk of offending.	Mentoring programme.	On average 20 hours of contact time.	Improvements were found in the young people's attendance and behaviour at school, increases in literacy and numeracy, and improvements in accommodation and family relationships. Increased involvement in community activities such as sports, clubs, social groups and voluntary organisations at school or in the community was reported for 50% of Black minority ethnic mentees overall. The findings available do not provide convincing evidence that mentor programmes produce a reduction in offending during the first year after the start of a programme.	0.942
Sundell, Hansson, Andrée Löfholm, Olsson, Gustle & Kadesjö (2009).	156 youths who met the diagnostic criteria for conduct disorder.	Multi-Systemic Therapy	Youths and families were enrolled in MST for an average of 145.8 days.	Results showed a general decrease in psychiatric problems and antisocial behaviours among participants across treatments. There were no significant differences in treatment effects between the treatment group and control group.	0.941

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