Child Centered Outcomes

Our mission

* To transform the lives of children and young people who are at significant risk of harm to their wellbeing as a consequence of the environment in which they are being raised and their own complex needs.
* For each child we seek to develop their capacity to live in healthy, hopeful relationships with others. On this depends all of the other necessary outcomes which contribute to their ability to enjoy life and reach their potential.

Client Target Group

Children aged 5 to 12 and their families who:

- are at significant risk of harm to their wellbeing as a consequence of the **environment** in which they are being raised and their own complex needs
- already demonstrate various levels of harm and/or a range of symptoms of **traumatisation** due to exposure to multiple risks and maltreatment including:
  - Health and physical effects
  - Intellectual and cognitive development
  - Emotional, psychological, and behavioural consequences
- have the **right to protection** from further harm
- need **therapeutic support** to ensure their recovery and to enhance their wellbeing

Theory of Change

Three principles underpin our approach:

* Harm caused by relationships is best healed by relationships.
* That a child's home and family, school and teachers, neighbourhood and friends all play a critical role in a child's world and each system requires attention to improve a child's quality of life.
* Transformative environments that provide therapeutic relationships and authentic experiences of belonging, mastery, independence and generosity are quicker and more effective for a child's journey of recovery.

Outcome Example
'Improved family functioning'

Tools to measure the outcome – need a range across clinical tests and experience of service:

* **SDQ**
* **AAPI-2**
* Parenting Capacity **objectives met**
* Child Development **objectives met**
* **Satisfaction Surveys objectives met**
* **Child Outcome Rating Scale**
* **Parental Programme Evaluations**
* Facilitated **access to** Drug, Alcohol, Adult Mental Health and Family Violence services
* New additions –
* Behaviour questionnaire – based on DSM4
* McMasters Family Assessment Device

Strengths and Difficulty Questionnaire

What the SDQ Measures:

* *The SDQ asks questions about 25 psychological attributes.*
* *The 25 items are divided between five scales:*
* *Emotional symptoms*
* *Conduct problems*
* *Hyperactivity/inattention*
* *Peer relationship problems*
* *Prosocial behaviour*

SDQ also provides an Impact Report that measures how much the difficulties the child is experiencing is impacting on their home and school life.

Uses of the SDQ

* *Clinical assessment.*
* *Evaluating outcome.*
* *Epidemiology.*
* *Research.*
* *Screening.*

Adult Adolescent Parenting Inventory-2

What the AAPI-2 Measures:

* *Inappropriate Expectations of Children*
* *Parental Lack of Empathy Towards Children's Needs*
* *Strong Parental Belief in the Use of Corporal Punishment*
* *Reversing Parent-Child Family Roles*
* *Oppressing Children's Power and Independence*

Uses of the AAPI-2

* *To assess the parenting and child rearing attitudes of adolescents.*
* *To assess the parenting and child rearing attitudes of prospective parents.*
* *To assess changes in parenting and child rearing practices after treatment.*
* *To screen and train prospective foster parent applicants.*
* *To assess the parenting and child rearing attitudes of prospective employees who want to work with children*

Benefits

* Keeps the child and family/whanau at the centre of all we do and sharpened our focus
* Provides clarity of service design – connected to mission and theory of change
* Provides real time feedback on intervention efforts to frontline staff and guides best practice
* Strengthens service development and innovation as we gain deeper understandings of what works
* Supports ownership and accountability throughout the organisation

Thoughts on Outcome Based Contracts

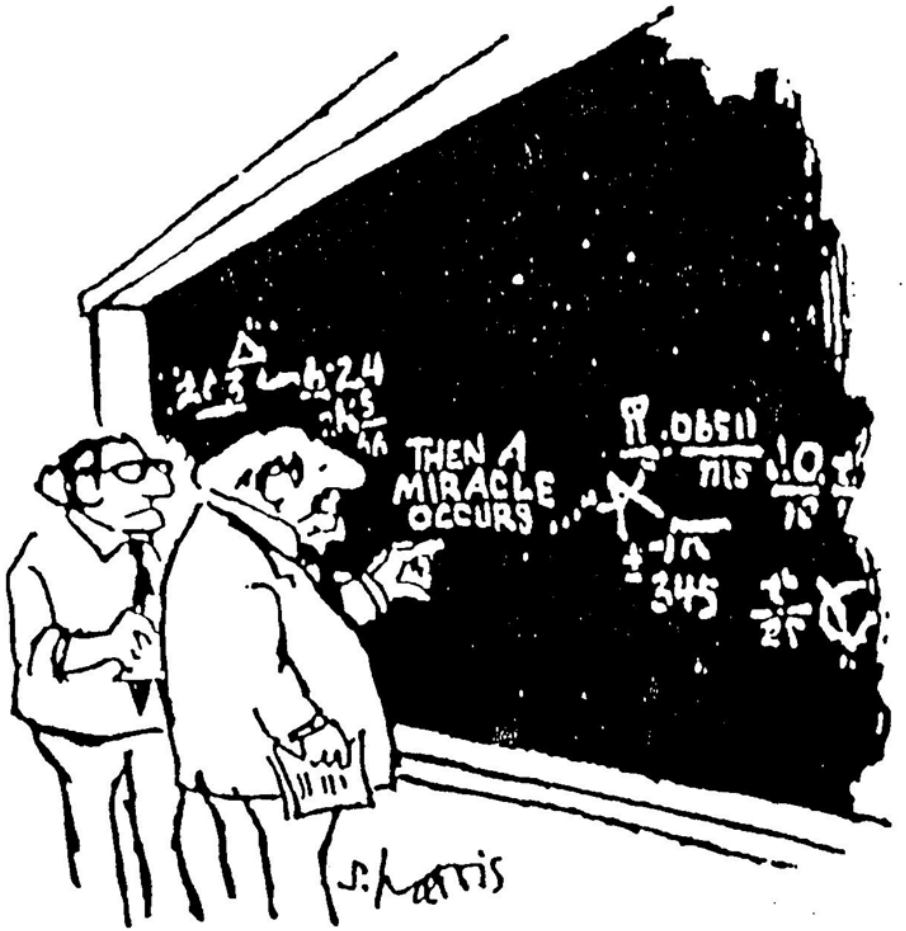
* MSD Outcomes Trial: "Moving to results based services / contracting is a complex process. The time, culture change, system, personnel, data collection and analysis and other capability requirements for both MSD and providers is significant"
* Conventional performance metrics often fail to capture the full impact and value of the work done by nonprofit organizations that operate on the front lines of social change *(Standford)*
* Currently too little investment and capability/capacity for evaluating complexity (vs easier 'results measures')

Thoughts on Outcome Based Contracts

* Highly defined purchasing e.g. working only with the 'vulnerable' who need specialist help (Group D) and who will achieve specified outcomes in the specified time frame - could drive 'organisational survival mode'
* Humans are not widgets. At what point is a family 'fully functioning'? Change is a process that varies in length, may not have a defined 'end point' and is difficult to measure precisely
* Social services are only of 'value' if it is of value to those for whom it is provided – who's definition of value will define success?
* May have an adverse effect and drive behaviours that create more silos rather than collaboration as competition for scarce resources remains

“I think you should be more explicit here in Step Two.”

Theory in the humane professions is not static but evolves constantly in the light of new experience and changing social landscapes...



Children's Services Tū Māia Whānau
A world strong with children

Hopes and Dreams

AND… we can create the necessary conditions for outcomes and innovation to succeed

* invest, invest, invest – workforce and organisations
* practicing real partnership/co-design across the whole sector and community
* embracing and understanding complexity
* move from diagnostic approach to dialogic approach
* curate rather than create knowledge