Te Hurihanga Pilot: Evaluation Report

Prepared for the Ministry of Justice by

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Disclaimer

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Note on style
Because of the strong links between Tainui and the Te Hurihanga pilot programme, this report has adopted the Tainui preference for doubling the vowels in Maaori words to indicate a long vowel sound, rather than a macron (for example Maaori rather than Māori).

Abbreviations used in this report
CAMHS – Child and Adolescent Mental Health Services
CYF – Child, Youth and Family
CYPF Act – Children, Young Persons and their Families Act 1989
FFT – Functional Family Therapy
FGC – Family Group Conference
MST – Multi-Systemic Therapy
YHT – Youth Horizons Trust

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Background

This evaluation report provides the Ministry of Justice with findings from a two-year evaluation that began late June 2007 and was completed in July 2009.

Te Hurihanga (The Turning Point) is a Ministry of Justice response to the problem of youth offending. It is a three-year pilot that reflects concerns about trends in youth offending and lack of suitable options open to the judiciary when dealing with some young offenders. The focus of this programme is to encourage young people to turn their lives around. It is a nine to eighteen month therapeutic programme for young males (aged 14 to 16 years at entry) who have appeared before the courts and who live within the Hamilton/Waikato region. The three-phased programme aims to: reduce re-offending; hold young people accountable for their offending; and provide tailored, specialist support to young people and their whaanau/families so they can make positive choices rather then continue on current (offending) pathways.

The therapeutic, residential programme is bicultural and community-focused. It is designed to be delivered in a context of care, aroha, manaakitanga, wairuatanga and whanaungatanga.

The therapeutic framework within which staff carry out their prescribed roles is structured around the following treatment models:

- Risk, Needs, Responsivity Model
- The Good Lives Model: Adapted to Adolescents
- Psycho-Educational Intervention and Cognitive Behaviour Therapy
- Behaviour Theory and Therapy (Based Upon Operant Learning Principles)
- Relapse Prevention Model
- Parenting and Family Therapy Interventions
- Multi-Systemic Therapy Model and, in the future
- Functional Family Therapy.

Evaluation findings: In general, the programme's referral and admission processes run smoothly. However, sometimes referral agencies experienced difficulties getting the young people and/or their families/whaanau to agree to participate in a programme that could take eighteen months to complete. Also, some effort is needed on the part of the programme providers to ensure that Te Hurihanga remains 'at the front of the mind' of referral agencies as an intervention option. There is some debate about the criteria: some have argued for relaxing the criteria while others would like to see the criteria tightened up.

A steady increase in client numbers, coupled with young people progressing through the treatment phases, resulted in Phases 1 and 2 operating at almost full capacity within six months from commencement and the programme as a whole operating at almost full capacity a little over a year from commencement. A steady,

but modest, increase in the number of young people in the programme is consistent with what could be expected of a well-performing pilot.

Providers have found that the flows of new entrants to Te Hurihanga and young people moving between programme phases need to be managed to maintain established routines in the residence, minimise any disruptions to established relationships and manage resources.

Young people's progress through the three phases of the programme is outcomes-driven, rather than process-driven. The maximum duration of each phase is six months. Experience so far shows that the young people progressed through Phase 1 in around four months; that more recent participants progressed through Phase 2 in four to five months and that Phase 3 takes six months.

The cultural components of the programme are highly valued by families/whaanau, who attributed important changes in their young people's attitudes and behaviours to the presence of the programme Kaumaatua and cultural activities.

Appreciation of the therapeutic role that the residential team plays in the overall treatment programme has increased as the programme has developed. That growing appreciation has both reflected the skills that the residential team has developed and provided a foundation for the team to further build on its skills base. The skills and commitment of the team makes it potentially one of the most skilled residential teams in the country.

The delivery of the Multi-Systemic Therapy (MST) component of the programme (in Phase 3) improved after a problematic start, through the appointment of an experienced supervisor, team capacity building and the introduction of strategies to strengthen integration between the three programme phases. From late 2009 or early 2010, Functional Family Therapy (FFT) will replace MST as the treatment model for Phase 3 of the programme.

The importance of family involvement in the treatment programme is recognised in the treatment model and in the acceptance criteria. Whaanau were overwhelmingly supportive of the programme and their involvement in programme activities.

The points system is being delivered in a consistently robust way. Adaptations to the points system, aimed at increasing its strengths base and consistency and ease of application, improving its manageability, and enhancing its capacity to capture subtleties of behavioural changes, have been largely successful.

Results indicate the programme's intermediate outcomes have been achieved for most young people. The young people themselves and their families/whaanau were generally confident about their futures. External stakeholders were also confident that young people nearing the end of the programme, and those who had completed the programme, had made positive changes.

One of the most challenging issues for the future, to maintain the achievements of the young people, is how to keep them productively occupied in the medium to long

term – in school, training or work. For most of the young people, successful reintegration into mainstream schooling seems unlikely. Most had been out of the school system for a long period of time before entering the programme. So far, there seems to be considerable community and employer commitment to creating work and training opportunities.

Discussion points: The following key findings and conclusions can be drawn from the evaluation:

- Although Te Hurihanga has effectively attracted the targeted young people, and built up referral numbers in a comparatively short period of time, there is debate about the eligibility criteria. This, coupled with some possible flattening out of referral numbers, may signal a need to reassess the entry criteria in the light of the size and characteristics of the pool of young offenders in the Hamilton area.

- The treatment model requires skilled, experienced, committed staff members who have the professional orientation to work in a clinical and bicultural context. Given that ecological[1] programmes like Te Hurihanga are relatively new to New Zealand, and bicultural programmes are still rare, the pool of people who already have the skills and experiences needed is very small. Nevertheless, Te Hurihanga has, over time, successfully built a competent team through its recruitment, training and supervision policies and practices.

- Achieving positive change in young people with the offending histories typical of the Te Hurihanga entrants is extremely difficult. Results provide a consistent picture of individual improvements across the range of areas; widespread stakeholder and family/whaanau confidence in the Te Hurihanga team and the programme; and family/whaanau support for continued support and skill development. Stakeholders generally believed that Te Hurihanga is well placed to continue achieving positive outcomes for the young people although it is still too early to make any definitive judgements about achievements in the medium and long term. Monitoring of ultimate outcomes is needed in the next two years.

- This evaluation has shown that Youth Horizons (YHT) is competently delivering the programme. It is effectively delivering a community-based residential programme with well embedded cultural and therapeutic dimensions. The programme has established effective relationships with Maaori agencies to assist with Maaori young people, and their whaanau or caregivers.

[1] Ecological approaches to addressing an individual's inappropriate behaviours recognise that the determinants of those behaviours are complex and multi-layered. They relate not only to an individual's characteristics but to the environments in which an individual operates: the family, their neighbourhoods, their schools and their network of friends and associates. That is, in the individual's 'ecological system'. Ecological treatment models attempt to provide a holistic approach to adjusting not only an individual's behaviour but also the way in which the individual relates to others and the way in which others relate to the individual. MST is one of many ecological approaches, another is the Ecological Systems Theory (Brofenbrenner, 1979).

- The Multi-Disciplinary Team is a key component of programme delivery. Their skills, professionalism and attention to programme capability and capacity building are respected by the range of external stakeholders.

- There is always scope to improve practice. The providers have already made changes to the treatment model, specifically by adapting the points system and reconfiguring the culture-specific roles.

- The current treatment model is aligned with ecological approaches used in New Zealand and internationally. The Te Hurihanga team, supported by the wider Youth Horizons Trust infrastructure, has the necessary foundations, including practice ideals, professional acumen, experience and support from stakeholders to continue strengthening the treatment focus.

- The bicultural dimensions of the programme, including the involvement of a Kaumaatua, and the work of the Whaanau Worker and Kaitakawaenga Rangatahi, are essential to family/whaanau engagement with the programme both initially and throughout each phase.

- The perceived quality of family/whaanau responsiveness to the treatment model and their overall satisfaction with their involvement in the programme together provide a sound basis for maintaining and building on the family therapy component to the programme.

- There is some value in consolidating the best practice developed within the programme. Te Hurihanga has provided an opportunity to establish a team with a core set of skills and experience to address the needs of young offenders through a therapeutic, residential programme. There is considerable scope to use the team's expertise more widely to develop best practice in services targeting high risk young people.

1 Introduction

This evaluation report provides the Ministry of Justice with findings from a two-year evaluation that began late June 2007 and was completed in August 2009.

Te Hurihanga (The Turning Point) is a Ministry of Justice response to the problem of youth offending. It is a three-year pilot that reflects concerns raised about a perceived increase in the level of youth offending (including the level of youth violence) and lack of suitable options open to the judiciary when dealing with some young offenders. The rehabilitative programme aims to fill a gap in residential programmes that are available for young males who are either recidivist and/or serious offenders and are at risk of continuing to offend in their adulthood. The programme aims to reintegrate young males who offend back into their whaanau and communities, after an intensive period of tailored and specialist intervention designed to move them off a high risk path to future imprisonment.

Trends of concern in youth offending are:

- an absolute rise in the numbers of youth offenders
- an increase in adolescent violent apprehensions,[2] although the rate has remained at around 10 percent of all violent apprehensions for some years
- an over-representation of adolescent Maaori in the criminal justice system
- an over-representation of Pacific Island adolescents committing violent offences.

Although there has been an increase in the absolute number of youth offenders (given a population increase) youth apprehension rates declined over the 1995 to 2007 period. In 2006 and 2007 youth apprehension rates were lowest since 1995. In 2007, the rate for young people aged 14–16 years was 1,540 per 10,000. In 2007, 60.2 percent of youth apprehensions were for property offences. However, youth apprehension rates for violent offences generally trended upwards from 1995 to 2007 (Ministry of Justice, 2009). Apprehensions in the 14–16 years population group account for more than 70 percent of all youth apprehensions.

The judiciary and young offenders' families need a range of treatment and sentencing options available to them to address the needs of young people. High-risk adolescent offenders exhibit antisocial behaviours from early childhood and typically have personal, social and family characteristics that identify them as at high risk of progressing towards chronic adult offending. Te Hurihanga provides an option to help young people get off their high-risk path. The Programme is consistent with the Youth Offending Strategy (2002), which called for initiatives across different sectors to adopt a more focused, coordinated and collective approach to addressing youth offending.

[2] As noted in Crawford and Kennedy (2008:8), it is still unclear whether the increase "has been caused by an increase in actual offending, a change in public reporting of violence and the focus of policing, changes in Police recording practices, or a combination of these".

The focus of this programme is to encourage young people to turn their lives around. Before entering Te Hurihanga the programme participants may have been on their way to prison. However, after successful completion of the programme, they will have skills, knowledge and experience alongside a stable external environment that will help promote and maintain a more positive offence-free future.

Te Hurihanga is located in Hamilton's Te Ara Hou Village, the location of a range of social services and facilities. The programme operates out of a facility specifically designed for the programme. The facility includes the residence, which has the appearance of a family home, and a wharenui. The residence has eight lockable bedrooms, a kitchen, a classroom, a craft-room, a time-out room, some common living space, ablution facilities, and staff facilities. These include an observation area, two offices and a room for one-on-one and group therapy sessions. There is also some fenced outside space, including garden areas. A one-bedroom flat for house parents is also located within the residential building. The Programme Manager and administrative staff are located in offices elsewhere in the Te Ara Hou Village.

The programme is funded by the Ministry of Justice and delivered by Youth Horizons Trust and Raukura Waikato Social Services (a local Kaupapa Maaori provider). There is a strong relationship with the other youth justice agencies in the Waikato area. This programme is both residential and community-based and takes nine to eighteen months to complete.

1.1 Background to the programme

Early lobbying for Te Hurihanga came from a Youth Court judge, facilitated by some initial seeding money from the Warehouse founder. The Ministry of Justice picked up the project in 2002, after some initial development work had taken place, including some general scoping of the treatment model based on international best practice. The initiative reflected longstanding concern about limited sentencing options in the Youth Court by the judiciary, including concern about the negative effects of residential youth justice facilities.

1.2 Entry criteria

To enter the programme, each young male offender has to meet certain criteria including that he:

- has been assessed as having a high risk of recidivism
- is aged between 14 and 16 years (upon starting Phase 1)
- is located within sixty minutes drive of Hamilton
- has appeared before either the Youth Court or the District Court
- is sufficiently motivated (as they can withdraw) to complete the programme
- has a whaanau member or caregiver prepared to be a main support line
- has a level of intellectual ability able to benefit from particular models of treatment offered.

Those who have unstable mental conditions, co-offenders/co-associates on the programme or have been charged with serious violent offences (eg, murder or manslaughter) or sexual offences will not be considered for participation in the programme.

At the end of data collection for the evaluation (16 June 2009) seventeen young people had participated in the programme. As Table 1.1 shows, eight were currently on the programme, four had completed the programme, and five had exited early.[3]

Table 1.1: Status of programme participants at 16 June 2009

Current status	Number
Phase 1	1
Phase 2	3
Phase 3	4
Completed	4
Exited early	5
Total	*17*

1.3 Evaluation approach

1.3.1 Goals and objectives

The general goal of the evaluation is to provide information to the Ministry of Justice regarding the effectiveness of the Te Hurihanga Programme and the extent to which it is achieving positive outcomes for the young male participants. Because it is a pilot, the programme is continuously evolving. This evaluation is intended to provide part of the evidence base for informed adaptations and improvements.

1.3.2 Data collection methods

Data collection methods included focus groups, interviews, case file reviews, literature review, observation, consultation and data analysis. These are described in brief below and in more detail in Appendix 1.

Focus groups with:

- Te Hurihanga staff on a six-monthly basis: including the Management Team, the Residential Team, the Multi-Disciplinary Team (MDT) or Clinical Team and the Multi-Systemic Therapy (MST) Team
- Stakeholders, including youth aid officers, CYF social workers and community groups.

[3] Reasons for early exits are discussed in Section 5.2.

Interviews with:

- Youth Horizons Trust and Te Hurihanga staff including: the Youth Horizons Clinical Director, the Te Hurihanga Programme Manager, Kaumaatua, Clinical Leader, Residential Manager, and individual clinical and residential staff, and Raukura Waikato Social Services personnel
- The young people on the programme, on a six-monthly basis
- Family/whaanau members, on a six-monthly basis where possible
- Ministry of Justice personnel (including advisors)
- Stakeholders, including judges, youth advocates, social workers, training providers, education providers, youth aid officers.

Case file reviews using a purpose-developed case review schedule (attached as Appendix 4).

Reviews of key literature and programme documentation:

- Te Hurihanga Therapeutic Programme, the programme kete, including amendments
- Literature on offending and treatment options.

Observation:

- Therapeutic team supervision sessions
- Staff/programme participant interactions.

Data collection and analysis:

- Te Hurihanga administrative data
- Police offending data.

1.3.3 Limitations to the evaluation

Limitations to the evaluation relate to the number of young people on the programme, the number of young people who had completed the programme and difficulties in accessing some key informants.

Over the evaluation duration, seventeen young people had entered the programme. However, as two had early exited before the fieldwork began, only fifteen young people could be interviewed as part of the evaluation. As described in Appendix 1, the number of times each young person was interviewed depended on the scheduling of the fieldwork. One young person was interviewed three times, but the majority were interviewed twice. Those who entered the programme after November 2008 were interviewed once only.

Follow-up of programme graduates was not possible. Only four of the young people had completed the programme at the completion of the evaluation. Another was due to graduate soon after the evaluation completion. This small number of graduates is largely explained by the duration of the treatment

programme (up to 18 months). The early exit of the first two participants is also a contributing factor. Three of the programme graduates had completed the programme six months before the end of the evaluation and one had completed only a month beforehand.

Organising interviews with whaanau, was sometimes difficult, despite their general willingness to participate, and considerable help from Te Hurihanga staff. The reasons for these difficulties give some insight into the family circumstances. It was difficult to contact some whaanau members to organise interviews as they lacked a telephone connection or shared a cellphone with other whaanau members. A number of whaanau members either could not find a time to be interviewed, had to reschedule interviews or had to abandon scheduled interviews because of their own illness or that of family members (often these illnesses were serious). In one or two cases, whaanau were incarcerated and could not be interviewed. On two occasions, the whaanau member was not home for a scheduled interview – and on one occasion rescheduling the interview proved impossible. Two whaanau effectively refused to be interviewed, in one case directly and in another by not answering calls or responding to messages.

1.4 Report structure

The report is structured as follows:

- Section 2 focuses on the client group and treatment models. It provides a summary of literature that places Te Hurihanga in the wider context of best practice internationally for young offenders.

- Section 3 describes the Te Hurihanga treatment model, specifically: the programme objectives and entry criteria; the structure of the programme; the therapeutic framework; the programme's bicultural dimension; the entry pathway; and the assessment process.

- Section 4 focuses on programme delivery, specifically: the referral and admission process; programme targeting, occupancy and client flow; young people's progression through the treatment programme; the bicultural character of the programme; the therapeutic teams; family/whaanau engagement with and involvement in the programme; and the points system.

- Section 5 summarises intermediate outcomes gained. It provides a profile of the young people on the programme and their achievement of intermediate outcomes relating to family/whaanau circumstances; educational/vocational progress; peer relations; substance abuse; leisure and recreation activities; personality/behaviour; attitudes/orientation; cultural identity; identity development; mental health / safety and physical health issues; and development of life skills. It also provides some insight into the young people's preintake and (for some) within-programme offending.

- The final section provides a brief overview of the key findings and conclusions that can be drawn from the evaluation.

2 The client group and treatment models

2.1 Severe conduct disorder behaviours and risk factors

This section of the evaluation report places Te Hurihanga in the wider context of best practice internationally for young offenders. There is considerable overlap in treatment approaches for young offenders and young people with conduct disorder. This is because there is a considerable overlap in the populations of youth offenders and conduct-disordered young people (Liabo and Richardson, 2007). The characteristics of the Te Hurihanga participants bear this out. As Table 5.5 (in Section 5) shows, all the young people who had entered the programme during the evaluation period met conduct disorder or severe conduct disorder criteria. That is, they displayed repetitive and persistent patterns of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviours include the following:[4]

i. aggressive conduct that causes or threatens physical harm to other people or animals
ii. non-aggressive conduct that causes property loss or damage
iii. deceitfulness or theft
iv. serious violation of rules.

Young people with conduct disorder often have other coexisting (or comorbid) psychiatric and other conditions such as Attention Deficit Hyperactivity Disorder (ADHD), substance abuse and depression. As Table 5.5 shows, the Te Hurihanga participants also typically had coexisting conditions. All but two of the young people had a history of drugs and/or alcohol misuse, almost one in two had ADHD and almost one in two came to the programme with previous suicide ideation/intent or attempts.

It is because of the overlap in the populations of young offenders and young people with conduct disorders that overviews of treatment options for young offenders turn to treatment options for those with conduct disorders (eg, Liabo and Richardson, 2007). Research indicates that the development of conduct disorder leading to offending is caused by a complex interaction between individual, parent and family, peer, school and community factors. Table 2.1 contains a summary list of identified factors across these four groups.

[4] These behaviour groups are identified by the American Psychiatric Association's diagnostic guidelines, the DSM-IV-TR, for the diagnosis of conduct disorder.

Table 2.1: Risk factors

Individual factors	Parent and family factors	Peer factors	School and community factors
▪ Coexisting psychiatric conditions (ADHD, substance abuse, depression) ▪ Poor social skills ▪ Low intellectual functioning and academic achievement ▪ Favourable attitudes toward antisocial behaviour ▪ A cognitive bias to attribute hostile intentions in others	▪ Lack of parental monitoring ▪ Inept discipline ▪ Maltreatment ▪ Parent psychopathology (substance abuse, psychiatric conditions, criminal behaviour) ▪ Low warmth and family cohesion	▪ Association with deviant peers ▪ Poor relationship skills	▪ Poor living conditions ▪ Disadvantaged school setting ▪ A dangerous neighbourhood

2.2 Treatment options

The most effective treatment options reflect the multiplicity of risk factors that underpin delinquent behaviour. Treatment is difficult (Curtis et al, 2004; Advisory Group on Conduct Problems, 2009). After antisocial behaviour has become established it is very resistant to change, as demonstrated by the high recidivism rates of juvenile delinquents and the failure of most interventions to maintain change (Brunk, 2000).

Reviews of youth interventions (Kazdin, 1997; Woolfenden et al, 2002; Advisory Group on Conduct Problems, 2009) identify promising treatments that met strict criteria for effectiveness. What links these treatments is their broadly ecological approach, which addresses the entire social context within which the young people live. That is, they address the individual, parent and family, peer, and school and community factors that contribute to their behavioural patterns. According to Brunk (2000), interventions are most likely to be effective if they are individualised and address all the factors that contribute to the youth's delinquency, are strongly family-based and delivered in the community. The Advisory Group on Conduct Problems (2009) also notes that interventions with adolescents tend to be intensive, expensive and less effective than interventions with younger children. Among the most effective treatment options for young offenders and others with conduct problems are Multi-Systemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC), Functional Family Therapy (FFT), and Cognitive Behaviour Therapy (CBT). Further details are provided in Appendix 2.

2.3 Lessons for treatment best practice

Comparative analysis of treatment best practice across a range of ecological approaches (particularly drawing on MST and MTFC practice) provides the following principles of best practice for treatment interventions targeted at young delinquents.

- Intensive treatment interventions are tailored to the specific needs of youth and family after extensive assessment of the systems contributing to antisocial behaviour.
- Progress towards outcomes for youth and family/caregivers is monitored closely.
- Families/caregivers are full collaborators in treatment planning and delivery. The treatment team are responsible for engaging families in this process.
- Treatments seek to empower family/caregivers with skills and resources to address the difficulties that arise in raising youth. These are provided through interventions such as family therapy, parent-management training, and problem-solving skills training.
- Treatments seek to empower youth to cope with family, peer, school, and neighbourhood problems. A positive and predictable environment is set up (eg, in own home, foster home, or family home setting) through a structured behaviour management system with predictable consequences. Positive behaviour is encouraged through frequent reinforcement, and negative behaviour is discouraged through predictable consequences.
- School engagement and academic performance is encouraged and supported.
- The treatment team's adherence to the intervention model and treatment principles is critical and promoted via systematic quality assurance procedures including training and supervision.
- Members of the treatment team represent a range of skills and also coordinate access to other services (eg, medical, educational and recreational services).
- Cultural fit is key to increasing the success of interventions. Thus, therapists require dual clinical and cultural competencies (Te Roopu Kaitiaki reporting in the Advisory Group on Conduct Problems, 2009).

The next section of this report describes the Te Hurihanga treatment model, which is consistent with the lessons of best practice listed above. The programme provides the basis for: building positive relationships with the young people; implementing motivational interventions with them and their family/whaanau; implementing structured, well-designed behaviour management systems; and delivering an educational programme in a culturally responsive way. There are also individual and group therapy (including CBT), skills development, vocational/employment training, and recreational activities.

3 The Te Hurihanga treatment model

3.1 Programme objectives and entry criteria

Te Hurihanga is a 9 to 18 month therapeutic programme for young males (and their whaanau) aged 14 to 16 years who have appeared before the courts and who live within the Hamilton/Waikato region. Its objectives are to:

- reduce re-offending
- hold young people accountable for their offending
- provide tailored, specialist support to young people and their families so they can make positive choices rather then continue on current (offending) pathway towards prison.

Thus, through the three-phased[5] treatment programme, it is intended that the young people will graduate from the programme well resourced to make prosocial choices and reduce frequency and severity of future offending, and their families/whaanau will have increased skills in supporting their young person sustain a prosocial lifestyle.

The programme is designed to be bicultural. That is, it is designed to be delivered in a context of care, aroha, manaakitanga, wairuatanga and whanaungatanga. It is also designed to be community-focused. That is, it is designed to be delivered in a context of care and reciprocal commitment between the programme, young people, their families, natural community networks and professional stakeholders.

The admission criteria reflect the focus of the programme on young people at risk of offending into their adulthood. The young people are eligible if they are:

- males aged 14 to 16 years
- appeared before the Youth or District Court and assessed to be at high risk for recidivism (offence risk is defined by likelihood of reoccurrence rather than severity of individual offences)
- whaanau live within 60 minutes of the residence with designated family/whaanau member committed to support role for youth for duration of the programme
- youth (and family) sufficiently motivated to participate in the programme.

[5] As described in Section 3, each lasts 3 to 6 months depending on the needs and progress of the individual young people. In Phase 1 the young people stay in the residence and attend school. In Phase 2, they transition into school, training or employment in the community while living in the residence. In Phase 3, they live with their family/whaanau, who are supported through MST and, from late 2009, Functional Family Therapy.

Young people are excluded if they:

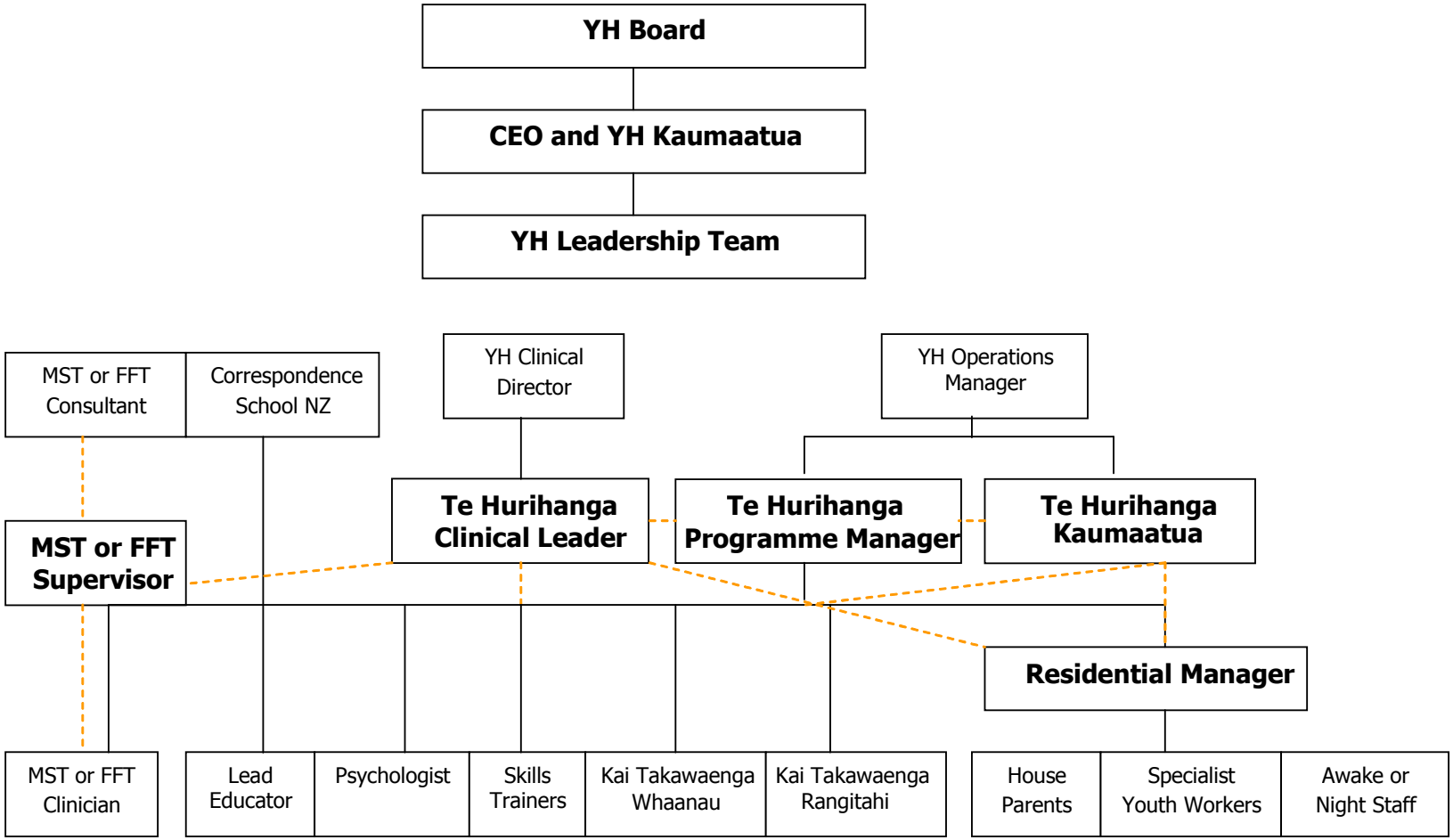
- have committed sex offences, murder, or manslaughter
- pose such significant risk to self or others or threaten to undermine security and safety of the facility, young people, staff or community
- have an unstable medical condition, intellectual disability or psychiatric condition which prevents meaningful engagement and completion of the programme
- lack a designated caregiver/whaanau member (within the region) who has committed to acting in a parental/support role for duration of the programme
- have co-offenders (current or past) or close criminal associates on the programme.

3.2 Structure of the programme

The Te Hurihanga programme is one of several programmes provided by the Youth Horizons Trust. The programme is delivered by three integrated therapeutic teams: a Multi-Disciplinary (or clinical) Team, a Residential Team, and a Multi-Systemic Therapy team (to be replaced by a Functional Family Therapy Team). As shown in Section 3.3 those therapeutic teams have some common members. The teams and the Programme Manager and Kaumaatua are located within the wider Youth Horizons Trust organisational structure. This organisational structure includes a Youth Horizons Clinical Director and Operations Manager, above which are the Youth Horizons Leadership Team, Chief Executive Officer and Kaumaatua, and the Youth Horizons Board. The Correspondence School, which oversees the school unit, and the MST Consultant, who oversees the MST Team, sit outside the Youth Horizons structure. These relationships are presented in Figure 3.1.

Te Hurihanga consists of three phases which each take three to six months to complete. These include a residential phase, a transition phase and a community phase. The first two phases are set in a residential facility located within close proximity to the young person's community. The residence was built to replicate a home environment as much as possible. During the residential phase the young people are taught to live with routines, structure and consistency, and experience rules and consequences of their behaviour. The young people learn about working and living respectfully alongside others and are supported to develop self-awareness and self-regulatory skills. They are taught about their cultural background and heritage. They re-engage with schooling and participate in a wide variety of cultural, educational and physical experiences and challenges. They are supported to develop confidence and explore a wide variety of recreational, educational and/or occupational possibilities.

Figure 3.1: Te Hurihanga organisational structure[6]



[6] This Figure is adapted from a figure in the latest version of *Te Hurihanga Therapeutic Programme*, the programme Kete.

3.2.1 Phase 1 – Residential

Young people remain in the residential phase for three to six months. There are no more than eight young people in the residential and transition phases combined. They live at the Te Hurihanga residence seven days per week. During this phase participants are monitored by residential staff twenty-four hours a day, seven days a week. The residential phase focuses on engagement, stabilisation, motivation, education, cultural confidence and skill acquisition. It also focuses on keeping family involved in the programme, increasing their knowledge about interventions being used in the programme, assisting them stay connected to, or increasing their connection with, their son and supporting them to consider their own parenting practices. Tikanga Maaori values and practices are woven through all aspects of the programme. These include aroha, wairuatanga, maanakitanga, and whanaungatanga.

On-site activities include education and therapy treatment. During this phase the young person participates in a comprehensive assessment from which individual goals are set. Intended outcomes for this phase focus on the young people (i) becoming engaged in the programme, (ii) becoming motivated to address their identified risks and (iii) working towards developing their individual goals for Phases 2 and 3.

3.2.2 Phase 2 – Transition

When the young people reach this phase they will be able to gradually integrate back into the community through community-based education, courses, work experience and overnight/weekend stays in their home environment. Phase 2 experiences are different for each young person and are determined by his individual situation, goals, aspirations, potential, community options, and the supported decisions that he makes. During this phase, the young people will not have the same level of supervision as Phase 1. However the level of supervision and support will remain high initially with a gradual reduction over the phase. It is expected that, to begin with, the young people will continue to live at the residence, and they will begin community-based activities; for example, attending a school close to their home or, beginning work experience. After the young person has settled into community-based activities, they will gradually move from the residence back into their own home. This is also a good opportunity for the participants and providers to see where individuals may need extra support.

The intended outcomes for Phase 3 provide the basis for the young people to achieve the ultimate outcome, to reduce the rate and severity of offending. Intermediate outcomes include the following:

- Young people make a successful transition from living at Te Hurihanga residence to living at home with their family.

- Young people are productively engaged in either full-time employment, or training, or attending either secondary or tertiary education.
- Young people are engaged in pro-social, -recreation, -leisure activities, and -peer relationships in the community.
- Young people demonstrate increased confidence in life and self-management skills.
- Families of the young people are able to support pro-social behaviour by providing appropriate expectations, boundaries, consequences, and support to their young person.
- Families are engaged with the programme and other stakeholders, eg, Child Youth and Family Services (CYF) and Police Youth Aid, and other community supports, eg, community centres, sports clubs, Housing New Zealand, Child and Adolescent Mental Health Services (CAMHS), Work and Income New Zealand, recruitment agencies, and other natural support networks.

3.2.3 Phase 3 – Community

During Phases 1 and 2 Te Hurihanga staff started to work with whaanau to provide them with skills and resources to enable them to support the young person during Phase 3. This is the final phase where the young person is back in the community and living full-time with their family, caregiver or sometimes independently. A Multi-Systematic Treatment (MST)[7] model, described in more detail in the following section, provides support to the families and young people to ensure they are capable of dealing with any challenging behaviours and can maintain what they have learnt from Phases 1 and 2 of the programme. The focus of Phase 3 is to ensure parents and other family are well supported to sustain a high level of supervision, accountability, behavioural expectations and appropriate parenting responses.

3.3 Therapeutic framework

It is intended that staff build on youth competencies and strengths in a culturally responsive way through:

- building positive relationships with the young people
- implementing motivational interventions with them and their family/whaanau
- modeling pro-social behaviours, values and attitudes
- implementing structured, well-designed behaviour management systems (eg, the points system)
- delivering an educational programme.

[7] MST is to be replaced by Functional Family Therapy in late 2009 or early 2010.

There are also individual and group therapy, skills development, vocational/ employment training, and recreational activities.

The Te Hurihanga programme has three integrated therapeutic teams:

- Residential Team
- Multi-Disciplinary (or clinical) Team
- Multi-Systemic Therapy (MST) team. This team is to be replaced by a Functional Family Therapy Team (FFT).

During Phases 1 and 2, interventions are delivered by the Residential Team and the Multi-Disciplinary Team.

The Residential Team comprises:

- Programme Manager (operational oversight of programme)
- Clinical Leader (clinical oversight of programme)
- Kaumaatua (cultural oversight of programme)
- Residential Manager (operational oversight of residential team)
- House Parents
- Specialist Youth Workers (Permanent and Causal)
- Awake (or Night) Staff.

The Multi-Disciplinary Team (MDT) or Clinical Team comprises:

- Programme Manager (operational oversight of MDT)
- Clinical Leader (clinical oversight of MDT)
- Kaumaatua (cultural oversight of programme)
- Programme Psychologist
- Educator
- Skills Trainers (2–3)
- Kaitakawaenga Whaanau
- Residential Manager
- Kaitakawaenga Rangatahi.

During Phase 3, intervention is delivered by the MST team (to be replaced by the FFT Team). The Multi-Systemic Therapy (MST) Team comprises:

- MST Clinician
- MST Supervisor
- MST Consultant
- Te Hurihanga Clinical Leader.

The Functional Family Therapy (FFT) Team will comprise:

- FFT Clinician
- FFT Consultant
- THH Clinical Leader.

The therapeutic framework within which these three teams carry out their prescribed roles is structured around the following treatment models:

- Risk, Needs, Responsivity Model
- The Good Lives Model: Adapted to Adolescents
- Education, Psycho-education, and Cognitive Behaviour Therapy
- Individual and Group Therapy
- Behaviour Theory and Therapy (Based Upon Operant Learning Principles)
- Social Learning Theory and Therapy
- Relapse Prevention Model
- Parenting and Family Therapy Interventions
- Multi-Systemic Therapy Model and, in the future, Functional Family Therapy.

These are described in summary below and in more detail in *Te Hurihanga Therapeutic Programme*, the programme Kete.

- **Risk, Needs, Responsivity Model** (RNR) is based on three principles, including:
  - risk principle – highly resourced interventions should be delivered to high risk offenders
  - needs principle – identification and targeting the individual and systemic risk factors directly relating to crime (ie, criminogenic needs are differentiated from non-criminogenic needs[8])
  - responsivity principle (potential barriers to successful treatment are identified and targeted).

- **The Good Lives Model (Adapted to Adolescents)** is a holistic and strengths-based model that complements and builds on the Risk-Needs-Responsivity Model. It focuses on the development of 'approach goals' and supporting young offenders to meet basic human needs pro-socially. These basic needs, adapted to adolescents, include: Self Control; Doing Well; Being Well; Spirituality; Friendships; Whaanau; and Community.

- In **Education, Psycho-education, and Cognitive Behaviour Therapy**, the educator delivers the school programme, the Kaumaatua delivers cultural classes, and the programme psychologist delivers psycho-education or group therapy classes. Topics covered in group therapy include family relationships and parenting practice, past offending, the influence of peers, leisure and recreation activities, the importance of education and employment, behavioural and personality factors, relationship skills, and attitudes and beliefs.

[8] Criminogenic (crime related) needs relate to: family/whaanau circumstance; educational/vocational progress; peer relations; substance abuse; leisure and recreation activities; personality/behaviour; and attitudes/orientation. Non-criminogenic (non-crime related) needs relate to: cultural identity; identity development; mental health / safety and physical health issues; and development of life skills.

- **Individual and Group Therapy,** facilitated by the programme psychologist, focuses on assisting the young person develop a range of self-regulatory skills (including problem solving, distress tolerance, aggression control, offence mapping, and relapse prevention/safety planning). Cognitive-behavioural intervention (CBT) is employed in individual sessions with the psychologist.

- **Behaviour Theory and Therapy** (Based on Operant Learning Principles) focuses on strengthening or weakening a young person's behaviours by what occurs after the behaviour. Mechanisms used include: positive reinforcement, differential reinforcement, negative reinforcement, response cost, punishment (via consistent judicial consequences) and positive role-modelling.

- **Social Learning Theory and Therapy** proposes that behaviour patterns are developed through the continuous and reciprocal interplay between the individual and his/her environment and the resulting differential reinforcement, vicarious learning and modelling opportunities this creates. Appropriate staff modelling and reinforcement and shaping of appropriate client behaviours is a core programme intervention.

- **Relapse Prevention Model** is a self-management model, enabling the young people to (i) recognise the sequences of thoughts, feelings and behaviours that increase the risk of engaging in offending and (ii) develop skills to interrupt these sequences in order to avoid increasing risk.

- **Parenting and Family Therapy Interventions** incorporate aspects of social learning principles, behaviour theory, and systems theory to target parental modelling, behaviour management contingencies (house rules, disciplinary practices, and consistency), parental monitoring, parent–child attachment, appropriate parental expectations and family relationship dynamics. A whaanau worker is involved in engaging and working therapeutically with the family/whaanau in Phases 1 and 2 and supports the family's transition to, and engagement with, an MST Clinician in Phase 3.

- **Multi-Systemic Therapy Model** (MST), incorporating aspects of systems theory and social-ecological models, is based on the understanding that problem behaviour is multidetermined, and occurs across multiple contexts/settings. It targets known causes of youth offending.

3.4 Bicultural dimension

Te Hurihanga is a bicultural programme designed to be culturally responsive. To ensure cultural responsiveness, there are cultural specific positions, including a Kaumaatua; a Kaitakawaenga Rangatahi, and Kaitakawaenga Whaanau. The programme works in partnership with Raukura Waikato. During 2009, the configuration of these positions was altered. When the programme started, each of the Kaumaatua and Kaitakawaenga Rangatahi positions was a half-time position shared by one person. Given the scope of the Kaumaatua role, both within Te Hurihanga and within Youth Horizons Trust as a whole, the Kaumaatua position

was extended to a full-time position and a new person was appointed to the part-time Kaitakawaenga Rangatahi position. Cultural responsiveness is to be promoted through a cultural–clinical interface, embedding cultural values in the treatment programme and strengthening the young people's cultural identity and whaanau and hapuu links.

Tikanga Maaori concepts and values are woven throughout all aspects of the programme. The values and practices of manaakitanga, wairuatanga, whaanaungatanga, and aroha are foundation principles of the programme and underlie and inform the kaupapa and practices of the treatment programme. These values and practices align with the therapeutic framework, as described in Section 3.3. It particularly aligns with the Good Lives Model, but also with the Parenting and Family Therapy Interventions, the Multi-Systemic Therapy Model and Functional Family Therapy models.

The Good Lives Model, Adapted to Adolescents, takes a holistic approach to young people's wellbeing by equipping them with *primary human goods* to live more fulfilling lives. These goods, which align with the intermediate outcomes discussed in Section 3.2, include the following:

- Self Control: Self-directedness, autonomy, emotional regulation, happiness/pleasure
- Doing Well: Work, play, creativity, knowledge
- Being Well: Healthy living and functioning
- Spirituality: Having meaning/ purpose in life
- Friendships: Peer attachments
- Whaanau: Kin attachments
- Community: Societal/cultural belonging.

The delivery of the cultural dimensions of the programme includes the following:

- Assessing the cultural needs of each young person, through a structured cultural assessment process that focuses on turangawaewae, whaanau oranga, mana reo, and wairuatanga. It focuses on the young people's:
  - personal cultural affiliation (ie, self-described ethnicity);
  - identification of cultural knowledge and participation, including:
    - knowledge of te reo;
    - knowledge and identification of whakapapa and iwi/hapuu affiliations
    - knowledge of tikanga and kawa
    - knowledge of, and contact with, whenua and marae
    - engagement in cultural activities.

- Creating a culturally safe and respectful experience for the young person and his whaanau while they participate in the programme.

- Identifying and targeting potential barriers to successful treatment, including cultural values and practices.

- Embedding cultural values in the programme.

- Strengthening young people's cultural identity and whaanau links through a focus on the cultural backgrounds of each of the young people, skills enhancement through the kura and workshops, visits to local paa sites and noho marae.

Each phase of the programme is characterised by different activities carried out by various internal staff members and programme partners.

- During Phase 1, the young people are taught about their cultural background and heritage. They participate in a wide variety of cultural experiences to practice and embed cultural protocols. They are also supported to develop cultural confidence and skill acquisition. Activities include:
  - regular whakatau and poowhiri;
  - daily karakia and waiata;
  - learning pepeha;
  - dedicated cultural education classes in the school timetable;
  - educational trips with specific cultural focus;
  - kapa haka classes;
  - noho marae;
  - individual korero;
  - whaanau waananga.

- In Phase 2, the individual programmes are designed to reflect and promote engagement with cultural values and practices.

- In Phase 3, the programme Kaumaatua and/or Kaitakawaenga Rangatahi establishes and maintains cultural links and supports the young person as he reintegrates with his extended whaanau and hapuu.

The intended cultural outcomes of the programme are listed below. These have informed the measurement of intermediate outcomes achievement reported in Section 5 of this report. These outcomes are:

- increase cultural pride and belonging
- experience and knowledge of rituals and customs
- experience and knowledge of te reo
- knowledge of personal genealogy
- ability to state pepeha
- experience and knowledge of whakawhanaungatanga
- knowledge of marae and connection to whenua
- understanding of cultural values and morals
- young people having a stronger connection with their marae
- young people learning local history
- tamaiti and whaanau supported by Kaumaatua as needed
- whaanau supported to understand and be connected to programme.

3.5 Entry pathway

A young person is referred to the programme by Child, Youth and Family Services (CYF) through his Youth Justice Family Group Conference (FGC) coordinator or social worker. When a young person is apprehended for an offence the Police either: (i) signal an intention to lay changes and place referral for a pre-charge FGC before laying matters in Youth Court, or (ii) lay charges directly in the Youth Court. This leads to a defended hearing or an FGC. An FGC is called if charges are proved in a defended hearing or a young person does not deny the offence. The youth then reappears in court and the FGC plan is submitted for approval by the Youth Court judge. It is intended to hold the young offender accountable and encourage him to take responsibility for the offending behaviour.

Screening enquiries often come through from CYF FGC coordinators or social workers prior to FGCs. Also anyone attending an FGC can suggest a Te Hurihanga assessment as part of the plan. At this point, the processes of obtaining consent, referral, and assessment can take place. At the completion of the assessment process, a Te Hurihanga report is submitted to the Youth Court providing indication of whether a placement can be offered pending court approval. If the judge supports a Te Hurihanga placement then the young person is bailed to the Te Hurihanga programme.

If the young person's case was transferred to the District Court then the process of referral to the programme would vary from that described above, with a pathway through the District Court rather than through an FGC process. Through the District Court process, the judge could remand the young person and set bail conditions that require the young person to reside at and participate in the programme. If the young person did not comply with these bail conditions they could be discharged from the programme and an alternative sentencing/ conditions option imposed.

Once the young person starts the programme they will need to appear before the Youth Court or District Court judge at least every three months and/or to request approval of the court to proceed to the next phase of the programme. If they are progressing well then their bail or remand conditions are altered to allow movement onto the next phase. However, if the young person is not complying with the programme or lack of progress has been made during their time spent at Te Hurihanga then either of two options occur. Either programme progression is slowed or the young person may be exited from the programme via a reconvened FGC for development of an alternative plan and reappearance in the Youth Court for sentencing. If the young person successfully completes the Te Hurihanga programme, a reconvened FGC will occur to discuss final disposition of the offending for which the young person was bailed to the programme. FGC recommendations and a final Te Hurihanga discharge report will be submitted to the Court (with copies to CYF, Police, youth advocate) and the young person will then reappear in Youth Court (or District Court). The court has a range of sentencing options as provided under the Children, Young Persons and their Families Act 1989. If the youth completes the programme successfully then likely outcomes are either full admonishment or discharge without further sentencing. Some of the young people seemed to have some misunderstanding about programme outcomes.

Several expected their charges to be withdrawn. For instance, two or three referred to a 'clean slate' if they completed the programme.

By engaging in the Te Hurihanga programme it is expected that the young person will:

- have a more responsible attitude to offending such as feeling accountable, remorseful and/or wanting to make a new start
- have improved family/whaanau relationships and support
- be compliant with the sentencing conditions
- be engaged in prosocial activities like education, employment, cultural activities and recreation
- have a reduced risk of reoffending compared with preprogramme.

3.6 The assessment process

During the assessment process, the Te Hurihanga team gather sufficient information across the categories of Risk, Need (criminogenic and non-criminogenic), and Responsivity, to accurately assess suitability for the programme. It also includes a cultural assessment, including cultural affiliation, cultural knowledge and participation. The process for collecting the information is designed to:

- prepare the programme for the safe intake of the young person
- begin the engagement process with the young person, family and stakeholders
- ensure the family understand the purpose, culture, and mechanics of the programme
- ensure the family and young person have a clear understanding of the expectations of the programme and the obligations of all parties
- ensure the young person and his family experience increased hopefulness and motivation in relation to making changes and receiving support for change
- create awareness of severity of offending and other options available
- provide a basis for the young person and his whaanau/family to make an informed and consensual decision regarding participation or not in the programme.

Te Hurihanga staff members involved in the referral and assessment process include:

- Clinical Leader or delegated staff liaising with social worker, whaanau, and young person
- Clinical Leader and Whaanau Worker at any FGC or reconvened FGCs
- Clinical Leader, Psychologist, Kaumaatua, and Kaitakawhaenga Whaanau complete a multidisciplinary assessment and then submit a Te Hurihanga assessment report (signed by the assessment team) to the presiding judge (copies to CYF, the NZ Police, and the youth advocate)

- Psychologist, whaanau worker, and residential manager provide induction of young person and whaanau into Te Hurihanga.

Assessment following intake includes further educational, cognitive and mental health screening, via clinical interviewing and completion of relevant psychometrics.

4 Programme delivery

This section of the report describes the Te Hurihanga programme in practice, with reference to key aspects of programme delivery. Findings are based on interviews and focus groups with Te Hurihanga staff members and stakeholders (eg, Ministry of Justice, Child Youth and Family social workers, Police youth aid officers, the judiciary and other external stakeholders), interviews with the young people and their families/whaanau, analysis of programme and Ministry of Justice administrative data and review of relevant documents including the programme Kete. The key aspects of the programme addressed include the following:

- the referral and admission process
- programme targeting, occupancy and client flow
- young people's progression through the treatment programme
- bicultural character of the programme
- the therapeutic teams
- family/whaanau engagement with and involvement in the programme
- the points system.

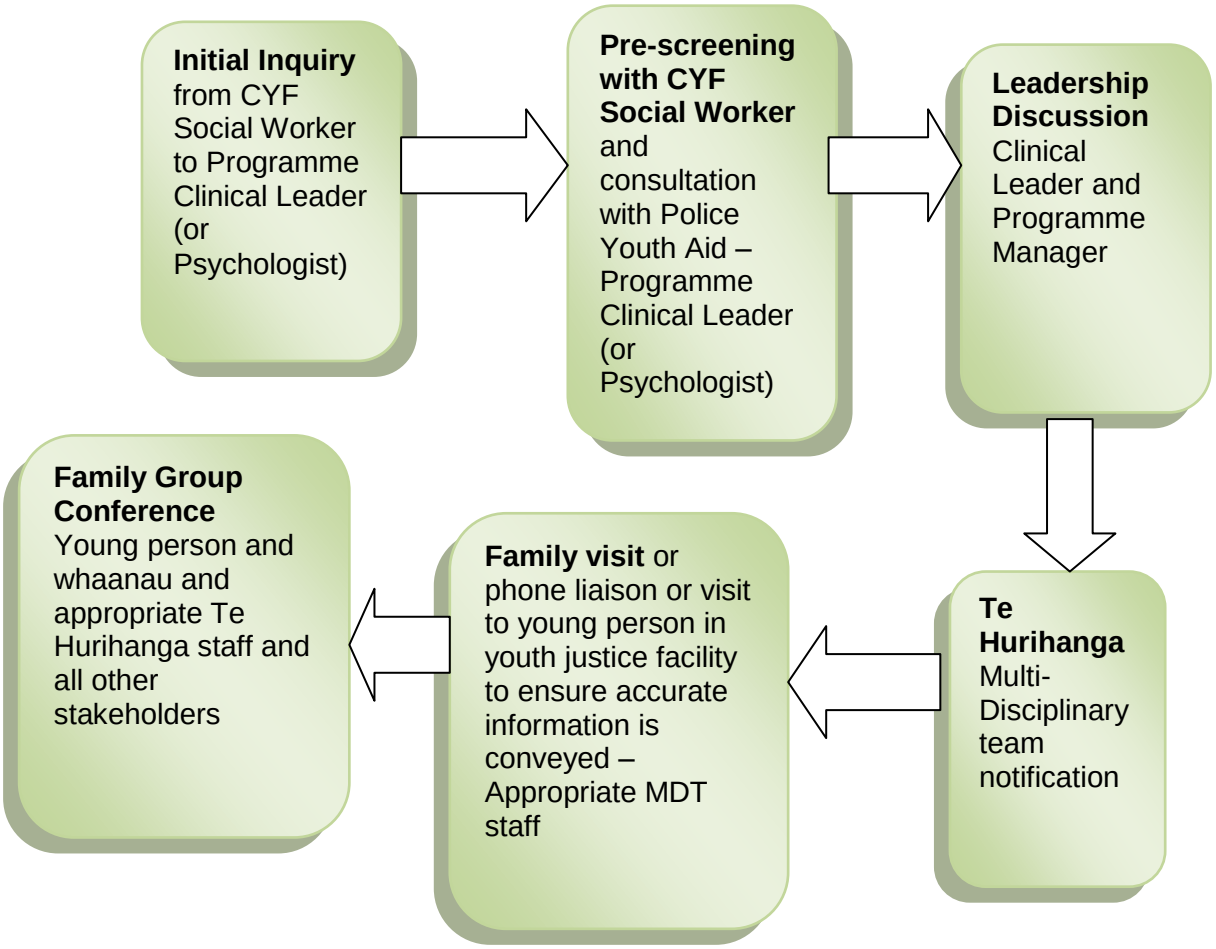
4.1 Referral and admission process

A young person's referral to Te Hurihanga is triggered by his offending behaviour and apprehension by the Police. At the apprehension stage, Police will either signal to a CYF Youth Justice Coordinator an intention to charge the young person or will directly lay charges in the Youth Court.

After being apprehended by Police, there are two possible intersecting referral and admission pathways for a young person to enter the Te Hurihanga programme. Family Group Conferences (FGCs) are integral to both these pathways and the timeframes within which they unfold are shaped by requirements set out in the Children, Young Persons and their Families Act, 1989. Notably, there are set time requirements within which FGCs must be convened and completed.

The referral process and the people involved are presented in Figure 4.1.

Figure 4.1: Te Hurihanga referral process and people involved



Source: Latest version of Te Hurihanga Therapeutic Programme, the programme Kete

4.1.1 Pathway One

Police signal an intention to lay charges to a Youth Justice Coordinator, which triggers the convening of a pre-charge FGC. In most cases, this will not be the first FGC that the young person has participated in (that is, for the young people who are likely to be referred to the programme, their past offending is likely to have already triggered FGCs). Sometimes, one or more of the FGC participants (eg, the Police, the CYF social worker or, in some cases, whaanau/family members) may suggest Te Hurihanga as a possible intervention before the FGC is held. As stakeholders have become more familiar with the programme, this early consideration of its suitability (or the suitability of the young person) is more common. For instance, it may be that the Police and/or CYF have informal discussions with Te Hurihanga at this stage to discuss issues such as eligibility or programme capacity. In these cases, the Youth Justice Coordinator may invite Te Hurihanga staff to attend this initial FGC to provide information or answer questions. Te Hurihanga personnel report that the earlier they are involved, the more likely the young people and their family/whaanau will respond positively and, when needed,

consent to assessments and admission and engage with the treatment programme. The strong interagency links between public and community sector youth service providers in the Hamilton area have provided an important foundation for these early discussions about the best intervention options. These early discussions, and their value, are less likely to be replicable in areas where strong interagency links are not evident.

There are three possible outcomes of this pre-charge FGC: no charge; the young person not denying the offending behaviour; or the young person denying the offending behaviour (in which case the FGC is adjourned). If there is no charge, the young person cannot be referred to the programme, regardless of their offending histories. The Police will lay charges in the Youth Court if the young person denies the offending behaviour or does not deny the offending behaviour. At this stage, Pathway One intercepts with Pathway Two.

One of the concerns raised about young people proceeding through the first pathway relates to the composition of the FGCs. For instance, youth advocates may not be present as they would not have been appointed at this stage. This means that the young person will not have legal representation present if the Te Hurihanga programme is first proposed. The role of the FGC Coordinator is to ensure alternative options are also proposed and understood by the young person and their family. During such an FGC, the young person and their whaanau are provided with information about the programme and given the option of participating in a Te Hurihanga assessment process. FGCs may need to be adjourned and charges laid so that the programme is discussed at a court-appointed FGC, where a youth advocate would be present.

4.1.2 Pathway Two

After the young person is apprehended, Police lay charges in the Youth Court (that is, they may not signal their intention to lay charges to the Youth Justice Coordinator). This response is more likely to occur if the offending is serious in nature.

If the Police lay charges, the young person appears in the Youth Court. Three outcomes are then possible – the charge is dismissed; the young person does not deny the charge (effectively admitting the behaviour); or there is a defended hearing during which the charge is dismissed or proven. If the offending is admitted or the charge is proven, a post-charge FGC is then convened.

During this post-charge FGC the possibility of Te Hurihanga can be raised by anyone involved in the FGC. In this second pathway to Te Hurihanga (that is where charges are directly laid in the Youth Court) the programme may not have been considered until after the young person's first appearance in the Youth Court. Again any participant in the FGC can raise the possibility of referring the young person to Te Hurihanga. If this possibility is raised before

the FGC occurs (and this is typically the case) then the Youth Justice Coordinator invites someone from Te Hurihanga to attend. As is the case in pre-charge FGCs, their presence helps with the consent and engagement process.

If circumstances signal that a young person might be eligible for the programme, the FGC is adjourned so that referral and assessment can occur. The young person and parents/caregivers consent is needed for referral and assessment to proceed.

The FGC is reconvened after the referral and assessment processes are completed. Te Hurihanga provides a summary of the outcomes of the assessment at the reconvened FGC. At this stage, the young person and their family/whaanau are advised whether a placement can be offered by Te Hurihanga (pending approval by the Youth Court or District Court judge). If supported by the FGC, then the Te Hurihanga programme is included as part of the FGC plan and presented to the Youth Court (along with a copy of the Te Hurihanga assessment report) for direction when the young person reappears.

Admission to the programme then depends on the Youth Court supporting the FGC plan and intake. Evidence suggests strong judicial support for the programme: the support expressed by judges for the concept of the programme and for the providers is reflected in their more or less universal support for FGC plans that include participation in Te Hurihanga.

If the Youth Court Judge supports an FGC plan that includes participation in Te Hurihanga, then the young person is placed on bail under Section 238(1)(b)[9] of the Child Youth and their Families Act 1989. Participation in the programme is one of the conditions of bail. These bail conditions necessarily change as the young person progresses through the programme. For instance, in the first two phases, conditions require living full-time (or part-time in the second transitional phase of the programme) at the Te Hurihanga residence. In the third phase, the young person is remanded at large, subject to the completion of the community phase and any other conditions set.

Young people's referral and admission to Te Hurihanga is regularly reviewed and endorsed by the Youth Court as the young people progress through the programme. The young people are required to reappear in court at key times, particularly when they complete different phases of the programme, to check their progress and to change bail conditions to reflect the requirements of the treatment programme. Sometimes their reappearance is triggered by their breaching of bail conditions (eg, absconding, not making progress) and may result in these conditions being altered or, very rarely, their being exited from the programme.

[9] Section 238: Custody of child or young person pending hearing
1) Where a child or young person appears before a Youth Court, the Court shall –
(b) release the child or young person or bail.

4.1.3 Views on referral and admission process

In general, Te Hurihanga staff members, the referral agencies and family/whaanau reported that the referral and admission process ran reasonably smoothly. When issues were raised, they related to the difficulties referral agencies sometimes faced getting the young people and/or their families/whaanau to agree to participate in the programme and difficulties keeping the programme 'at the front of the mind' of referral agencies.

Most young people and their whaanau have been motivated to consent to participate in the programme because it provides an opportunity for the young person to avoid a residential sentence. And the young people themselves were often under a misconception that successful completion of the programme would allow them to start again with a clean record. They used terms like "clean the slate" to describe this expectation. However, as the programme has developed and become better known in their communities, whaanau members have also reported being interested in the programme because of its positive influence on young people's behaviour.

Sometimes, whaanau/families were reluctant to commit to a programme for up to eighteen months. For instance, one mother reported she was very reluctant to agree to participate because she felt it was too long for both her son and for the whaanau. In that case, her son was highly motivated and talked her into it. In other cases, it was the young people who were reluctant, and whaanau who encouraged them to participate because they wanted to avoid their sons going to a youth justice facility. And in other cases both the whaanau/families and their sons were reluctant.

Some stakeholders suggested a solution would be to allow a staged consent process, for instance for an initial six months. Given that both the young people and their families/whaanau generally became more positive about the programme as they progressed through the phases, subsequent consents would probably become easier.

Te Hurihanga reported that this approach is unlikely to be useful. It could lead to an increase in the number of premature exits and a potential 'snowball' effect as other young people observe an easy way out. Should the young people and their family/whaanau choose not to reconsent after six months, there may be a risk that no further interventions occur because the young person has already spent a lengthy time in the Te Hurihanga residence. In addition, the Phase 3 intensive family/whaanau intervention would not proceed.

Referral agencies do not always have Te Hurihanga at the top of the list of possible interventions to address young people's offending. Individuals reported that this in no way reflected badly on the programme; it is just that there are a number of other programmes available as well and it is sometimes difficult to remember all of them when seeking optimal responses. This is a common experience for pilots as it takes time for a programme to

become part of referral agencies' stock of usual services. As one stakeholder stated, "*It is sometimes difficult to keep up to date with what options are available and which of these is a quality intervention*". On the day that comment was made, a visit to a referral agency by one of the clinical team generated four possible referrals which may otherwise not have been made. Keeping individuals in referral agencies aware of Te Hurihanga as an intervention option, and aware of the eligibility criteria, is not easy in a context of staff turnover. This does not seem to be an issue in Hamilton, however, where turnover of CYF Youth Justice and Police Youth Aid personnel is reported as comparatively low. But it may be that personnel in offices out of the main centre are less aware of Te Hurihanga. For instance, one parent in a centre outside of Hamilton reported that Te Hurihanga was only offered as an option when a city-based social worker was seconded to the smaller centre to fill in for someone on leave. Whether this was the case or not, it does signal the need for Te Hurihanga staff members to continually keep agencies aware of the programme, its target population and its successes on a regular basis.

4.2 Programme targeting, occupancy and client flow

4.2.1 Targeting

The Te Hurihanga programme has been designed to meet the criminogenic needs of a small group of young men between the ages of 14 and 16 years (at the time of entry) and identified as having the greatest likelihood of re-offending. That is, consideration is given to the frequency and severity of his offending and co-offending (for instance through links with antisocial peers), but excluding some types of serious offending such as murder and sexual offending. Young people with a limited history of violent offending are also considered and accepted. A summary of young people's preintake offending (see Section 5) shows that a number of the young people accepted to the programme have had violent offences, the most serious of which was aggravated robbery. More commonly, however, their violent offences were common assault.

There seems to have been some initial confusion about what types of violent offences preclude young people from being referred to the programme. In the early stages of the programme, the Police were of the opinion that most violent offenders were precluded, other than, for instance, those who had a one-off violent incident that was out of character or occurred because of some mitigating circumstances. In general the offences of the young people referred to the programme are categorised as moderate by Police. However, these offences include what the public would view as relatively serious offences such as arson, burglary with a weapon, demands to steal, assault with intent to injure, and robbery (see Section 5 for further discussion).

Given these eligibility criteria, the population from which the programme can draw is small. Indeed, police officers, social workers and other stakeholders

interviewed as part of the evaluation commented on the large proportion of young offenders who could benefit from such a programme, but are precluded from participation because of the eligibility criteria, particularly those relating to the offending history of a young person and to the requirement for cooperative, supportive caregivers. As discussed in Sections 2 and 3, the programme model was developed to reflect international best practice in the treatment of young offenders. Best practice models such as MST and FFT work intensively with families as they address systemic risk factors. While these stakeholders appreciated the systemic approach of the programme, they also expressed their frustration about the lack of interventions for young offenders who presented with high-risk indicators (eg, long histories of increasingly high-tariff offending, families with criminal histories), but who were alienated from their whaanau or had whaanau who were unlikely to agree to participate in the treatment programme.

In the early stages of the programme, some stakeholders (eg, the Police, Child Youth and Family social workers) were concerned about a perceived lack of clarity about the eligibility criteria. While they generally understood that the programme is targeted at young people with higher tariff offending histories (in terms of frequency and severity), they were less clear about how young people's offending severity would be interpreted. Each of them could identify someone they had referred to the programme but was not admitted, for instance because his offending was considered to be insufficiently severe to meet the criteria. Some wanted clearer guidelines (for instance, the number of offences) rather than the case-by-case consideration. However, by the end of the evaluation period, these frustrations seemed to have dissipated, mainly because referral agencies and the programme were in more regular contact and cases could be discussed prior to any further action.

Te Hurihanga has put a number of mechanisms in place to ensure that the referral process is transparent. As well as the initial road show, handouts and pamphlets, mechanisms include monthly or bi-monthly Te Hurihanga newsletters (providing updates about number of spaces, referral criteria and process); an ability for stakeholders to telephone the clinical leader to participate in the pre-screening process and ask questions; and assessment reports outlining decision making (clinical and actuarial risk estimate measures) and recommendations. Copies go to all key stakeholders.

Although stakeholders are generally well aware of eligibility criteria, they were not entirely supportive of them. Some stakeholders felt that the criteria excluded young people who could have benefited from the programme more than some of those who were admitted (the first two admissions were identified as examples of young people whose behaviour was too entrenched to change). They also felt that the programme had set itself unachievable outcomes by targeting young people and whaanau with highly ingrained negative (eg, criminal) behaviour patterns. There was no evidence that the programme therefore targeted or accepted young people with less

entrenched offending behaviour. As discussed in Section 5.4.1, the young people accepted onto the programme had extensive offending histories.

Stakeholders identified some groups of young offenders who could benefit from the programme but are not eligible. They included young people who:

- are likely to continue their offending but have either temporarily ceased offending or their offending has not come to the notice of the Police
- have long offending histories, but the offending is not seen as serious enough to be eligible for the programme
- offend but have not been apprehended (or found guilty).

Referring stakeholders would like to be able to refer some young people to the programme to 'nip their offending in the bud' before it escalates further (that is, to the severity or frequency suggested by the admission criteria). They see merit in using the programme as a preventative measure for some young people rather than a reactive response to offending that has already reached a severe and possibly irreversible level. That could require some adaptation of the referral and admission pathway as, in many cases, the offending of these young people would be dealt with through an FGC rather than through a Youth Court appearance.

These experiences have led to some debate about the criteria: some have argued for relaxing the criteria, for instance to enable less serious offenders into the programme. These include both police officers and social workers. Others would like to see the criteria tightened up so that only the very serious offenders would be eligible for entry (eg, those with violent offending histories).

The programme providers noted that intake decisions are reflective of international literature on 'what works' for young offenders, including consistency with Risk, Needs, Responsivity principles (see Section 3.3): that best practice involves matching highly resourced interventions to high-risk offenders (while lower risk offenders require lower intensity interventions). The programme providers also note that arguments for relaxing the criteria have ethical ramifications (and a likely response from youth advocates). That is, an 18-month programme for a lower intensity offender (eg, judicial response and costs) would be out of proportion to the risk rating and costs of alternative sentencing options. Providers also raised potential motivation and consent ramifications from relaxing the criteria. They believe that a possible sentencing to a youth justice facility (a typical FGC alternative to Te Hurihanga) acts as an external motivator for the young people and their whaanau to agree to participate in Te Hurihanga.

4.2.2 Programme occupancy

A steady increase in client numbers, coupled with young people progressing through the treatment phases, resulted in Phases 1 and 2 operating at almost full capacity within six months from commencement, and the programme as a whole operated at almost full capacity a little over a year from commencement. The programme caters for a maximum of 13 young people at any one time, with room for no more than eight young people in the programme's residential and transition phases combined (that is, Phases 1 and 2) at any one time. In practice, however, staff members reported that a maximum of six young people at a time might be more appropriate, given the intensity of treatment and the often volatile interactions between the young people. During these residential phases, the young people live at the Te Hurihanga residence seven days per week. However, those in Phase 2 will also have periods of time in their family home as part of the transition process.

Table 4.1, below, shows the number of young people whose referrals were accepted by the programme on a month-by-month basis from programme start until June 2009 (the final data collection for this evaluation).[10] It also shows the young people's progression through the programme. The first young people were accepted onto the programme in July 2007; the first young person progressed to Phase 2 in October 2007; and, in June 2008, the first young person progressed to Phase 3. The twelve-month gap between the first young person entering the programme and the first young person progressing to Phase 3 reflects the expected progression through the programme phases. It is anticipated that young people will spend up to three to six months in each phase of the programme, depending on their individual needs and achievements. Thus, a six to twelve month gap between first entry and entry to Phase 3 would be expected.

In November 2008, just under eighteen months from the first referral acceptance, the first young person completed the programme. In the meantime, there had been two early exits (in July 2007 and February 2008) and one young person withdrawn (in October 2008).[11]

By August 2008, Phases 1 and 2 had more or less reached capacity (at seven young people), and the total number of young people in these phases has since fluctuated between six and seven. While the programme capacity as a whole is set at thirteen, the highest number of young people on the programme (across the three phases) has been eleven (reached in September 2008).

[10] This data has been sourced from the programme's Pipeline report, which is sent to the Ministry of Justice on a regular basis.

[11] See Section 5 for a description of reasons for early exits.

The steady build up of referral numbers in a comparatively short period of time, despite considerable negative publicity around the programme and early absconding incidents, is testament to the high regard that referrers had in the programme and its staff members, the work of the Community Liaison Group,[12] the Waikato Leadership Group[13] and the already existing strong interagency links.

This steady increase in the number of young people in the programme over the evaluation period is consistent with what could be expected of a well-performing pilot. Indeed, other New Zealand pilot programmes with similar treatment models and target client groups have not achieved such steady growth in client numbers (eg, see Warren, Saville-Smith, Grace, Rucklidge and Wehipeihana 2008 and Grace, McLean and Warren 2006).

4.2.3 Client flow

It is important to manage the flow of new people entering Te Hurihanga and the flow of young people moving between programme phases.
Providers have found that referrals and acceptances need to be managed so that new entrants do not arrive in clusters, as they can disrupt the established routines of the residence and the potentially volatile interrelationships between the existing residents.

A controlled flow of young people between phases is also necessary for managing resources. For instance, resource levels (particularly staff numbers) need to be matched to the intensity of service required at different stages and phases of the treatment programme. Significant staff resources per young person are needed in the first phase of the programme, when more intensive supervision is required and monitoring as part of the points system is more intensive. Table 4.1 shows the flow of young people through the programme phases.

[12] The Community Liaison Group, comprising a range of community-based representatives from the local area, was established to facilitate interactions between Te Hurihanga, as part of the wider Te Ara Hou Village, and the community.

[13] The successful delivery of Te Hurihanga is dependant on the actions and processes of a number of agencies. The Waikato Leadership Group, which comprises representatives of these agencies (Child Youth and Family, NZ Police, Ministry of Education, Waikato DHB CAMHS, Ministry of Justice, judiciary, and Youth Horizons) provides a support system for the programme.

Table 4.1: Te Hurihanga client flow

Month	Phase 1	Phase 2	Phase 3	Total in programme	Completed	Early exit
July 2007	2	0	0	2	0	1
August 2007	2	0	0	2	0	
September 2007	4	0	0	4	0	
October 2007	3	1	0	4	0	
November 2007	3	1	0	4	0	
December 2007	4	2	0	6	0	
January 2008	4	3	0	7	0	
February 2008	3	3	0	6	0	1
March 2008	2	4	0	6	0	
April 2008	2	4	0	6	0	
May 2008	0	6	0	6	0	
June 2008	1	5	1	7	0	
July 2008	1	4	2	7	0	
August 2008	4	3	3	10	0	
September 2008	4	3	4	11	0	
October 2008	4	2	4	10	0	1
November 2008	4	1	5	10	1	
December 2008	2	4	3	9	3	
January 2009	3	4	3	10	3	
February 2009	2	5	2	9	3	1
March 2009	2	4	2	8	3	
April 2009	2	5	2	9	3	1
May 2009	2	3	3	8	4	
June 2009	1	3	4	8	4	

Providers reported considerable staffing needs for both Phases 1 and 2. While some aspects of the treatment model reduce in intensity in Phase 2 (eg, the points system is increasingly less intensive as the young people learn to regulate their own behaviour) others require higher staff to client ratios. For instance, in Phase 2 the young people increase their time away from the residence in home-leave and community-based activities, many of which require a staff presence. Providers found a need to manage the number of people in Phase 2 because out-of-residence staff activities put pressure on overall staff resourcing when the numbers in Phase 2 get out of balance.

4.2.4 Total referrals

Table 4.2 below provides a summary of the total number of people referred to the programme, the total number of young people who were assessed, the number who completed the programme as at June 2009 and the number who exited early, as at June 2009.

Table 4.2: Referrals, assessments, entrants, non-entrants, completers and early exits at June 2009

Young people	Number
Total referrals	86
Young people assessed	23
Assessed and non-entrants	6
Assessed and entrants	17
Completed programme	4
Early exit from programme	5

In total, approximately eighty-six young people were referred to the programme at a pre-screen stage over the duration of the evaluation. Up to two-thirds of these pre-screen referrals did not proceed to assessment for a mix of reasons. Most commonly, the young people and their families/ whaanau were not ready for the programme. Sometimes it was the case that either the young person or the family/whaanau was not ready. Consent is needed from both for the process to proceed. Often these young people will be considered again for referral, maybe six to twelve months later when they are more ready. Sometimes there were care and protection issues, most often that there was not a nominated caregiver.

Twenty-three of these referrals progressed to the assessment process. Of these, seventeen entered the programme. Six young people were assessed but did not enter the programme. After the assessment, a report was submitted to the Youth Court for each of the young people advising of the outcome of the assessment and Te Hurihanga's recommendations.

- In three cases, Te Hurihanga made the decision for non-entry. Reasons for non-entry included:
  - the offending history and risk posed to other young people and staff was deemed too great
  - the young person fell into a 'moderate risk for re-offending' range based on actuarial measures. Young person later continued to offend and was re-assessed and placed on the programme
  - the young person fell into a 'moderate risk for re-offending range' based on actuarial measures. He had significant vulnerability factors for victimisation.

- In one case the Court made a decision for non-entry. An alternative plan was perceived as more appropriate.

- In two cases, the young people made decisions for non-entry:
  - young person changed his mind and advised the Court that he would prefer an alternative option. Programme requires voluntary consent from youth to participate in programme
  - young person changed his mind and expressed preference for alternative option.

A further five to six young people were booked to be assessed, but the assessment did not proceed for reasons external to the programme. For instance, in one case the young person moved to Auckland and in other cases the young person decided they were not ready for the programme. These young people who were not ready may well be referred again, when they are more ready.

4.2.5 Summary

Given the eligibility criteria, the population from which the programme can draw is small. A number of young people in the Hamilton area who stakeholders believe could benefit from such a programme are precluded because of these eligibility criteria. There is some debate about the criteria: some have argued for relaxing the criteria while others would like to see the criteria tightened up.

As the programme has developed, the referring stakeholders have become more confident about recognising who is suitable for the programme and the development of effective working relationships between the referrers and the programme have overcome most referral problems. In general, the referral process was described as straightforward and efficient.

A steady increase in client numbers, coupled with young people progressing through the treatment phases, resulted in Phases 1 and 2 operating at almost full capacity within six months from commencement and the programme as a whole operating at almost full capacity a little over a year from commencement. While referral numbers decreased in the last two months of the evaluation period, this may simply reflect the usual fluctuations of referral numbers in pilot programmes.

The steady number of young people in the programme over the evaluation period is consistent with what could be expected of a well-performing pilot. Indeed, other New Zealand pilot programmes with similar treatment models and target client groups have not achieved such steady growth in client numbers.

Providers have found that the flow of referrals and acceptances need to be managed to maintain established routines, minimise any disruptions to established relationships and manage resources.

4.3 Young people's progression through the programme

Young people's progress through the programme is guided by their individual treatment plans. These treatment plans are initially informed by their rangitahi assessment reports and then by their achievement of individual goals. The young people's achievements of these goals (or intermediate outcomes) are reported in Section 5.

As Table 4.3 shows, on average, it took almost sixteen months for young people to complete the programme. It needs to be remembered that, at the time the data was collected (mid-June 2009) only four people had completed Phase 3. However, we have not included one young person in the calculation for Phase 3 duration because the Youth Court granted him an early graduation because his family left the area. On average, young people spent four months in Phase 1 and just under six months to complete each of Phases 2 and 3.

Table 4.3: Phase duration for young people completing[14] phases 1–3 to June 2009

Phase	Average months to completion
Phase 1 (n=15)	4 months
Phase 2 (n=8)	5.9 months
Phase 3 (n=3)	5.8 months

4.3.1 Assessment reports

The psychological assessment is informed by the Risk Needs Responsivity (RNR) and Good Lives models:

- Risk Principle: The assessment determines if the young person obtains a high risk estimate for re-offending.
- Needs Principle: The assessment identifies criminogenic (crime related) and non-criminogenic (non-crime related) needs.
- Responsivity Principle: The assessment is structured to promote engagement and informed decision making, establishment of motivation for participation, and identification of potential barriers (youth and whaanau) to effective intervention.
- The young person's offending history, family background, developmental history, educational background, and health and mental health history is assessed.

Further assessment occurs as the young person progresses through the programme to inform ongoing intervention planning.

Often, the young people's families/whaanau had issues that needed addressing including: mental illness, drug and/or alcohol misuse, criminal activities, and/or domestic violence. In most families/whaanau there was an absence of consistent parental guidance, boundary setting and discipline. Most of the young people were habitual users of alcohol and drugs, often from an early age; most had been out of school for a prolonged period (the transition between primary school and secondary school seems to provide opportunities for the young people to cease their schooling without coming to

[14] The figures for each phase exclude young people who (i) exited the programme early during that phase; (ii) were yet to complete that phase; and (iii) had yet to reach that phase. Their inclusion would distort the overall averages.

the notice of any authorities); and most had extended histories of offending, the seriousness of which has been accelerating over time.

A risk for re-offending is identified using multi-informant interviews, file review and administration of two internationally recognised actuarial risk for re-offending measures: The Youth Level of Service/Case Management Inventory (YLS/CMI) and the Hare Psychopathy Checklist – Youth Version (PCL-YV). The YLS/CMI focuses on antisocial attitudes, antisocial associates, antisocial personality, and history of antisocial and problematic behaviour at home, school, work, and socially. These factors, which can be either static (unchangeable) or dynamic (changeable), have been identified by research as correlated to risk of re-offending. Identifying dynamic risk factors (needs) is useful as they can be targeted in treatment. The forty-two risk/needs/strengths items are grouped into eight scales relating to prior and current offences/dispositions; family circumstances/parenting; education/employment; peer relations; substance abuse; leisure/recreation; personality/behaviour; and attitudes/orientation.

4.3.2 Outcomes-based transition

The Programme specifications include a three-phase progression through care and treatment services intended to support ongoing progress through a set of integrated interventions. Transition between each phase is dependent on progress made by each participant, with programme providers deciding whether young people are ready to progress to the next phase.

Phase 1: This phase of the programme is a stabilising and settling-in period where the young person:

- learns rules of the programme (and begins to abide by them)
- is introduced to a routine living environment (set meal and bed times, required hygienic activities, some domestic responsibilities)
- is weaned off substance use and abuse (drugs and alcohol are not permitted and routine tests are carried out to ensure the young people are not obtaining substances from elsewhere)
- is introduced to regular education and training (through the in-house classroom and activities with the skills workers)
- is introduced to prosocial recreational activities (in preparation for subsequent participation in community-based rugby and other recreational activities in Phases 2 and 3 of the programme)
- attends individual and group therapy to address his criminogenic needs and develop prosocial competencies.

The points system forms a key part of the Phase 1 suite of interventions. In general, the young people take two to three days to learn the rudiments of the system and a week or two to learn its subtleties. The amended system (introduced in August 2008) enabled young people to learn the subtleties more quickly.

Transition from Phase 1 to Phase 2 depends upon the young person achieving the required number of points[15] (available only through adopting targeted positive behaviours and reducing or ceasing identified negative behaviours). The young people are expected to make progress in achieving their individual goals, identified through further assessment. These goals (which translate into the programme's intermediate and ultimate outcomes) relate to attendance at school; attendance at therapy sessions, engagement with programme activities and behavioural improvements (see Section 5 for an analysis of young people's progress against intermediate and, at a very preliminary level, ultimate goals). The young people know that their progress to Phase 2 will depend on their accumulating 4,000 points in Phase 1.

The time that it takes for the young people to transition between phases differs for different boys. For some, the transition to Phase 2 occurred after a very short time, while, for others, it took considerably longer. Although the programme plan sets out guidelines for each phase of the programme, the young people's progress through them is outcomes-driven not time-driven. That is, the treatment programme is flexible enough to reflect all individual needs, with individual progress based on achievement of identified goals.

The treatment plan is not entirely outcome driven, however. For instance, even if a young person immediately demonstrates a willingness and ability to adopt prosocial behaviours and cease antisocial behaviours, shown through consistent compliance with programme rules, he will still need to stay in Phase 1 for sufficient time to accumulate the required number of points (4,000). That minimum time is around two weeks (at a maximum of 280 points per day). One young person's experience is a case in point. Although no incidents are recorded for him in Phases 1 and 2, it still took 15 weeks for him to complete Phase 1 and 23 weeks for him to complete Phase 2.

At the end of Phase 1, a report is submitted to the Youth Court (with copies provided to referring CYF social worker, Police, and youth advocate). This reappearance serves several purposes. Firstly, it provides an opportunity for the judge to provide approval for transition into the next phase of the programme. First, bail conditions need to be changed to allow the young person to engage in community activities. Previous bail conditions will have required the young person to remain in the residence on a 24-hour basis. The reappearance also provides an opportunity for the judge to remind the young person of the seriousness of his offending and of its consequences (including his requirement to engage in programme activities). Also, importantly, the reappearance provides the opportunity for the judge to formally note the young person's progress to Phase 2. Typically, Youth Court judges, along with social workers, whaanau and other key stakeholders attend the graduation ceremony as the young person progresses to Phase 2. Families/whaanau, the young people, Te Hurihanga staff members and

[15] See Section 4.7 and Appendix 3 for a more detailed description of the Points System in practice.

attending stakeholders described the pride and sense of achievement that most young people clearly felt at these important ceremonies.

Phase 2: To get to this phase the young people have had to achieve demonstrable improvements in their day-to-day behaviour – that is earned 4,000 points through point-earning on a daily basis. This phase provides a young person with opportunities to put into practice the skills and behaviour learnt in Phase 1 – both in the Te Hurihanga residence and in community settings. These community settings include the young people's whaanau homes (initially they may be supervised but the level of supervision tails off as the young person progresses through intervention goals); sports activities (a number of the young people have joined rugby teams); outings (these include organised group outings with staff, one-on-one staff and young person outings like shopping); work settings (some young people had work experience, one worked full-time during Phase 2); and school settings (one young person attended mainstream secondary school during Phase 2).

The young people also have increasing contact with their whaanau, with overnight and weekend visits increasing to an extent that transition to full-time home-based residence in Phase 3 will be a natural progression. These visits, however, are contingent upon the young people adhering to individual goals. If progress is stalled or reversed, home visiting privileges are reduced. Thus, progress towards full integration into whaanau and community can take time and progress can fluctuate on a day-to-day basis. It was not unusual for some young people to go backwards at times although overall progress towards goals might still be steadily achieved over the period they are in Phase 2.

As in Phase 1, the young people are expected to engage in school activities, demonstrate improved behaviour, and achieve individual goals. But they are also expected to engage in whaanau and community activities. Often the sporting activities that the young people become involved in, especially rugby and league, provided the first opportunity for them to participate in a community activity. Over Phase 2, the young people's behaviour is less closely monitored. For instance, one young person who worked full-time was not monitored from the time he left in the morning until he returned home for the evening meal. His employers, however, knew the young person was on the programme and, if need be, called the programme if he had not arrived or there had been an incident. Similarly, the principal of the school attended by one young person called for support if there were any incidents.

Progress through Phase 2 is monitored and shaped by the points system, with more and better privileges and greater freedom from supervision and monitoring. During this Phase, the young people still earn points but these are 'spent' on privileges as the young people earn them. The transition to Phase 3 is, therefore, not contingent upon an accumulated total of points earned but upon assessed achievement against specific goals that reflect an individual's identified criminogenic needs (as above, see Section 5 for a report on progress against these outcome areas). While most young people

progressed through Phase 2 in around six months, because the phase is entirely outcomes-focused, there is considerable variation in the time young people spend in this Phase (eg, from 23 weeks to 27 weeks, with an average of 25 weeks).

Again at the end of Phase 2, a report is submitted to the Youth Court (with copies provided to referring CYF social worker, Police, and youth advocate). The reasons for reappearance again include providing opportunities for: the judge to give approval for transition into the next phase of the programme; maintaining formal responses to the offending; and changing the bail conditions and acknowledging the progress made. The formal graduation event put on to celebrate each young person's achievement at the end of Phase 2, which also includes a presentation, provides an opportunity for all those involved in the process to collectively acknowledge the success. Most of the young people who had progressed to Phase 3 over the duration of the evaluation described their feelings of pride at these ceremonies. Celebrations of success in these young people's lives, as the staff of Te Hurihanga stress, have been rare – if non-existent.

Phase 3: The young people progress to Phase 3 of the programme when their prosocial behaviour is stabilised and internalised to such an extent that reward systems such as a points system are less necessary. Accordingly, in the latter stages of Phase 2, points are not awarded as part of behaviour contingency management. In Phase 3, the young person returns to a whaanau setting, to live with his nominated support person. While most of the young people returned to their parents, or to a parent, there were exceptions. One young person, for instance, went to live with his older brother and another moved in with his aunt and uncle after an unsuccessful transition home to his parents. At this stage of the programme the focus is on the whaanau setting. During the evaluation, MST was delivered in all but one case. In that case, the whaanau relocated to another region and approval was given through the Youth Court for early discharge. As described in Section 3, MST is an intensive family and community-based intervention for violent and chronic youth offenders based on the premise that problem behaviours are linked to the multiple social systems (ie, individual, family, peer, school and community) in which the young person is embedded.

While this intervention focuses on the wider family situation (within the wider social situation), the young people are expected to be fully involved in work, education and/or training. They are also expected to remain engaged in community activities introduced in Phase 1 and to find new community activities to build on prosocial contacts and activities. Together these activities are expected to discourage the young person from relapsing into offending. The MST component of Phase 3 lasts around 20 weeks and Te Hurihanga monitoring and assistance increasingly dissipates until the suggested programme participation comes to a close – at the end of the defined period of bail.

At the end of MST intervention, a reconvened FGC is organised by CYF to consider final disposition of the offending for which the young person was bailed to the programme (either admonishment or discharge without sentencing). The FGC recommendation is submitted to the Youth Court by CYF, and a final discharge report is submitted to the Youth Court by Te Hurihanga. At this stage, the judge can discharge the young person or set further requirements. This decision is likely to rest on the progress the young person has made, and his success in not relapsing into re-offending. Certainly, the young people and their whaanau expect the young person to be discharged without conviction.

4.3.3 Summary

During Phase 1 young people are able to drive their own progress via the points system (see a more detailed description of how the points system works in Section 4.7). As shown in Table 4.3, on average, they complete this phase in around four months (2 months less than maximum duration). On average, young people remained in Phase 2 for almost the maximum length of time. However, the programme providers have reported that, more recently, the young people's progress to Phase 3 has been encouraged at four to five months (depending on family/whaanau readiness/capacity to have their young people back in their care). Phase 3 progress is driven by family/whaanau achievement of MST goals. Given family/whaanau needs, therapy has typically occurred for near to the maximum time. These patterns of progress suggest that the initial expectation that each phase would take three to six months is more or less appropriate to the treatment model.

4.4 Bicultural character of the programme

The young people, families/whaanau and external stakeholders value the cultural dimensions of the programme. For instance, as described in Section 5, families/ whaanau often attributed much of the improved attitude of their young people and their new respect for parents, siblings and others to the programme Kaumaatua's influence. They also saw the potential for the young people's new appreciation of their cultural identity as possibly providing an alternative identity to that of the local gang cultures. Often the families/whaanau blamed, in part at least, their sons' offending on their association with or respect for gang culture.

As the programme has developed, internal appreciation of the scope of the Kaumaatua role, within both Te Hurihanga and Youth Horizons Trust, has increased. The Kaumaatua role includes both physical and wairua dimensions of care for the young people and staff. As the Kaumaatua explained, the role comes "as a full package". That includes making sure the kawa and tikanga are in place all the time, up-skilling staff in things Maaori, and training of young people and Te Hurihanga (and sometimes Youth Horizons) staff. Some specific tasks include:

- attending treatment-related meetings (eg, case reviews, leadership, MDT and residential team meetings)

- informal staff supervision
- classes with the young people (twice-weekly)
- taking kapa haka with staff and young people
- contributing to the assessment process
- undertaking poowhiri for young people and staff
- involvement in graduation ceremonies and discharge processes
- involvement in morning meetings (eg, karakia and waiata)
- some one-on-one time with young people
- co-working with whaanau worker and MST therapists to aid whaanau engagement and working with whaanau in the community
- taking responsibility for organising for visits (eg, MPs, CEOs, international visitors, etc)
- attending management meetings in Auckland
- supervising the Kaitakawaenga Rangatahi
- setting up marae visits, overnight stays and other activities linking with local iwi.

One consequence has been a reconfiguration and expansion of the culture-specific roles in the programme. When the programme started, each of the Kaumaatua and Kaitakawaenga Rangatahi positions was a half-time position. One person filled both these positions. In practice, however, the Kaumaatua's responsibilities were greater than a half time position – particularly as the role straddled across both Te Hurihanga and Youth Horizons Trust as a whole. It became clear that the role required at least a full-time position. In 2009 the Kaumaatua position was extended to a full-time position and a new person was appointed to the Kaitakawaenga Rangatahi position in a part-time capacity (10 hours per week). This reconfiguration occurred towards the end of the evaluation period, so there has been no time to assess the effects of this change.

Part of the Kaumaatua role is to ensure that Tikanga Maaori concepts and values are woven throughout all aspects of the programme. As the Kete indicates, the values and practices of Manaakitanga, Wairuatanga, Whaanaungatanga, and Aroha are foundation principles of the programme and it is intended they underlie and inform the kaupapa and practices of the treatment programme. As described in Section 3.4, the delivery of the cultural dimensions of the programme includes assessing the cultural needs of each young person, creating a culturally safe and respectful experience for them and their whaanau; identifying and targeting potential cultural barriers to successful treatment; embedding cultural values in the programme; strengthening young people's cultural identity and whaanau links; promoting engagement of young person and family (as per the RNR model); and providing cultural input via case review meetings (Multi-Disciplinary Team, Residential Team, and interagency) to ensure consistent cultural input into every case.

In other programme settings, cultural supervision has been found valuable as a means to ensure that cultural considerations are integrated into assessment, treatment planning and programme activities in a systematic and replicable way (Grace, McLean and Warren, 2006). Through a supervision process that more or less mirrors clinical supervision, cultural supervision requires clinicians and others

with a therapeutic role (eg, residential staff members) to specifically consider young people's social and cultural context.

The introduction of cultural supervision has the potential to ensure that the effectiveness of the cultural components of Te Hurihanga is not solely dependent on the skills and experience of particular individuals. It also has the potential to ensure that the cultural dimensions of the programme can be replicated elsewhere.

4.5 The therapeutic teams

4.5.1 The Multi-Disciplinary Team (MDT)

The MDT team provides clinical oversight to Te Hurihanga. It, in turn, is clinically overseen and supervised by the Youth Horizons Clinical Leader. As described in Section 3.3, the team includes: the Programme Manager, the Clinical Leader, the Kaumaatua, the programme Psychologist, the Educator, Skills Trainers, a Kaitakawaenga Whaanau, the Residential Manager, and a part-time Kaitakawaenga Rangatahi.

Amongst their roles are: facilitating prosocial peer relationships; addressing personality/behaviour, attitudes/orientation and mental health issues; building parenting skills and addressing family context issues; managing a graduated transition home; education and educational transition; vocational transition; recreational transition; and, alcohol and drug referrals.

The careful recruitment of skilled and experienced staff in the setting up of Te Hurihanga has provided a strong foundation for continued refinement of the therapeutic delivery models and effective targeting of the criminogenic and non-criminogenic needs of the young people. The team's skill level has progressed over the course of the programme, given the establishment of a range of capability and capacity-building mechanisms, including: MDT planning days, regular supervision, the introduction of a case manager role (filled by the skills trainers) and six-weekly whaanau waananga.

4.5.2 The Residential Team

The residential team provides a key part of the treatment programme as, in a behaviour modification-based treatment programme, every staff/young person interaction is part of the treatment intervention. Of the overall Te Hurihanga team, it is the residential team that has the most intensive day-to-day contact with the young people. And it is the residential team that implements the points system. The residential team is a therapeutic team. To effectively deliver the therapeutic interventions, all team members' interactions with the young people need to be consistent. This requires team members to understand and adhere to the treatment model as part of their daily and nightly rostered responsibilities and tasks and respond to the young people's behaviour in consistently transparent ways. For instance, the points system needs to be delivered absolutely consistently and openly, as the

young people can be highly sensitive to any discrepancies and can take advantage of these or can feel aggrieved if they think they have been treated unfairly.

Appreciation of the therapeutic role that the residential team plays in the overall treatment programme has increased as the programme has developed. That growing appreciation has both been an outcome of the skills the residential team has developed and provided a foundation for the team to further build on its skills base. The skills and commitment of the team, coupled with ongoing capacity building activities, makes it potentially one of the most skilled residential teams in the country. Further capacity building can only improve the effectiveness of the team and the treatment programme.

Previous and current strategies to build the capacity and capability of the residential team include the following:

- creation of permanent positions amongst residential staff (to enable the formation of residential teams, to provide a better basis for capacity building, etc)

- establishment of teams amongst residential staff, with team leaders, to improve consistency of treatment across the teams and between shifts (eg, in the implementation of the points system)

- establishment of regular residential supervision sessions, which involve both permanent residential staff and members of the casual pool. Supervision is facilitated by the Residential Manager, with the Te Hurihanga Clinical Leader joining sessions on an as-needs basis (eg, to support processing of, transference-counter transference reactions etc)

- development of a residential practice mode or residential guiding principles, which include: safety, relationships, learning and behaviour change, teamwork, and professionalism.

Recognition of the key role that residential staff members play in an ecological programme such as Te Hurihanga raises a number of issues around recruitment and retention. These include the following:

- There are difficulties recruiting the skilled people needed, given the small pool of skilled residential workers available. Te Hurihanga is doubly disadvantaged. In New Zealand, overall, there is a comparative lack of established residentially-based therapeutic programmes through which residential workers can build therapeutic experience and skills. In Hamilton, there is a lack of residential programmes through which workers can build experience and skills in residential care.

- There is a need for considerable training at entry and ongoing training and supervision to develop and maintain the skills required of an effective residential team in a context of New Zealand-wide and Hamilton-specific skill shortages.

- Contracting arrangements need to recognise the skill levels required of residential teams in therapeutic treatment programmes, including any remuneration implications.

The configuration and operation of the residential team changed with the relatively late appointment of the residential house parents (in December 2008). This delayed appointment reflected the considerable difficulty the programme experienced recruiting suitable people. Reasons for the difficulty were identified as: a shortage of people experienced in residential service in Hamilton, and some reluctance, on the part of potential recruits, to take up the position given what they saw as inadequacies in the accommodation. A settling-in process has been necessary, part of which has focused on how to resolve some tensions around the different roles and approaches of the house parents and residential staff. As discussed above, residential staff members, as part of the therapeutic team, are required to respond to the young people in consistent and prescribed ways. For instance, there are prescribed processes for allocating rewards and consequences. The house parents, on the other hand, see their role as more like parents. Concepts like aroha and warmth shape how they respond to the young people. Tensions have arisen when the house parents are rostered on residential shifts (which is part of their job description), as they then are required to respond to the young people in the same prescribed way as the rest of the residential staff do.

It may be that the tensions around house parenting and residential staff roles can be resolved through training and supervision. After all, it took some time to build residential team capabilities and for team members to understand the need for consistency and adherence to the therapeutic model. The extra dimensions the house parents bring to the residence are appreciated and valued by the rest of the team, the young people and the whaanau/families. However, it may be of some value to reconsider how the house parent role should operate in a prescribed therapeutic residential setting.

4.5.3 Multi-Systemic Therapy (MST) Team

MST was the principal therapeutic model for the third phase of the programme throughout the evaluation period. MST was implemented from the time the first group of young people transitioned to Phase 3 in mid-2008.

MST is a short intensive home-based ‘twenty-four hours, seven days a week’ intervention that focuses on the young people and the components of their wider social systems – their peers, school, family, and communities – in which they and their families/whaanau live. MST promotes and facilitates behaviour change in the young person’s family and community environment,

using existing strengths within each system to facilitate change. This change is supported through the mobilisation of existing family and community supports.

High adherence to the MST treatment model on the part of supervisors and therapists is seen to be critical to obtaining favourable long-term outcomes for serious youth offenders. Therapist practice is guided by nine treatment principles and MST Services (the international owner of the MST treatment model) promotes adherence through a stringent quality assurance system. In New Zealand, the MST framework is operated under licence to the Richmond Fellowship, the local franchise owner. Quality assurance mechanisms include on-site supervision,[16] measurement of adherence to the treatment model using research-validated instruments[17] and intensive, standardised training for all MST staff. Training includes a five-day orientation or introductory training for all clinical staff; quarterly booster sessions; and weekly consultation with an MST expert consultant.

The supervisor's role is core to therapists' adherence to the model and, therefore, MST effectiveness. As emphasised in international literature (eg, Borduin, 1999; Henggeler et al, 1997), in addition to regular supervision sessions (including field-based and one-on-one clinical sessions), the effectiveness of clinical supervision depends on the skills of supervisors and therapists and the respect therapists have for supervision as a practice and for the clinical supervisors themselves. It also depends on managerial and MST-NZ support for the clinical supervisors.

Recruitment of experienced MST supervisors and therapists is still difficult in New Zealand, given the level of skill required for effective supervision and the relatively limited opportunity there has been to build capacity across the country. MST has been implemented in New Zealand for less than 10 years (the first teams started working in 2001) and a focus on serious offenders has been fairly recent.

The caseloads of the MST team working with the whaanau/families of the young people in Phase 3 included both Te Hurihanga and, of necessity, other cases. Consideration was given to the value of one MST therapist taking all the Te Hurihanga cases. However, this could not work in practice as the staggered progress of young people through the programme, given its individualised treatment plans, and the small numbers of programme participants overall, was too low to maintain an optimal caseload for one therapist (around four to six at any one time), let alone the team as a whole. Instead, the Te Hurihanga cases were allocated to all three therapists in the team, whose caseloads also comprised other clients.

[16] In most MST applications internationally, one full-time supervisor works with two teams (usually comprising four therapists). Weekly team clinical supervision sessions are a mandatory part of the MST model. Separate sessions are provided by the clinical supervisor and by the MST-NZ consultant (usually on the same day).

[17] Therapy Adherence Measures (TAM) and Supervisor Adherence Measures (SAM).

The first young people progressed to Phase 3 in June 2008, with a gradual increase to five by November 2008. The time-lag between setting up the MST team and young people progressing to Phase 3 affected the bedding down of the MST component of the programme. The factors affecting the bedding down include the following:

- There was a lack of opportunity, in the early months of the programme, for the MST supervisor and team therapists to develop into an effective working team. As discussed above, a mutually respectful team relationship, along with a credible clinical authority on the part of the MST supervisor, is essential for achieving programme adherence. There were early signs that the supervisor was finding it difficult to establish the clinical authority required, mainly because of the inexperience of both the supervisor and the therapists. A new more experienced supervisor was subsequently appointed and she made considerable progress developing team cohesion and building capacity.

- There was also a lack of opportunity, in the early development of the programme, for the MST team to become an integrated part of the wider Te Hurihanga clinical team. Again this was probably an inevitable outcome of the time-lag between the setting up of the programme and the progress of young people into its third phase. The working relationship between the MST team and the wider Te Hurihanga clinical team was strengthened with the appointment of a more experienced MST supervisor, the inevitable increase in the number of young people progressing to Phase 3 and the roles of skills workers and the whaanau worker continuing through Phase 3. The role of the whaanau worker was strengthened with the appointment of a more experienced person in 2008. For a short time, there was some uncertainty about the involvement of the skills workers and whaanau worker in Phase 3, reflecting some tensions between the treatment models. However, these were resolved at the same time as the new supervisor was appointed. The skills workers subsequently played a vital role throughout Phase 3. The skills workers role is core to the integration between the three phases as envisioned at programme set-up. For instance, they are responsible for supervising and monitoring the young people in the community; assisting them to establish positive, prosocial community interests and connections; teaching them the life skills to meet their ongoing needs in prosocial ways; helping them make successful education and vocation transitions, and making alcohol and drug referrals to external providers.

- An initial lack of appreciation, by the clinical team as a whole, of the need to introduce the MST team and the MST kaupapa to whaanau as early as possible in their programme involvement. For this reason, the families/whaanau of the first group of young people to progress to Phase 3 were ill-prepared for the challenges and work involved in MST participation. This affected their engagement with the programme. However, since the September 2008 introduction of six-weekly whaanau waananga, families are more intensively involved in the programme from

the beginning. These whaanau waananga provide a forum for the programme providers to introduce the programme as a whole and all the relevant staff members to families/whaanau more or less as soon as their young people start the programme. This contact is maintained through regular hui. Families are now introduced to the MST team and to the MST concept and its place in Phase 3 of the treatment programme during the time that their young people are in Phase 1. As discussed elsewhere, these hui are highly valued by both staff and whaanau.

Given these factors, the providers believe MST was less effective for the whaanau and the young people for first group who progressed to Phase 3 – that is, for the four young people who had completed the programme by the time that data collection for the evaluation ceased (June/July 2009) compared with those who progressed to Phase 3 later. In particular, the MST therapists found it very difficult getting this first group of families to engage with MST. Family/whaanau engagement and re-engagement with MST is an ongoing process throughout the treatment programme. The strength of the working relationship between therapists and the family/whaanau is fundamental to MST's effectiveness.

The programme providers overall recognise that the challenges therapists faced in getting these families to engage were exacerbated by the late introduction of MST (both the model and the therapists) to the first group of families. For these families, it was not until their young people progressed to Phase 3 that they had to consider their own part in the offending of their young ones and the part they would have to play if their young people were to achieve positive change. They tended to be unprepared for the challenging work involved in participating in MST and still tended to believe that the problems were largely the fault of the young people themselves rather than an outcome of a complex set of factors, including family factors.

4.5.4 Functional Family Therapy

From late 2009 or early 2010 Functional Family Therapy (FFT) will replace MST as the treatment model for Phase 3 of the programme. Thus, this treatment model was not implemented during this evaluation.

Like MST, FFT is an evidence-based practice model that takes a multisystemic perspective to treat at-risk and conduct-disordered young people and their families. FFT is used both as an intervention programme and a prevention programme. The model has evolved through thirty years of clinical and research experience and application in a wide range of sites in the United States and elsewhere (Sexton and Alexander, 2000). The programme is designed for young people aged 10 to 18 who engage in violence, aggression, property destruction and substance abuse. The therapy is designed to improve family interactions so that disruptive behaviour is no longer functional for the youth. The programme model has similar measurable outcomes to MST and Multi-Dimensional Treatment Foster Care

(MTFC). As with MST, FFT is a community-based whaanau/caregiver-focused intervention.

FFT is a multi-phase model: The first phase involves engaging with whaanau/families and finding ways for them to want to be involved. The engagement and motivation phase is as necessary as any other aspect of the programme to facilitate changes within a family. Operating from the premise that everyone in a family has a role to play, the FFT therapist endeavours to meet with the whole family throughout the duration of the programme. The second phase focuses on behaviour change.

4.6 Family/Whaanau engagement with and involvement in the programme

4.6.1 International best practice

The international and New Zealand practice models that have informed the development of the programme treatment model emphasise the importance of whaanau/family involvement. As the literature on best practice in treatment for delinquents points out, because families are implicated in the development of their young people's conduct problems (eg, Collins et al, 2000; Parke and Bhavnagri, 1989 and Dodge et al., 1990) they have an important role in their prevention and treatment. Youth offending is attributed to a complex interaction between individual, family/whaanau, peer, school and community risk factors. That is, the underlying causes of offending are rooted in the offenders' homes, schools and communities. The treatment of young offenders and their families is difficult (Curtis et al., 2004). After antisocial behaviour has become established it is very resistant to change, as demonstrated by the high recidivism rates of juvenile delinquents and the failure of most interventions to maintain change (Brunk, 2000).

4.6.2 Te Hurihanga practice

Programme providers recognise the need to involve families/whaanau from the earliest programme participation. To this end, whaanau members are encouraged to visit their young person after they have progressed from the initial settling down period and, from Phase 2, the young people are increasingly reintegrated into family and community life through increasingly extended home visits. As shown in Table 5.8 (in Section 5) families/whaanau have participated in programme activities and engaged in sessions with the whaanau worker and MST therapist.

As the programme implementation progressed, providers found that more family/whaanau involvement was required to ensure positive outcomes for the young people. The need for more family involvement was revealed through the MST engagement process. The wider clinical team (including the MST team) concluded that the difficulties experienced by MST therapists struggling to get the first group of families to engage with MST could, to some

extent, be attributed to the families' lack of awareness of the MST component and lack of appreciation of the part they played in their young people's offending. There was a tendency for these families/whaanau to continue blaming the young people for their behaviour rather than recognise the complexity of contributing factors and their own role in successful programme outcomes. The programme providers reported a general whaanau expectation that young people would return to the home 'fixed' and that whaanau life could continue as before.

Steps were then taken to strengthen families/whaanau involvement from the earliest stages of the programme. These included the internal appointment of a new whaanau worker who has a strong background in family therapy and the establishment of whaanau waananga. The latter, the whaanau waananga, were established to better engage families/whaanau in the treatment programme from the start, including preparing them for the work they will need to do in Phase 3 and beyond to support their young person both reintegrate into family/whaanau and community life and reduce their offending.

The opportunities provided by the whaanau waananga, which now occur six-weekly, were four-fold. First, they provided opportunities for the Te Hurihanga team to introduce families/whaanau to the concepts behind the treatment programme as a whole (including explaining the work they will also be expected to do). Second, they provided opportunities to establish relationships between the families and the entire clinical team (including the MST team) so that the MST team were seen as an integral part of the team overall (that is, the engagement process starts at the beginning of the treatment programme not when the young person progresses to Phase 3). Third, they provided opportunities for the MST team, along with the Te Hurihanga whaanau worker, to do some preparatory work with the families while their young ones were in the residence (and have some respite from their behavioural problems). And fourthly, it provided families/whaanau with opportunities to meet other families participating in the programme. Some positive outcomes of this were that the families did not feel so isolated and the meetings laid the foundation for future support networks.

4.6.3 Views of whaanau

For most of the whaanau members interviewed, such regular and intensive involvement in a programme was a new and valued experience, as was the respect they felt staff members gave them. As one parent noted, the staff "*ask my opinion and are family-orientated"*. Another said, *"the programme is great – staff ask us, don't tell us. They are considerate"*. And another felt that their involvement was just right: *"It is what we expect and want. Too much involvement may affect Te Hurihanga"* [that is, its effectiveness].

It was clear from whaanau responses to questions about their involvement with the programme that it surpassed their expectations. In general whaanau had not heard of the programme before their young people's referral.

However, towards the end of the evaluation period, it was more common for whaanau to know about the programme and have some views about its value. For instance, in one case a mother said that the son of a friend was in the programme. In another case, people in the small community in which they lived knew about the programme. And whaanau members were also taken with the philosophy and focus of the programme after formal presentations at a Family Group Conference (FGC) and / or discussion with the programme providers. Typical comments included:

- *I like that there is something for Maaori young men.*
- *Te Hurihanga has a good name.*
- *Keen after Te Hurihanga presentation – explaining approach and philosophy about how boys would be treated.*

Whaanau all talked about their programme involvement, for instance in identifying their young people's needs and planning interventions. One of the fathers described stressing the importance of schooling issues that he wanted the programme to work on. He wanted his son to "*get back to enjoying education* [he had been skipping school], *and leaving drugs behind*". Another parent described collective discussion about "*classroom work and ways to find work and make contacts with employers"*. Another described the MST therapist as "*cool as*" in keeping them informed about their son. And another liked the fact that the programme is consistent and puts boundaries around her son: [staff] "*cuts [his] visits when [son] wouldn't listen*". Other parents liked being kept up to date with the progress of their son: "*We are happy that Te Hurihanga handles things one at a time. For example, bump downs.[18] At home we would have treated it differently – Te Hurihanga is fair and firm*". Almost everyone said that their involvement was more than they expected. No one said they wanted more involvement.

Some families had minor criticisms about Te Hurihanga's communication with them. They felt they were not adequately informed of what was going on, or that it was sometimes difficult to make contact with the programme. For instance, there were times when they could not get an answer when they telephoned. However, they also noted that staff took the effort to listen to their criticisms and find solutions. For instance, one mother said the programme provided her with a cellphone so that she could keep in better touch with the programme and with her son: "*Now I text and Te Hurihanga helps with phone and travel costs*". However, not all families were unhappy about communication. As one mother said: "*They kept me informed from the start, told me my son was loving it".*

The whaanau waananga were greatly valued by most whaanau. They talked about the opportunity these hui gave them to meet staff members and gain a better understanding about how the programme worked and its activities. One of the greatest benefits of the whaanau waananga, according to several of the parents, was the chance to meet other families with young people in the programme. Some were relieved to meet other parents with similar

[18] See Appendix 3 for discussion of 'bump downs'.

problems, some were relieved to meet parents with greater problems than they had, and some enjoyed the support that the collective hui provided. One parent was less positive: "*I gave the hui three out of five*" because of communication problems he perceived when he tried to follow up on some matters.

Most whaanau were positive about the programme from the start. In some cases, their initial support for, or acceptance of, the programme was more a reflection of the young person's enthusiasm. To a question about whether she was keen about the programme, one mother responded: "*Not really*", but added that her son wanted to go on to it. "*He knew he needed to change. I wanted him to know it was his last chance*". A small number were sceptical about its potential success in the very early stages, largely because of their previous experience with interventions. For instance, one mother hoped that her son would not "*waste their time*" as she considered that he was "*too used to getting away with everything, ready to voice his opinion*".

Almost without exception, whaanau enthusiasm about, and support for, Te Hurihanga increased as their young people progressed through the phases. Reasons for their initial enthusiasm tended to reflect their growing weariness about the behaviour of their sons and not knowing what to do about it and their despair about what would happen next. As one mother said, she was "*ready to give anything a go*". Another said that she had "*been through hell with [my son] and want it [the programme] to help [us]*". Once the programme started, they became more supportive. One parent's comment sums up what others said: *"the programme was better than anticipated"*. One reason for the increased support was their feeling of relief at having some respite and confidence that their sons were in a safe place where their offending behaviour was managed. Another reason was their observation of tangible and positive changes in their young people's attitudes, demeanour, and behaviour. One constant theme was the increased respect the young people showed to their parents. The comments below illustrate their views.

- *I'm very supportive – [my son] is also very positive. His positiveness is infectious. He needed to do the programme and wanted to.*
- *I like knowing my boy cannot offend.*
- *The abusive behaviour is disappearing – and he is not being bullying around the home.*
- *He is back to what he used to be like – dressing like he used to.*
- *He stops and thinks about things.*

4.6.4 Summary

Whaanau were overwhelmingly supportive of the programme and their involvement in programme activities. Their level of involvement was generally greater than they had expected but considered to be appropriate. They also felt that staff members were respectful, listened to them and made themselves available. The only consistent criticism related to communication difficulties.

4.7 The points system

The points system underpins the young people's early behavioural changes in Te Hurihanga as it is an effective tool for working with young people who present with severe problem behaviours. It can be used to assist in teaching them how to behave in different social contexts, including their everyday interactions. Points are allocated to the young people for appropriate social behaviours and taken away from them for antisocial behaviours. They can then be redeemed for goods and/or services at a later date.

Young people who participate in Te Hurihanga are accustomed to punishment. Rewards are rare. In order to bring about a change in their behaviour, the points system needs to provide a much needed alternative to the negative consequences that typify their life experiences. The Te Hurihanga points system (described in detail in Appendix 3) aims to establish structure and consistency in the young people's lives. It also aims to encourage them to learn what is expected of them and how they can modify their behaviour to meet these expectations. It also helps them to learn about the relationship between their actions and the consequences of their actions.

The system forms a significant part of the daily monitoring of the rangitahi in Phases 1 and 2 of the programme. When a young person enters Te Hurihanga his behaviour is monitored by staff members at all stages of the day and in all settings. In Phase 1 the young people’s behaviour is closely monitored, and earning points determines advancement. There are three different stages in Phase 1, which act as medium-term targets for the young people. This helps motivate the young person to maintain their efforts in self-management. In Phase 2 there are an additional two stages that support the young people as they transition to spending increasing amounts of time in community settings. The importance of the system naturally decreases as contingencies in the community take over. As the young people are close to returning home, they are trialled without a points system in place. Behavioural controls are designed to more closely replicate a family home setting. For example, behavioural infractions incur more natural consequences, such as reduced freedom of choice. There is no universal system employed in Phase 3 of the programme. The MST component supported whaanau setting boundaries and consistently implementing positive and negative consequences.

Given the importance of the points system, it is essential that it is implemented in a transparent, consistent and fair way. In a residential setting, where there are multiple staff members (including casual staff) working in three shifts and multiple young people (all in different stages of the points system), the system needs to be practical and straightforward. It also needs to be protected (as far as possible) from misinterpretation by both the staff and the young people. In August 2008 modifications were made to the points system to improve consistency and ease of implementation. The newly modified system is less complex, and easier for staff to learn, understand, and use.

The amendments to the points system, to simplify its design and implementation, and make it more strengths-based, include the following:

- a shift to electronic management of the scoring and automatic tracking of scores from shift to shift
- a reduction in the areas of behaviours that are scored
- a more finely calibrated five-point scale, with marking guidelines for staff and young people on the points sheets
- the separation of earning daily rewards from earning progression through Phase 1, and a refocus on the timelines for earning advancement
- a simplified daily rewards structure
- a requirement for the young people to demonstrate appropriate behaviour across every domain assessed, in order for them to advance through Phase 1
- the addition of graduated levels of achievement being required across Stages 1 to 3.

A shift from a three-point to a five-point scale, with scoring criteria written on the points sheets, was introduced as part of the modified points system in 2008. The amended system was designed to address issues of consistency, ease of use and clarity as well as perceived fairness on the part of the young people. It is viewed as very manageable, but still capable of capturing subtle changes in the young people's behaviour and maintaining sufficient simplicity to ensure usability, consistency and clarity. The amendments were introduced in tandem with staff training.

The responses of both the staff (particularly the residential team who are mainly responsible for implementing the system) and the young people indicate that the modifications to the system have been effective:

- Both the residential staff and the clinical team were confident about the quality of their application of the system, although there were initial teething problems as a small number of staff members struggled with perceived tensions between the principles underpinning the system and their own value systems and beliefs. For instance, some struggled with how to express cultural values such as aroha within a prescribed points system that they sometimes felt was overly harsh. These tensions have been largely overcome as staff understanding of the principles behind the system and the treatment programme overall have increased through training and ongoing supervision.

- The young people on the programme varied in their ability to learn the finer details of the points system, which can be complex for both them and the staff members allocating points. Some of the young people reported learning the system quickly (for instance in two weeks) and others described needing time to come to terms with its structure and implementation. In general, they recognised the value of the points system. For instance, it was not unusual for young people to attribute their improved behaviour to the system, and in some cases the young people could only describe their achievements in terms of points earned or the stage in the system achieved. However, at the same time, some resented the

level of oversight involved. For instance, one young person talked about his experience of the graduated system and his relief when monitoring of his behaviour diminished as he progressed through the stages; as he commented, *"it's a privilege not to have people watching".*

If they had concerns, young people mostly referred to a need for fairness. Youth offenders tend to have a strong sense of unfair treatment and use this to excuse their non-compliance with social rules. For the points system to be effective, it is essential that the young people in the programme view it as fair. Their generally positive views about the system suggest that they see it as fair overall. Terms like "*fine"*, "*sweet as"* and "*okay"* were commonly used to describe the system, although some young people also described instances where they felt they had been treated unfairly. For instance, one young person was indignant about his slower than expected progress through the stages of the system because he had not achieved his required daily point count. He seemed to find it difficult to acknowledge his own part in this slow progress and resented staff decisions: *"when you have low points you have to stay here another day… it should just be a bump down"*. Although the suggested duration periods for each stage of the points system are provided as guidelines only, some young people seemed to interpret them as more prescriptive. As a consequence, they felt disappointed or resentful when they did not progress through the stages as these guidelines would suggest.

It is important that the Te Hurihanga points system is used as a strength-based tool with positive reinforcement to promote good behaviour, rather than a deficit-based tool. Strength-based tools identify what is working well and encourage more of it, while also acknowledging risk and protective factors within each individual. The task of the Te Hurihanga points system has been to achieve a balance between appropriate reinforcement and appropriate punishment. The changes made to the system to date have encouraged this effective balance. The young people are able to maintain high levels of success, especially with respect to achieving daily rewards. However, they are also held responsible for their actions and are required to address their excesses of antisocial behaviour. Thus, the young person's day-to-day successes provide a background level of achievement for them that 'cushions' the effects of negative feedback; the success maintains their engagement and motivation, letting them continue with a rewarding life, while they address the antisocial behaviours that are problematic for them.

4.8 Summary

After some initial problems, mostly arising from referral agencies' uncertainty about the eligibility criteria, the referral and admission process ran reasonably smoothly. Any issues raised generally related to the difficulties referral agencies faced getting the young people and/or their families/whaanau to agree to participate in the programme. Given the eligibility criteria, the population from which the programme can draw is small. There is some debate about the criteria: some have argued for relaxing the criteria while others would like to see the criteria tightened up.

A steady increase in client numbers, coupled with young people progressing through the treatment phases, resulted in Phases 1 and 2 operating at almost full capacity within six months from commencement and the programme as a whole operating at almost full capacity a little over a year from commencement. The steady number of young people in the programme over the evaluation period is consistent with what could be expected of a well-performing pilot.

It is important to manage the flow of new people entering Te Hurihanga and the flow of young people moving between programme phases. These flows need to be managed to maintain established routines in the residence, minimise any disruptions to established relationships and manage resources.

Young people's progress through the three phases of the programme is outcomes-driven, rather than process-driven. Experience so far suggests that the suggested maximum time for Phase 2 and 3 is required for most young people to achieve identified outcomes. However, providers report some more recent reduction in the time required. Young people typically progress through Phase 1 in a shorter period (4 months on average).

The cultural components of the programme were highly valued by families/whaanau. They attributed important changes in their young people's attitudes and behaviours to the presence of the programme Kaumaatua. As the programme has developed, internal appreciation of the scope and complexity of the Kaumaatua role, within both Te Hurihanga and Youth Horizons Trust, has increased. One consequence has been a reconfiguration of the culture-specific roles within the programme.

The Multi-Disciplinary Team continues to develop, with structured targeting of the young people's criminogenic needs; and monitoring and review of their change over time (eg, through case review, progress reports, psychometric testing). The appointment of a third skills trainer provided more opportunity to focus on the young people's educational and vocational needs during the transition phases.

Appreciation of the therapeutic role that the residential team plays in the overall treatment programme has increased as the programme has developed. That growing appreciation has both reflected the skills the residential team has developed and provided a foundation for the team to further build on its skills base. The skills and commitment of the team, coupled with ongoing capacity building activities, probably makes it one of the most skilled residential teams in the country. Further capacity building can only improve the effectiveness of the team and the treatment programme.

There are indications that MST was less effective for the whaanau and the young people for first group who progressed to Phase 3. However, with the appointment of a more experienced MST supervisor, the MST team made substantial progress. The subsequent implementation of MST was further enhanced by the introduction of whaanau waananga, which improved the integration between the three phases of the programme. From late 2009 or early 2010 Functional Family Therapy (FFT) will replace MST as the treatment model for Phase 3 of the programme.

The importance of family involvement in the treatment programme is recognised in the treatment model and in the acceptance criteria. Young people and their families/whaanau need to agree to participate in the programme. Whaanau were overwhelmingly supportive of the programme and their involvement in programme activities. Their level of involvement was generally greater than they had expected but considered to be appropriate. They also felt that staff members were respectful, listened to them and made themselves available. The only consistent criticism related to communication difficulties.

The points system is being delivered in a quality way. The adaptations made in August 2008 to the Te Hurihanga points system, to achieve consistency and ease of application, improve its manageability and enhance its capacity to capture subtleties of behavioural changes and become more strengths-based, have been largely successful.

5 Programme outcomes

5.1 Introduction

The end of data collection for the evaluation coincided with completion of the second year of the pilot programme. Thus, it is not possible to provide any robust analysis of ultimate outcomes achieved. Also, this evaluation has focused on formative and process evaluation questions rather than outcome-focused questions. Nevertheless, the evaluation does provide some insight into the achievement of intermediate outcomes and some preliminary consideration of the achievement of ultimate outcomes (a reduction of offending severity and/or frequency). The young people need to achieve the intermediate outcomes as part of their progress towards achieving the ultimate outcome, to reduce offending. These intermediate outcomes relate to criminogenic and non-criminogenic drivers of offending. These are discussed further in Section 5.3, below. Several sources of information have been used to build a picture of the achievement of programme outcomes. These include:

- Case files, through a systematic collection and analysis of documented progress based on a questionnaire19 (attached in Appendix 4).
- The young people themselves, their perceptions canvassed through regular face-to-face interviews with them as they progressed through the programme, based on a structured interview schedule (attached in Appendix 5).
- Whaanau members (mothers, fathers, sisters, brothers, aunts and uncles), their perceptions canvassed through face-to-face regular interviews as their young people progressed through the programme, based on a structured interview schedule (attached in Appendix 5).
- Stakeholders (social workers, police, the judiciary, child advocates, teachers, employers and others involved in the welfare and progress of the young people), their perceptions canvassed through face-to-face interviews based on a structured interview schedule (attached in Appendix 5).
- Police statistics (that is, youth offending data).

5.2 Profile of the young people on the programme

Seventeen young people had entered the Te Hurihanga programme by the end of the evaluation data collection period. The file review was carried out on 16 June 2009. Interviews with young people and their whaanau were completed by 30 July 2009. As Table 5.1, below, shows, four of these young people had completed the programme at the time of data collection, five had exited early, and eight were still in the programme at various phases.

[19] The questionnaire collected quantitative and qualitative data on: progress through the programme; demographic characteristics of young people and whaanau; young people's preintake history; treatment needs and treatment programme; and achievement of outcomes.

5.2.1 Early exits

Five young people exited the programme early. One exited in Phase 1; three exited in Phase 2 and one exited in Phase 3. Below are the stated reasons for the early exits:

- one young person exited early during Phase 1, having absconded from the programme on three occasions;
- one young person absconded from the programme during Phase 2 and did not return; he was formally exited two months later;
- one young person voluntarily exited from the programme and was formally exited a month later;
- one young person voluntarily exited in Phase 2;
- one young person exited early in Phase 3, having re-offended. He was sentenced to a placement in a Youth Justice residential facility.

Table 5.1: Status of programme participants at 16 June 2009 (n=17)

Current status	Number
Phase 1	1
Phase 2	3
Phase 3	4
Completed	4
Exited early	5
Total	*17*

5.2.2 Age and ethnicity

Most of the young people (14 in all) were 15 years old when they entered the programme. Three were 14 years old. Most identified as Maaori or Maaori/New Zealand European. As Table 5.2 shows, five of the young people also had Pacific identities.

Table 5.2: Principal ethnic identity (n=17)

Principal ethnic identity	Number
Cook Island Maaori	1
Cook Island Maaori/Maaori	2
Maaori	6
Maaori, NZ European	5
Maaori, Samoan, Chinese, Australian	1
NZ European	1
NZ Maaori/Tahitian/Rarotongan	1
Total	*17*

5.2.3 Iwi affiliations

The young people's iwi affiliations, as listed in Table 5.3, were varied. Most were affiliated with North Island iwi, but, until the programme Kaumaatua traced their whakapapa, a number did not know much about their iwi affiliations. Although one young person was New Zealand European and did not have iwi affiliations, his Irish ancestry was acknowledged.

Table 5.3: Iwi affiliations (n=17)

Iwi affiliation	Number
Aitutaki, Atiu, Moeke, Ngaati Toa	1
Kahunguungu, Apia in Upolu	1
Moeke and Aitutaki	1
Ngaapuhi	2
Ngaapuhi and Tainui	1
Ngaapuhi, Tainui, Waikato, Hauraki regions	1
Ngaati Maahanga, Ngaati Apakura, Ngaati Maniapoto, Ngaapuhi	1
Ngaati Maniapoto/Aitutaki	1
Ngaati te Ata, Ngaati Tamoho, Ngaati Naho, Ngaati Mukirangi	1
Ngaati Maniapoto, Ngaapuhi nui tonu	1
Ngaati Maniapoto, Ngaati Kiriwa	1
Ngaati Paoa (Tainui), Whaanau Apanui, Ngamahinerangi, Ngaati Pukenga	1
Ngaati Porou, Te Aitanga a Hauiti, Irish	1
Ngaati Tuwharetoa Ratana	1
Tainui, Ngaati Mahanga, Mahanga Hourua, Ngaati Porou	1
Total	*16*

5.2.4 Principal caregiver and household income

The largest group of young people lived in single-parent, low income[20] households (all but one single-parent being the mother). In three cases, the young people's fathers had died. In other cases the parents were separated. See Table 5.4. Sometimes these living arrangements were fluid, however. During the evaluation, there were times when fathers, step-fathers or mothers were in custody; when family conflicts resulted in one young person living with his brother; when an unsuccessful transition home was reversed when the young person moved in with an aunt and uncle.

[20] Eleven lived in low income households and six in average income households, as defined by Te Hurihanga.

Table 5.4: Principal caregivers (n=17)

Caregiver	Number
Single-parent – mother	7
Single-parent – father	1
Two-parent – biological	5
Two-parent – one step-parent	3
Extended whaanau	1
Total	*17*

5.2.5 Pre-existing health status

The young people came to the programme with a variety of pre-existing mental health and health-related conditions. All the young people met the criteria for severe conduct disorder or conduct disorder and almost all misused drugs and / or alcohol. The next most prevalent conditions were Attention Deficit Hyperactivity Disorder (ADHD) and suicide ideation/intent or attempt.

Table 5.5: Preintake mental health and heath-related conditions (n=17)

Preintake condition	Number
Meets Conduct Disorder or Severe Conduct Disorder Criteria	17
Attention Deficit Hyperactivity Disorder (ADHD)	7
Drug and/or alcohol misuse	15
Depression	2
Suicide ideation/intent or attempt	7
Other non-accidental self injury (no suicide intent)	2
Cognitive disability	5
Trauma symptoms	4
Anxiety symptoms	2
Other Mental Health	1
Physical illness or disability problems	1

5.2.6 Preintake referrals

As Table 5.6 below shows, all the young people on the programme had been through the Child Youth and Family (CYF) Youth Justice system previously (to be expected given their offending histories), and had been referred to the programme by their Youth Justice FGC coordinator or social worker. Most of their whaanau/families had a prior history of CYF Care and Protection notifications prior to the young people's entry onto the programme. Three were in the custody of CYF at intake – under Section 101 of the Children, Young Persons and their Families Act 1989. More than half had previously been in a residential programme or service and had been to an educational psychologist or other Ministry of Education service. Given that most of the young people had ceased going to school before or in the early years of

secondary school, it is likely that some or most of the education-related services had been accessed while they were in primary school. Although most of the young people had a drugs and alcohol problem, only two had previously attended a drugs and alcohol service.

This history of preintake interventions suggests that these young people reached the 'end of the line' in terms of CYF and other services in their early adolescence. They had experienced multiple residential and non-residential services as well as very erratic schooling, possibly in a number of different schools. This high turnover of services and schools mirrors one of the major contributors to the development of conduct problems – the unstructured dynamics of family and community life (see Section 2). This high turnover of services potentially aggravates their unacceptable behaviours and leads to the young people and their whaanau/families being even more resistant to change and improvement.

Table 5.6: Preintake referrals to agencies, services and programmes (n=17)

Agencies, services and programmes	Number
CYF Youth Justice	17
Family/whaanau involvement with CYF Care and Protection	13
• Under current 101 Custody	3
Residential service	9
Educational Psychologist/MOE services	9
CAMHS/Hauora Waikato	7
Other mental health service	1
Alcohol and Drug services	2

5.2.7 Incident reporting as an insight into young people's within-programme behaviours

Detailed incident data collected on a regular basis provides an insight into the daily behaviours of the young people on the programme. Data is collected about the following categories of incidents and detailed behaviours:

- verbal aggression – loud noises, mild insults, swears, moderate threats, clear threats
- physical aggression to objects – slams, messes, throws, breaks, fires, danger
- physical aggression to others – gestures, swings, strikes, attacks mild, attacks severe
- self-harm (no suicidal ideation) – picks/scratches, bangs head, small cuts/bruise, mutilates
- self-harm (suicidal ideation) – ideation, ideation plus attempt
- rules – rule breaking general
- victimised

- abscond – within village, offsite less than 12 hours, offsite more than 12 hours
- drugs – admits or positive test, possession, sells
- sexual – sexualised behaviour, consensual sex, sexual assault
- other offences – theft/dishonesty, fraud, violations, robbery, driving, weapons, obstructing justice, arson.

As Table 5.7 shows, verbal aggression was the most commonly recorded incident overall, followed by physical aggression (both to objects and to people) and rule breaking. The data also provides an insight into the incident rate per week for each young person, based on the amount of time he has been in the programme. These averages, which are included in the right hand column, vary considerably. One young person had no incidents recorded and other averages varied from 0.8 to 7.4. The young person with the highest rate of incidents engaged in high levels of verbal aggression and rule breaking until his early exit.

Table 5.7: Number of recorded incidents by behaviour group and weekly average per young person

Young people	Weeks on the programme	Current status	Behaviour group											Average number of incidents per week in programme
			Verbal aggression	Physical aggression to objects	Physical aggression to others	Self harm (no suicidal ideation)	Self harm (suicidal ideation)	Rules	Victimised	Absconding	Drugs	Sexual	Other offences	
01	5	Exited	0	0	0	0	0	0	0	3	2	0	0	1
02	36	Exited	9	6	3	1	0	0	0	3	2	0	3	.8
03	68	Completed	49	10	11	2	0	22	3	3	0	0	4	1.5
04	66	Completed	26	10	17	1	0	18	0	2	2	0	4	1.2
05	72	Exited	63	19	35	3	0	29	0	5	0	0	10	2.3
06	79	Still in TH	12	6	8	0	0	5	0	2	8	0	18	.8
07	74	Completed	74	23	28	7	0	22	0	5	10	0	9	2.4
08	45	Completed	61	42	15	8	0	31	0	5	1	0	10	3.8
09	17	Exited	28	3	8	0	0	8	0	1	4	0	1	3.1
10	37	Exited	130	41	40	6	0	48	0	5	1	0	4	7.4
11	46	Still in TH	57	27	17	6	13	40	0	6	1	0	14	3.9
12	42	Still in TH	0	0	0	0	0	0	0	0	0	0	0	0
13	41	Still in TH	30	6	12	1	2	30	5	4	3	0	10	2.5
14	32	Still in TH	30	28	13	3	0	16	0	0	0	1	0	2.8
15	26	Still in TH	35	7	14	0	0	17	0	1	0	0	2	2.9
16	22	Still in TH	40	13	16	1	0	18	0	1	0	0	4	4.2
17	9	Still in TH	11	1	4	2	0	6	0	0	0	0	0	2.7
Total			655	242	241	41	15	310	8	46	34	1	93	

While the incidents reported usually involved inappropriate behaviour on the part of a young person or a group of young people, some arose from situations the young people had found themselves in. Incidents ranged from minor events such as playing out of bounds to more serious events such as

assault. They almost all incurred some consequence, including staff interventions, Police involvement and, in some cases, a charge and a court appearance (the latter incidents are reflected in the within-programme offences data presented in Section 5.4).

Examples[21] of incidents include:

- absconding, ranging from very short absences (eg, 30 minutes), to longer absences (eg, when a group left to attend a party) to overnight and longer absences
- capsizing another's kayak
- having gang associates present during a home visit
- assault, including pushing and shoving a staff member, and assaulting a member of the public
- play fighting escalating into a fight
- playing out of bounds (eg, entering a neighbour's property)
- driving a car while not licensed during a home visit
- verbal abuse of staff
- theft
- drug and alcohol incidents such as gaining petrol to sniff and smoking marijuana.

The range of responses to the reported incidents reflected their different levels of seriousness. Examples of responses included the following:

- advising the Police, family/whaanau and/or the CYF social worker
- restraint by a staff member
- time out – the young person voluntarily going to his room
- internal consequences, including those managed through the points system
- a charge and a night spent in Police cells
- Youth Court appearance.

5.2.8 Summary

The education, health and offending histories of the young people, coupled with their referral histories and within-programme behaviours, are consistent with the targeting criteria of the programme. These are young people whose personal and offending histories and disruptive and aggressive behaviours signal the likelihood they are on a pathway to adult offending and imprisonment.

[21] These examples were obtained from the weekly reports provided to the Ministry of Justice by an external contractor.

5.3 Achievement of intermediate outcomes

Intermediate outcomes reflect the changes that the young people and/or their families/whaanau need to make for the young people to journey towards achieving the ultimate programme outcomes, a reduction in the frequency and / or severity of offending. Progress towards these intermediate outcomes will increase the chances that the young people will reduce their offending. The intermediate outcomes include both criminogenic and non-criminogenic outcomes. Criminogenic outcomes relate to:

- family/whaanau circumstances
- educational/vocational progress
- peer relations
- substance abuse
- leisure and recreation activities
- personality/behaviour
- attitudes/orientation.

Non-criminogenic outcomes relate to:

- cultural identity
- identity development
- mental health / safety and physical health issues
- development of life skills.

Specific intermediate outcomes for which progress has been measured are described below.

Aspects of **Family/Whaanau circumstances** reported on include: family/whaanau involvement in and engagement with the programme; the success of the young person's transition home; whaanau insight, skills acquisition, and improved monitoring, supervision and discipline of their young people and control of their behaviour; family members' behaviour; family conflict and parent–child relationships; and family/whaanau use of formal and informal support.

Aspects of **Educational and vocational** progress reported on include: young people's school attendance; behavioural issues; attitude to learning; participation in the curriculum; progress towards education, employment and/or recreational goals (including drivers licence and curriculum vitae); and transition into mainstream secondary or tertiary education, training, work experience or employment and its maintenance.

Aspects of **Peer relations** reported on include: young people's engagement with prosocial peer and family activities and relationships (eg, recreation, education and employment) and involvement in coercive and antisocial peer activities.

Aspects of **Substance abuse** reported on include: young people's changes in level of use; knowledge of associated risks; referrals and engagement in alcohol and

drugs counselling; and access to illicit substances in and out of home; and family/whaanau role modelling on home leaves.

Aspects of **Involvement in leisure and recreation** reported on include: young people's adjustment to and taking increasing responsibility for adherence to residential structure and routines; engagement with recreational activities; engagement in individualised recreational activities in the community; goal setting; and family/whaanau promotion of structure and routines.

Aspects of **Personality and behavioural** outcomes reported on include: young people's skills to self-regulate behaviour and impulsivity; incidents of aggression; compliance with Te Hurihanga rules and judicial consequences; and ability to concentrate.

Aspects of **Changes in attitudes and orientation** reported on include: young people's antisocial and prosocial thinking; moral reasoning and awareness and concern for others; consequential thinking; seeking and accepting help; and compliance with authority.

Aspects of **Cultural outcomes** reported on include: young people's awareness of cultural identity; knowledge of the kaupapa of Te Hurihanga; kawa oo te whare; Mangaonua (the land Te Hurihanga is on), local iwi, Waikato Awa; and knowledge of and ability to do a pepeha and to participate in a poowhiri/whakatau.

Aspects of **Identity development** reported on include: young people's thoughts and behaviours relating to personal appearance; and gang identity.

Health issues reported on include: the extent to which mental health and safety and physical health of young people are addressed.

Aspects of **Life skills** reported on include: young people's attention to personal hygiene; skills or participation in domestic chores; and skills or participation in food preparation.

The extent to which these intermediate outcomes have been achieved has been assessed from information contained in the young people's case files. Results are presented in Tables 5.8–5.18. Extracts taken from the case file notes, and the perceptions of young people, whaanau/family members and programme stakeholders are included in the discussion of results to both illustrate and elaborate on the kinds of progress (or lack of progress) the young people and/or their families/whaanau have made.

5.3.1 Family circumstances

Table 5.8, below, summarises the level of achievement in outcomes relating to family circumstances. As described in Section 3 of this report, family/whaanau involvement in, and engagement with, the programme is a core principle of ecological treatment models. Achievement of long-term changes in the young people, including their internalisation of behavioural

improvements established in Phase 1, depends on the success of the young people's transition home, the strength of family relationships and whaanau/families' ongoing supervision of and responses to the young people's behaviours. To maximise the programme outcomes for the young people, family/whaanau need to understand the factors that trigger their young people's unacceptable behaviour and encourage their acceptable behaviour; have the skills and will to monitor, supervise and discipline their young people and control their behaviour; and monitor their own behaviour. Families/whaanau also need to identify and use formal and informal support available in their communities.

As Table 5.8 shows, in Phase 1, most families/whaanau had regular contact with their young people (eg, through telephone calls and visits), participated in programme activities and engaged with the whaanau workers (whose interventions could, at times, be challenging). However, in some cases, family involvement was less than ideal. Sometimes, family circumstances limited the level of visiting. Reasons varied. Some whaanau lived some distance away (eg, up to an hour's drive) but did not have access to a car. Some had periods of illness and could not visit. Some spent time in prison and could not visit. When possible, the programme facilitated contact. For instance, whaanau members reported Te Hurihanga staff picking them up, or providing taxi chits, so that they could visit their sons. They also reported the programme providing them with cellphones or call 'top-ups' so that they could send and receive phone calls. Whaanau activities include whaanau waananga and weekly or fortnightly individual parent sessions. Most whaanau members talked about whaanau waananga they had attended. Examples of comments in case file notes show the range of involvement and the complexity of some family circumstances:

- *Mother maintains daily phone contact and weekly contact with young person.*
- *Contact – but not at the frequency expected by the programme.*
- *Phone was the primary way of contacting young person. Mother has been unable to visit young person at Te Hurihanga until second to third week of admission because of her home detention status. Young person's father has visited on an infrequent basis.*

For those who had reached or completed Phase 2 at the time of the data collection (15 in total), most (11) had made a successful transition to home (via the home-leave process). However, four had not. In thirteen of fifteen cases, family participated in programme activities, engaged in sessions with the whaanau workers, gained insight into factors influencing their young people's behaviours and learned skills to respond to them appropriately. Most also improved their supervision. The following extracts from the case files illustrate the degree that some families changed while their young people were in the programme, and the difficulties some faced in supervising their young people and carrying on their other roles:

- *Stepfather and mother are working together to implement house rules and family rules. Although young person will still push the boundaries, mother has confidence to manage this with stepfather's support. She has taken on board any new learnings and is not afraid to give them a go or ask for assistance from Te Hurihanga if the need arises.*
- *Irregular visits of whaanau worker with mother and other members of whaanau.*
- *Parents have tried to implement safety measures to ensure the supervision of young person while they have been at work. However, young person has shown that he is not ready and this has resulted in mother and stepfather making the decision to stop their current working contract of working nights and taking on a day shift role that would meet all the family's needs.*

Despite the progress their young people had made on the programme, whaanau had mixed views about the extent to which their young people were ready to come home and fit back into the family and community. Most felt the programme had resulted in their young people being more considerate, affectionate and respectful. They expected family relationships to be better and generally looked forward to their young people coming home. Typical comments included the following:

- *More appreciative and considerate – but he needs to reflect on what he has done. Still needs attention.*
- *Expect him to settle back in.*
- *More considerate, better family relationships.*
- *Don't see any problem – always had a good relationship. Now back to sleeping in my bed.*
- *Pretty stoked.*
- *Appearance improved – body language changed. Stature upright – grins, happy.*

However, some whaanau, including those who could see positive changes, were still ambivalent about their boys coming home. In some cases, they thought the young people still needed time for the positive changes to become established. However, they generally become more optimistic as their young people progressed through the programme. Sometimes, the ambivalence about their boys coming home reflected concerns about their being able to maintain boundary setting. Sometimes it reflected their worries about their boys' lack of training or work to fill their days. While some whaanau could see some value in their boys going back to school they did not see that as a realistic possibility given their previous school experiences. There was also a sense that some of the mothers remained frightened of their sons. Here are some typical comments:

- *Not ready yet to have [son] home.*
- *He's not ready to come home – even though we miss him. He'll know when he's ready – he'll let the whaanau know. Regular visits important but not too many, not allowed to visit him in Te Hurihanga without making an appointment.*
- *[Son] needs a job to ease boredom.*
- *Still unsure about him coming home – will need to keep up changes.*
- *Want [son] in work – and not in trouble. But he's probably already there.*
- *Yes [I want him home] on some levels – involved in his holiday programme for respite. But would have liked counselling and a focus on his violence.*
- *Friends who were a bad influence are not out working, so temptation still there. World keeps turning, so [son] needs skills to cope with situations.*

The intermediate outcome measures for Phase 3 relating to family circumstances reflect the expectation that family/whaanau will both implement the tools they have learned to better monitor and supervise their young people and address family issues that can negatively impact on the behaviour of their young people. Eight of the young people had progressed to Phase 3, when MST is implemented, by the end of the data collection period (June 2009). Four of these young people had completed the programme. As Table 5.8 shows, in most cases (four to five of the eight), the families/whaanau were increasing their control of their young person's behaviour. For instance, whaanau/families had implemented more effective disciplinary practices, and become better role models through improving their own responsible behaviour. They also addressed family issues by reducing conflict in the home and strengthening parent–child relationships (eg, more warmth and affection). In general, they also engaged well with MST case workers and actively sought formal and informal support. However, only two of the eight were consistently following through with MST interventions.

Whaanau members could also identify positive changes they had made as a consequence of the programme (canvassed through interviews). Most talked about being better at responding to the negative behaviour of their young people. That is, they felt the programme had provided them with more skills and tools to set boundaries. For instance, one mother commented:

> *He hasn't changed in his make-up but we can see how to react day-to-day. Staff deal with things in ways that we didn't know were appropriate. He has to learn that he can't get away with what he wants. Has to accept 'no' without feeling rejected.*

It was also common for mothers to reflect on their past responses to the behaviour of their sons and realise that they had seldom stopped them from doing whatever they wanted. Some talked about the programme providing them with new insights about mothers' rights (and indeed obligations) to put boundaries around the activities and behaviours of their sons.

Some of the specific gains whaanau identified for themselves included the following:

- *Better organisation of their personal lives, for instance through keeping a diary and a roster.*
- *More space and time to focus on the needs of other children, especially while their young people were in the residential phases.*
- *Skills to manage the behaviour of their young people.*
- *Having someone to contact (call or text) when they are stressed out.*
- *Better understanding of why their young people behave the way they do and how to avoid situations that lead to escalating behaviour problems.*

The following file extracts illustrate the efforts some families took to address family issues and work on implementing what they had learned, and the multiple difficulties some whaanau faced:

- *Mother's move back to Hamilton has made a huge impact on his progression through the programme. She and the young person's stepfather have been working on their relationship and have since resumed as a de facto couple. Stepfather is making an effort to improve his relationship with the young person and encouraged him to play social rugby with him. They also have a shared interest in cars and have a project to fix a vehicle that will some day be young persons.*
- *To date, mother and whaanau are taking this responsibility seriously.*
- *Initially, mother displayed ambivalence in terms of engagement and participation in MST. Often she was not present for arranged sessions or communicated that she is too busy. However, engagement improved during the last 2–3 months. The family had been facing multiple stressors including overcrowded housing, an incident of domestic violence (resulted in stepfather being remanded to prison), subsequent solo parenting by mother and her own experiences of depression.*

In almost all cases, responsivity issues (or identified barriers to achieving outcomes) were identified and plans put in place in an attempt to address them. Examples of identified barriers included the following:

- *No family worker at this stage.*
- *Both father and mother are working full time.*
- *Location of home and possible transport issues.*
- *Mother does not have transport and may find this a challenge to have regular visits into Te Hurihanga [Te Hurihanga provides family with transport].*
- *When young person absconded the family were inconsistent with their support to assist Te Hurihanga to ensure young person's return.*

- *Mother will benefit from MST input as she still has a tendency to fall back into a permissive state.*
- *Young person still has a tendency to push boundaries and attempt to dictate to the family as to how things are going to be and his parents have a tendency to allow him to do this.*
- *… Mother wanted as little as possible to do with young person's biological father as this had been a volatile relationship. She had a very poor relationship with her own father and would not attend any interagency meetings if young person's biological father or her father were present.*
- *Initial responsivity barriers included the family's 1) comprehension of information being provided 2) tendency to live day-by-day (with little structure) 3) transport difficulties.*

Table 5.8: Changes in family circumstances at 16 June 2009[22]

Outcomes	Phase 1 (n=17)	Phase 2 (n=15)	Phase 3 (n=8)
Regular family involvement with young person	14		
Family involvement through participation in programme activities	16		
Engagement in sessions with whaanau worker	14		
Successful transition to home		11	
Family involvement through participation in programme activities		13	
Family engagement in session with whaanau worker		13	
Parental insight and skills acquisition		13	
Improved parental supervision		11	
Family is monitoring and supervising the young person appropriately			5
Family has increasing control of young person's behaviour			5
Increasing parental responsibility			5
Family members have increased responsible behaviour and decreased irresponsible behaviour			4
Family has implemented effective disciplinary practices			4
Reduction of conflict in the home			5
Parent–child relationships are strengthened			5
Family is actively seeking formal and informal support			5
The family has engaged well with MST case worker			5
Parents have consistently followed through with MST interventions			2

[22] In this, and other outcome areas, the balance between the number who made progress and the number of people in that phase comprises: those who did not make progress, those for whom Te Hurihanga staff were unsure of the answer and those for whom the outcome was not applicable as the young person/whaanau had not spent enough time in the phase.

5.3.2 Education and vocational outcomes

The young people on the programme had generally been out of school for a number of years. Typically, whaanau would report that their young people had left school when they were twelve or thirteen years old. Thus, it was rare for the young people to have had much experience of secondary school. Their average reading comprehension age (at 7.7 years) is one reflection of this lack of schooling. In Phase 1, the young people are reintroduced to regular schooling, which aims to reduce their behavioural problems (eg, because they are productively occupied in a structured environment), enhance their attitudes to learning, provide opportunities for them to participate in academic/core curriculum and the wider curriculum, and assist them to progress towards goals set in relation to education, employment and recreation (eg, gaining their drivers licence and completing their CVs).

As Table 5.9 shows, almost all of the young people made progress in their Phase 1 educational and vocational outcomes. However, three to four young people failed to improve their attitude to learning, achieve set goals, or complete their CVs. The following extracts from their case files provide an insight into the young people's motivations and the gains they made:

- *The young person has been involved in three literacy and three numeracy classes per week. He has been enrolled with the Correspondence School of New Zealand and is completing the school's materials. The level and content of the materials reflect his ability and general interest. The focus of his work has been at Level 2 and 3 of the National Curriculum. The content has included fishing, driving and health in literacy and measurement, graphs and geometry in mathematics. Young person is often given one-on-one support to optimise his learning in these areas.*
- *He did demonstrate motivation to improve his basic skills in numeracy and literacy. He recognised the deficits in his learning and showed willingness in addressing them. He was especially conscientious in his progress in mastering the spelling lists as identified by the NZIER. He spent many sessions undertaking the 'copy, cover, compare' method to improve his spelling.*
- *Young person has struggled to identify short term and long term vocational goals. He has not expressed particular preferences for the sort of job he wants. However, he would like to make enough money to have whatever he wanted; for him this meant to buy a car, maybe a V.8 and in time to rent a house.*

In Phase 2, the educational, vocational outcomes sought reflect the young people's transition to their whaanau and communities. The outcomes include: transition into mainstream secondary or tertiary education, training, work experience or employment and achievement of vocation-related individual goals (e.g. learner or restricted licence, CV completion, interview skills, job applications, etc). Twelve of the fifteen young people who reached Phase 2

by the end of the data collection period had made progress towards these outcomes. One example is a young person who resumed his secondary schooling. The school noted the need to keep the young person 'off drugs' and concluded that the NCEA (National Certificate of Educational Achievement) credits he gained would not have been possible without Te Hurihanga. The following extracts from the file review provide further insight into the context within which these gains might be made. One describes the types of goals one young person had developed and the other notes the need for collaborative effort to overcome some of the learning difficulties the young people face:

- *Young person is working on his CV and driver licence and is currently working out if he wants to work in the fast food industry for the qualifications that they provide.*
- *Young person received extensive one-on-one tutoring but still showed a lack of self motivation while in the classroom. His learning style has now been focused on his vocational pursuits and young person's hands-on preference to learning new things. The process is currently underway seeking an exemption for the young person from Ministry of Education. Te Hurihanga is working with the Ministry in order to identify the most user-efficient and best approach to assist the young person with his future goals.*

In Phase 3, the education, training and vocational outcomes focus on maintaining the gains made in Phase 2 (ie, maintaining participation in mainstream secondary or tertiary education, training, work experience or employment). The file review indicated achievement in six out of eight cases. However, the education, training and/or work status of the young people can be fluid, especially in the economic climate that existed during the latter half of the evaluation. For instance, during interviews of young people in Phase 3 at the end of 2008, it was evident that young people's involvement in educational and vocational activities was not ideal. One was attending secondary school on a full-time basis, one was in employment and two were not involved in education, training or work. One trainer noted the need to address attitudes to keep the young people in work: *"if they had good work ethics – reliability is big for employers"*. The following extracts from the case files provide some illustration of the range of experiences:

- *CV recognises dive achievement – open water dive ticket and recent work commitments. Continuing with his dive career. Studying for his Water Rescue certificate. Completion will then allow for his advanced divers ticket.*
- *Went through many different avenues of employment and is currently employed by Waikato Forestry Service as a planter/pruner.*

In sixteen of the seventeen cases, barriers to achieving the identified outcomes were identified. These include:

- *With respect to literacy, young person is currently reading at an approximate 10 year old reading age.*
- *Young person had negative idea about education. Needed to break tasks down to make them more relevant and manageable for him.*
- *Young person experienced high levels of frustration during interactions with peer staff relationships.*
- *Significantly low intellectual functioning.*
- *Young person has been disengaged from education.*
- *Low cognitive function and ADHD diagnosis…Behaviour problems, including non compliance and verbal aggression towards teachers, fighting with students and truancy are manifestations of frustrations held within the learning environment.*
- *Young person's main barrier to succeeding in a mainstream setting is his aggression.*
- *Un-medicated ADHD and tendencies for frustrating tasks to result in outburst of aggression.*

Table 5.9: Education and vocation outcomes for young people

Education/Vocation outcomes	Phase 1 (n=17)	Phase 2 (n=15)	Phase 3 (n=8)
Regular school attendance (versus truancy)	16		
Reduction in behavioural issues	16		
Enhanced attitude to learning	13		
Participation in academic/core curriculum	16		
Participation in the wider curriculum	16		
Progress towards goals set in relation to education/employment/recreation	14		
Progress towards gaining drivers licence	14		
Progress towards completing CV	13		
Transition into mainstream secondary or tertiary education, training, work experience or employment		12	
Achievement of vocation-related individual goals		12	
Young person has maintained participation in mainstream secondary or tertiary education, training, work experience or employment			6

5.3.3 Substance abuse

As shown in Table 5.5 (earlier in this section of the report) almost all the young people had a substance abuse problem when they entered Te Hurihanga. The outcomes sought in the three phases of the programme reflect efforts to progressively enhance young people's knowledge of the risks associated with drug and alcohol use (along with enhanced consequential thinking); reduce their substance use; encourage their families/whaanau to provide appropriate role models; address access to drugs and alcohol; and encourage the young people to engage in appropriate counselling. As the results in Table 5.10 show, ensuring that young people abstain or moderate their use is more easily achievable in the residential phases of the programme (as noted in the first case notes extract below).

The majority of young people maintained their reduced use of drugs and alcohol in Phase 3. In most cases, they were supported by families/whaanau providing appropriate role modelling (eg, through no access or use in front of the young person). One stakeholder described the pleasure he got from observing one young person's reduced reliance on alcohol and, particularly, marijuana: *"Because he is supervised and doesn't have access to drugs and alcohol I see his good points again. His natural politeness, etc isn't distorted by drugs"*. As subsequent case note extracts show, however, young people can revert back to old habits when they abscond. These extracts reflect the prevalence of drug use amongst the young people before entry to the programme and amongst some of their whaanau/families:

- *Residential house reduces access to substance – although the young person frequently comments about the need to get some weed.*
- *Young person has completed the Pacific People Addiction Services Inc (PPASI) Drug and Alcohol programme. Young person had attended in-house education in regard to risks and consequences of substance abuse.*
- *Young person admitted to cannabis use during his recent abscond.*
- *Nil use of drugs while in residence and actively engaged in Phase 2 of the programme. When young person absconded from the programme he would smoke cannabis on abscond.*
- *Brother wasn't a parental model so found it hard to act as such. Acted more as a sibling to young person [eg, did not always limit alcohol consumption].*
- *Immediate family members have reported that they have been consistent in denying young person access to cannabis. Young person has advised his MST clinician that he has engaged in infrequent use (roughly fortnightly) when provided opportunity from peers. On these occasions access had been free, and he has conveyed that he would never "waste" his own money purchasing it himself.*

Table 5.10: Substance abuse outcomes for young people

Substance abuse outcomes	Phase 1 (n=17)	Phase 2 (n=15)	Phase 3 (n=8)
Abstinence or moderation of alcohol and drug use	15	12	
Enhanced knowledge of substances and their risks	15	13	
Referred to alcohol and drug counselling (through local provider)	15		
Engagement in alcohol and drug counselling		10	
Opportunities to access illicit substances out of the home are addressed		13	
Appropriate parental role modelling on home leaves		12	5
Reduced access to alcohol and drugs			5

5.3.4 Peer relations

Two of the most important intermediate outcomes for young people in Phases 1 and 2 are, on the one hand, development of prosocial relationships and, on the other, withdrawal from antisocial peers. To achieve these outcomes, the young people need opportunities to meet with new sets of young people. Most of the young people in Phases 2 and 3 had more engagement with prosocial peer and family activities and relationships (see Table 5.11). They also need to be dissuaded and distracted from meeting with their previous antisocial friends and acquaintances (eg, those with whom they may have engaged in offending behaviour). As Table 5.11 shows, most of the young people in Phases 2 and 3 had reduced their involvement in coercive and antisocial peer activities. As discussed earlier, and re-enforced in the following extracts, leisure, recreation, education and employment provide the best opportunities to achieve these outcomes. However, as one of the extracts also illustrates, it is difficult for some of the young people to abandon the gang culture:

- *Played touch for Te Hurihanga social team, rugby for …College Under 16s, attended hip hop dance practices and competitions with dancing peers. He made these peers while working at … . Attended and participated in monthly Whaanau waananga over a period of five months in preparation of an unveiling ceremony for his maternal grandmother.*
- *Young person made a number of new friends at school. In particular he learnt to develop his social skills (communication/appropriate responses, develop and maintain safe relationships, gaining an awareness of how girls think and how to keep himself safe). He also made male friends/acquaintances through playing sport (rugby) and individual class groups. Young person continues to build on his social relationships and has made a number of new friends at .. College. In particular, he has been proactive in seeking support to interact appropriately with his female peers. Young person's goals for next term are to continue the positive relationships.*

- *Through his dive training peers, young person has taken an interest in graphic arts.*
- *Has developed pro-social hobbies such as kick boxing and rugby and is currently interacting with pro-social peers in the work environment.*
- *Throughout MST therapy the young person continued to engage in gang activity.*

Table 5.11: Peer relations outcomes for young people

Peer relations outcomes	Phase 2 (n=15)	Phase 3 (n=8)
More engagement with prosocial peer and family activities and relationships	12	5
Reduced engagement in coercive and antisocial peer activities	11	5

5.3.5 Leisure and recreation

Leisure and recreational activities provide opportunities for the young people to adjust to a more structured lifestyle, reintegrate into community activities, work towards identified goals, and mix with prosocial young people. Engagement in these activities also reduces their opportunities to mix with antisocial young people. In Phase 1, the focus is on the young people making adjustments to the residential structure and routines, engaging with multiple, programmed, residential and educational recreational activities, and selecting a community-based individualised goal. As Table 5.12 shows, in most cases progress towards these outcomes has been made. The young people are less successful at selecting a community-based recreational goal. As these extracts from the case notes show, motivation can be a problem as, of course, can early exit from the programme:

- *Minimal engagement without prompting.*
- *By the end of Phase 1 young person had identified current skills that he would like to continue to improve including: guitar playing, horse riding, painting, and carving. He would also like to monitor his weight and improve his physique. Young person expressed that he was interested in furthering his involvement with horses and that he was "ready to give it (equestrian course) a go, to see if I like it" and to see if he would like to work in that area. Young person expressed that he was looking forward to the opportunity of involvement in a community rugby-league team and that he would like to try playing with a grid-iron team. Young person absconded during early stages of Phase 2 and was exited from the programme before this could be implemented.*

In Phase 2, the outcomes sought reflect a focus on the young person increasingly taking responsibility for adherence to structure and routines and choosing and engaging in an individualised recreational activity. Again, most young people had made gains (two extracts from the notes provide details). However, they have had less success at becoming involved in an individualised activity:

- *Young person continues to follow the in house routines and knows the house routine inside out. There are times where young person will challenge these. While in Phase 2 he has maintained a high standard in this area.*
- *Young person has joined college old boys under-16 rugby league team. He has also joined a league academy which may lead him into a career in the NRL as a professional league player.*

In Phase 3, the outcomes sought reflect the programme focus on supporting family/whaanau so that they can provide an environment that encourages and supports acceptable behaviour. It also focuses on the young people's reintegration into community through recreational activities. While, in five out of eight cases, the families/whaanau promoted structure and routines (supported through the MST component of the programme), only two of the eight young people had maintained engagement in a recreational or other prosocial activity (see Table 5.12). The extracts below show the sorts of efforts some families made:

- *Mum engaging in board games and activities for family.*
- *During Phase 3, young person and his siblings have attended a youth group attached to the local church (weekly). Young person has also engaged with a youth activities worker through CYFS. With this worker he has attended a gym. Young person seemingly enjoys the role modelling and the positive individual attention of this youth worker.*

Table 5.12: Leisure and recreation outcomes for young people

Leisure/recreation outcomes	Phase 1 (n=17)	Phase 2 (n=15)	Phase 3 (n=8)
Made adjustment to residential structure and routines	16		
Engagement with multiple programmed residential and educational recreational activities	16		
Selected a community-based individualised goal	13		
Increase in taking responsibility for adherence to structure and routines		12	
Engagement in an individualised recreational activity		11	
Parental promotion of structure and routines			5
Young person maintained engagement in a recreational/prosocial activity			2

5.3.6 Personality and behaviour

The achievement of intermediate outcomes relating to young people's behaviour is core to a successful pathway towards a reduction in the severity and frequency of offending. These outcomes include enhancement of self-regulation skills (eg, problem solving and aggression control); reduction in incidents of aggression (eg, tantrums, verbal and physical abuse and wilful damage); compliance with Te Hurihanga rules; compliance with judicial consequences (eg, community hours, other FGC requirements); improved ability to attend or focus (ie, compliance with ADHD medication regime); better control of impulsivity; and reduction in incidents in the community.

The file review shows that young people's achievement of these personality and behaviour outcomes has been variable (see Table 5.13), particularly with reference to improved ability to attend. Whaanau/family reports of changes, canvassed through interviews, tend to be more positive. Most talked about their young people regaining their previous positive personal qualities and having improved their behaviour. They felt that their young people were more motivated to improve their behaviour, more disciplined about their daily activities, and had better skills to avoid responding to situations in inappropriate ways. They also felt that their young people were more considerate, less self-centred, and less impulsive.

Some tempered their positive reports with doubts about the ability of their sons to desist from offending altogether. As one mother explained, her son "*is easily influenced so might still offend – sees family as boring and friends as exciting. We can't compete with what attracts him*". And a sister still felt her brother remained self-centred: "*He needs a reality check – feels like he's too important*".

Some specific observations that whaanau members made about positive changes include the following:

- *Has skills to cope in different situations.*
- *Able to step back when something happens, think before reacting, make right decisions and identify what things won't always go his way. It's not always about him.*
- *Stops and thinks about things.*
- *It's good to have my son back, the son I used to have – old sparkly-eyes not the red-eyed zombie.*
- *He is happier, more open, more confident, more assertive. Not a 'I don't know boy' anymore. Now a 'yes, I'll think about that young man'. He is more reflective, more 'head held high'. He is also remorseful.*
- *Gets himself up in the morning, makes his bed, more self-care. He sees this as a second chance.*
- *Learned what triggers his anger.*

As the case file extracts below illustrate, because the young people are typically oppositional and aggressive, achieving behavioural changes can be challenging. The prevalence of aggressive behaviour is also reflected in the incident reporting discussed in Section 5.2 and in preintake offending reported in Section 5.4. The extracts also illustrate how aggression is more able to be moderated in the residential setting compared with the home and community settings:

- *In therapy, young person was initially oppositional when discussing offending matters, but became engaged when the content shifted to problem solving and distress tolerance skills. Young person has participated well in individual and group sessions and has shown ability to use simple skills outside of the therapy setting.*
- *During Phase 1 of the programme there were minimal incidents of aggression. Young person's communication and relationship skills improved so that he can and will engage in meaningful discussion with staff about the programme and his life. He has also been observed engaging in appropriate conversation during family visit.*
- *The young person could be verbally and physically aggressive. He presented with poor frustration tolerance. He engaged in tantrum-like behaviour (including property destruction at home).*
- *Young person's behaviour has generally been very appropriate in the presence of Te Hurihanga staff and/or when otherwise supervised at work or rugby. Behaviour when unsupervised has yet to be tested.*
- *During Phase 3, young person has not physically assaulted anyone according to verbal reports from the family, school and Police. However, he has continued to threaten his younger siblings with violence and could be rough when playing with them. Mother conveyed that she had struggled to control his behaviour since stepfather had been away from home. Mother was encouraged to provide consistent consequences, including calling the Police should young person engage in heightened intimidation or aggression.*

Table 5.13: Personality and behaviour outcomes for young people

Personality/behaviour outcomes	**Phase 1** (n=17)	**Phase 2** (n=15)	**Phase 3** (n=8)
Self-regulation skill enhancement	11	9	
Reduction in incidents of aggression	10	10	
Compliance with Te Hurihanga rules	10	10	
Compliance with judicial consequences	12	10	
Improved in ability to attend	3	3	
Better control of impulsivity			5
Reduction in incidents in the community			5

5.3.7 Attitude and orientation

In Phases 1 and 2, the programme seeks to reduce young people's antisocial thinking and/or enhance their prosocial thinking as a pathway towards reducing their offending. It also seeks to enhance their moral reasoning, including their consequential thinking and awareness and concern for others (including remorse and victim empathy), and consequential thinking (including consideration of positive and negative short-term and long-term consequences for their actions). The programme also encourages the young people to actively seek and accept help and comply with authority.

As Table 5.14 shows, young people's progress in these outcome areas has also been variable. Few have achieved enhanced moral reasoning, especially while in Phase 1. More than half, however, have improved compliance with authority and a majority have reduced their antisocial thinking and/or increased their prosocial thinking. Twelve of the seventeen young people have achieved enhanced consequential thinking, no doubt at least partially attributable to the effective delivery of the points system. More than half the young people also actively sought help, including after they had completed the programme.

- *Experienced job loss due to cannabis use and focused on future incarceration if behaviour didn't change.*
- *Young person's engagement with the programme during Phase 1 has been appropriate for a youth in Phase 1. He has had difficulty in situations where he has been asked to try new activities, but appears to be less anxious now than when he first started. He has also been challenged when he has wanted to relax rather than engage, and when he has had to cope with the control staff have over his life. He has acknowledged "I don't like being told what to do". However, he has generally been compliant and has coped well in the programme to date and has experienced some new activities such as carving and rock-climbing.*
- *During Phase 1 and Phase 2 he displayed a level of engagement with and help-seeking from adults and professionals. However, his incident reports and drug test results indicated ongoing anti-social tendencies. He typically displayed limited guilt and delayed responsibility-taking following behavioural transgressions.*
- *Young person has requested help from staff at Youth Horizons, to assist in his transition from Phase 3 into the community.*
- *There has been some evidence for more anti-social thinking at times (comments relating to wanting to join a gang; idolisation of stepfather's past gang affiliations). However, young person has continued to access and utilise adult supports (MST clinician, teacher aid, youth support worker, parents).*

Table 5.14: Attitude and orientation outcomes for young people

Attitudes/orientation outcomes	Phase 1 (n=17)	Phase 2 (n=15)
Reduction in antisocial thinking and/or enhancement of prosocial thinking	10	10
Enhanced moral reasoning	1	4
Enhanced consequential thinking	12	11
Actively seeking and accepting help	11	10
Increased compliance with authority	9	8

5.3.8 Cultural outcomes

Te Hurihanga is a bicultural programme in which the cultural aspects of the treatment model are fundamental to the achievement of positive outcomes for the young people.

Cultural outcomes are measured by way of increased awareness, knowledge and/or ability to participate in eight areas, as listed in Table 5.15 below. They include: the young people's own identity; the kaupapa of Te Hurihanga; kawa oo te whare (kawa/tikanga); Mangaonua (land Te Hurihanga is on); local iwi; Waikato Awa; pepeha and poowhiri/whakatau and wero.

As Table 5.15 shows, virtually all the young people have made progress in achieving these outcomes. In one case, the young person had only very recently entered the programme, so opportunities to introduce him to some cultural components of the programme (eg, marae visit) were limited. Outcome measures reflect this. Whaanau/family members identified further positive changes they attributed to the cultural components of the programme. For instance, some mothers, including a New Zealand European mother, attributed their sons' increased thoughtfulness for whaanau members and respect for their mothers and other adults to the influence of the programme Kaumaatua.

Extracts from the case files provide some insights into the achievements of the young people:

- *Young person struggled with his cultural background and would often remove himself from participating. Continuous encouragement to engage was effective around a third of the time. Young person became aware of his cultural identity.*
- *Young person has been active on his own marae since being placed back there at the end of last year to complete his community work hours. He has done a wonderful job in the dining room of Te Kaharoa marae, redoing the kowhaiwhai patterns which adorn the whare kai, moerangi. Whaanau from the marae have all commented on the work that he has done and young person and whaanau are very proud of his work.*

- *Young person has progressed with Te Reo Maaori, with pronunciation of Maaori. Young person generally uses and respects the values of the house, Manaakitanga, Wairautanga, Aroha and Whaanaungatanga, and uses them to the best of his ability. He has demonstrated consistent interest depicted by him often asking the Kaumaatua questions.*
- *Young person has a closer relationship with his Marae and others in the region.*

Table 5.15: Cultural outcomes for young people

Cultural outcomes	Phase 1 (n=17)
Increased awareness of own identity	17
Increased knowledge of kaupapa of Te Hurihanga	17
Increased knowledge of kawa oo te whare (Kawa/Tikanga)	16
Increased knowledge of Mangaonua (land Te Hurihanga is on)	16
Increased knowledge of local iwi	16
Increased knowledge of Waikato Awa	16
Increased knowledge of/ability to do pepeha	16
Increased knowledge of/ability to participate in a poowhiri/whakatau	17

5.3.9 Identity development

The outcomes sought in relation to identity development relate to both personal appearance and to gang culture. According to a number of the young people's parents, gang culture is ubiquitous in the areas the young people live in or hang out in. Indeed, they were concerned about how their sons would reintegrate into community life, given the importance of 'patches' to their self-identity. They hoped that the young people's increased awareness of, and pride in, their cultural identity might provide a counter to the gang culture and influence. One focus of the cultural component of the programme is to provide an alternative identity to that of the gangs; a cultural identity. The aim is to give the young people an alternative cultural basis (eg, an iwi or hapuu identity) upon which they can gain a sense of pride and of belonging. Thirteen of the seventeen young people have achieved identity outcomes (see Table 5.16). The following extracts from the case notes provide an insight into the young people's identity development:

- *Increase in self-esteem due to feeling that one is improving one's self looks. Level of personal presentation increased when formal functions were attended.*
- *Residential house removes young person from public and anti-social areas – has immediately reduced gang identity. Young person plays on and often provokes gangland behaviour. Staff are concerned he doesn't really affiliate or have known gang associates; this is viewed as childish result from too much television.*

- *No visual appearance of gang recognisable in young person's attire. He is purchasing clothing reflective of his employment.*
- *Young person has changed his clothing to head to court and formal occasions to a smart casual look. He also increased daily hygiene practices. Young person has also made personal appearance changes to himself that have increased his self-esteem.*

Table 5.16: Identity development outcomes for young people

Identity development outcomes	Phase 1 (n=17)
Increased thoughts/behaviours relating to personal appearance	13
Reduction in gang identity (increased prosocial identity)	13

5.3.10 Mental health/safety and physical health

As discussed in Section 5.2, some of the young people entered the programme with pre-existing mental and/or physical health conditions. Two of the outcome areas relate to these and other health conditions being addressed appropriately. As Table 5.17 shows, eleven young people have received treatment or assistance for pre-existing or subsequently diagnosed mental health conditions. All the young people's physical health conditions were addressed through internal and external specialist, general practitioner and dentist visits. The extracts below illustrate some of the interventions provided:

- *During Phase 1 young person established routine of utilising doctors and dentists and a pride in his physical wellbeing.*
- *Treatment through therapy with Te Hurihanga psychologist and CAMHS.*
- *Young person's physical health issues were addressed. Young person went to see the doctors and specialist for injuries received while on outing. Staff enforced the doctors recommendations but young person refused to listen to them. He also went to see an orthopaedic surgeon for an old injury that flared up after he started work.*
- *Young person has continued to be treated for mental health issues with bi-monthly appointments at Child and Adolescent Mental Health Services. He has continued to take his medication.*

Table 5.17: Mental health/safety and physical health outcomes for young people

Health outcomes	Phase 1 (n=17)	Phase 2 (n=15)
Mental health/safety concerns/issues addressed	11	9
Physical health/safety concerns/issues addressed	17	15

5.3.11 Life skills

Life skills outcomes include improved attention to personal hygiene, increased skills or participation in domestic chores, and increased skills or participation in food preparation. These were generally achieved by the young people (see Table 5.18). As the following descriptions illustrate, the young people often lacked basic life skills when they entered the programme:

- *Improved attendance to daily personal hygiene. Would have shower daily, brush teeth twice a day, finger nails would be cut when needed. Hair would be brushed and styled using hair product. Hair would be clean, cut and tidy.*
- *Young person required assistance when first entered programme (needed instruction).*
- *Has always had an interest in food and preparation and is responsible for making his own breakfast and lunches.*
- *Young person showed he was able to complete tasks when it suited him and continued to recognise the structure but struggled to engage full participation without staff support and prompts.*

Table 5.18: Life skills outcomes for young people

Life skills outcomes	**Phase 1** (n=17)	**Phase 2** (n=15)
Improved attention to personal hygiene	15	15
Increased skills or participation in domestic chores	16	14
Increased skills or participation in food preparation	14	14
Other outcomes	1	4

5.3.12 Summary

Evidence from the file review and interviews with whaanau members, the young people themselves and stakeholders consistently indicate that the young people on the programme have generally made good progress in achieving the identified intermediate outcomes. However, lower levels of achievement in some outcome areas for some of the young people, specifically those relating to their attention span, moral reasoning and compliance with authority, may affect their capacity to desist from offending after their completion of the programme.

5.4 Ultimate outcomes – offending frequency and severity

One of the programme's ultimate outcomes is to reduce re-offending. Reductions in offending may be indicated by:

- a cessation of offending
- reduced frequency of offending
- reduced severity of offending.

The above measures can be used over the course of the programme and post-programme. Measures of within-programme offending may be considered evidence of short-term effectiveness. However, while the young people are in the programme, they are under an artificially high level of supervision and management (particularly in Phase 1 and, to a slightly lesser extent, in Phase 2). Also, one of the consequences of some categories of inappropriate behaviour is that the Police will be notified. Measures of post-programme offending can be considered as evidence of longer-term effectiveness. However, the pilot had been operating for only two years at the end of the evaluation period. At that stage, only four young people had completed the programme, and none had completed it sufficiently long ago to allow any medium to long term follow-up. Thus, any analysis of post-programme offending data would be premature.

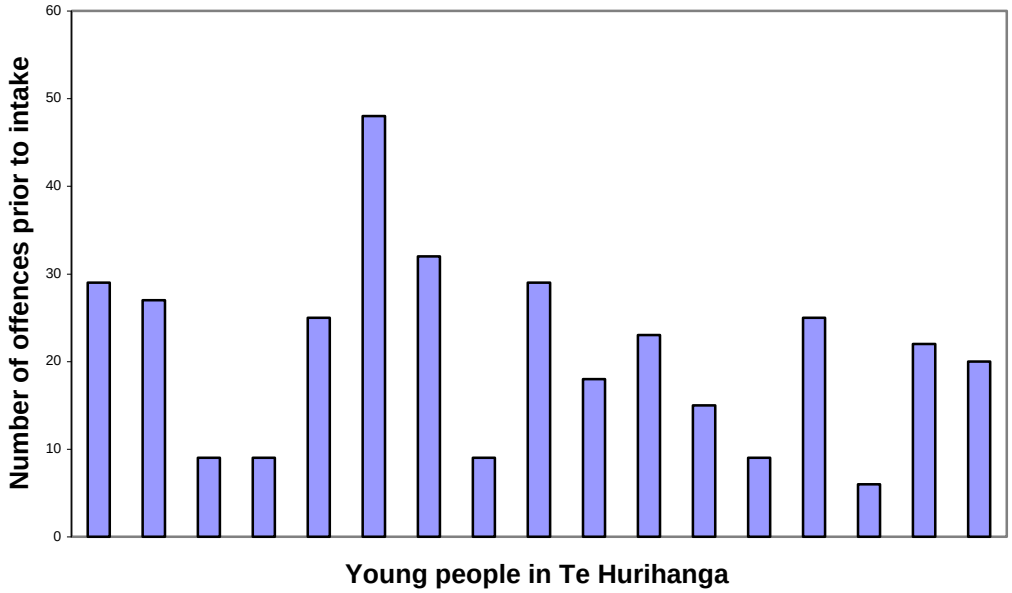
This section of the report provides some insight into the young people's offending patterns by presenting the young people's: preintake apprehension numbers (including severity ratings); and some descriptive commentary on within-programme and, for the four completers and five early exits, post-programme offending.

5.4.1 Preintake offences[23]

For the seventeen young people accepted to Te Hurihanga before the end of the evaluation period, Figure 5.1 shows the pattern of preintake offending across the programme entrants. The number of offences ranges from a high of forty-eight to a low of six. On average, the young people had 21 offences prior to entering Te Hurihanga. It would seem that this offending rate is considerably higher than the rates of offending typical of young people entering intensive ecological programmes internationally. These international programmes, albeit usually non-residential, are also set up to address the needs of young offenders with serious offending histories. However, evidence from evaluations of MST programmes in the US suggests that young people participating in these programmes typically have three to four arrests[24] prior to programme entry (Borduin et al, 1995; Henggeler et al, 1997).

[23] An offence is recorded if an apprehension leads to a charge and the charge is admitted or proven.
[24] It is not clear whether these arrests result in offences. Their offences may be fewer than three to four.

Figure 5.1: Number of offences prior to Te Hurihanga intake



Severity of offences: In most cases, the young people's preintake offences were categorised as Moderate, using the Department of Corrections' four offending severity categories. The Department of Corrections' severity categories are based on a list for all offences. The categories include: Lowest, such as wilful damage, shoplifts, common assault, assaults Police, possess knife in a public place; Low, such as theft ex car, theft, threatens to kill, assault with a weapon; Moderate, such as burglary, arson, burgles with a weapon, demands to steal, assault with intent to injure, robbery; and High, such as aggravated robbery.

Table 5.19, below, presents the severity category for the most serious offence of each young person. These are based on Police records. They range from Low to High. However, for fifteen of the programme entrants, their most serious offence was categorised as Moderate. Since Moderate offences can include arson, burgles with a weapon, demands to steal, assault with intent to injure, and robbery, such categorisation may not necessarily reflect how the public views the seriousness of offending.

A comparison of the number of offences and the severity category for each young person illustrates the dual focus that offending reduction interventions need to take. Either or both measures of offending may be used in assessing the seriousness of a young person's offending. Programme entrants provide examples of both aspects of seriousness. For instance, one young person had a relatively low number of preintake offences (at nine). However, his most serious offence (aggravated robbery) was categorised as High severity rating. Conversely, another young person had a relatively high number of preintake offences (at 32). However, his most serious offence was categorised as Low severity rating.

Table 5.19: Number and seriousness of preintake offences

Case	Number	Severity category for most serious offence
1	29	Moderate
2	27	Moderate
3	9	Moderate
4	9	High
5	25	Moderate
6	48	Moderate
7	32	Low
8	9	Moderate
9	29	Moderate
10	18	Moderate
11	23	Moderate
12	15	Moderate
13	9	Moderate
14	25	Moderate
15	6	Moderate
16	22	Moderate
17	20	Moderate

5.4.2 Within-programme offences[25]

Nine of the young people offended while they were on the programme. Given that one of the programme's ultimate outcomes is to hold the young people accountable for their offending, offences during the programme are to be expected. Appropriate Police involvement is one of the prescribed responses to, and consequences of, the young people's unacceptable behaviour while in the programme. Hence, incidents such as assault and wilful damage are likely to result in Police action. Below is a description of the preintake and within-programme offences of the nine young people:

- One young person with 29 preintake offences, who exited the programme before completion, failed to appear on warrant on two occasions. This occurred while in Phase 1 of the programme. He exited the programme during Phase 1, having spent just over one month on the programme.
- One young person with nine preintake offences (of which the most severe was categorised as High) breached bail once during Phase 3 of the programme. He went on to complete the programme.
- One young person, with 25 preintake offences (the most serious categorised as Moderate) offended six times in Phases 1 and 3. Excluding a bail breach, the offences occurred on two separate occasions. These five offences included: common assault (manually); wilful damage; assaults Police; resists Police; and assault with intent to injure (manually). He exited the programme in the latter part of Phase 3. His offences led to sentencing to a Youth Justice residential facility.

[25] The Police offending data was collected on 22 July 2009.

- One young person with 48 preintake offences (the most serious of which was categorised as Moderate), had 15 offences in Phase 3. Most occurred over a 10-day period. They included: operating a vehicle carelessly; receives property; theft; operating motor vehicle etc; possession of needle/syringe etc for cannabis; procure/possess cannabis plant; theft ex car (under $500); receives property ($500–$1000); take/obtain/use document for pecuniary advantage; burgles (other property) ($500–$5000) by night; and burgles (other property). Since relocation to another family/whaanau setting, this young person had not offended again. He was due to graduate from the programme soon after data collection.
- One young person with nine preintake offences (the most serious of which was categorised as Moderate), had four offences during Phase 2 of the programme. These included: common assault (twice); breach of bail; and person under 20 exceeded breath alcohol limit. This young person graduated from the programme in November 2008.
- One young person with 29 preintake offences (the most serious of which was categorised as Moderate) failed to appear on warrant once while in Phase 2. This young person absconded from the programme during Phase 2 and did not subsequently return.
- One young person with 18 preintake offences (the most serious of which was categorised as Moderate) had three offences including two of common assault (other weapon) and one of wilful damage. These occurred on the same day, while in Phase 1. This young person made a voluntary exit from the programme during Phase 2.
- One young person with 23 preintake offences (the most serious of which was categorised as Moderate) had one offence (shoplifting) which was still being processed at the time of data collection. This occurred while he was in Phase 2. At the time of data collection, the young person was in Phase 3.
- One young person with six preintake offences (the most serious of which was categorised as Moderate) had one breach of bail, while in Phase 2. He was in Phase 3 at the time of data collection.

5.4.3 Post-programme offences

Completers: To date (16 June 2009), none of the young people who had completed the programme had offences recorded since their graduation. The young people who had completed from the programme graduated at the following dates:

- November 2008
- December 2008
- December 2008
- May 2009.

Three of these young people had completed the programme six months or more prior to data collection.

Early exits: Five of the young people who entered the programme did not complete it. One withdrew and the others were early exits. One young person exited after fifteen months in the programme as his offending led to a sentence in a residential Youth Justice facility. The following outlines the preintake, within-programme and subsequent offences of those who exited the programme early:

- One young person with 29 previous offences has had 45 offences since his early exit from the programme in Phase 1. He was in the programme for approximately one month. This young person's offending started soon after he absconded from the programme. He was formally exited from the programme approximately two months after his abscond.
- One young person with 29 previous offences has had a relatively modest seven offences since his early exit in Phase 2, after approximately nine months on the programme. He desisted from offending for almost twelve months after his early exit. The offences since his early exit include: unlawfully gets into/upon motor vehicle/car; aggravated assault; end life/safety/health by criminal nuisance; unlawfully gets into motor vehicle/motor cycle; threatens to kill/do GBH (manually) and two offences of behave threateningly (manually).
- One young person with 25 previous offences has had no further offences since his early exit from the programme. He was on the programme for approximately 17 months. This lack of offending is primarily explained by the residential sentence he received after offending while in Phase 3 of the programme.
- One young person with 29 preintake offences has not offended since withdrawing from the programme while in Phase 2. He spent about four months on the programme altogether.
- One young person with 18 preintake offences has had no offences since his recent early exit after about 10 months – he was in Phase 2. He offended three times while in Phase 1 of the programme.

Summary: The young people accepted onto the programme had relatively high levels of preintake offending. This is consistent with programme targeting. This level of offending significantly exceeds the apparent offending levels of young people entering similar programmes internationally (as discussed in Section 5.4.1). It also exceeds what some stakeholders consider appropriate to achieve success (as discussed in Section 4). Some stakeholders would prefer to see less serious offenders enter the programme because, as they see it, there is likely to be a better chance of reducing the frequency and/or severity of their offending. However, there are no signs that young people with less serious offending histories (in terms of severity and/or frequency) are being referred to the programme.

At this stage, it is not possible to make any definitive conclusions about whether the programme leads to reduced offending. However, early signs are that offending levels may have reduced for the very small number of young people who have completed the programme. Indeed, none have offended so far, although some did during their time on the programme.

5.5 Summary

A triangulation of data from different data sources provides some confidence that programme outcomes are being achieved. Case file notes provide evidence that most young people are achieving most of the intermediate outcomes. The Police data provides preliminary indications that the young people's offending frequency and severity may have reduced. However, these indications are very preliminary and need to be treated with considerable caution. The young people themselves and their families/whaanau were generally confident about their futures, especially when they had reached the final phase of the programme. The young people believed they would not re-offend, and this confidence was reiterated by their families/whaanau (parents and siblings). Police were also confident that young people nearing the end of the programme, and those who had completed the programme, had made positive changes.

One of the most challenging issues for the future, to maintain the achievements of the young people, is how to keep them productively occupied in the medium to long term – in school, training or work. For most of the young people, successful reintegration into mainstream schooling seems unlikely – most had been out of the school system for a long period of time before entering the programme. Despite educational achievements while in the residential school, the young people's generally very low cognitive and comprehension levels would suggest that fitting back into mainstream schooling would be difficult. Providing training and / or employment opportunities for these young people may also become more difficult as the current recession deepens. However, skills trainers now put considerable effort into finding the right fit between training and job opportunities and the young people's aspirations and abilities (throughout Phases 1 and 2). And, so far, there seems to be considerable community and employer commitment to creating work and training opportunities.

6 Summary and discussion

The evaluation of Te Hurihanga has focused on:

- describing the delivery of Te Hurihanga in relation to programme delivery, including targeting and key components of the treatment programme
- describing the outcomes of the programme, principally in terms of intermediate outcomes.

A cost-benefit analysis of the programme is outside the scope of this evaluation.

This section provides a brief overview of the key findings and conclusions that can be drawn from the evaluation.

The current costs to society of managing high risk youth offenders are considerable, whether they are in a programme such as Te Hurihanga or, as is likely, in a Youth Justice residential service. Given the high likelihood that, without effective interventions, these young people will progress to adult offending, costs can be assumed to continue into adulthood. These young offenders have typically come to the notice of CYF during their childhood years and have been exposed to multiple interventions as they progressed through CYF Care and Protection, Police, education and other services.

The young people in Te Hurihanga all presented with characteristics consistent with conduct disorder (although they may not have been formally diagnosed as such). Typically, they had a long history of offending (for some it also involved violence), had dropped out of school before or early in their secondary schooling, had drug and alcohol problems, and had (or aspired to have) gang connections.

Treatment for these young people is difficult. Ecological approaches that address the complexity of causal factors have been identified as model programmes. The treatment model for Te Hurihanga is broadly consistent with key areas of international best practice for addressing serious youth offending. That is, it is an ecological model that includes:

- intensive, individualised and monitored treatment interventions
- full involvement of whaanau/families
- self-regulation skills enhancement
- empowering of young people to cope within their wider social context
- encouragement and support for educational, training or work engagement
- systems to promote treatment adherence
- multi-skilled treatment teams with strong community links.

The specification of a model that is bicultural in character has the potential to inform and improve on international best practice.

The evaluation identifies some strengths and weaknesses with treatment delivery and where further development could be of benefit. These findings are summarised under the following headings:

- targeting and referral and admission process
- programme delivery
- further development of the practice model
- consolidating best practice
- capacity building
- achievement of intermediate and ultimate outcomes.

6.1 Targeting and referral and admission processes

The programme has succeeded in both reaching capacity in a reasonable timeframe and targeting the intended population – that is, young people with serious offending histories who, with their families/whaanau, were available and willing to receive intensive residential and community-based treatment.

Referral flows built steadily over the duration of the evaluation and the profile of young people who were accepted onto the programme matched that intended. The referral numbers faltered a little in the last one to two months of the evaluation period, with no identifiable reasons for the fall-off in referral numbers. However, the potential influx of new referrals at the end of the evaluation period may indicate that the programme is likely to experience ebbs and flows of referral numbers throughout a year, especially in its pilot stage. There is widespread support for the programme by the judiciary, social workers, the Police and other stakeholders, which suggests these ebbs and flows of referrals could reflect a number of factors rather than any disaffection with the programme. Factors could include: patterns of young people's offending; the size of the population of motivated, consenting young offenders and their whaanau at any one time; the extent to which programme staff are actively recruiting; and the extent to which referral agencies (eg, CYF and the Police) keep the programme at the 'front of their minds' as they consider options for individual young people.

The steady build up of referral numbers in a comparatively short period of time, despite considerable negative publicity around the programme and early absconding incidents, is testament to the high regard that referrers had in the programme and its staff members, the work of the Community Liaison Group and the strong interagency links. It is usually the case that providers face difficulties establishing themselves as part of social workers' menu of 'usual services'. The programme has needed to employ a range of mechanisms to ensure that referrers do not overlook Te Hurihanga when they are considering possible intervention options. In general, though, CYF Youth Justice coordinators and social workers and the Police see the programme as a core, specialised service.

It was the view of external stakeholders, including the Police and social workers, that the right people were referred to the programme. However, some thought the programme also accepted some young people whose behaviour (and that of their families) was so intractable that they were unsuitable for the programme. Some of the barriers to success they identified included the young people's dysfunctional families; the cognitive disabilities of some of the young people (and/or their whaanau /families); mental health problems within some families; and the criminality of some families. As the Police pointed out, some of these families were third or fourth generation criminals and, since the young people go back into this environment, expectations of success need to be moderated in light of these family circumstances.

That there was some debate about the eligibility criteria and slight concern about some temporary flattening out of referral numbers in the second quarter of 2009 may signal a need to reassess programme targeting. Some queried whether the size and characteristics of the pool of serious young offenders in the Hamilton area is large enough to support the programme and whether it is targeting the most appropriate young people.

6.2 Programme delivery

This evaluation has shown that Youth Horizons Trust is competently delivering the programme:

- It is effectively delivering a community-based residential programme with well embedded cultural and therapeutic dimensions.
- Given that most of the programme participants are Maaori, it is important that the treatment focus is consistent with the needs of Maaori young people. For Maaori, it is important that treatment approaches are developed in the context of whaanau and hapuu as well as community-based residential services such as Te Hurihanga. This seems to be the case.
- The programme has established effective relationships with Maaori service providers to assist with Maaori young people, and their whaanau or caregivers. This can be attributed to the partnership arrangement with Raukura Waikato Social Services as well as other aspects of the programme that have further strengthened community relationships and stakeholder confidence. There is a general confidence in the effectiveness of the programme for Maaori and non-Maaori young people. These include: the respect with which the programme Kaumaatua is held, especially by the families/whaanau, and his work to ensure the programme operates in a culturally safe way that meets the needs of Maaori young people and staff; the establishment of the whaanau waananga; the commitment of individual staff members; the strong role models that the staff, including the Residential and Multi-Disciplinary Teams, provide for the young people; and the teaching of tikanga or cultural knowledge to the young people.

6.3 Further development of the practice model

Preliminary findings suggest that Te Hurihanga has developed a valuable treatment model. However, there is always scope to improve some practices. The providers themselves have made some evidence-based changes to the treatment model, specifically adapting the points system. Replacing the MST component of Phase 3 with Functional Family Therapy (FFT) is another significant change.

The current treatment model is aligned with ecological approaches used in New Zealand and internationally. These approaches target known risk and protective factors that contribute to conduct disorder and youth offending by: increasing opportunities for the young people to mix with prosocial peers through positive activities (eg, education, work and recreation); reducing opportunities for the young people to mix with antisocial peers and engage in antisocial activities (eg, by creating alternative positive opportunities and developing young people's positive self-identities); building consequential thinking; and strengthening whaanau/families (eg, though skill enhancement, building positive parent–youth relationships, positive reinforcement).

The Te Hurihanga team has the necessary foundations, including the adoption of best practice models, well-developed capability and capacity-building processes, increasing practical experience and support from stakeholders, to continue strengthening the treatment focus. Family/whaanau responsiveness to and engagement with the treatment model, and their overall satisfaction with their involvement in the programme, together provide a sound basis for maintaining and building on the family therapy component of the programme.

6.4 Consolidating best practice

If New Zealand is to address the criminogenic and non-criminogenic needs of its costly population of young serious offenders, strategies are needed to make best use of the expertise and experience developed in Te Hurihanga. Consolidating best practice in well-resourced professional organisations is an effective way to make best use of the limited number of specialist practitioners in any given area.

Te Hurihanga has provided an opportunity to establish a team with a core set of skills and experience to address the needs of young offenders through a therapeutic, residential programme. This programme enables progressive reintegration of the young people into whaanau/family and community settings, where both the young people and their families/whaanau have enhanced understandings, better family relationships, and tools to respond appropriately to the young people's unacceptable behaviours. The expertise, experience and commitment of this team, including management, the clinicians, the residential team, and the skills workers, are widely acknowledged and valued amongst the Hamilton community of stakeholders working with (or having an interest in) similarly high risk young people.

Given the training and supervisory systems and clinical skills of both Te Hurihanga and the wider Youth Horizons Trust organisation, the providers are well placed to further develop best practice for the treatment of young offenders within a residential setting. There is considerable scope to leverage off the team's expertise for the development of best practice in other services targeting high risk young people. However, given the small pool of people with appropriate skills in New Zealand, nurturing the current team is also important.

6.5 Capacity building

Staff recruitment and retention problems are to be expected in a specialised area such as that occupied by Te Hurihanga. The treatment model requires skilled, experienced, committed staff members who have the professional orientation to work in a clinical and bicultural context. However, given that ecologically-based, bicultural programmes like Te Hurihanga are relatively new to New Zealand, the pool of people who already have the required skills and experiences is very small. This is especially the case amongst residential workers and in the whaanau/family therapy area. Te Hurihanga is one of only a very small group of specialised therapeutic residential programmes, where residential and other staff members are required to have the skills and training needed to implement behaviour modification techniques such as points systems and interpret and respond to the subtleties of young people's social interactions, personal and health issues and behaviours. Recruitment and capacity-building problems are exacerbated by a lack of quality training opportunities in areas such as family therapy. Nevertheless, Te Hurihanga has, over time, successfully recruited staff and established training and supervision processes to prepare them to implement all aspects of the treatment programme. These processes provide a sound basis to build on these competencies, thus expanding the clinical capacity of the programme.

6.6 Achievement of intermediate and ultimate outcomes

Analysis of data from the case file review and Police records, coupled with information from interviews with programme personnel, whaanau and young people, provided insight into the outcomes achieved by the young people and their whaanau. Achieving positive change in young people with the offending histories typical of the Te Hurihanga entrants is extremely difficult. Highlights from the outcome assessment provide a consistent picture characterised by individual improvements across the range of domains for the young people participating in the programme and widespread stakeholder and family/whaanau confidence in the Te Hurihanga team and the programme.

On the basis of evaluation results, there can be some optimism for the programme's ability to generate improved outcomes in the medium term. Stakeholders generally believed that Te Hurihanga is well placed to achieve positive outcomes for the young people, although most acknowledged it is still too early to make any definitive judgements about achievements in the medium and long term. Monitoring of ultimate outcomes is needed in the next two years.

6.7 Summary

Te Hurihanga has been effectively established as a new therapeutic residential programme in an area relatively devoid of residential programmes for young offenders. Youth Horizons Trust has developed and delivered a new programme which continues to evolve in response to the experience of international and New Zealand practitioners. Programme modifications have generally been evidence-based and are consistent with international best practice.

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Appendix 1: Evaluation approach

1 Evaluation goal and objectives

The general goal of the evaluation is to provide information to the Ministry of Justice regarding the effectiveness of the Te Hurihanga Programme and the extent to which it is achieving positive outcomes for the young male participants. Because it is a pilot, the programme is continuously evolving. This evaluation is intended to provide part of the evidence base for informed adaptations and improvements.

The **formative** aspects focus on strengths and weaknesses in the implementation of the programme, which provides an evidence base for any adaptation and improvement as it progresses.

The **process** aspects of the evaluation broadly examine how the programme works in practice by:

- documenting the programme's establishment, implementation and operation, and community response
- describing the key components (supervised living in a purpose-built residence; a transitional phase from the residence to the family home; and supervised and monitored living in the community)
- describing the young people and their progress through the programme
- describing how programme activities are implemented and delivered, including comparing that with what was intended
- describing how young people are transitioned between phases, including identifying indicators of readiness used to transition them
- assessing the extent to which the programme engages the young people into a therapeutic programme which addresses their criminogenic needs.

The **outcome** aspects of the evaluation focus on assessing the programme success in achieving its desired outcomes for participants (including whaanau and young people). These outcomes are reported in the evaluation report. The evaluation assesses the extent to which the young people:

- achieve reduced frequency and/or severity of offending
- are held accountability for their offending
- engage in prosocial activities such as culture, education and employment.

Achievement of these outcomes for the young people indicates positive family/whaanau change, specifically from the third MST-based phase of the programme. The evaluation assesses the extent to which families/whaanau have

increased skills and ability to effectively respond to and manage the negative behaviour of their young people.

The **Process** aspects describe and/or assess:

- programme targeting, including:
  - the eligibility criteria and how they are applied
  - the referral and admission process
  - a profile of the participants
  - sentencing or referral pathways
- programme assessment and planning:
  - how the programme addresses their criminogenic needs
- implementation and delivery of the programme's activities across three phases (and how these could affect achievement of outcomes) including:
  - the range of programme therapeutic activities/interventions provided overall (across different phases of the programme)
  - the extent to which the providers deliver services according to the programme's principles and with programme integrity (this links to the formative evaluation focus on factors that affect staff adherence)
  - the level of engagement with the programme across the three phases by the young people, their family/whaanau, and the wider community – including schools, community services, employers, neighbours, iwi, etc)
- how young people progress through the three phases, including identifying the indicators of readiness used formally or informally and how the assessment occurs. Some factors to consider include:
  - the adequacy of planning
  - the level of family/ whaanau and other stakeholder involvement
  - the level of support in place at transition points (eg, family/whaanau readiness, school/employer places, prosocial opportunities)
  - young people's (and their family/whaanau) understanding of what they had achieved in the previous phase and what they were to achieve in the next phase
- the cultural components of the programme.

The **Outcome** aspects of the evaluation assess the extent to which intended programme outcomes (both intermediate and ultimate) are achieved during the programme. This component describes and assesses the following:

- the perceptions of programme effectiveness/success held by young people, family/whaanau, community and others involved in the programme process. The domains of effectiveness (to be verified by Justice, CYF, programme providers, family/whaanau and other stakeholders) include:
  - the programme delivery kaupapa such as its local focus, iwi partnerships, community involvement, whaanau/family involvement and the three-phased approach
  - outcomes achieved.

- the individual progress of young people as they participate in each phase of the programme, including their achievement of:
  - outcomes identified in their treatment plans and achieved over the programme's duration
  - any identified assessment criteria for progressing through each phase of the programme (other than outcomes identified in treatment plans).

- young people's achievement of ultimate outcomes, including the extent of their successful reintegration from residential care into the community as positive members of it through assessing their:
  - engagement in prosocial activities like education, employment, cultural activities, recreation
  - more responsible attitude to offending such as feeling accountable, remorseful and/or wanting to make a new start
  - improved family/whaanau relationships.

2 Data collection

The evaluation team visited Te Hurihanga nine times over the two-year evaluation period:

- Five of these visits were prescheduled multiday fieldwork visits. These fieldwork visits occurred six-monthly, starting in mid-2007.
- Two multiday visits related to the file review. One was for planning and piloting the schedule and the other was to carry out the file review.
- One visit was for evaluation feedback (on other occasions, feedback was incorporated into the fieldwork visits).
- One visit related to the planning and collection of Police offending data.

Data collection methods included the following:

Focus groups

- Fifteen focus groups with Te Hurihanga staff during five fieldwork visits (in July and November 2007, June and November 2008 and June 2009). These focus groups included: the Management Team; the Multi-Disciplinary Team; the Residential Team and the MST team.
- Five stakeholder focus groups with Youth Aid officers, CYF social workers, the Community Liaison Group, the Hillcrest Action Group, and the Hillcrest Support Group.

Interviews

- Eighteen interviews with Te Hurihanga and partner staff, including the Programme Manager, Programme Kaumaatua, Clinical Leader, Residential Manager, Psychologist, Lead Educator, Skills Trainers, House Parents, MST Supervisor, Kaitakawaenga Whaanau and Raukura Waikato Social Services.

- Twenty-four interviews with young people on the programme. The number of interviews carried out with young people depended on when they entered the programme. We interviewed all young people currently on the programme at the scheduled fieldwork periods, unless they refused to, or could not, be interviewed (eg, one refused while he was in Phase 3). Seven young people were interviewed once, seven were interviewed twice and one was interviewed three times.
- Fifteen interviews with family/whaanau members (sometimes singly and sometimes in pairs or groups). These whaanau members included mothers, fathers, sisters, brothers, and aunts. Eight whaanau groups were interviewed once, two whaanau were interviewed twice and one was interviewed three times (but the third interview was with different whaanau members as the young person had moved to a different whaanau placement). In general, they were keen to participate and made themselves available for face-to-face interviews. Some whaanau were not interviewed because they would not give consent, were sick, were unavailable at prescheduled interviews or would not respond to phone calls and other contact to set up interviews.
- Six interviews with Ministry of Justice personnel.
- Thirteen interviews with stakeholders, including members of the judiciary, youth advocates, Child Youth and Family social workers, Police Youth Aid officers, training providers, education providers, and the MST Consultant.

Case file reviews

- Seventeen case file reviews were completed and analysed using a purpose developed case review schedule.

Review of literature and programme documentation

- *Te Hurihanga Therapeutic Programme*, the programme Kete in various editions
- International and New Zealand literature on youth offending and treatment options
- Weekly and Pipeline reports
- The points system.

Programme observation

- Two clinical supervision sessions involving the Residential Team
- Staff/programme participant interactions in common areas of the residence.

Data collection and analysis

- Police offending data
- Programme administrative data on: incidents, programme referrals, acceptances, completions and early exits.

Appendix 2: Literature review – The client group and treatment models

1 Background

This literature review places Te Hurihanga in the wider context of best practice internationally for young offenders. There is considerable overlap in treatment approaches for young offenders and young people with conduct problems. This is because there is a considerable overlap in the populations of youth offenders and conduct disordered young people (Liabo and Richardson, 2007). The characteristics of the Te Hurihanga participants bear this out. All the young people who had entered the programme during the evaluation period met conduct disorder or severe conduct disorder criteria (see Table 5.5 in Section 5). That is, they displayed repetitive and persistent patterns of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviours include the following:[26]

- aggressive conduct that causes or threatens physical harm to other people or animals
- non-aggressive conduct that causes property loss or damage
- deceitfulness or theft
- serious violation of rules.

Young people with conduct disorder often have other coexisting (or comorbid) psychiatric and other conditions such as Attention Deficit Hyperactivity Disorder (ADHD), substance abuse and depression (Lochman, 2003). The Te Hurihanga participants also typically had coexisting conditions. All but two of the young people had a history of drugs and/or alcohol misuse, almost one in two had ADHD and almost one in two came to the programme with previous suicide ideation/intent or attempts (see Table 5.5 in Section 5). The potentially comorbid conditions are described below.

- *Attention-Deficit Hyperactivity Disorder (ADHD)* is the most common condition associated with conduct problems, with rates of 65 to 90 percent reported in clinical samples (Abikoff and Klein, 1992). ADHD usually precedes the onset of conduct disorder. When young people with conduct problems also have ADHD, they display more symptoms of conduct disorder, an earlier onset of 'severe' conduct problems and increased substance abuse (Lochman, 2003).

[26] These behaviour groups are identified by the American Psychiatric Association's diagnostic guidelines, the DSM-IV-TR, for the diagnosis of conduct disorder.

- *Substance Abuse:* Conduct problems in young people are often associated with alcohol and drug abuse. A study (Fergusson et al, 2004) using data from the Christchurch Health and Development Study[27] (CHDS) and the Dunedin Multidisciplinary Health and Development Study[28] (DMHDS) showed a high rate of association between substance abuse and conduct problems in adolescents. When a young person with conduct problems is also involved in substance abuse, the risk of more serious delinquency is increased (Lochman, 2003).

- *Depression:* Conduct problems are also commonly associated with depression. Depression has been shown to occur in 15 percent to 31 percent of youth with conduct problems (Zoccolillo, 1992). This increased risk of depression may be due to peer and family conflicts as well as to numerous learning problems. The presence of depression also appears to increase the risk of suicide; however, it does not appear to alter the course of conduct disorder (Lochman, 2003).

2 Contributory factors to conduct problems

Research indicates that the development of conduct problems is caused by a complex interaction between individual, parent and family, peer, school and community factors. Table A1 contains a summary list of identified factors across these four groups. These four groups and factors are discussed below in greater detail.

Table A1: Risk factors

Individual factors	Parent and family factors	Peer factors	*School and community factors*
▪ *Coexisting psychiatric conditions (ADHD, substance abuse, depression)* ▪ *Poor social skills* ▪ *Low intellectual functioning and academic achievement* ▪ *Favourable attitudes toward antisocial behaviour* ▪ *A cognitive bias to attribute hostile intentions in others*	▪ *Lack of parental monitoring* ▪ *Inept discipline* ▪ *Maltreatment* ▪ *Parent psychopathology (substance abuse, psychiatric conditions, criminal behaviour)* ▪ *Low warmth and family cohesion*	▪ *Association with deviant peers* ▪ *Poor relationship skills*	▪ *Poor living conditions* ▪ *Disadvantaged school setting* ▪ *A dangerous neighbourhood*

[27] The Christchurch Health and Development Study follows the health, education and life progress of a group of 1,265 children born in the Christchurch urban region during mid-1977.

[28] The Dunedin Multidisciplinary Health and Development Research Unit conducts the long-running cohort study of approximately 1,000 babies born in Dunedin in 1972–73.

2.1 Individual characteristics

There are a number of individual characteristics that are associated with conduct problems. As well as coexisting conditions such as ADHD, substance abuse, and depression, young people with conduct problems also often show low intellectual functioning and academic achievement, particularly in regards to reading. They also have poor social skills in relation to peers and adults, have deficits in cognitive problem-solving skills, and are likely to view others as having hostile intentions (Dodge et al, 1990; Kazdin, 1997).

2.2 Parent and family characteristics

A number of parent and family characteristics are associated with young people's conduct problems. Parents often lack important parenting skills. In addition, the risk of their children developing delinquent behaviours is increased in the event of parent psychopathology such as substance abuse, the existence of psychiatric conditions and criminal behaviour. Also, coercive parenting practices, inconsistent discipline, low warmth and family cohesion, and a lack of parental monitoring have all been linked to the development of delinquent behaviours (Kazdin, 1997; Collins et al, 2000). Evidence also suggests that depressed mothers may indirectly contribute to child behaviour problems through: directing increased commands and criticisms to their children (who in turn respond with increased non-compliance and deviant behaviour), poor boundary-setting, emotional unavailability, and reinforcement of inappropriate behaviour (Webster-Stratton and Dahl, 1995).

2.3 Peer characteristics

Young people with conduct problems have poor relationship skills for interacting with their peers, often suffering peer rejection. The youth that they do associate with are more likely to be other delinquents (Kazdin, 1997). Studies have shown that in terms of relative risk, association with delinquent peers is one of the most powerful influences on young people at risk for conduct problems (Elliott, 1994; Dishion et al, 1999). Studies have also shown the reverse. That is, that association with prosocial peers can positively influence later functioning. For example, aggressive youth have been found to play less aggressively when put in situations with non-aggressive youth (Coie et al, 1989). It has been found that matching antisocial or aggressive youth with prosocial peers can have treatment benefits (Tremblay et al, 1995). Consequently, interventions that directly take into account the influence of peers can be expected to be more beneficial.

2.4 School and community factors

The development of delinquent behaviours is associated with a number of wider social risk factors that can place stress on parents and young people, reducing their ability to cope with everyday issues. These risk factors include poor living conditions (overcrowding, large family size, low-quality housing), disadvantaged school settings, and a dangerous neighbourhood. These risk factors can result in increased antisocial and aggressive interactions between parent and child (Kazdin, 1997).

3 Treatment options

The treatment of youth with conduct problems and their families is difficult (Curtis et al, 2004; Advisory Group on Conduct Problems, 2009). After antisocial behaviour has become established it is very resistant to change, as demonstrated by the high recidivism rates of juvenile delinquents and the failure of most interventions to maintain change (Brunk, 2000).

A number of interventions have been used to treat youth offenders with conduct problems. Reviews of youth interventions (Kazdin, 1997; Woolfenden et al, 2002; Advisory Group on Conduct Problems, 2009) identify promising treatments that met strict criteria for effectiveness. What links these treatments is their broadly ecological approach, which addresses the entire social context within which the young people live. That is, they address the individual, parent and family, peer, and school and community factors that contribute to their behavioural patterns. According to Brunk (2000), interventions are most likely to be effective if they are individualised and address all the factors that contribute to the youth's delinquency, are strongly family-based and delivered in the community. The Advisory Group on Conduct Problems (2009) also notes that interventions with adolescents tend to be intensive, expensive and less effective than interventions with younger children. Among the most effective treatment options for young offenders and others with conduct problems are Multi-Systemic Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy. These have been found to be effective for young people between the ages of 12 and 17 years. Treatment options can be assisted by the use of some medications. Treatment options are described below.

3.1 Multi-Systemic Therapy

Multi-Systemic Therapy (MST) is an intensive family- and community-based intervention for violent and chronic youth offenders (Henggeler et al, 1998). Problem behaviours are viewed as being linked to the multiple social systems (ie, individual, family, peer, school and community) in which the child or young person is embedded. MST intervenes in all of these systems using interventions that promote disengagement from deviant peers, build stronger ties with family and school, improve family management skills (ie, monitoring and discipline) and develop greater social and academic competence. Treatments are tailored to the specific needs of the youth and their family after an extensive assessment of the systems contributing to the antisocial behaviour.

MST has a high degree of evidence-based support for treating violent and chronic youth offenders (Henggeler et al, 1992; Borduin et al, 1995; Ogden and Halliday-Boykins, 2004). Results show that, in comparison to the usual treatments, young people who participated in MST had:

- reduced long-term rates of criminal offending
- reduced recidivism, re-arrests, and rates of out-of-home placements
- improvements in family functioning
- decreased behavioural and mental health problems.

The design and delivery of MST interventions along with monitoring and evaluation frameworks will be discussed later.

3.2 Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) is an intervention for serious youth offenders who are unable to remain in their own homes. It acts as an effective alternative to residential care where the grouping of deviant peers can negatively impact treatment. The goal of the MTFC intervention is to reduce antisocial behaviour and increase prosocial behaviour in seriously conduct disordered youth offenders in need of out-of-home placement. Treatment goals are achieved by providing close supervision, fair and consistent boundaries for behaviour, a supportive relationship with at least one foster parent, and reduced contact with deviant peers.

A number of randomised trials and other studies have provided evidence of MTFC's effectiveness (Chamberlain and Moore, 1998; Eddy et al, 2004). Results show that, in comparison to usual treatments, children and young people who participated in MTFC had:

- half the number of arrests at follow-up than those in group care
- significantly lower participation in violent criminal activity
- a lower likelihood of running away from foster care than from group care
- fewer days in lock-up following treatment
- a higher likelihood of returning to family settings than children and young people in group care.

3.3 Functional Family Therapy (FFT)

Like MST, FFT is an evidence-based practice model that takes a multisystemic perspective to treat at-risk and conduct-disordered young people and their families. FFT is used both as an intervention programme and a prevention programme. The model has evolved through thirty years of clinical and research experience and application in a wide range of sites in the United States and elsewhere (Sexton and Alexander, 2000). Evaluations suggest that the approach is moderately successful in reducing offending (Advisory Group on Conduct Problems, 2009).

FFT is designed for young people aged 10 to 18 who engage in violence, aggression, property destruction and substance abuse. The intervention is designed to improve family interactions so that disruptive behaviour is no longer functional for the youth. The programme model has similar measurable outcomes to MST and MTFC. As with MST, FFT is a community-based whaanau/caregiver-focused intervention.

FFT is a home-based intervention. As described by the Advisory Group on Conduct Problems (2009), it involves a trained therapist delivering up to twelve one-hour sessions. The first phase involves engaging with whaanau/families and finding ways for them to want to be involved. The engagement and motivation phase is as

necessary as any other aspect of the programme to facilitate changes within a family. Operating from the premise that everyone in a family has a role to play, the FFT therapist endeavours to meet with the whole family throughout the duration of the programme.

3.4 Good Lives Model

The Good Lives Model (GLM) of offender rehabilitation is a positive and strength-based approach to treating offenders. It is based on the idea that the best way to lower re-offending is to equip individuals with tools to live more fulfilling lives. Like all of us, offenders need to be loved, valued, to function competently, and to be part of a community. The GLM aims to give offenders the ability to get *primary human goods* in ways that are socially acceptable and personally meaningful. *Primary human goods* are defined as being valued aspects of human functioning and living that have an intrinsic benefit and are sought for their own sake. These *primary human goods* include:

- healthy living and optimal physical functioning
- knowledge
- excellence in play and work
- autonomy and self-directedness
- inner peace
- relatedness (including intimate, romantic and family relationships) and community
- spirituality
- happiness
- creativity.

People all attempt to achieve these primary human goods regardless of their education, intelligence, or class. When people achieve these goods it results in high levels of wellbeing, and when they do not achieve these goods, it results in lower levels of wellbeing.

With criminal behaviour, there are four types of difficulties in achieving goals: problems with the methods used to secure goods; a lack of scope within a good lives plan; conflict among goals or incoherence; inability to adjust a GLM to changing circumstances (eg, impulsive decision making). A treatment plan should be constructed in the form of a good lives conceptualisation that takes into account an offender's unique circumstances, abilities, preferences and strengths. A rehabilitations strategy should be designed to strengthen an offender's internal conditions (ie, skills and capabilities) and external conditions (ie, opportunities and support). The strength of this model is that it focuses on *primary human goods*, thus providing a clear avenue to motivate offenders. The link between the cause and treatment of antisocial behaviour is clear and focuses on human goods, problems in an individual's GLM, and the role of therapy in setting up the internal and external conditions to implement a particular individual's good lives plan. The GLM supports the importance of maintaining a twin focus in treatment: promoting welfare and reducing harm. The idea that risk factors are internal or external obstacles that

frustrate or block the acquisition of human goods provides a useful way of integrating the two approaches. It is also important that therapists see the offender as a person and have positive and respectful attitudes toward them.

4 Best practice in treating conduct problems

In 2001, the U.S. Surgeon General released a comprehensive report on youth violence.[29] This report used approaches such as meta-analysis and review of evaluation research to identify best practice for reducing youth violence. The report identified MST and MTFC programmes as *model* programmes for reducing youth violence. It recommended these treatment models because they met the following strict criteria:

- rigorous evidence-based programme design and internal adherence monitoring
- significant deterrence effects on violence, risk factors for violence, and serious delinquency
- replication in other settings that achieve the demonstrated effects
- sustainability of effects.

The design and delivery of services for MST and MTFC interventions along with their internal monitoring frameworks will be discussed below as a basis for drawing out some principles of best practice .

4.1 Best practice for MST

As discussed previously, MST is an intensive family- and community-based intervention for violent and chronic youth offenders that views problem behaviours as being linked to the multiple social systems (ie, individual, family, peer, school and community) in which the child or young person is embedded.

Design and delivery of services: Treatments are tailored to the specific needs of the youth and their family after an extensive assessment of the systems contributing to the antisocial behaviour. MST seeks to empower parents with the skills and resources needed to address the difficulties that arise in raising youth, and to empower youth to cope with family, peer, school, and neighbourhood problems. Families are seen as full collaborators in the planning and delivery of treatment and there is a constant focus on making sustainable changes so that at the completion of treatment, families can continue with the gains made (Henggeler et al, 1998).

An MST treatment team consists of one clinical supervisor and three to four therapists. Each therapist carries a small caseload, working with only four to six families at a time. Therapists are available 24 hours a day, 7 days a week (Henggeler, 1997). The average MST intervention involves about 60 hours of contact over a four month period. MST therapists use a number of evidence-based

[29] Youth Violence: A Report of the Surgeon General examines the factors that lead young people to gravitate toward violence, reviews the factors that protect youth from perpetrating violence and identifies effective research-based preventive strategies.

techniques such as family therapy, problem-solving training, and school consultation (Brunk, 2000). They can directly provide most treatments themselves and coordinate access to other services (eg, medical, educational, and recreational services). The treatment team accepts responsibility for engaging families in treatment and for positive treatment effects. It is not an option to give up on families, or describe them as them as "unmotivated" or "resistant". The underlying principle for action is to do "whatever it takes".

Internal monitoring framework: Research has shown that to achieve favourable long-term outcomes for children and young people, it is important that the MST treatment team follow a high level of adherence to the MST model and its nine treatment principles (Henggeler et al, 1997; Schoenwald et al, 2000). See Infobox 1 for the principles. Adherence is promoted via systematic quality assurance procedures including: introductory training, quarterly booster sessions, and weekly telephone consultation with an MST expert. Therapists also receive weekly case-based group clinical supervision and individual supervision as required.

Infobox 1: Nine principles guiding MST assessment and interventions

1. **The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.**
2. **Therapeutic contacts emphasise the positive and should 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 specified 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 generalisation and long-term maintenance of therapeutic change by empowering care-givers to address family members' needs across multiple systemic contexts.**

Introductory training: Five days of introductory training are provided for the MST treatment team in order to:

- familiarise staff with the causes and correlates of serious behaviour problems in youth
- describe the theory behind the MST treatment model and intervention strategies
- train staff to view interventions in terms of nine MST treatment principles
- provide practice in designing MST interventions.

Quarterly booster sessions: These are conducted to provide training in special topics such as marital therapy and parental depression. These sessions also allow discussion of particularly difficult cases.

Weekly telephone consultation: On-the-job training is provided for each treatment team via weekly *consultation* with an MST expert consultant. There is a focus on case conceptualisation, treatment goals, intervention strategies, and progress. Ongoing consultation with an MST expert is seen as important for maintaining adherence to the MST model and achieving positive outcomes (Schoenwald et al, 2004).

The adherence of therapists and supervisors is monitored using two standardised questionnaires: the Therapist Adherence Measure (TAM) and the Supervisor Adherence Measure (SAM) (Henggeler and Schoenwald, 1999).

Caregivers assess the adherence of their therapist by completing a 28-item TAM questionnaire (this revised TAM measure replaces the previous 26-item measure). Caregivers provide ratings of their therapists once a month, beginning two weeks into treatment. The TAM is usually conducted via a phone call between the caregiver and an MST-based researcher, with the information entered onto an internet-based database. Therapists assess the adherence of their supervisor by completing the 43-item SAM questionnaire. Therapists provide ratings of their supervisor once every two months, beginning one month after their first supervision session.

The information obtained from these two questionnaires can be used by programme administrators to identify those therapists and supervisors who are achieving desired results as well as those who are not. Training resources can then be selectively targeted toward teams who need additional support.

4.2 Best practice for MTFC

As discussed previously, MTFC is an intervention for serious youth offenders who are unable to remain in their own homes. It acts as an effective alternative to residential care where the grouping of deviant peers can negatively impact treatment.

Design and delivery of services: An MTFC treatment team is led by a programme supervisor who also provides support and consultation to the foster parents. Other members of the treatment team may include a family therapist, an individual therapist, a child skills trainer, and a daily telephone contact. The team meets once a week to review progress and to adjust the treatment plan if necessary.

Children and young people are placed in a family setting for six to nine months. Foster parents are recruited, trained and supported as part of the treatment team. They implement a structured and individualised programme. Each programme is designed by the programme supervisor and the treatment team and builds on the child or young person’s strengths while setting clear rules and expectations about behaviour.

Foster parents receive regular professional support including: 12–14 hours of pre-service training, participation in weekly group foster parent meetings, and 24-hour on-call back up services. Also, foster parents are contacted daily (Monday to Friday) via telephone to provide a Parent Daily Report which can be used by the treatment team to provide quality assurance on implementation.

A positive and predictable environment is set up for children and young people in the foster home through a structured behaviour management system with predictable consequences for rule breaking. Positive behaviour is encouraged through frequent reinforcement from the foster parents. The child or young person is closely supervised in the foster home and community. School behaviour and academic performance is monitored daily. Skill-building exercises are provided for academic and social activities.

The birth family receives family therapy and parent-management training. They are taught to provide supervision, consistent discipline, and encouragement. Therapy is used to prepare parents for their child's eventual return home and to reduce conflict and increase positive family relationships. Family sessions and home visits during the child's placement in MTFC allow the parents to practice skills and receive feedback (Eddy et al., 2004).

Internal monitoring framework: A number of research studies have shown that maintaining adherence to treatment models is critical to achieving positive outcomes for young people and families in evidence-based programmes such as MTFC (Kazdin, 1997; Dowden and Andrews, 1999; Latimer et al, 2003).

As mentioned previously, foster parents are contacted daily (Monday to Friday) via telephone to provide a Parent Daily Report which can be used by the treatment team to provide quality assurance on implementation. An MTFC treatment team can also assess programme adherence by completing a detailed certification review questionnaire. This questionnaire provides a standardised measurement of important components of the MTFC model. It assesses a range of criteria such as programme completion, youth outcomes, therapy and behavioural components, foster parent meetings, clinical team meetings, and training (TFC Consultants, Inc).

Members of the treatment team can use this questionnaire to self-assess the degree to which they think their programme meets certification standards. Also, as part of an official certification process, they can submit the questionnaire to TFC Consultants, Inc. who conduct a thorough evaluation and provide feedback regarding programme strengths and areas requiring improvement. To become officially certified a programme must meet consistent standards.

5 Lessons for best practice in interventions for young offenders

Reviews of treatment options for young people with conduct problems (including findings from a recent New Zealand-based review[30]) provide the following principles of best practice for treatment interventions targeted at young people with conduct problems.

- Intensive treatment interventions are tailored to the specific needs of youth and family after extensive assessment of the systems contributing to antisocial behaviour. Progress towards outcomes for youth and family/caregivers is monitored closely by the treatment team (eg, through weekly team meetings).
- Families/caregivers are full collaborators in treatment planning and delivery. The treatment team is responsible for engaging families in this process.
- Treatments seek to empower family/caregivers with skills and resources to address the difficulties that arise in raising youth. Skills to enable caregivers to give young people supervision, consistent discipline, and encouragement are provided through interventions such as family therapy, parent-management training, and problem-solving skills training.
- Treatments seek to empower youth to cope with family, peer, school, and neighbourhood problems. A positive and predictable environment is set up (eg, in own home, foster home, or family home setting) through a structured behaviour management system with predictable consequences. Positive behaviour is encouraged through frequent reinforcement, and negative behaviour is discouraged through predictable consequences.
- School engagement and academic performance is encouraged and supported.
- The treatment team's adherence to the intervention model and treatment principles is critical and promoted via systematic quality assurance procedures including training and supervision.
- Members of the treatment team represent a range of skills and also coordinate access to other services (eg, medical, educational and recreational services).
- Interventions are culturally acceptable for Maaori as cultural fit is key to increasing the success of interventions. Thus, therapists require dual clinical and cultural competencies (Te Roopu Kaitiaki reporting in the Advisory Group on Conduct Problems, 2009).

6 Summary

The following summarises what is known about best practice for interventions to reduce youth offending.

- Complex interactions between individual, family/caregiver, peer, school and community risk factors are implicated in youth offending.

[30] Advisory Group on Conduct Problems. 2009. *Conduct Disorder Best Practice Report*. Ministry of Social Development, Wellington

- Young offenders often have other coexisting conditions such as ADHD, substance abuse and depression.
- The treatment of young offenders with established offending histories is extremely difficult. The most effective interventions for adolescents take an ecological approach, with Multi-Systemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC) and Functional Family Therapy (FFT) among those identified as model programmes of best practice.
- The design and delivery of MST, MTFC and FFT interventions are clearly specified, with internal monitoring frameworks that promote adherence to the treatment model.
- Therapists require dual clinical and cultural competencies.

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Appendix 3: The Te Hurihanga points system and behaviour modification

1 What is a points system?

Points systems are derivatives of 'token economy' contingency management systems. In a token economy, desired behaviours are reinforced through the delivery of physical tokens that can later be redeemed for desired activities or goods. Likewise, undesirable behaviours are punished through the removal of tokens, or lack of delivery of tokens. As such, points systems are forms of contingency management systems like star charts used for children by parents and teachers. In a points system, physical tokens are not given or taken away, but 'points' are used in their place. The points can then be redeemed for goods and/or services at a later date. The difference between a points system and a token economy is similar to being paid in cash versus direct electronic payment. A token economy is like a cash-only system, and a points system is similar to using electronic payment: you see the receipts, transactions, and bank statements, but you do not actually handle any money. Contingency management systems can be used to assist in teaching young people how to behave in different social contexts including their everyday interactions. Points are given for appropriate social behaviours and points are taken away for antisocial behaviours.

Young people who present with severe problem behaviours are a difficult group to work with. They are frequently less responsive than other young people to naturally occurring incentives, such as the approval of adults or doing well at school. They are often focussed on short-term rewards and have not learnt to behave 'correctly' simply because it is the right or moral thing to do, or in order to generate long-term benefits for themselves. Points systems can be an effective tool for these young people as they can deliver proximate, powerful, and tangible reinforcements, and be used to pair the good feelings associated with these rewards with social reinforcements, such as, praise. Further, by encouraging patterns of appropriate behaviour using short-term reinforcements, the young people can be exposed to naturally occurring long-term rewards that they would not otherwise experience. Once they have experienced these naturally occurring, long-term, rewards the young people are able to be 'trapped' into continuing to behave appropriately to achieve these ends.

In points systems, point allocations and deductions are commonly applied alongside other methods of behaviour management such as time-out and/or the imposition of additional work chores. Time-out is considered effective for children under 12 years of age (Church, 2003), but privilege loss and/or increased task demands are suggested for older young people.

The three key reasons why a points system is an important aspect of clinical practice for young people with problem behaviours as stated in the Te Hurihanga Programme Kete are listed below:

1. *Skills Development:* It is important to develop prosocial skills to help correct young people's inappropriate behaviour. Prosocial skills can help 'crowd out' antisocial behaviour and help sustain a young person's progress outside of a structured programme.
2. *Use of tangible rewards and sanctions:* Antisocial young people are more responsive to tangible rewards and, conversely, less responsive to social rewards like approval and praise. Similarly, tangible sanctions are more effective than social disapproval. Through a point system, young people can learn to pair tangible sanctions with social responses and learn to respond to social cues that guide most behaviour.
3. *A 'fair system':* Young people offenders have a strong sense of being treated unfairly. They can use this perception of lack of fairness as justification for their non-compliance with social mores. If a points system is applied correctly (that is transparently and consistently) it creates a fair and predictable environment where there are clear expectations and consequences for behaviour.

The point system approach to behaviour management has been shown to be effective as it appeals to young people because they feel they have some control over what happens. That is, they know that points can be earned through appropriate behaviour. Also, depending on how the system is implemented, it can be a strengths-based tool that gives the young people tangible achievements.

A points system works in two ways. First, it works by encouraging young people to behave in a desirable or appropriate manner through the positive reinforcement associated with earning and redeeming points, ie, attempting to 'crowd out' antisocial behaviour. And second, it works by discouraging antisocial or inappropriate behaviour. This is through the process of negative punishment (losing points and the associated rewards or freedoms) and positive punishment (imposing additional work chores or remedial tasks).

The allocation and subtraction of points instead of informal rewards and consequences allows for:

- greater consistency across staff: allocations are fair and clear to the young people
- immediate and delayed rewards and consequences: points can be given out or taken away both immediately after a behaviour, and at a later more convenient time (for example, when the young person is less likely to escalate his behaviour further)
- rewards and/or consequences to be accumulated across many behaviours in the course of a shift or week
- points to be cashed in for rewards some time after earning them: this can help young people learn to save and delay gratification
- a variety of rewards or activities: as there is a menu to choose from.

2 The Te Hurihanga contingency management (points) system

As the majority of young people who participate in the programme are youth offenders, they are accustomed to punishment. Rewards are rare. In order to bring about a change in the behaviour of young offenders, the points system needs to provide a much needed alternative to the negative consequences that typify their life experiences. The points system aims to establish structure and consistency in young people's lives. It also aims to encourage them to learn what is expected of them and how they can modify their behaviour to meet these expectations. It also helps them to learn about the relationship between their actions and the consequences of their actions.

The Te Hurihanga points system was derived from a model used by the Oregon Social Learning Centre (OSLC), based in the United States. OSLC is a multidisciplinary research and development centre that focuses on increasing understanding of social and psychological processes related to healthy development and family functioning. The OSLC has been a leader in developing research based and effective interventions for children and young people with severe behaviour problems. The system also builds on practical experience gained by Youth Horizons through other applications of points systems used in a variety of programmes over a number of years.

The system is designed to assist the young people on the programme to control their behaviour. It forms a significant part of the daily monitoring of the rangitahi in Phases 1 and 2 of the programme. It helps the young people understand the difference between acceptable and non-acceptable behaviours and encourages them to adjust their behaviour accordingly. However, although prominent in the improvement of rangitahi behaviour, the system is not the answer to all problematic behaviours. It is a ‘temporary crutch’ to assist the young people to ‘tune into’ naturally occurring contingencies. These are predicted to maintain appropriate behaviour after the withdrawal of the system.

The stated aims of the Te Hurihanga contingency management (points) system are to:

- motivate the young people to progress in treatment through reinforcing identified prosocial behaviours and teaching the young people that there is a direct relationship between their behaviour and its consequences
- be a system that monitors and records behaviour to act as feedback for young people and to assist staff in designing interventions and evaluating their outcomes
- define the rules and standards expected of young people and immediately and effectively deal with antisocial behaviour
- have individualised contingency management through tailoring of points and target behaviours for each young person
- provide a derivative of the token economy systems to young people; a system that formally identifies prosocial behaviours that are linked to the criminogenic needs of the young person.

The system is intended to be individualised, in that the behaviours targeted reflect the criminogenic needs of each of the young people. Young people have their own targeted behaviours for which they are rewarded or receive consequences. The system is also structured around the dimensions of the Good Lives Model (described in Section 3).

3 The points system in practice

When a young person enters Te Hurihanga his behaviour is monitored by staff members at all stages of the day and in all settings. For instance, within the residential facility (including the school setting) and when out on field trips and other external outings. He then earns or loses points dependent upon his behaviour. Once earned, the points can be exchanged for a range of rewards and privileges. As described later, the system is graduated, with an increasing level of achievement required for advancement through the first phase of the programme. As their competencies in self-management and interpersonal skills increase across that phase, so does the criterion for reward and access to privilege. This is designed to make success achievable for each young person from his first day through to completion of the phase. In the second phase, focus on the points system as a determiner of advancement is reduced. The young person still earns access to privileges on a daily basis, but their progress through the phase now relies on them demonstrating achievements in various life domains (like employment/education, family relationships, sport and leisure, and abstinence from drug use).

Points are earned and marked on a 'point sheet' by staff members over the course of each day. Initially this was a solely paper-based exercise but electronic management of the points was introduced in the latter part of 2008 to ensure accuracy and consistency. Each young person has his own 'point sheet' and can earn a maximum of 280 points a day. The points system is similar across each young person to enhance correct implementation by staff. But there is a section that can be individualised, with points available to each young person for performance of different, individually targeted tasks. Further, additional and supplementary incentive schemes are run over the top of the standard points system to enhance its individualisation to meet the criminogenic needs of each young person.

The points system uses several 'stages' through the first two phases of the programme. Phase 1 of the programme (the residential phase) involves the first three stages, in which the young people's behaviour is closely monitored, and earning points determines advancement. The three different stages act as medium-term targets, for the young people. This helps motivate the young person to maintain their efforts in self-management. As each stage is earnt, the list of default privileges available to the young person increases.

In Phase 2 of the programme (the community skills training phase), there are an additional two stages, Stage 4 and Stage 5. In Stage 4, points remain in place, but as the young people spend an increasing amount of time in community settings, the importance of the system in terms of controlling behaviour naturally decreases as contingencies in the community take over. In Stage 5, as the young people are

close to returning home, they are trialled without a points system in place. Behavioural controls are designed to more closely replicate a family home setting. For example, behavioural infractions incur more natural consequences, such as reduced freedom of choice.

There is no universal system employed in Phase 3 of the programme – where Multi-Systemic Therapy is delivered and the young people continue their integration into whaanau and community settings. Multi-Systemic Therapy targets generation of parental rules, and consistency of the delivery of both positive and negative consequences.

As noted, progress through Stages 1 to 3 is based on the young people acquiring points given appropriate behaviour across prescribed areas. Progress through Stages 4 and 5 is determined by engagement and success in life domains known to relate to reducing risk of re-offending, such as: employment/education, family influences on crime and interpersonal relationships, sport and leisure activities, management of drug and/or alcohol issues, peer group, and self-control and attitudes to offending. While there are guidelines for the duration of each stage, progress depends on each young person's achievement. In Stages 1 to 4 each young person is scored on a morning and afternoon shift in the following eight areas:

1. Hygiene
2. Group meeting (karakia, waiata, turn taking, appropriate assertiveness)
3. Effort (participating and contributing)
4. Achievement (quality and completion of work)
5. Self-management (compliance and taking responsibility for own actions)
6. Individually targeted behaviour
7. Relating to others (verbal and physical behaviour, appropriate engagement etc)
8. Chores.

Scoring is based upon a five-point scale, so that a score of 1, 2, 3, 4, or 5, in each area relates to a certain number of points lost, not earned, or earned. There is also the capacity to impose point fines and loss of privileges for specific behaviours.

As well as being the mechanism for the young people to advance through Phase 1 of the programme, the points system also offers the ability to earn prescribed privileges at the end of each day. The points accumulated over the day determine the reward level that the young person is on for the next 24 hours. There are four set reward levels within Stages 1–4. Rewards include phone calls, television time, and time with the games console.

3.1 Stage 1

A young person entering Te Hurihanga starts in Stage 1 of the points system. This is regarded as the 'settling-in' period when his 'likes and wants' are discovered. The young person has a restricted level of privileges available to him without additional rewards. The young person earns points over the day to determine which reward level he is on that night, and for the following 24 hours. The young person needs to

earn two ‘bonds’ in Stage 1 to progress to Stage 2. Each ‘bond’ is earned by the young person cumulating 14 ‘achieved shifts’. In Stage 1, the young person needs to earn two or higher points, out of five, in all eight of the areas assessed (see above) on one shift. This threshold, of two out of five, is intentionally set low, to enable quick success and buy-in to the system. There are two shifts, AM and PM, in each 24-hour period, and this sets the minimum time needed to earn one bond as one week. Thus, this stage takes two or more weeks.

3.2 Stage 2

In Stage 2, the young person has an increased level of basic privileges available without rewards. The young person’s points are again totalled up each day to determine his reward level for that night and the following 24 hours. The young person needs to earn six ‘bonds’ to progress to Stage 3. Each bond is earned by cumulating 14 ‘achieved shifts’. Each ‘achieved shift’ is earned when the young person is marked three or higher out of five, in all eight of the areas assessed on one shift. This stage takes six or more weeks.

3.3 Stage 3

Stage 3 is essentially the same as Stages 1 and 2. However, the base level of privileges that the young person has access to is increased. He must now earn four or five points out of five across all eight areas assessed, in order to earn an ‘achieved shift’. Four bonds are required for the young person to earn the right to request advancement to Phase 2 and Stage 4. The decision to advance is put to the court. This stage takes four or more weeks.

3.4 Stage 4

In Stage 4, points are not used to advance the young person through the Phase. Achievement in his life domains is the criteria and this information is fed back to the court. However, in Stage 4 the young person has increased freedoms and base-level privileges, and his points for the day are still totalled to determine which reward level he achieved.

3.5 Stage 5

The transition to Stage 5 is judged on the basis of a young person’s overall progress and attainment of individualised goals. This stage, in which points are not allocated, typically occurs in the last few weeks the young person is in Phase 2.

4 Behaviour management strategies

Various behaviour management strategies are also incorporated into the points system. They include: target behaviours, bump downs, and point fines. Each is described below:

4.1 Target behaviours

Each young person has his own target behaviour goals to work towards. Target behaviours include socially important behaviours and key skills with which the young person is having difficulty, or are otherwise judged as important. Accomplishment of target behaviours is assessed daily and reflected in the allocated points assigned to them. Where there is a specific need, a supplementary reward or response cost system is implemented. This provides additional motivation for the young people to address a specific problem, eg, significant aggression. Where behaviours are severe, the behaviour management system is always considered an adjunct to the law. Where it appears an offence is committed, (eg, assault upon another young person or upon a staff member), the Police are notified and appropriate action is taken.

4.2 Bump downs

A ‘bump down’ is a significant loss of privilege. Of the four levels of reward available, it is the lowest level. It involves the removal of the basic privileges available to the young person on his current stage, and the imposition of additional chores and tasks to remedy and/or provide recompense for significant behavioural infractions. Effectively, when a young person is on ‘bump down’ he is put back to privilege access less than Stage 1 and also has additional work to do. A young person can end up on ‘bump down’ for a number of reasons, including: not earning a required standard of points, having fines that make a point standard unattainable, or for a single significant antisocial act. For the young person to redress the ‘bump down’, he needs to earn a set number of points, complete his additional chores and tasks, and keep to his restricted privilege level. He can then return to the level and privilege status he was on previously. The severity of an incident will determine the duration of loss of privilege and the number of tasks allocated. For example, insufficient points results in a one day ‘bump down’, one additional chore, and one piece of additional work, like writing an analysis of the cause of the ‘bump down’.

4.3 Points fines

Fines based on standard intervals of point losses are given when specific inappropriate behaviour has occurred. There are standard, preset fines for each young person. Examples of behaviours that will result in fines include self-harm, drug misuse, verbal disrespect or abuse, physical aggression, and non-compliance. Fines are recorded by staff members on fines sheets.

5 Amendments to the original Te Hurihanga points system

As the points system underpins the young people's early behavioural changes, it is essential that it is implemented in a transparent, consistent and fair way. In a residential setting, where there are multiple staff members (including casual staff) working in three shifts and multiple young people (all in different stages of the points system), the system needs to be practical and straightforward. It also needs to be protected (as far as possible) from misinterpretation by both the staff and the young

people. In August 2008 modifications were made to the points system to improve consistency and ease of implementation. The newly modified system is less complex, and easier for staff to learn, understand, and use.

The amendments to the points system, to simplify its design and implementation, and make it more strengths-based, include the following:

- a shift to electronic management of the scoring and automatic tracking of scores from shift to shift
- a consolidation of the areas of behaviours that are scored
- a more finely calibrated point scale, with marking guidelines for staff and young people on the points sheets
- the separation of earning daily rewards from earning progression through Phase 1, and a refocus on the timelines for earning advancement
- a simplified daily rewards structure
- a requirement for the young people to demonstrate appropriate behaviour across every domain assessed, in order for them to advance through Phase 1
- the addition of graduated levels of achievement being required across Stages 1 to 3.

5.1 Electronic management of the scoring

Points are now recorded and managed electronically, using Excel spreadsheets. This change reflects some previous problems the programme providers experienced with the paper-based system. These problems related to coordination of the daily points allocations, including ensuring accurate accounting of points allocated, and to feedback points allocations to all staff members. Changes include the following:

- All staff now input points and fines into an Excel spreadsheet, which automatically calculates point totals, reducing the opportunity for errors.
- Daily reward levels are calculated automatically, based upon the score inputted.
- The allocation of ‘achieved shifts’ and ‘bonds’ is calculated automatically.
- Changes in behaviour are automatically tracked and graphed.
- All point information is available to all staff members including information about a young person’s progress towards ‘bonds’ and changes in behaviour over time.

5.2 Consolidation of the areas that are scored

One of the motivations for consolidating the number of areas scored, in addition to a wish to simplify the system for staff members and the young people, was a desire to focus on managing social behaviours. The point system now focuses on three areas, with points being weighted on self-management and interpersonal behaviours. These three areas are:

- Managing social behaviour, including group meeting time, self-management (compliance and taking responsibility), relating to others (verbal and physical behaviour) and individual behaviours.
- Engagement with programmed activities, including effort and achievement.
- Life skills, including chores and hygiene.

The eight areas for scoring (listed previously) remain unchanged. However, they are grouped into the three areas above. This allows interventions to be more individually targeted to specific areas of behaviour that require attention.

5.3 A more finely calibrated point scale, with marking guidelines

The previous system used a three-point scale for points allocation, zero, half, or full points, in each area assessed. There were additional bonus points available but these were not assigned to any area. Guidelines for marking were in the staff manuals. The requirements for achieving standard points and bonuses were vague and not easily available for both young people and staff. Further, the three-point system had the side effect of biasing staff towards giving full points in each area. This occurred to the extent that the young people developed the expectation of starting the day with full points in return for an absence of incidents, rather than starting the day needing to earn points for appropriate behaviour. This made the system appear like a pure response cost system: where points were taken for inappropriate behaviour, rather than points being earned for good behaviour as well as points being taken for inappropriate behaviour.

As noted, the five-point marking system has specific criteria for the number of points allocated within each category. For each possible score there is a scoring guide and a description to assist the staff in their decision-making, and to help the young person understand how others might interpret his behaviour. The following scoring guide (showing highest to lowest scores) from the category 'grooming and hygiene' is illustrative of the five-point scoring framework:

- To get a **5** (15 points allocated), the scoring guide is 'Going to the Ball' by the young person showing "Excellent grooming: Number 1's clothes, clean and groomed".
- To get a **4** (10 points allocated), the young person has to achieve 'Adult' status by having "Washed, hair done, teeth, fresh clothes: No prompts".
- To get a **3** (5 points allocated), the young person's behaviour should resemble that of an average 'Teenager' by having "Washed, hair done, teeth, fresh clothes: Prompted".
- To get a **2** (0 points allocated), the scoring guide is 'Slob' as indicated by "Partial completion, eg, face washed but not teeth".
- To get a **1** (-10 points allocated) the young person as the scoring guide is 'Ew Yuk! Don't come near me' as the young person is "Unwashed".

The shift to a five-point scale, with scoring criteria written on the points sheets, was designed to address the issues presented – to deliver consistency in scoring across staff, and to make explicit the need for young people to earn higher value scores through their day-to-day efforts, rather than to get the points as of right. The five-point system is viewed as very manageable, which is important given that changes to the system are also intended to improve its ease of use. The providers recognise the need for balance between capturing subtle changes in the young people's behaviour and maintaining sufficient simplicity to ensure usability, consistency and

clarity. They recognise that staff training is key to the new system's efficient and consistent implementation.

5.4 The separation of earning daily rewards from earning progression through Phase 1, and a refocus on the timelines for earning advancement

The previous system used different rules for progression through Phase 1 for Stage 1 (cumulative points earned) and Stages 2 and 3 (number of bonds purchased from points earned). Stages 2 and 3 employed a weekly cut-off (Sunday night) for the young person to earn a set number of points necessary to purchase a bond. Any points not spent by the young person by this cut-off were wiped. This was designed to motivate the young people to behave during the week, and learn to 'save' a proportion of points for the long-term goal (the bond and quicker movement through Phase 1), rather than 'spend' the points on daily rewards. The young people generally grasped this concept too well and chose not to purchase any daily rewards until they had saved enough points to purchase a bond; typically four to five days without incident. This negated any effect of daily rewards as a source of proximate control over the young people's behaviour, as the young people did not access daily rewards on a regular basis. Further, when incidents occurred and points totals were correspondingly lower, the young people would continue trying to earn and save through to Sunday night. They would either, just succeed, and maybe have a few points left over to purchase a small reward or they would fail to earn enough points for a bond and frequently engage in various aggressive behaviours, ie, tantrums. An analysis of one young person's points saving and purchasing behaviour showed that in a one-month period he purchased only one reward (half an hour television time). He committed the remainder of his points to attempting, and sometimes failing, to earn bonds. The young people developed a culture in house of "saving for bonds at all cost". This proved detrimental to behaviour change, to staff ability to manage day-to-day behaviour, and it increased the likelihood of escalations in antisocial behaviour towards the end of each week.

The changes made to the system were to remove the weekly cut-off for earning a bond, and to separate the requirements for earning bonds from earning day-to-day rewards. As previously described, in the new system the young people earn 'achieved shifts' where they have demonstrated appropriate behaviour across all eight areas assessed. When they have 14 of these 'achieved shifts' they earn a bond. The points they earn also determine what rewards they have access to on a daily basis.

5.5 A simplified daily rewards structure

The original system entailed each young person spending points on various reward options from a menu, including bonds. This occurred in the early evening, and was a time consuming process involving balancing each young person's points book in the same manner as an accounting ledger. The system was simplified to reduce the necessity for decision making on behalf of both staff and young people. Four levels of reward were established.

- The lowest level is ‘bump down’, when the young person fails to earn 200 or more points over the day.
- Level 2 is ‘basics’, between 200 and 230 points: TV access, early bed, radio in room, one 10 minute phone call.
- Level 3 is for greater than 230 points up to 260 points: as for Level 2 but 15 minutes later bed time, 15 minute phone call, choice of two rewards from 15 minute block of computer time (2 max), 15 minute block of games console time (2 max), food treat (1 max).
- Level 4 is for greater than 260 points: as for Level 2 but latest bed time, 20 minute phone call or two 10 minute phone calls, free access to DVD, computer, games console as available, food treats.

The electronic system calculates the reward level that each young person has achieved and the results are posted on a white board for the next 24 hours. The changes have resulted in greater uptake of daily rewards by the young people, increasing the ability for behavioural control by the points system. It has also reduced the staff resource needed to audit, implement, and monitor the system.

5.6 A requirement for the young people to demonstrate appropriate behaviour across every domain assessed, in order for them to advance through Phase 1

In the original system, a young person needed to purchase bonds in Stages 2 and 3 of Phase 1. They saved points to do this, and points would come from all areas in which points were earned. The weakness was that a young person could advance himself through Phase 1 by earning points in a restricted range of areas, while continuing to present with poor performance in one or two areas. The system for advancement was changed so that advancement would only be earned when the young person demonstrated achievement in every area considered in the points system, via the ‘achieved shift’.

5.7 The addition of graduated levels of achievement being required across Stages 1 to 3

Flowing on from the requirement for young people to demonstrate achievement in every area of the behaviour management system, was the necessity to set achievable thresholds for success. Working backwards from the behaviour desired at the end of Phase 1, thresholds for ‘achieved shifts’ were set for Stages 1, 2, and 3. These thresholds were set using the five-point scale used for grading performance in each area of the points system. In Stage 1 the threshold is low (2 or more out of 5), to allow the young people to experience success using the skills they enter the programme with. In Stage 2 the requirement is raised slightly (3 or more out of 5). This is the longest stage of Phase 1 and the threshold is set so that the young people should be able to achieve it easily in most of the areas assessed, and earn reasonable points each day. However, each young person typically struggles to consistently reach the threshold in one or two areas. This facilitates two outcomes: the young person can maintain a degree of daily success via daily

rewards, but his attention is also focussed on the areas in which he is not meeting the threshold. The young people are then motivated to work on these areas in order to move forward in the phase.

6 User responses

The discussion below provides an insight into young people's and staff members' responses to the points system and the ease of use for staff.

6.1 Young people

Young people focused on the fairness of the system, although they also noted its complexity, its impact on their behaviour and the value of the amendments. As discussed, youth offenders tend to have a strong sense of unfair treatment and use this to excuse their non-compliance with social rules. Therefore, for the points system to be effective, it is essential that the young people in the programme view it as fair. Their generally positive views about the system suggest that they see it as fair overall. Terms like "*fine"*, "*sweet as"* and "*okay"* were commonly used to describe the system. Such acceptance is not universal, however. For instance, one young person felt he was disadvantaged compared with newer arrivals given recent changes in bedtime rules: he felt the previous bedtime had been too early and was pleased at the newly established later time. But he felt aggrieved that new arrivals could now stay up later than he had been able to.

The young people on the programme varied in their ability to learn the finer details of the points system, which can be complex for both them and the staff members allocating points. Some of the young people reported learning the system quickly (for instance in two weeks) and others described needing time to come to terms with its structure and implementation (for instance, five months).

In general, the young people recognised the value of the points system. For instance, it was not unusual for young people to attribute their improved behaviour to the system, and in some cases the young people could only describe their achievements in terms of points earned or the stage in the system achieved. However, at the same time, some resented the level of oversight involved. For instance, one young person talked about his experience of the graduated system and his relief when monitoring of his behaviour diminished as he progressed through the stages; as he commented, *"it's a privilege not to have people watching".*

Some of the young people still feel the system is unfair. For instance, one young person was indignant about his slower than expected progress through the stages of the system because he had not achieved his required daily point count. He seemed to find it difficult to acknowledge his own part in this slow progress and resented staff decisions: *"when you have low points you have to stay here another day… it should just be a bump down"*. Although the suggested duration periods for each stage of the points system are provided as guidelines only, some young people seemed to interpret them as more prescriptive. As a consequence, they felt

disappointed or resentful when they did not progress through the stages as these guidelines would suggest.

6.2 Staff

In general, the residential staff members have most of the day-to-day contact with the young people. While, overall, the residential staff and the clinical team are reasonably confident about the quality of their application of the system, they also recognise that there have been some teething problems. One is a perceived tension, for a small number of staff members, between the principles underpinning the system and their own value systems and beliefs. For instance, some have struggled with how to express cultural values such as 'aroha' within a prescribed points system that incorporates negative consequences as well as rewards. They feel the system is sometimes overly harsh. To ensure that the points system is implemented as intended, it needs to be sufficiently well-defined to overcome any individual staff tendencies to impose rewards and consequences that reflect their own values and beliefs. Others feel that the system is insufficiently strengths-based to enable them to balance their own cultural values with the requirements of the system.

Staff comments illustrate both their increasing confidence with the system, given their increasing experience and the modifications made, and their remaining frustrations:

- *The new points system allows you to make comments at the bottom and add notes to the young person's file.*
- *Different rewards are needed: for example more informal, sustainable rewards and tangible rewards like movies, vouchers.*
- *Was told off for not scolding: but don't like putting the young person down.*
- *Some interactions with young people had been viewed as too intimate, like greeting with a hug, but interactions are ok now.*
- *Scold a kid and it's fine, but you can't reward or give bonuses to them if they make up for their bad behaviour; at times it feels like double consequences. Young people can't come back and make up for behaviour (like apologise) and get rewarded for it.*

Overall, staff members are happier with the modified system, for instance commenting that *"the staff love it, it is great"*. Nevertheless, as with any prescribed system, there is a learning period. As one staff member noted: *"there is some level of getting your head around it, some stress, some anxiety, it is better than the last one … more easily understandable"*. Another commented: *"took a lot to get used to but it flows"*.

At the end of the shift, staff now need to enter points into an Excel spreadsheet, this provides instant feedback where you can see the behaviour graphed. This helps to work out behaviour themes etc. The new system allows the young people to focus on their individual behaviours. They can see where they went wrong and how they need to act in order to get the full points. It is now strength-focused and more

positive. The boys are measuring themselves more by it; for example, they are frequently asking for their points.

7 Strengths-based

It is important that the Te Hurihanga points system is used as a strength-based tool with positive reinforcement to promote good behaviour, rather than a deficit-based tool. Strength-based tools identify what is working well and encourage more of it, while also acknowledging risk and protective factors within each individual. Nevertheless, Patterson (2002) describes the history of parent training interventions, and how attempts to solely reinforce behaviours that compete with aggression, ie, positive-only practice, failed. When positive only-practice was paired with non-violent forms of limit setting, such as time-out (for young children) and work chores, rapid reductions in deviant child behaviour have been generated. Taking this into account, the task of the Te Hurihanga points system has been to achieve a balance between appropriate reinforcement and appropriate punishment. The changes made to the system to date have encouraged this effective balance. The young people are able to maintain high levels of success, especially with respect to achieving daily rewards. However, they are also held responsible for their actions and are required to address their excesses of antisocial behaviour. Thus, the young person's day-to-day successes provide a background level of achievement for them that ‘cushions’ the effects of negative feedback; the success maintains their engagement and motivation, letting them continue with a rewarding life, while they address the antisocial behaviours that are problematic for them.

Appendix 4: Case file review schedule

1. Identification

a) Case number:
b) Referral date:
c) Admission date:
d) Time in Phase 1 (in days):
e) Time in Phase 2 (in days):
f) Time in Phase 3 (in days):
g) Extra Info:
h) Current status (at 16 June 09)

- ☐1 Phase 1
- ☐2 Phase 2
- ☐3 Phase 3
- ☐4 Completed. Date:
- ☐5 Exited early. Date:

2. Demographic characteristics

a) Principle ethnic identification:
b) Iwi affiliation/s:
c) Date of birth:
d) Age at entry:

3. General history before entering Te Hurihanga

a) Mental Health and heath-related conditions

- ☐1 Meets Conduct Disorder or Severe Conduct Disorder Criteria
- ☐2 Attention Deficit Hyperactivity Disorder (ADHD)
- ☐3 Drug and/or alcohol misuse
- ☐4 Depression
- ☐5 Suicide ideation/intent or attempt
- ☐6 Other non-accidental self injury (no suicide intent)
- ☐7 Cognitive disability
- ☐8 Trauma symptoms
- ☐9 Anxiety symptoms
- ☐10 Other Mental Health, specify:
- ☐11 Physical illness or disability problems
- ☐12 Other, specify:

Extra:

b) Agencies, services and programmes to which client have been referred prior to programme

☐1 CYF Youth Justice
☐2 CYF Care and Protection (if yes, see below)
☐3 Under current 101 Custody
☐4 Residential service Specify:
☐5 Educational Psychologist/MOE services
☐6 CAMHS/Hauora Waikato
☐7 Other mental health service
☐8 A and D services
☐9 Other. Specify:
Extra:

4. Family/whaanau characteristics

a) Status of main family/whaanau/other household

☐1 One-parent - mother
☐2 One-parent - father
☐3 Two-parent - biological parents
☐4 Two parent - one a step-parent
☐5 Extended family/whaanau Specify:
☐6 Non-family Specify:
☐7 Other Specify:
Extra:

b) Parents' ethnicity

Father
Mother
Step Father
Step Mother
Other
Dominant culture in household
Extra:

c) Socio-economic circumstances of main family/whaanau

☐1 High income
☐2 Average income
☐3 Low income
Extra:

d) Other family characteristics (eg, Parental/sibling criminality)

5. Assessment process

Behaviours and other factors identified as problematic in referral documentation

☐1 Offending: Prior and current offences (Self Control)
☐2 Family circumstances and parenting issues (Good Whanaau relationships)
☐3 Education and employment/training: e.g. lack of involvement in education/employment (Doing Well and Community Belonging)
☐4 Substance abuse (Being Well)
☐5 Leisure/recreation: Lack of engagement in pro-social leisure/recreation options (Doing Well and Community Belonging)
☐6 Personality/behaviour: Skills deficits in emotional/behavioural regulation (Self Control)
☐7 Attitude/orientation
☐8 Peer relationships (Good Friendships)
☐9 Cultural
☐10 Other
Extra:

6. Treatment plan

Behaviours and other factors identified in the treatment plan

☐1 Offending: Prior and current offences (Self Control)
☐2 Family circumstances and parenting issues (Good Whaanau relationships)
☐3 Education and employment/training: Lack of involvement in education/employment (Doing Well and Community Belonging)
☐4 Substance abuse (Being Well)
☐5 Leisure/recreation: Lack of engagement in pro-social leisure/recreation options (Doing Well and Community Belonging)
☐6 Personality/behaviour: Skills deficits in emotional/behavioural regulation (Self Control)
☐7 Attitude/orientation
☐8 Peer relationships (Good Friendships)
☐9 Cultural
☐10 Other
Extra:

OUTCOMES: PHASES 1 and 2

CRIMINOGENIC

7. Offending outcomes – Phase 1

a) Reduction in frequency of offending
☐1Yes ☐2 No

Comment:

b) Reduction in severity of offending
☐1Yes ☐2 No

Comment:

8. Offending outcomes – Phase 2

a) Reduction in frequency of offending
☐1Yes ☐2 No

Comment:

b) Reduction in severity of offending
☐1Yes ☐2 No

Comment:

9. Family Circumstances – Phase 1

a) Regular family involvement with young person (eg, phone/visit)
☐1Yes ☐2 No

Comment:

b) Family involvement through participation in programme activities
☐1Yes ☐2 No

Comment:

c) Engagement in sessions with whaanau worker
☐$_1$Yes ☐$_2$ No

Comment:

d) Other progress indicators
☐$_1$Yes ☐$_2$ No

Comment:

e) Responsivity Barriers
☐$_1$Yes ☐$_2$ No

Comment:

10. Family Circumstances outcomes – Phase 2

a) Successful transition to home (via home leave process)
☐$_1$Yes ☐$_2$ No

Comment:

b) Family involvement through participation in programme activities
☐$_1$Yes ☐$_2$ No

Comment:

c) Family engagement in sessions with whaanau worker
☐$_1$Yes ☐$_2$ No

Comment:

d) Parental insight and skills acquisition
☐$_1$Yes ☐$_2$ No

Comment:

e) Improved parental supervision
☐$_1$Yes ☐$_2$ No

Comment:

f) Other progress indicators
☐$_1$Yes ☐$_2$ No

Comment:

g) Responsivity Barriers
☐$_1$Yes ☐$_2$ No

Comment:

11. Education/Vocation outcomes – Phase 1

a) Regular school attendance (versus truancy)
☐$_1$Yes ☐$_2$ No

Comment:

b) Reduction in behavioural issues
☐$_1$Yes ☐$_2$ No

Comment:

c) Enhanced attitude to learning
☐$_1$Yes ☐$_2$ No

Comment:

d) Participation in academic/core curriculum
☐$_1$Yes ☐$_2$ No

Comment:

e) Participation in the wider curriculum (eg, sex education)
☐$_1$Yes ☐$_2$ No

Comment:

f) Progress towards goals set in relation to education/employment/recreation
☐$_1$Yes ☐$_2$ No

Comment:

g) Progress towards gaining drivers license
☐$_1$Yes ☐$_2$ No

Comment:

h) Progress towards completing CV
☐$_1$Yes ☐$_2$ No

Comment:

i) Responsivity Barriers (and how these were addressed)
☐$_1$Yes ☐$_2$ No

Comment:

12. Education/Vocation outcomes – Phase 2

a) Transition into mainstream secondary or tertiary education, training, work experience or employment
☐$_1$Yes ☐$_2$ No

Comment:

b) Achievement of vocation-related individual goals (eg, learner or restricted licence, CV completion, interview skills, job applications, etc)
☐$_1$Yes ☐$_2$ No

Comment:

13. Peer relations outcomes – Phase 2

a) More engagement with pro-social peer and family activities and relationships (eg, recreation, education and employment)
☐$_1$Yes ☐$_2$ No

Comment:

b) Reduced engagement in coercive and anti-social peer activities
☐$_1$Yes ☐$_2$ No

Comment:

14. Substance abuse outcomes – Phase 1

a) Abstinence or moderation of A and D use
☐$_1$Yes ☐$_2$ No

Comment:

b) Enhanced knowledge of substances and their risks (and enhanced consequential thinking)
☐$_1$Yes ☐$_2$ No

Comment:

c) Referred to A and D counselling (through local provider)
☐$_1$Yes ☐$_2$ No

Comment:

15. Substance Abuse outcomes – Phase 2

a) Abstinence or moderation of A and D use
☐$_1$Yes ☐$_2$ No

Comment:

b) Enhanced knowledge of substances and their risks (and enhanced consequential thinking)
☐$_1$Yes ☐$_2$ No

Comment:

c) Engagement in A and D counselling (through local provider). Movement through the stage of change cycle
☐$_1$Yes ☐$_2$ No

Comment:

d) Appropriate parental role modelling on home leaves (eg, nil access or use in front of young person)
☐$_1$Yes ☐$_2$ No

Comment:

e) Opportunities to access illicit substances out of home are addressed
☐$_1$Yes ☐$_2$ No

Comment:

16. Leisure/Recreation outcomes – Phase 1

a) Made adjustment to residential structure and routines
☐$_1$Yes ☐$_2$ No

Comment:

b) Engagement with multiple programmed residential and educational recreational activities
☐$_1$Yes ☐$_2$ No

Comment:

c) Selected a community-based individualised recreational goal
☐$_1$Yes ☐$_2$ No

Comment:

17. Leisure/Recreation outcomes – Phase 2

a) Increase in taking responsibility for adherence to structure and routines
☐1 Yes ☐2 No

Comment:

b) Selection of and engagement in an individualised recreational activity
☐1 Yes ☐2 No

Comment:

18. Personality/Behaviour outcomes – Phase 1

a) Self-regulation skill enhancement (eg, problem solving, aggression control etc)
☐1 Yes ☐2 No

Comment:

b) Reduction in incidents of aggression (tantrums/verbal/physical/wilful damage)
☐1 Yes ☐2 No

Comment:

c) Compliance with Te Hurihanga rules
☐1 Yes ☐2 No

Comment:

d) Compliance with judicial consequences (eg, community hours, other FGC requirements)
☐1 Yes ☐2 No

Comment:

e) Improved in ability to attend (compliance with ADHD medication regime)
☐1 Yes ☐2 No

Comment:

19. Personality/Behaviour outcomes – Phase 2

a) Self-regulation skill enhancement (eg, completing an offence map, and relapse prevention plan)
☐1Yes ☐2 No

Comment:

b) Reduction in incidents in residence/community (tantrums/verbal/physical/wilful damage)
☐1Yes ☐2 No

Comment:

c) Compliance with Te Hurihanga rules
☐1Yes ☐2 No

Comment:

d) Compliance with judicial consequences (eg, community hours, other FGC requirements)
☐1Yes ☐2 No

Comment:

e) Improved in ability to attend (compliance with ADHD medication regime)
☐1Yes ☐2 No

Comment:

20. Attitudes/Orientation outcomes – Phase 1

a) Reduction in anti-social thinking and/or enhancement of pro-social thinking
☐1Yes ☐2 No

Comment:

b) Enhanced moral reasoning and awareness and concern for others, including remorse, victim empathy
☐1Yes ☐2 No

Comment:

c) Enhanced consequential thinking (consideration of positive and negative short-term and long-term consequences for actions)
☐1Yes ☐2 No

Comment:

d) Actively seeking and accepting help
☐1Yes ☐2 No

Comment:

e) Increased compliance with authority
☐1Yes ☐2 No

Comment:

21. Attitudes/Orientation outcomes – Phase 2

a) Reduction in anti-social thinking and/or enhancement of pro-social thinking
☐1Yes ☐2 No

Comment:

b) Enhanced moral reasoning (enhanced consequential thinking and awareness and concern for others, including remorse, victim empathy)
☐1Yes ☐2 No

Comment:

c) Enhanced consequential thinking (consideration of positive and negative short-term and long-term consequences for actions)
☐1Yes ☐2 No

Comment:

d) Actively seeking and accepting help
☐$_1$Yes ☐$_2$ No

Comment:

e) Increased compliance with authority
☐$_1$Yes ☐$_2$ No

Comment:

NON-CRIMINOGENIC

22. Cultural outcomes – Phase 1

a) Increased awareness of own cultural identity
☐$_1$Yes ☐$_2$ No

Comment:

b) Increased knowledge of kaupapa of Te Hurihanga
☐$_1$Yes ☐$_2$ No

Comment:

c) Increased knowledge of kawa o te whare (Kawa/Tikanga)
☐$_1$Yes ☐$_2$ No

Comment:

d) Increased knowledge of Mangaonua (land Te Hurihanga is located on – taken from name of local stream)
☐$_1$Yes ☐$_2$ No

Comment:

e) Increased knowledge of local Iwi
☐$_1$Yes ☐$_2$ No

Comment:

f) Increased knowledge of Waikato Awa
☐$_1$Yes ☐$_2$ No

Comment:

g) Increased knowledge of/ability to do a peepeha (small mihi – you and your place)
☐$_1$Yes ☐$_2$ No

Comment:

h) Increased knowledge of/ability to participate in a poowhiri/Whakatau
☐$_1$Yes ☐$_2$ No

Comment:

23. Identity Development outcomes – Phase 1

a) Increased awareness of sexual identity
☐$_1$Yes ☐$_2$ No

Comment:

b) Increased thoughts and behaviours relating to personal appearance
☐$_1$Yes ☐$_2$ No

Comment:

c) Reduction in gang identity (increased pro-social identity)
☐$_1$Yes ☐$_2$ No

Comment:

24. Identity Development outcomes – Phase 2

a) Increased awareness of sexual identity
☐$_1$Yes ☐$_2$ No

Comment:

b) Increased thoughts and behaviours relating to personal appearance
☐$_1$Yes ☐$_2$ No

Comment:

c) Reduction in gang identity (increased pro-social identity)
☐$_1$Yes ☐$_2$ No

Comment:

25. Mental Health / Safety outcomes – Phase 1

Mental health/safety concerns/issues addressed
☐$_1$Yes ☐$_2$ No

Comment:

26. Mental Health / Safety outcomes – Phase 2

Mental health/safety concerns/issues addressed
☐$_1$Yes ☐$_2$ No

Comment:

27. Physical Health (Medical/Dental) outcomes – Phase 1

Physical health/safety concerns/issues addressed
☐$_1$Yes ☐$_2$ No

Comment:

28. Physical Health (Medical/Dental) outcomes – Phase 2

Physical health/safety concerns/issues addressed
☐$_1$Yes ☐$_2$ No

Comment:

29. Life Skills – Phase 1

a) Improved attention to personal hygiene
☐1Yes ☐2 No

Comment:

b) Increased skills or participation in domestic chores
☐1Yes ☐2 No

Comment:

c) Increased skills or participation in food preparation
☐1Yes ☐2 No

Comment:

30. Life Skills outcomes – Phase 2

a) Improved attention to personal hygiene
☐1Yes ☐2 No

Comment:

b) Increased skills or participation in domestic chores
☐1Yes ☐2 No

Comment:

c) Increased skills or participation in food preparation
☐1Yes ☐2 No

Comment:

31. Other outcomes – Phase 1
☐1Yes ☐2 No

Comment:

32. Other outcomes – Phase 2

☐1 Yes ☐2 No

Comment:

PHASE 3

CRIMINOGENIC

33. Offending outcomes

a) Reduction in frequency of offending

☐1 Yes ☐2 No

Comment:

b) Reduction in severity/intensity of offending

☐1 Yes ☐2 No

Comment:

34. Family Circumstances outcomes

a) Family is monitoring and supervising the young person appropriately

☐1 Yes ☐2 No

Comment:

b) Family has increasing control of young person's behaviour

☐1 Yes ☐2 No

Comment:

c) Increasing parental responsibility

☐1 Yes ☐2 No

Comment:

d) Family members have increased responsible behaviour and decreased irresponsible behaviour
☐$_1$Yes ☐$_2$ No

Comment:

e) Family has implemented effective disciplinary practices
☐$_1$Yes ☐$_2$ No

Comment:

f) Reduction of conflict in the home
☐$_1$Yes ☐$_2$ No

Comment:

g) Parent-child relationships are strengthened (e.g. warmth and affection)
☐$_1$Yes ☐$_2$ No

Comment:

h) Family is actively seeking formal and informal support
☐$_1$Yes ☐$_2$ No

Comment:

i) The family has engaged well with the MST caseworker
☐$_1$Yes ☐$_2$ No

Comment:

j) Parents have consistently followed through with MST interventions
☐$_1$Yes ☐$_2$ No

Comment:

k) Responsivity Barriers
☐$_1$Yes ☐$_2$ No

Comment:

35. Education/Vocation outcomes

Young person has maintained participation in mainstream secondary or tertiary education, training, work experience or employment
☐$_1$Yes ☐$_2$ No

Comment:

36. Peer relations outcomes

a) More engagement with pro-social peer and family activities and relationships (eg, recreation, education and employment)
☐$_1$Yes ☐$_2$ No

Comment:

b) Reduced engagement in coercive and anti-social peer activities
☐$_1$Yes ☐$_2$ No

Comment:

37. Substance Abuse outcomes

a) Reduced access to A and D
☐$_1$Yes ☐$_2$ No

Comment:

b) Appropriate parental role modelling (eg, nil access or use in front of young person)
☐$_1$Yes ☐$_2$ No

Comment:

38. Leisure/Recreation outcomes

a) Parental promotion of structure and routines
☐$_1$Yes ☐$_2$ No

Comment:

b) Young person maintained engagement in a recreational/pro-social activity
☐1 Yes ☐2 No

Comment:

39. Personality/Behaviour outcomes

a) Young person is better at controlling his impulsivity
☐1 Yes ☐2 No

Comment:

b) Reduction in incidents in community
☐1 Yes ☐2 No

Comment:

Appendix 5: Interview schedules

Date _____

YOUNG PEOPLE

Case number _____

What do you want out of the Programme overall?

_____

_____

_____

_____

_____

_____

Let's look at the programme phase by phase.

Phase 1 – What did you expect to achieve and what did you achieve?

Expected to achieve: _____

_____

_____

_____

_____

_____

_____

Have achieved: _____

_____

_____

_____

Phase 2 – What did you expect to achieve and what did you achieve?

Expected to achieve: _____

_____

_____

_____

_____

_____

Have achieved: _____

_____

_____

_____

_____

_____

_____

Phase 3 – What did you expect to achieve and what did you achieve?

Expected to achieve: _____

_____

_____

_____

_____

_____

_____

Have achieved: _____

_____

_____

_____

_____

_____

_____

What have you achieved overall out of the Programme? _____

_____

_____

_____

_____

_____

What things do you like about the Programme? _____

_____

_____

_____

_____

What things do you not like? _____

_____

_____

_____

_____

_____

_____

_____

Is there anything else you would like to add? _____

_____

_____

_____

_____

_____

_____

Date _____

WHAANAU/FAMILY OR CAREGIVERS

Case number

Relationship to young person _____

Involvement with Te Hurihanga

How did you find out about the programme? _____

_____

_____

_____

How keen were you at the start for _____ to be on the programme?

_____

_____

_____

How keen are you now?

_____

_____

_____

If there is a difference, why is that? _____

_____

_____

_____

Describe your involvement in the assessment process _____

_____

_____

_____

Identifying problems _____

_____

_____

_____

Planning interventions _____

_____

_____

_____

What other involvement have you had in the programme?

Has your involvement been as you expected? Explain.

Programme achievements

What are the positive things that have come out of the programme?

For you?

Better ways to manage _____'s behaviour _____

_____

_____

_____

_____

_____

_____

_____

_____

For _____

Behaviour

_____

_____

Fitting back into the family/whaanau_____

_____

_____

Fitting back into the community _____

_____

_____

_____

_____

_____

How has your relationship with _____ changed as a result of the programme?

Did you get enough support so that you would be ready for _____ to come home?

_____

_____

_____

_____

_____

_____

STAKEHOLDERS

Date _____

Name

_____

Position _____ Organisation _____

History with Te Hurihanga _____

_____

_____

_____

Describe your normal contact with Phases 1,2 and 3 of the Programme?

Phase 1_____

_____

_____

_____

_____

_____

Phase 2_____

_____

_____

_____

_____

_____

Phase 3_____

_____

_____

_____

_____

_____

Referral pathway

Do you think the right young people are being referred to and accepted for the programme?

Are there young people who are missing out? If so, who and why?

Support for and involvement in the programme

What does your organisation think about the concept of the programme?

Is the programme being provided in a way that fits with the local community?

_____

_____

_____

_____

_____

Are there enough opportunities for the community to be involved in the programme?

_____

_____

_____

If not, what could be changed to increase community involvement?

_____

_____

_____

_____

_____

What level of support do you think the community has for the programme?

_____

_____

_____

_____

Are there enough opportunities for whaanau/family to be involved in the programme? If not, what could be changed to increase their involvement?

_____

_____

_____

If not, what could be changed to increase their involvement?

_____

_____

_____

What do you think about the way that the Programme is run? What are its strengths and weaknesses?

Strengths: _____

_____

_____

_____

_____

_____

Weaknesses: _____

_____

_____

_____

_____

_____

Programme achievements

What outcomes are important to monitor to assess the success of the programme?

_____

_____

_____

_____

How do you see the programme success in the following areas of the young people's lives?

Behaviour _____

_____

Cultural identity and knowledge, cultural pride, self esteem _____

_____

Education _____

_____

Employment_____

_____

Health _____

_____

Family relationships _____

_____

Mixing with more positive peer group _____

_____

Other social interaction _____

_____

Other. Specify _____

_____

_____

_____

_____