

RESPIRE CARE WITH A DIFFERENCE

**Responding to Vulnerability & Increasing Resilience through Group
Respite Care**

The Voices of Children, Parents & Carers

By

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**Submitted in accordance with the partial fulfilment of requirements
for the degree of**

Master of Science in Child and Youth Care

**University of Strathclyde
Scotland**

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2017

RESPITE CARE WITH A DIFFERENCE: Responding to Vulnerability & Increasing Resilience through Group Respite Care: The Voices of Children, Parents & Carers

Children and families perspectives on their experience of group respite care and its impact on their individual and family resilience.

Abstract

This paper is submitted as a dissertation to meet the partial requirements of the Masters of Science in Child and Youth Care. This paper is based on the qualitative study of the perspectives and views of children and their parents and carers who use a non-government organisation group respite care service in Christchurch, Canterbury, Aotearoa New Zealand. Data was gathered through semi structured interviews and child focus group discussion with a total of 10 adult and 10 child participants. Key findings highlight the importance of respite care for children living with risk factors and vulnerability; the importance for their parents and carers, the essential elements to create a child centred culture of care using a child and youth care approach and the impact of child centred family focused respite care on individual and family resilience.

Acknowledgements

I would like to thank the following people for their involvement and support:

- The children, parents, carers and whānau who so generously gave their time and shared their stories, perspectives, views and expertise
- The board of Cholmondeley Children's Centre which supported me to complete the masters programme
- The staff and Cholmondeley whānau whose relational care, commitment, creativity and aroha make the centre the place it is
- Shane Murdoch CEO of Cholmondeley Children's Centre for his support, empowering leadership and willingness to share his knowledge, wisdom and aroha
- Graham McPheat Supervisor University of Strathclyde, Scotland for his teaching, support and guidance throughout this research study
- Tutehounuku (Nuk) Korako of Ngai Tahu iwi for his awahi with Nga-iwi Māori interactions
- My friend and mentor Dr Leon Fulcher for his knowing and encouragement
- My partner Shane and my boys Jack and Trev for their support, understanding and grá from their various parts of the world.

He aha te mea nui o te ao

What is the most important thing in the world?

He tangata, he tangata, he tangata

It is the people, it is the people, it is the people

Māori whakataukī proverb

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Chapter 1 Introduction

Cholmondeley Children's Centre has been delivering group residential care for ninety years in Aotearoa New Zealand. Since 2010 it has challenged orthodox thinking on using group care for children as an option of last resort (McPheat *et al.* 2007) required for the most damaged and damaging children and young people by developing 'respite care with a difference'.

Cholmondeley is a non-government organisation partially funded by government social development and education contracts. The vast majority of funding is raised through the support of the local community. This service provides short term emergency and planned respite group care and education for children aged between three and twelve years whose families are experiencing vulnerability through stresses or crises in their lives, and whose usual supports are not enough or unavailable. A child can stay as many times as needed, based on their best interests. A child's engagement with the service is personalised and non-prescriptive, with the length of stay determined by balancing the child's emotional wellbeing, responses to being separated from primary carers, and the level of vulnerability and needs of the family. This is assessed on an ongoing basis in collaboration with the child's parents/carers, the child and other professionals involved (Cholmondeley Childrens' Centre Practice Guidelines, 2017).

The Cholmondeley service is child centred, family focused with practice underpinned by a child rights philosophy of care (Gharabaghi & Stuart, 2013; Freeman, 1996; Save the Children, 2002). It is directly accessible, free and guided by a family preservation and early intervention philosophy. It works with children across the spectrum of vulnerability; including children from families with a one off crisis, those with the involvement of multiple agencies, those with statutory service involvement and those in foster or kinship care. The service aims to relieve tension in families so that negative impacts for the child are avoided or escalate no further – recognising that the child does not live in isolation. Through its engagement with children Cholmondeley also develops relationships with the parent/carer, empowering them to connect with other services with the goal of creating opportunities to increase protective factors or resilience, and preservation of the family system as a whole, as encouraged by

Schroder *et al* (2014). The service views respite care as a break for the child, as well as a break for the parent or carer. It is relationship-based, planned and purposeful with a focus on activity and experiential learning, growing strengths within a therapeutic milieu, and a place where children can be children and have fun (Garfat *et al*, 2013; Cameron, 2013; Cholmondeley Childrens' Centre Practice Guidelines, 2017).

It is important to note that whilst Aotearoa New Zealand celebrates a clean green image for a country that is a wonderful place to raise children, the fact remains that our children and young people also experience the highest rate of youth suicide and some of the highest rates of child poverty, ill health and domestic abuse in the OECD (Hayward, 2012; OECD 2009; UNICEF NZ, 2013). "One in four New Zealand children (268,000) live in medium- to high-risk households with roughly 67,000 children (6 percent) living in households defined as high risk (those with five or more of 11 risk factors). A further 19 percent of children (201,000) live in medium-risk households (those with three or four risk factors)" (Statistics New Zealand, 2012 p.4). Recent developments by the Ministry of Vulnerable Children have resulted in a focus on vulnerable children and their families of whom there are thought to be roughly 2,000 living in our Canterbury region.

In September 2010 a magnitude 7.1 earthquake hit the Canterbury region causing widespread damage and trauma. Five months later, early in 2011 a 6.3 magnitude earthquake devastated the city of Christchurch, causing death, destruction and trauma. This started an ongoing series of seismic events with up to 10,000 aftershocks, many of which measured in excess of 5 magnitude. More recently in November 2016 a 7.8 earthquake hit the northern part of the region causing further trauma. Aftershocks continue resulting in many vulnerable children and families now having added stressors and vulnerabilities (Shirlaw, 2014). In addition families not deemed to be vulnerable before are now experiencing post-earthquake stress leading to marked increases in the numbers of children and families seeking support from government and Non-Government services, including respite care.

In 2014 an independent evaluation of the service was completed (Schroder *et al*, 2014) as the first step in the development of a more evidenced-based approach to service delivery, seeking to ascertain the role of Cholmondeley Children's Centre in the

community and whether it contributes to the prevention of statutory intervention (Schroder, *et al*, 2014). The aim of this research is to add to that evidence base by finding out about how a sample of the children and families experience the respite care service and what key elements or features are important to them. This research also aims to determine if there are links between the use of respite care and the development of resilience in children and in their family and if so, how this contributes to family preservation.

Two research questions were formulated:

1. How do children and their families experience the service?
2. To what extent does involvement with Cholmondeley services contribute to increased resilience for the child and the family?

A qualitative methodology has been adopted for this research (Liamputtong & Ezzy, 2008), relying on semi structured interviews with children and parents/carers who have used the service in the last year. The participants were selectively invited from a range of children based on age, gender, family constellation, siblings, cultural identity, those who have come once and those who have stayed numerous times. Parents/carers were similarly selected based on gender, cultural identity, number of times they have used the service and type of carer, for example, a grandparent raising a grandchild. In addition, a focus group of children was formed to provide opportunity for them to discuss their experiences at Cholmondeley and potentially unearth themes that may not have been discovered in one-to-one interviews (Kitzinger, 1995, p.299).

As Service Development Manager I have been instrumental in the design and development of the Cholmondeley service and I am very passionate about child-centred spaces and providing an experience that is truly child-centred, where children are provided with *mana-enhancing* (that is, respectful and honoured) relationship-based experiences where they can discover and grow their strengths. I aim to determine the impact of this approach and model in the lives of children and their families. I am also committed to hearing the voices of children and am aware of a dearth of children's voices in studies regarding respite care (Schroder *et al*, 2014; Madden *et al*, 2016). I am thus very motivated to become informed by their voices, adding to our understanding from their perspective.

The findings from this research will inform and help to further refine and improve the Cholmondeley respite care practice model. This research will be shared with the Board of Governance, will help to inform strategic development and will be used for fundraising and government contracting purposes. This research will also add to the development of practice-based evidence in this unique respite care sector. The findings may challenge orthodox thinking about the use of group care and respite foster care, perhaps inspiring us to explore how group respite care might become an option for children and their families who are living with vulnerabilities.

The language of vulnerability is now the accepted and encouraged terminology in Aotearoa New Zealand even though questions can be posed about labelling ordinary people with deficit terminology like “vulnerable children” or “vulnerable families”. Our preference is to engage with children or families living with vulnerability, or within vulnerable environments or situations. Within Cholmondeley Children’s Centre, a language of strengths is the deliberate norm but for ease of understanding and clarity, I will use the language of vulnerable children and families, having apologised for this in advance to readers from outside Aotearoa New Zealand.

Chapter 2: Literature Review

In attempting to understand the context in which this research on respite care occurs, it must be noted that there is a dearth of literature available in Aotearoa New Zealand on group, respite and other forms of out of home care (Schroder, 2014). Therefore, an international literature regarding group care, building resilience, and risk and vulnerability has been explored. For this to relate to an Aotearoa New Zealand context it has also been important to review an indigenous perspective which gives an appropriate level of cultural relevance specific to this country. Also relevant to this research is literature related to the impacts of natural disaster on families. This chapter explores literature as it relates to the research topic beginning with definitions of risk and vulnerability, then contextualising to a local perspective regarding the impact of natural disaster, understanding resilience and the use of respite care as a support for children and families, identifying key elements that inform the delivery of best practices for children and families.

This review of the literature began with a search using SUPrimo, Social Care Institute for Excellence (SCIE), IRISS, Google Scholar databases, using 'respite care for children and young people', 'residential child care', 'resilience', 'risk and vulnerability' and 'children in natural disaster' as key words. This led to further searches based on the references in these articles. In addition, Government and social agency reports and Aotearoa New Zealand local sources were accessed where available.

Risk and Vulnerability

Risk factors are described as "stressors that have proven effects on increasing the likelihood of poor development in children" (Gutman, 2008, p.334) and these threaten child wellbeing through deprivation of their basic needs. Such deprivation can result in the child being vulnerable to experiencing poor outcomes. Risk factors can occur in various domains, whether related to the child's own characteristics, such as their experience of a disability, to the child's family (Jones *et al*, 2013) or to the child's community. Individual factors such as difficult temperament, mental health problems or the child's behaviour difficulties (Carr, 2006), and others such as chronic illness or

learning, developmental or physical disabilities (Cohen, 1982; Bruns & Burchard, 2000) are risk factors. Family risk factors include the impact of parental and maternal mental ill health; parental substance misuse; lone parenthood; poverty; family violence; harsh parenting; poor attachment; lack of connection and transient, unsuitable housing (Ball *et al*, 2016). Community risk factors include living in an unsafe community; racism and discrimination; and natural disasters (Fergusson, Horwood & Lynskey, 1994; Centre for Social Research and Evaluation, 2011).

Longitudinal research illustrates that having only one risk factor minimally increases the likelihood of poor outcomes whilst the presence of more than one risk factor increases the threat to the child's development, wellbeing and life outcomes (Fergusson *et al*, 1994; Centre for Social Research and Evaluation, 2011; Gutman, 2008). Additionally the Aotearoa New Zealand Ministry of Social Development (2011) noted that any single risk factor on its own generally only raises the risk of poor child outcomes by a modest amount, but an accumulation of risks significantly heightens the likelihood of poor outcomes. The outcomes for this latter group include "poor education, health and employment and high rates of criminal behaviour" (Fergusson *et al*, 1994 p.1126). In addition it is generally agreed that children in the care and protection system or state out-of-home care have emotional, social, mental health, behavioural and educational difficulties, which significantly increases their vulnerability to negative life outcomes such as homelessness, teenage pregnancy, criminal activity and unemployment (Rutter, 2000; Bleach & Robertson, 2009; Aotearoa NZ Office of the Children's Commissioner, 2015).

Risk & Vulnerability: The Impact of Natural Disasters

The impact of conflict and natural disaster on children and young people often manifests negatively on their social, emotional and psychological wellbeing (Smith, Cowie & Blades, 2003) and Kousky (2016) considers the way that natural disasters may harm children disproportionately, often with long-lasting effects. Whilst the disasters themselves are stressful, additional factors may contribute to poor mental health as "children can suffer psychological harm from the damage to their homes and possessions; from migration; from the grief of losing loved ones; from seeing

parents/carers undergo stress; from neglect and abuse; and from breakdowns in social networks, neighbourhoods, and local economies” (Kousky, 2016 p.74). In addition familiar spaces, people and routines, such as going to school can be disrupted or destroyed. Studies of the long-term effects of traumatic experiences show that children may continue to have psychological symptoms long after the trauma (Green, Korol, Grade, *et al*, 1991; McFarlane, 1987). Trauma may negatively affect the child's life both by causing psychological disorders, such as anxiety, depression and phobias, and also by interacting with the emerging personality of the child, inhibiting the maturation process (Pynoos, 1996).

“Even in developed countries, disasters have a knack of finding the poor and vulnerable”(Gould, 2009 p.169) and this has certainly been the case in Christchurch as the most economically disadvantaged areas were worst affected. This has resulted in the substantial increase in incidents of family violence, homelessness, child abuse and neglect, adult mental health issues, substance misuse, behaviour and learning difficulties and problems relating to anxiety, depression and stress difficulties in children and their parents/ carers (Shirlaw, 2014). It is believed that this increase is representative of a stressed community. "The earthquake is ingrained in everyday life now. It's like the war; it's become part of the fabric" (Swadi, 2014 p.6).

Building Resilience

Contemporary thinking suggests that we should not talk about risk and vulnerability without considering strengths and resilience (Turnell & Edwards, 1999; Saleebey, 2010). Resilience has been described as “the ability to withstand and rebound from disruptive life challenges” (Walsh, 2003, p.1) or, the ability to bounce back in the face of challenge and adversity. Gilligan (1997) describes resilience as “qualities which cushion a vulnerable child from the worst effects of adversity in whatever form it takes and which may help a child to cope, survive and even thrive in the face of great hurt and disadvantage” (Gilligan, 1997, p.12). Daniel *et al* (2010) suggest that each child is born with potential and the aim is for them to reach that potential, and a number of factors such as relationships with caregivers, experience of life events, risk factors and circumstances will determine that.

Masten (2001 p. 230) defines resilience as “the intrapersonal, interpersonal and systemic characteristics of a person and their environment that are characterised by good outcomes despite serious threats to development”. Gutman (2008) suggests that the protective factors necessary for the mitigation of adverse effects of childhood trauma and risk factors fall into three domains, of ‘child characteristics’, ‘family characteristics’ and ‘external support systems’. Gutman (2008) also proposes that the child protective characteristics include gender, intelligence, temperament, sociability and self-esteem; family protective characteristics include parent-child interaction, parenting style, family cohesion, family resources and family support; and community protective characteristics include friendships, teacher support, organised activities and neighbourhood cohesion. Risks are complicated, complex and clustered and so too are resilience-promoting interventions. Therefore an emphasis on ecological dimensions which highlight the interactions between the individual and their social environment, in particular on how the child’s environment adapts to meet their needs in times of adversity, is crucial to build resilience, as suggested by Gutman (2008).

There is evidence of the negative impact of poverty, maternal depression, violence and substance abuse on parenting capacity and their consistent responsiveness to their child (Atwool, 2006), which may “interfere with the development of secure attachment relationships” (Daniel *et al*, 2010 p.110). Through early experiences of attachment the child develops an “internal working model”, that is the concept of self, which will act as a template, script or recipe for other relationships (Wassell & Gilligan, 2010) both now and into the future. Masten (2001) suggests the key protective factors that build resilience are connections to caring competent adults in the family and community, and positive peer relationships that contribute to the growth of the child’s cognitive and social skills and positive image of self. This stance is clearly supported by Gribble *et al* (1993) who believe that positive relationships with caring competent adults cannot be underestimated as it is within these key relationships based on positive support, nurture and guidance that the child develops their sense of self and resilience. Atwool (2006) suggests that consistent trusting and nurturing relationships with non-kin carers could assist the development of secure attachment and assist in the reworking of the internal working model that is characterised by self-concepts of unworthiness present in a child who has experienced trauma, poor treatment and poor relationships. Basarab Horwath (2009 p.195) also argues that “by altering people’s

experiences of close relationships, insecure internal working models, in which the self and others are represented negatively, can be changed” and that “the therapeutic aim for these children is to help them feel safe enough to recognise, acknowledge and process their emotions, both at the psychological and physiological level” (p.200). Atwool suggests that “linking attachment and resilience theories allows a different understanding that places children at the centre, encouraging decision making processes based on his/her unique circumstances and needs” (Atwool, 2006, p. 327).

Within Aotearoa New Zealand education protective factors for children are enhanced through the development of the Key Competencies, or developmental resilience builders, described as “the capabilities that people have, or need to develop, to live and learn today and in the future” (Aotearoa NZ Curriculum, 2016) . They are categorised into themes of relating to others; thinking; using language, symbols and texts; managing self, and participating and contributing. Through the medium of activity and experiential learning these resilience builders can be nurtured and encouraged to develop.

Child & Family Support and Respite Care

It is generally acknowledged that raising children can be difficult and stressful, and for most families an extended network of family and friends can be called upon for support when needed (O’Brien, 2001). Others do not have such help or cannot trust that the support available will be safe or adequate for their child. Families of children at risk or who are vulnerable “have traditionally needed support to manage stress, parenting and to prevent family breakdown and the need for more permanent out of home placements” (O’Brien, 2001 p.51). Studies indicate that mothers who are physically abusive towards their children tend to have fewer social and family contacts (Coohey, 1996), neighbours (Garbarino & Sherman, 1980; Corse *et al*, 1990), are less likely to access organised support services (Garbarino & Sherman, 1980), and have higher levels of isolation (Coohey, 1996; Whipple & Webster- Stratton, 1991). It is argued that social support is a buffer or protective factor against stress and has positive effects, protecting the person from “harmful effects of stressful events and the damaging influence of social and economic stressors” (Armstrong *et al*, 2005 p. 271). O’Brien

suggests that in addition to emotional support, physical assistance with caregiving is of similar importance (O'Brien, 2001).

Bruns & Burchard (2000) suggest that respite care was developed out of the need for families to gain physical support with child caregiving when this became difficult due to the impact of various individual, social and environmental stressors. O'Brien (2001) argues that respite care can help families who need crisis care, as when, for example, the main caregiver is unexpectedly hospitalised, and that social support in the form of respite care "may directly reduce the risk factors associated with poor child outcomes and child maltreatment" (O'Brien, 2001 p.54). "Much of the literature on respite care has focussed on the effectiveness of respite care for caregivers of adults or children with physical or developmental disabilities and those with serious mental or physical illnesses" (Madden *et al*, 2016 p.524). Studies have identified respite care as an essential component of the support service continuum that should be made available to families to help improve the success and longevity of placements (Marcenko & Smith, 1991; Mc Roy, 2007; Reilly & Platz, 2004; Smith & Pertman, 2010 cited by Madden *et al*, 2016). A recent study by Madden *et al* found that foster, adoptive and kinship carers who used formal respite care reported greater stress reduction and highlighted the value of respite services for "increasing family stability, cohesion and improvements in their ability to care for their children" (Madden *et al*, 2016 p. 530). Madden *et al* (2016) also suggest that respite should not only be provided as an emergency intervention; but services should be available to families on an ongoing basis. In addition it is argued that strengths-based "resilience enhancing interventions need to reflect a multi-system approach that aims to not only reduce risk but also improve the assets and adaptive functions of the child and their wider system" (Schroder *et al*, 2014 p. 27). It is argued that whilst respite-only services can be limited, a strengths-based service that involves a medium to long-term repeated event creates opportunities for developing competencies and building resilience within the child and the family (Schroder *et al*, 2014).

There appears to be a lack of research on the provision or effects of respite care for birth or non-birth families of children emotionally or behaviourally vulnerable (Bruns & Burchard, 2000), or those who are living with risk factors associated with vulnerability. There also appears to be a lack of research on the effects of group respite care with

a focus on early intervention and family preservation for children and their families across the spectrum of vulnerability. Respite is often cited as providing support to caregivers, providing relief from the normal stresses of being a parent and/or to prevent or delay admission to residential care (Armstrong & Shevellar, 2006; O'Brien, 2001). Indeed, it can reinforce the notion that the child is the problem for the family and is viewed as the burden. (Schroder *et al*, 2014; Armstrong & Shevellar, 2006). Boothroyd *et al* (1998) argue that it promotes wellness in parents and empowers parents to better care for their dependents, whilst MacDonald & Callery (2004) suggest it provides opportunity for respite carers to model behaviours and teach children new skills. It appears that there is little or no focus on the effects of respite care on children and there is a clear absence of children's voices on their perspectives of the experience (Madden *et al*, 2016). "This study found promising outcomes for caregivers related to respite services; however, few studies have examined the ways in which respite is beneficial to children"(Madden *et al*, 2016 p. 532).

As Schroder *et al* (2014, p. 29) demonstrate "the respite literature is overwhelmingly based on a one on one foster family model" and respite care is usually delivered in these settings. Group care is still viewed as a last-resort service (McPheat *et al*, 2007) and some remain cautious about the risks surrounding its use, such as children picking up and developing negative behaviours and the child receiving less attention if other children have greater needs (Meadowcroft, 2009; Bleach & Robertson, 2009; Schroder *et al*, 2014). Others cite positives such as accommodation of sibling groups; opportunities for the child to develop new, more positive identities and resilience focused relationships; a less emotionally demanding environment as they are not required to form close one on one relationships which may be too threatening for those who have experienced trauma; resources available for activities and peers helping the child to normalise their experiences (Meadowcroft, 2009; Ungar, 2001 & 2004; Stokholm, 2009 and Schroder *et al*, 2014). Schroder *et al* (2014) suggest that whilst some research indicates benefits of planned respite there is little known about the active ingredients and for whom and in what circumstances respite works. In addition, in the Cholmondeley Children's Centre context, published material on the use of respite services for Māori or Pacific peoples or with children's perspectives of respite care are still difficult to locate (Schroder *et al*, 2104).

Children's Spaces

Gharabaghi and Stuart (2103) advise that work in residential life spaces with children and young people requires a clear philosophy and consistent approach. The value of adopting a philosophy and practice informed by a child rights-based approach is evidenced in research as a most effective way to bring about positive and lasting change and resilience for children, their families and communities (Freeman, 1996; Rizzini & Thaplyial, 2005; Clark & Percy Smith, 2006; Smith, 2007; Save the Children 2002). Hobbs (1982) stresses the importance of children experiencing joy and looking forward to joyous events. As an increasing amount of attention is focused on future and adult outcomes for children, it is important that we also value the child's experience in the now. It appears that many children's services are focused on the child's vulnerability, with therapy and programmes to 'fix' them. Steckley & Smith (2011) suggest this may be overshadowing the power of good care. Moss and Petrie (2002) advise us that we should instead be putting an emphasis on the experience of joy, spontaneity, richness, vibrancy, wonder, curiosity, care and play, and that these need to be present for children as we address questions of the good life, including a good childhood, rather than focusing on children as 'adults in waiting'.

The *Māori Tikanga* or practice of *Te Whare Tapa Whā* (Durie, 1994) has a focus on developing holistic wellbeing, or *Hauora*, and building resilience of the child and their wider family connections through paying attention to the capacity to belong, to communicate, the capacity for physical growth and development, and the capacity for faith and wider communication (Durie, 1994) and their individual needs. This mana enhancing *tikanga*, that is respecting and honouring the whole person in all their dimensions, enhances a strengths-based approach; an approach which is "primarily dependent upon positive attitudes about people's dignity, capacities, rights, uniqueness and commonalities" (Fenton, 2008). Grant & Cadell (2009) suggest that this way of being recognises the potential of all people, focusing on the strengths, interests, abilities, culture, knowledge and capacities of individuals, rather than emphasising their limits. Conditions are created that enable people to identify and mobilise their strengths and resources in a way that compliments those that already exist. Collaboration and working in partnership with the child and their wider family is key (Lietz, 2011).

Garfat and Fulcher (2013) advocate for the vital importance of relational child and youth care characteristics in those working directly with children and young people. This approach positions the practitioner “in the daily life of another person”. That is, sharing the life space. Within the life space “meaningful use of daily life events” allows them to intervene pro-actively, responsively and immediately” supporting and guiding the child or young person “to learn new ways of acting and experiencing the world” (Fulcher & Garfat, 2008 p.7). Social pedagogy sees the practitioner as a person, in relationship with the child, sharing in and viewing all aspects of the child’s daily life as opportunities for learning (Cameron & Moss 2011; Eichsteller & Holthoff 2011). Garfat *et al* (2016) stress that the key elements of effective relational child and youth care in a residential setting include being in relationship, connection, the purposeful use of activity, a strengths and resilience focus, developmental responsiveness and hanging in. The meaningful use of these characteristics involves moment by moment opportunities for being, interpreting and doing as the practitioner engages with the child (Freeman & Garfat, 2014; Garfat & Fulcher, 2015).

Relationship and Activity

Both Hawkins-Rodgers (2007) and Atwool (2006) suggest that in order to ensure that the environment supports the development of resilience, the child needs to view the experience as emotionally secure with opportunities to engage in relationships with significant and supportive adults. Garfat and Fulcher (2012) emphasise that relational child and youth care practice is about developing a therapeutic relationship within the child’s life space and Stuart (2009) advises that the relationship is the intervention. Given the short-term emergency nature of respite care, the need to engage and support children in a very short space of time to feel secure “in relationship” (Gannon, 2008 & Garfat *et al*, 2016) where they feel valued is crucial. Ager & Metzler (2012) stress that in order that we acknowledge and start to address the stress associated with trauma experienced by many of the children, while at the same time building their resilience, a significant investment in strong relationships with children is required. Daniel *et al* (2010 p.41) state that “resilience grows through relationships that offer opportunities to develop” and it is vital that these experiential opportunities and activities are provided within relationships where the adults are patient, tolerant and

“able to attune to the child’s feelings, thoughts, needs and to offer attentive responsiveness” (Daniel *et al*, 2010 p.41). Ward (2004) argues for a special approach to the child’s every day, where their unique needs are understood and addressed so they may be able to feel ordinary. It is argued that the child needs to be cared for in an environment where the gaps are filled and Phelan (2012) suggests that we need to work developmentally with the child as “our response is to look for as many opportunities as possible in the life space for youth to feel powerful and strong” (Phelan, 2012: p.80). Appelstein (1998) suggests that we need to provide developmental “fillers” in the form of experiential, activity-based interventions. The child needs more opportunities to engage in recreation as this may provide opportunities to develop a sense of mastery whilst helping to nurture social roles that may enhance the child’s health and wellbeing (Daniel *et al*, 2010). Cameron (2013) advocates for the use of activity, adventure and experiential learning as these provide a vehicle for the development of the self and of skills. Ward (2004) encourages those working alongside the child to create opportunities to ensure that they get ‘experience-close’ so that we can gain an insight to how that child really sees their life world. (Ward, 2004).

In conclusion, the literature presents clear evidence of the importance of providing families with a strengths-based continuum of services to meet their needs, providing opportunities to grow individual and family resilience (O’Brien, 2001; Bruns & Burchard, 2000; Schroder *et al*, 2014). It is evident from the literature that respite care has been predominantly viewed as a service aimed at providing relief for parents and carers, with little consideration of the child’s experience or its impact on their wellbeing (Madden *et al*, 2016). It also appears that respite care has been most usually aimed at children with disabilities and mental health diagnoses, and when carers have reached the end of their tether. It also appears that the use of respite care has been viewed as a potentially positive support system (Madden *et al*, 2016; Schroder *et al*, 2014). However, the use of group care for this purpose is viewed with some scepticism, negativity and concern. It is therefore important to examine the impact of this approach to delivering respite care, and the key elements that contribute to such a service warrant further exploration. It is also apparent that the voices and perspectives of those most impacted by a respite care experience – that is, children –

are missing from the literature (Madden *et al*, 2016). With questions about how the children using group respite care experience such a service and about how parents believe this contributes to family wellbeing, this research will explore the child's world in relation to respite care, alongside further exploration of the impact of respite care on parents, carers and families, and their growing resilience.

Chapter 3: Methodology

This chapter introduces the research design used in this project whilst outlining the rationale and factors considered when making decisions about research methods which informed the data collection and analysis processes. The chapter also highlights the ethical considerations that were taken into account throughout the project.

Rationale of the Method

When considering which epistemological approach would be the most suitable theoretical framework to employ for this research, I considered both positivist and interpretivist research paradigms. Positivism assumes “that social science can be scientific in the same way as the physical sciences such as physics or chemistry” (Liamputtong & Ezzy, 2008: p. 15), preferring quantitative methods where scales, structured questions and statistics are used to measure things and provide explanations. Positivist researchers prefer methods that are linear and repeatable, avoiding and removing interpretations or “interpretivist explanations that refer to human intentions and emotions” (Liamputtong & Ezzy, 2008 p.15).

On the other hand the interpretivist approach argues that knowledge and meaning are central to human social life. As these interpretations are subjective and particular to each individual, shaped by culture, beliefs and opinions, they cannot be measured in a linear quantitative way. According to Berger & Luckmann (1967) one must understand a person’s interpretations of actions and events in order to understand why they do things. Liamputtong & Ezzy suggest that this “attempt to understand meanings and interpretations is at the heart of qualitative research” (2008 p.16). This research seeks to identify what works and improve the service through gaining a better understanding of people’s experiences of a respite care service through the use of a qualitative approach was deemed most appropriate.

An additional reason for using an interpretivist approach and qualitative methods was that these methods are more in tune with my world view, beliefs and practice approach as a child and youth care practitioner engaged in a service where relational practice is key. The use of theoretical frameworks of attachment, a strengths-based approach

and resilience that inform my practice as a social worker, also informed my approach as a researcher. This paradigm and method align well with this parallel process of engagement and viewing the service user as an expert about themselves and their experiences as I sought to “capture lived experiences of the social world and the meanings people give these experiences from their own perspectives” (Corti & Thompson 2004: p. 326). I believed that this flexible and interpretive approach would enable service users’ to value their own experience and engagement with Cholmondeley Respite Care.

As this particular way of viewing and delivering respite care is unique, it was also my intention for this research to add to the development of practice-based evidence in this specific area. Practice provides a rich treasure trove of enquiry, evaluation and theory development. Research which involves participation of the actors will be even more important for the development of more effective practice (Orme, 2003). Qualitative research provides a fitting framework for practice-based research as it acknowledges the complexities of working with people as we “search for all the possible alternative avenues that can lead us to new levels of understanding” (Martinez- Brawly, 2001: p.283). I deemed this most appropriate.

Ethics are about values, and ethical behaviour reflects values held by people at large. For Māori, ethics it is about ‘*tikanga*’- for “*tikanga* reflects our values, our beliefs and the way we view the world” (Te Puni Kōkiri, 1994). My understanding and application of *tikanga* and the principles of Te Tiriti o Waitangi (1840), of protection, partnership and participation were essential in my practice as *Tauīwi* (non-Māori) to ensure Māori were included, felt culturally safe and their *mana* (respect and honour) as *tangata whenua* (the indigenous people of Aotearoa New Zealand) was upheld .

Recruitment of Participants

Purposive sampling aims to select information-rich participants and this sampling method was used to ensure that the experiences of a range of service users were selected for “in-depth study to examine meanings, interpretations, processes, and theory” (Liamputtong & Ezzy, 2008 p.46). A range of criteria were used to recruit children participants including age, gender, ethnicity, number of children in their family

who use the service, and number of times they have come to stay at Cholmondeley. The status of the child's parent or carer, whether the child was living with their birth parent or kinship carers was considered. Children in state foster care were not invited to participate as there was no likelihood of these children being given permission to participate due to government policy. Purposive sampling was carried out in conjunction with two members of the Cholmondeley social work respite coordination team who best knew the parent or carer's current situation. Initial contact was made by the social workers via a phone call to explain the research project (Appendix One) and to ascertain people's interest in learning more about involvement. This was deemed appropriate to reduce the risk of potential participants feeling pressurised to take part as it may be easier to decline to someone other than the researcher. This telephone contact was followed up by an information letter (Appendix Two) offering the opportunity for participants to opt in if they chose. Those signalling their wish to participate were then contacted by the researcher to set up an appointment.

The United Nations Convention on the Rights of the Child (UNCROC, 1993) recognises children's participation rights, with Article 12 affirming any children's right to express their opinions and have these taken into account in matters that affect them, including participation in research and evaluation (Powell & Smith, 2006). Throughout the project, children were viewed as rational actors who through their narratives and self-expression were reliable data sources who shared details about their Cholmondeley experiences of respite care. Potential barriers to children's voices being heard in research, or viewing their opinions as unimportant or unobtainable, can be conquered through qualitative research methods. I was confident that the application of this method, combined with the principles and ethics of a strengths-based, relational child and youth care approach that children can fully participate so long as each child is made the centre of attention, cared for and respected within a safe and supportive environment.

Interviews and Focus Group

Semi-structured interviews (Appendices Three & Four) were carried out with ten children and ten parents or carers of those children. Sample size was determined by dissertation expectations and the time allowed. Matthew & Ross (2010) suggest that semi-structured face-to-face interviews follow a common set of topics or questions,

and the interviewer may introduce these in different ways as deemed appropriate for each interview. This allowed the participant to answer the questions and discuss the topic in their own way (May, 2011; Matthew & Ross, 2010) as the participants' experiences of the service were explored along with their perception of the effects this has had on their children and their families. Various probes, prompts and supplementary questions were used to explore themes and dimensions more fully for clarity and depth. With parental permission, children were given the option of being interviewed alone, with their sibling(s) and/or with their parent/carer. This use of semi-structured interviews left the researcher free to probe beyond the answers and enter into a more in-depth dialogue, where the participant was invited to expand and elaborate. It was important that the interviews moved at the child's pace, that language was age and stage appropriate and that the researcher attended to signs of when they wished to stop.

In addition to the semi-structured interviews, the qualitative research method of focus group discussion was used. A focus group consisting of different children to those individually interviewed was formed where participants between the ages of seven and twelve were encouraged to talk to one another around the topic of their respite care experiences, with the aim of providing a "rich and detailed set of data about perceptions, thoughts, feelings, and impressions" of people in their own words (Stewart & Shamdasani, 1990: p. 140). It was anticipated that this might provide children with a forum where hidden or unexpected information not raised individually may be discovered and explored. The information, open-ended questions and interactions with children were developed and delivered in a way that was appropriate for the individual children's ages and stages of development and understanding, informed by guidelines on best practice, approaches and tools (Participation Works UK, 2017). According to Kitzinger (1995, p. 299) group discussion is applicable when the researcher wishes to encourage research participants to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities. It is argued that it is essential that the researcher has the facilitation skills and experience to guide good group dynamics which in turn can create an environment where the research can be taken in new and often unpredicted directions (Kitzinger, 1995; Birmingham & Wilkinson, 2003). Transferable skills

developed as a child and youth care practitioner enabled the researcher to take on this role without difficulty.

Within the focus group, “ground rules” or a treaty, was drawn up, based on respect for individual experiences and what everybody else says in the group. The child focus group(s) participants were advised that they should only talk about things that they feel comfortable with and that there was every likelihood that information may be repeated outside of this setting. For all these reasons, confidentiality or anonymity could not be guaranteed. Throughout the focus group process, the researcher remained alert to closing down any sensitive information that was being shared, inviting the participant to share this later in a more private setting should they wish to do so. The creation of a warm, supportive and emotionally safe environment, good facilitation skills, a clear yet flexible focus and clear recording methods enabled the gathering of very rich data (Kitzinger, 1995; Birmingham & Wilkinson, 2003). In addition to the possibility of being interviewed face-to-face or being part of a focus group, children were offered the opportunity to use self-directed video. This did not occur due to unforeseen circumstances. Māori participants were given the option of interviews in culturally safe locations, such as *Marae*. Participants were also encouraged to have support people such as *whānau* (family) and *Kaumātua* (elders) present. *Kai* (food) was offered and shared and *Tikanga Maori* such as *Karakia* (prayer), *Waiata* (song) and other protocols were observed through guidance provided by a cultural advisor to ensure the research was culturally safe for Māori.

Data Analysis

All interviews were recorded, with the participant in control of the recording device and then transcribed verbatim for analytic purposes, to “describe, discuss, interpret, explain and evaluate the data and to reach a conclusion” (Matthews & Ross, 2010). The data was analysed using thematic analysis; “a process of segmentation, categorisation and relinking of aspects of the data prior to final interpretation” (Gribich, 2007: p. 16 as cited by Matthews & Ross, 2010). Themes within the data were identified and refined, with any links, similarities and differences within and between participants’ responses identified as interpretation and understanding developed (Matthews & Ross, 2010 p. 372). With a clear focus on the research questions, topics,

themes and issues to explore further, or the “gathering together of material on a topic, an opinion or experience” Matthews & Ross (2010, p. 317) were a starting point. As themes emerged, were named, amended and clearly defined, the Ritchie and Lewis (2003) framework or charts were used to focus in more detail to particular themes. As the data was interpreted, the exploration yielded categories and sub themes. The narrative transcripts were constantly referred back to as interpretations, statements and possible explanations were tested. Throughout that process, the credibility and transparency of interpretations, analysis and conclusions were of paramount consideration and links were made to other research and theories in this area.

Ethical Considerations

This research was guided by the general principles and expectations of ethical research practice (Silverman, 2010; ESCR, 2015) to ensure that no harm was done to participants. All adult participants were asked to give informed written consent and as children were invited to participate informed parental or guardian written consent was sought. In addition, informed agreement and written consent was obtained from the child participants. (Appendices Five, Six & Seven) This was essential in demonstrating respect for children and their participation rights (ESCR, 2015; UNCROC, 1993).

Whilst it is recognised that there are benefits to insider practitioner research, such as existing relationships and participants knowledge of the researcher, it also comes with potential risks which include participants’ sense of obligation to get involved and to say what they think the insider researcher may want to hear, issues of being unable to be anonymous and power imbalances (Costley *et al*, 2010; Labaree, 2002). As an older white woman and manager of the service, I was conscious of how I needed to consider my interactions and relationships carefully alongside ways of maintaining “enough distance to ensure that the analytical half of the insider/outsider coin operated effectively” (Hockey, 1993: p. 208). Power imbalances were acknowledged and participants were advised that participation was strictly voluntary, that they could decline to participate without this affecting their access to the service and that they could choose to cease their participation in the study at any time without question. All participants were advised that the information would be confidential and they were given an explanation of confidentiality and the limitations to this, such as if there is a

belief that someone is at risk of harm. Participants were reassured that any information in relation to the service would be treated anonymously and would not affect their access. I was mindful of using supervision in the event of issues relating to staff or agency performance being raised to explore my options should this occur. Given my direct involvement and enthusiasm for the service it was vitally important that I was mindful of researcher bias and the need for reflexivity. Liamputtong & Ezzy (2008, p. 38) suggest that “rigorous reflexivity refers to honest reporting of the role of the researcher in the research” and Mason (1996) suggests that “the researcher should constantly take stock of their actions and their role in the research process, and subject these to the same critical scrutiny as the rest of their data”. During the course of the interviews, the temptation to step out of the role of researcher and into that of a child and youth care practitioner and manager of the service was ever-present as participants shared their stories. This required continuing reflection whilst remaining mindful of the need to remain impartial and stay in the outsider role of researcher. As suggested by Gibbs (2001) reflective work as a researcher was just as important as the reflective work carried out as a child and youth care practitioner.

In conclusion, I believe that the interpretive approach and qualitative method adopted for this project together with research practice underpinned by the ethical principles of do no harm, child participatory rights and respect for all participants, enabled me to carry out practice research in a robust manner, with the risks associated with this research being addressed and mitigated.

Chapter 4 Findings and Analysis

The findings of this research project were derived through questions about how children and carers experience respite care within a group care setting and whether their use of this care has had any impact on the child's resilience and that of their family. The specific interview questions and the dominant participant responses enabled me to identify key themes for discussion.

The three key themes that emerged that will be discussed are:

- The Value of Respite Care for Vulnerable Children and Families
- The Care Experience
- Resilience and Respite Care

Theme One: The Value of Respite Care for Vulnerable Children and Families

This first theme was divided into three sub themes:

A) Respite Care and Vulnerability

A key finding which emerged through both the child and adult interviews was clear evidence of vulnerability and stressors across two or more domains for all of the participants, with all experiencing a variety of risk factors. Stressors relating to the child's domain included mental health and behaviour difficulties that were evident for all but two child participants which had led to challenges for family, peers and school relationships. For two participants these factors had resulted in school exclusion and subsequent social isolation. One grandparent highlighted the impact of caring for a grandchild with such stressors:

"When they came to live here we didn't realise how much had happened to them. We were left to cope with it....all the nightmares and behaviour. We were worn out. We are still worn out".

And a parent/carer highlighted similar stressors when they said:

“He’s very frustrating, even on the medication...he’s confrontational. He’s never had friends... now he doesn’t see anyone since being excluded”.

Stressors relating to the family domain in the form of parental mental health, substance misuse, poverty, lone parenthood, lack of family, cultural or community connection or support, family violence and unstable housing emerged with all adult participants. Two adults and two child participants voiced concerns about feeling unsafe in their communities due to the levels of violence and crime. Eight participating adults talked about the additional stress that the earthquakes had put on them, highlighting risks to individual and family wellbeing, a finding that is consistent with Shirlaw’s (2014) findings that after the earthquakes many children and families who were vulnerable through existing risk factors now have additional stressors.

One parent/carer highlighted multiple stressors:

“With my own mental health.....his problems at school...outbursts at home...the house moves coz of quakes.... money worries ... things were hell”.

And one child, aged 11, offered further confirmation:

*“I get low sometimes, like mum. I try to make good choices....it’s real easy to hang out with the wrong people round here (their neighbourhood). There’s all kinds of s*** happening”.*

B) Child and Family Support & Respite Care

Whilst all families need support to survive and thrive, many do not have a safe and available option for support with parenting during times of stress, thereby leaving children at risk (O’Brien, 2001). Parents/carers highlighted the value of emergency respite care for unexpected times of crisis, such as when a parent is unexpectedly hospitalised and when the alternative caregiving arrangements could have put their child at risk. As one parent/carer emphasised:

“Knowing I was going to have surgery...was going to be incapable of looking after my children...they could have gone to stay at their [sic] place butI don’t

know the things that go on...not a place for kids. I won't risk it. They weren't safe there before."

Another participant reinforced this dilemma:

"No-one else will have him...it's his behaviour. I can't ask anyone else. They don't know how to deal with him....they probably blame me for how he is. My emotions got on top of me and it's just chaos...but it's too hard (to ask anyone else)... just not worth it".

Madden *et al* (2016) suggest that respite should not be available just as emergency support but should be available on an ongoing basis. Three of the parent/carers initially sought respite care during a crisis and have since continued to use the service in a planned way. The remainder sought planned respite care initially to help alleviate some of the stress in their lives and all of these have since initiated a child's stay during times when stressors have become overwhelming. All parent/carers talked about the value of having access to both emergency and planned respite, including one parent who said:

"My sister passed...we needed to go to her. I couldn't take all of them. Their dad wasn't capable of watching them. They (the service) took the children straight away. That was huge. Now just knowing that I can have the children there every couple of months and they're safe, gives me a breather...I know if I need them they are there."

Another parent reinforced this point about the service being accessible at times other than crises:

"Cholmondeley has been there for us so many times and in our most desperate moments".

It is essential to recognise that the child does not exist in isolation and the value of providing a service that supports and empowers their family system to access other services with the aim of reducing stressors (Schroder *et al*, 2014). This recognition of an ecological approach to the improvement of outcomes for children, young people and their families fits with a Māori world view which focuses on the way in which well-being is influenced by both internal and external factors (Durie, 1994; Fulcher & Garfat, 2013). It was apparent that all of the adult participants valued how, whilst their child

comes to stay, they are supported to develop a relational network of existing or new people, community and other services as demonstrated by this parent:

“It’s not just respite. It’s much more than that. It gives support in our home life too. Like help with other places like school and Child, Youth and Family (statutory child protection), like coming to meetings to get the help. Without it I was on my own”.

The benefits of respite care for parents and caregivers are often cited (Armstrong & Shevellar, 2006; O’Brien, 2001; Boothroyd *et al*, 1998) whereas it appears that there is little focus on the benefits or effects of respite care on children. Eight of the children in this study shared their overall view of respite care at Cholmondeley Children’s Centre, highlighting the importance of such an opportunity for them and saying what they would tell other children who might be thinking of coming to stay:

“Come to keep safe. You might have other things going on, in the past.....this is a good place to help you. It’s a break from my family. Go along if you need a break”. (Focus Group Child, aged 11)

“Get a break from your family”. Yeah, get a break from home.” (Focus Group Child, aged 9)

And a child who has experienced repeated planned as well as emergency stays for 4 years said:

“It becomes part of your life. If you have problems at home, you can always go to Cholmondeley and get booked in. They’re like whānau (family)”. (Child, aged 12)

This highlights the importance of viewing respite care from the child’s perspective and as an opportunity for them to take a break away from the stresses of living with vulnerability. A total of seven parents and carers clearly viewed the opportunity for Cholmondeley Respite Care as a break for both the child and for them. One parent said:

“Sometimes I get to breaking point with my mental health... I just need a break. The girls need a break too”.

A grandparent emphasised this view:

“It works both ways. It gives them a break coz they don’t do anything otherwise and it gives us a break and a chance to recharge, ready with more energy when they come home”.

C) Respite Care in a Group Context

Much of the literature regarding respite care suggests that it is usually delivered in one-on-one foster care family settings. Some of the literature argues for caution in providing group care for children due to the possible risks (Meadowcroft, 2009; Bleach & Robertson, 2009; Schroder *et al*, 2014). The participants in this study talked overwhelmingly about the benefits of staying in such a setting, which many referred to as going on camp, being able to accommodate sibling groups and meeting new people. Six of the parent/carers voiced initial feelings of guilt about using the service and all said the camp-like environment helped to alleviate these feelings.

One parent said:

“I felt so guilty at first but now I see it’s an opportunity, yeah, a positive holiday. They love the break...yeah they absolutely love it”.

A grandparent raising grandchildren said:

“They usually go together which gives us all a break. Other times they go separately ‘coz they like time apart and that’s better sometimes. We get a chance to give that one time.”

All of the children talked about the value of meeting new people and forming friendships. It was apparent that they felt a sense of connection and belonging within the group during their stays, regardless of how many times they had been. Whilst not explicitly stated by the children, it could be that this sense of connectedness is as a result of peers helping the child to normalise their experiences (Meadowcroft, 2009; Ungar, 2001; Stockholm, 2009 and Schroder *et al*, 2014). As one child, aged 11 explained:

“It’s easy to make friends here....easier than at school. I love coming here to make new friends ...we see friends who were here last time. We play with friends here.”

One parent who said her child, aged 9, has no friends and is isolated, described crying with joy when on the child's first stay they rang to say they had made friends:

"He seemed so happy....got to share a room with some other kids....called it a pyjama party....never done that before...so happy. He said the staff talk about being part of a team; everyone's in the team. He said that means him too. The social thing, for me, for him, is huge and I'm pleased for him.

The child excitedly said:

"I had a good night sleep there with my friends".

It should be noted that two of the participant children commented on a negative aspect of group care. Whilst making positive comments regarding fun and friendships the same two children commented on witnessing other children acting out in what they described as "scary" behaviour. Both said they knew who to talk with during and after the event and were reassured about all of the children's wellbeing at the time. When asked about what advice they have for making the centre better both asked for the naughty children to be made to be nice. This highlights the importance of ascertaining the suitability of this group environment for individual children and a culture of care with support and restoration for all children, with opportunities for check-ins following any such events.

It has been suggested that the group experience is less emotionally demanding for children as they are not required to form close one-on-one relationships (Meadowcroft, 2009; Bleach & Robertson, 2009; Schroder *et al*, 2014). It could be argued that the mix of adults of different ages, gender, ethnicity, identity, personality and interests within the staff team enables the child to identify and grow relationships with those staff who best suit them, rather than needing to get in a one-on-one relationship with an adult with whom they have few common interests or points of connection. This was evident in the findings as all the children identified their favourite staff members and how they connected with them. As one 12 year old said:

"I can talk to (two male staff) about friends and stuff. If I had a girl problem I would talk to (three female staff)".

One parent viewed the presence of numerous adults as an important protective factor:

“I fear for my children forming relationships, getting attached to individuals...they’ve done that before and been hurt. I am quite comfortable about them being able to build relationships there coz the staff are trained people. They’re purely there for the betterment of children with no ulterior motives and it’s not so intense. There’s a certain amount of separation”.

The use of a group setting with numerous ‘professional’ caregivers would appear to be associated with less risk than a one-on-one setting. The parent/carers also talked about the value of having multiple adults for their child to connect with, including the value of positive male role models.

Theme Two: The Care Experience

This theme can be divided into two subthemes.

A) A Child Centred Strengths-Based Culture of Care

Gharabaghi & Stuart (2013), Freeman (1996) and Save the Children (2002) discuss the value of a child rights perspective and philosophy of care. In the child interviews and focus group discussion, clear evidence of this and a child-centred strengths-based culture of care where relationships were of key importance in the child’s experiences at Cholmondeley. All child participants talked about feeling safe and respected whilst there. One child participant, aged 10, talked about how they get a say in what happens and particularly valued being able to use the suggestion box to submit their comments, suggestions and complaints:

“I like that we get to say what we would like to do; how we would like to be treated. That’s good for when things get a bit tricky for me (difficult behaviour)”.

Another child aged 8 said:

“I feel really safe there....the staff are really kind. I can talk with them if I feel homesick or have worries”.

The children talked about the importance of opportunities to be children within a space and approach designed to celebrate them in the now and give opportunities for joy,

curiosity and excitement (Moss & Petrie, 2002; Hobbs, 1982). One child, aged 10 said:

“We just come and have a good time, just relax and enjoy ourselves”.

A 7 year old said:

“Camp is really fun. We do lots of fun stuff...it’s the ‘funnest’ camp”.

The grandparent of a 10 year old child who had recently come into their care said:

“She wouldn’t get excited over things, whereas she gets excited about going up there to Cholmondeley”.

And the child, aged 10 said:

“At Cholmondeley you learn to have fun... yeah, you do fun things to help you be happy”.

All child participants talked about the opportunities for play and fun at the centre. It was apparent that having fun was very important to their wellbeing and happiness. Whilst therapy has a place, it could be suggested that the focus on joy, creativity and fun within a therapeutic environment – where what is good about you is more powerful than what there is to “fix” – is the “good care” that Steckley & Smith (2011) suggest is needed for children to grow and to flourish.

B) Relationship & Activity

Hawkins-Rodgers (2007); Atwool (2006); Garfat & Fulcher (2012); and Ager & Metzler (2012) agree that the quality of the therapeutic relationship within the life space is key to growing resilience and a child’s sense of physical and emotional safety, connection and being cared – all qualitative findings that became apparent in this study. All of the child participants talked about how the adults interacted with them and made them feel. Descriptions like “kind and caring”, “listen well”, “easy to talk to”, “they don’t get grumpy with you” and “calm” were common responses from the children. They shared stories of being helped to go to sleep at night by having a story read to them, reassurance to join the group at the table at mealtimes, and staff caring for their hair. This indicates that staff are engaging with children through relational child and youth

care practices where they are using daily life events to connect and engage with children in a strengths-based and resilience-focused manner – being responsive to children’s developmental needs (Garfat *et al*, 2016). This is affirmed by one 12 year old:

“They really get to know you and you get to know them. And they just accept you...don’t judge you. They help you to sort stuff out... they encourage you a lot... they show a lot of empathy and stuff”.

During a child’s stay at Cholmondeley the focus is on activity, adventure and experiential learning (Cameron, 2013); features that nurture the development of self, life skills and resilience within a supportive therapeutic relationship. In the interviews and discussion it was apparent that when children talked about Cholmondeley activities, it was not the activity in isolation that they valued but the sharing of the experience with others. They talked with great enthusiasm about sharing everyday life events, activities and adventures alongside the adults and peers, or in relationship. The support, guidance and sharing of experiences were apparent and this enabled the child to feel safe and connected. Eight children talked of their sense of connecting with adults during activities. As they chuckled, one 8 year old child said:

“I like how the adults do stuff with me... they help you to try new things....I like (staff name). He likes doing the stuff I like. We have fun playing together on the bikes...we fix them together. I’m happy to do that together”.

As one 11 year old child shared her experience of adults hanging out with her their face lit up:

“We went fishing.... didn’t know that I would like that....I caught a crab....we think it was female...it was fun coz we just all chilled out together...the staff and me, we just chatted and chilled...had morning tea and a walk and more fishing and just chilled together”.

This connecting through activity or the common third is advocated by social pedagogy practitioners Eichsteller & Holthoff (2011) and it would seem that the child who talked of ‘chilling out together’ saw this seemingly ordinary interaction as a meaningful moment (Garfat *et al*, 2013b) which she treasured. All of the children became animated when talking about the first time they engaged in particular activities. Six

talked about pushing themselves out of their comfort zone when trying something new and what they learned from this. This suggests that engaging in activity with others is leading to self-discovery, the development of strengths and skills and a sense of being in relationship, as suggested by Garfat & Fulcher (2008), Phelan (2012) and Ward (2004).

Stuart (2009) advises that the relationship is the intervention and when children talked about their relationships with staff, their narratives suggest that they feel they are “in relationship” (Gannon, 2008) where they are really valued and have a sense of truly connecting and engaging. A 10 year-old said:

“I would say to friends and teachers, at Cholmondeley we actually get to spend time with the leaders and get to talk to them and get to tell them what we like and what we can do”.

Their 9 year old sibling added:

“Yeah, they get to know us”.

A developmental and trauma informed approach to the child’s unique needs (Daniel *et al*, 2010; Maier, 1981 & Ward, 2004) and a resilience focus was apparent when six children talked about how they feel supported even when their behaviour is ‘difficult’. This indicates the presence of a culture of care, not compliance, and clear indication of a relational child and youth care approach. The adults attune to the child and their world (Garfat *et al*, 2013) with responses that consider the individual developmental stage and needs of the child and react in a unique, supportive and restorative way. One 12 year-old shared how they experience this:

“When things get tricky, when I get angry...staff help me. They know me and I know them. They give me some space....they know to stay away coz they know me....just come back to see I’m alright...they stay with me if I want.....they ask if they can help.....they’re calm. That really helps...then afterwards I talk about things. They don’t growl at me or get grumpy... we just talk....you don’t need to hear all your bad stuff”.

This sense of being connected and in relationship with adults who they could trust was also emphasised when six of the children talked about how being able to talk with an

adult if they had worries helped. One 10 year-old shared her sense of relief when she shared her concerns about a situation at home:

“I got to talk with someone about my worries....was worried about some stuff...was all muddled in my head. I had got it all mixed up. I was able to tell her (staff) secrets coz I trusted her. She’s my trusted person. She’s kind and gentle, just her personality. Now I am going to a counsellor to help me”.

And an 11 year-old said:

“We have someone to talk to. It helps. If I am upset I can talk to them (staff). I know they have got my back. Yeah, that’s what it feels like. They’ve got my back”.

Within the risk averse world of services to children, physical touch is often frowned upon and to be avoided. Six of the participant children made reference to the importance of them being able to get a hug from staff when they needed one. One 10 year-old said:

“You can give them a hug if you are sad, or happy”. (With a laugh)

And another 11 year-old said:

“(Staff) is like a pillow. A cuddly pillow. I like a cuddle with her”.

This highlights the importance of touch as a physical demonstration that transmits empathy, a sense of connection and *aroha* (love) foundational dynamics for *hauora* (holistic wellbeing) (Durie, 1994) and echoes the sentiment of other children who have experienced out of home care (Molloy, 2015).

Four children and three adults talked of the use of *Te Reo Māori* and *Tikanga* at the centre, likening these rituals of encounter (Garfat *et al*, 2016), such as *karakia* (blessing of food) to the same values they hold as a family. This connection through cultural rituals is essential for *Tangata Whenua* (Maori) and *Tauīwi* (non-Maori) as we come together in a bi- cultural way that enhances *mana* and generates a sense of connection and belonging or *whānaungatanga*.

Equally important to the child and family was the sense that the service would hang in (Garfat *et al*. 2016) even when times were tough, with a focus on strengths, resilience and developing understanding and solutions together. One parent said:

“They haven’t let go of the kids, even when they are really bad....keep finding ways to help them stay again....talking to them about other help they need to have a better stay. It’s such a relief....like you really care”.

It was not only the children who valued the relationships and opportunities for activities whilst at the centre. All parent/carers talked about the connection that their child had with staff and how much the use of activity benefitted that child. This helped them feel more secure about letting their child stay.

Theme Three: Resilience and Respite Care

Phelan (2012) and Cameron (2013) suggest that a focus on the child’s psycho-social wellbeing through the use of activity enhances the development of the child’s skills to negotiate the world, or resilience. Garfat & Fulcher (2012) emphasise the importance of relational practice within the therapeutic relationship as the foundation for doing this.

At Cholmondeley, activity and interactions are meaningfully related to a child’s strengths, skills, wellbeing and the development of resilience. Every opportunity is taken to notice, name and grow strengths, or skills to negotiate their world. The children were asked about what they may have learned about themselves and what they may have noticed about this being present at home or at school, and in general. The language of the Key Competencies (Aotearoa New Zealand Education Curriculum, 2016) and Strengths Charts (internal tool developed for noticing and naming strengths) were referenced by the children.

All of the children spoke about how they now find it easier to make and keep friends, suggesting growth in their emotional and social skills. Four children talked about how they feel calmer, have learned new ways to interact when angry and less likely to engage in aggressive behaviour with peers. Four children noticed taking more responsibility for things and the environment. Seven children talked about making better choices at home and at school. One 7 year-old focus group participant explained:

“I learn how to be nice...I learn to use my words.... I care for stuff better... helps to make friends at school”.

Six children talked about how they had developed a better understanding of other people, or empathy. One 11 year-old focus group participant explained how this is helping her in relationships:

"It helps you to care for other people. It helps me to care about people's feelings...to understand them better...that helps you to get along better with other people. Yeah, it helps you not to be mean. I know a bit more about how I get on with my brother...but we still fight a bit".

A 12 year old said:

"I have humungous chats with staff. It's helped me to understand mum. I get it more, from her view. I suppose I respect her more now. So we get on better".

It appears that the opportunities for experiences and activity that are "developmental fillers" (Appelstein, 1998) are providing children with chances to develop a sense of mastery and wellbeing. From the children's responses, it is crucial that adults are attentive, taking every opportunity to notice, name and celebrate the child's strengths, giving them space to practice their new skill in an environment where it's okay to make mistakes whilst preparing for and supporting them through setbacks. Growth in these areas of physical, social and emotional wellbeing are deemed essential for building resilience in children.

While it was apparent that the children had noticed changes in their skills and 'competencies' it was important to ascertain the parents'/carers' view of this. Seven said that social skills and confidence with peers had increased noticeably, resulting in the child feeling happier and less isolated at school. One parent said:

"I think his social skills are a big one...now hanging with his peers at school. He's like, "I've got friends". He's actually hanging with kids the same age".

Another parent said:

"Going there means they're learning to socialise with other kids coz they've never been good at that. Definitely social skills for them. They make friends better and they stay friends".

After her child's second stay, one parent said that they noticed the child was much happier but was still aggressive. Another adult talked about how the child said they

were not happy during their last stay and felt this was due to anxiety about recent home events. One parent/carer did not identify any particular growth in their child's development, although they did talk about an increase in their child's general happiness. This overall increase in happiness featured in all the adult and child interviews with comments such as "boost my confidence so I'd be happy", "funny moments" and "lots of happy memories."

Other responses from parents and carers mirrored responses from the children that included increased communication and concentration at school, making better, safer choices and better connection with parents/carers. The adults talked about how their child returned with new skills such as baking which the adult and child were now doing at home and how this gives them a place to connect whilst the child demonstrates mastery (Garfat *et al*, 2016). Four parent/carers talked about an increase in the child's ability to think about other people's perspectives and feelings. One adult demonstrated the child's increase in empathy when sharing that:

"(Child) used to laugh about people being hurt. He doesn't do that now".

It is essential that the child's development is noticed and celebrated to grow resilience (Daniel *et al*, 2010) and opportunities for this were deemed important for eight of the children who talked about how the strengths charts that are completed are taken home and shared with their families and others. It appears that the children were using the strengths charts to remind themselves of their personal skills and strengths. One 10 year-old said:

"(Staff) wrote how I give things a go even when I'm worried. It made me feel very good. I give them to Nana.... keeps them in her room in a special place. I look at them...it makes me feel happy...makes me remember".

A 12 year-old said:

"They're actually really encouraging..... makes you happy that they think about you that way...really nice comments about you....good stuff...you don't really want to hear the bad stuff and you're hearing the good stuff. It's nice. If you're really sad, you can just read them...it makes you feel good".

It appears that growth in the majority of the children's 'competencies' is having an impact in other areas of their lives outside the centre. It would also appear that this

growth is altering children's views of themselves, or their internal working model (Atwool, 2006), is being noticed and acknowledged by significant people in their lives and is improving relationships. It can be argued that this decrease in issues related to the child's presentation and wellbeing reduces the stresses within the family and at school, thereby enhancing resilience.

Madden *et al* (2016) advocate for the availability of respite care on an ongoing basis. The findings of this study indicate that access to the service for regular planned and emergency respite does alleviate the stresses present in the households of vulnerable children and their families. It was apparent that the adults viewed the use of respite care as an essential option in times of crisis. All talked about the value of Cholmondeley Respite Care using words like "a lifeline; a Godsend and extended whanau". It was also apparent that if respite care had not been an option, children would have been left vulnerable in risky situations. Four participants talked about the only other option being foster care if respite at Cholmondeley was not available. One said:

"We didn't want to give up on (child). Foster care was the only other option. We didn't know what else to do".

Grandparents talked about the value of regular breaks and how this has helped them to continue caring for their grandchildren:

"We'd both probably be in the hospital absolutely worn out. I can tell you that. He has been so much calmer, having a place to go away from the family stresses has helped him. It's helped us all have a stronger relationship".

The findings suggest that both children and carers value an accessible respite care service for emergency situations and for ongoing planned respite care (Madden *et al*, 2016). It also appears that the development of a child's skills and strengths within a relational child and youth care context (Garfat & Fulcher, 2013) and therapeutic milieu that is grounded in a child rights philosophy of care (Gharabaghi & Stuart, 2103; Save the Children, 2002) to promote child wellbeing. Arguably, this promotes parent/carer wellbeing as these stresses are reduced. The findings suggest that these key factors, alongside collaboration in an ecological approach to family support (Lietz, 2011), that

enables a committed parent to carry on and to respond to adversity through increased resilience with enhanced potential for family preservation.

Chapter 5: Conclusion and Recommendations

The aim of this research was to give voice to the children and families using group respite care and discover the key elements or active ingredients that add to their experience. It also sought to explore links between the use of respite care and the development of resilience in children and families and if so, how this contributes to family wellbeing and preservation. Whilst the sample demographics and frequency of service use were varied and are reflective of those typically using the service, the scale of this study requires that caution must be taken in seeking to generalise these findings to other contexts or in drawing conclusions about how the findings relate to all children and families using respite care services. The study did not hear the voices of children in statutory foster care or from their carers.

Throughout this study the consistent narrative was that children and families who value a service that is easily accessible for emergency situations and for ongoing planned respite care as recommended by Madden *et al* (2016). The study suggests that there is a definite link between the purposeful use of group care for respite and the nurturing of resilience for vulnerable children and families. However, it is important to note potential risks associated with group care (Meadowcroft, 2009) and whilst the findings of this study are overwhelmingly positive from the child and family perspective, it also gives clear messages about what is required to ensure the needs of individual children and her or his best interests are central, whilst ensuring the wellbeing of the group.

The study clearly demonstrated the value that vulnerable children and families place on directly accessible respite care when they need it, during a one-off crisis or during the presence of ongoing risk factors (Schroder *et al*, 2014; Ball *et al*, 2016). It reveals the importance placed on the ongoing support that developed through service involvement. Schroder *et al* (2014) advocates for an ecological approach and the study suggests that brokerage and support to access counselling, education and health support are essential, as needs are met and as-needed help-seeking increases.

Respite care is generally seen as a break for the parent/carer, with minimal attention given to the child's wishes and their views (Armstrong & Shevellar, 2006; O'Brien,

2001; Madden *et al*, 2016). This study clearly demonstrates the importance that children place on being able to get a break. It was evident that there has been some shift in the traditional perception of respite being a break for parent/carers (Armstrong & Shevellar, 2006; O'Brien, 2001), as they too recognised the need for breaks for the child, or breaks for both parent and child. Children did not specify if breaks are particularly important during times of crisis, or as an ongoing planned option but the value they placed on breaks in a safe place, both options are important to them. The study revealed that children have a positive view of their experiences of respite care in a group setting, particularly finding benefit in the opportunities for friendships and meeting people in the camp-like environment, thereby supporting their notion of it being like a holiday and normalising the circumstances. Parents/carers also value the camp-like experience and seeing their child's positive response to the experience helps alleviate their guilt. Having a number of adults with whom to form relationships is valued, suggesting that this is seen as a potential protective factor and positive aspect of group care (Daniel *et al*, 2010; Ward, 2004).

It is suggested that an ecological approach is needed to build resilience and developing a protective web around personal and environmental domains (Daniels *et al*, 2010). This study found that children's involvement with the service supported their strength development in the personal domain for all but one child in at least some of the key competencies identified (Aotearoa NZ Education Curriculum 2016). The study demonstrates how the service positively impacted on areas of the majority of the children's worlds, providing changes in the dynamics at school and within relationships at home. This, it can be argued, reduces the stress levels, risks of tension and vulnerability, and increases resilience in both children and families. No one particular aspect of the child's experience whilst at the centre was identified as the reason for growth and development amongst these resilience builders. However, given what children said and what we know from the literature, it is likely that the combined elements of a child-centred culture of care, relational child and youth care practice, the use of activity, adventure and experiential learning that supports the growth of therapeutic relationships and developmental strengths, alongside the ability to stay as often as needed. All are critical factors, that is, not one factor operating in isolation from the other.

Gharabaghi & Stuart, (2013) and Freeman, (1996) highlight the importance of a child rights-focused philosophy of care and the study reveals how a child-centred culture of care, where practice is anchored in a child-rights philosophy of care, is experienced by children. Their responses reveal the importance they place on feeling safe, valued and supported and it is clear that the key elements that contribute to this are the space to be children (Moss & Petrie, 2002), being in relationship, the planned use of activities and unplanned opportunity moments, plus knowing that even when things get tough, they will be understood, supported and stuck by (Garfat & Fulcher, 2013). Moss and Petrie (2002) advise of the importance of child-centred spaces that allow for play and excitement, and it is clear from the study that the opportunity to be children, to make friends and to have fun with peers was particularly important. Whilst they didn't articulate it explicitly, it appears that the children were describing not only a physical space to be children, but an emotional space as they talked about chilling out and a place that makes you happy. The study reveals that building relationships with adults who answer the key unasked questions of "do you care about me?" and "will you keep me safe?" through their being, interpreting and doing (Garfat & Fulcher, 2012; Freeman & Garfat, 2014) alongside the child is a key element that is vital to children's positive experiences. The study highlights the respite care experiences of children coming to stay in this group environment for the first time. Even after only one stay, they can develop relationships quickly with the staff that had a positive sense of being cared about and cared for. This reinforces the importance of a relationship focus and staff capabilities to convey the message that they care (Garfat *et al*, 2016) and suggests that part of the reason for the speed at which the anxious child feels relaxed may be associated with the role of the group of children as culture carriers, passively or overtly giving new children the message that this place and these people are safe and okay.

Garfat *et al* (2016) advise of the importance of using of everyday life events and the use of planned and unplanned activities whilst Phelan (2012) highlights the value of adventure and experiential learning, elements highlighted in this study. Such experiences are seen as good memories and things to talk to your family about, frequently supporting a child's sense of a happy childhood (Moss & Petrie, 2002). This study clearly informs that it is not the activities in isolation that are important for children but the doing them in relationship is the important dynamic, proving the vital

importance of being in relationship for the child (Garfat *et al*, 2016). This study also clearly highlighted the importance that children placed on building attachments with trusting non-kin carers (Atwool, 2006) who really got to know them, to understand them and demonstrated a willingness to stick by them, particularly when things get tough. The children gave a clear message to the adults that they need to be allowed to make mistakes, understood, value their strengths being highlighted and helped to do things differently. It is evident from this study that a relational child and youth care approach (Garfat *et al*, 2016) enables these nurturing relationships within which the children feel supported to be themselves, to connect, engage, trust, see themselves and their world differently, and grow their strengths and sense of wellbeing.

Recommendations:

It is very clear from the findings of this study that what children and parents/carers deem important for respite care experiences are the same. Parents and carers seek an environment where their child is physically and emotionally safe and where they experience supportive caring relationships with a range of adults offering opportunities for activities, adventures and fun where their strengths grow (Daniel *et al*; Garfat & Fulcher, 2013; Cameron, 2013) and this is what the children wish for themselves. It is essential that the key focus on relationship within a culture of care informed by a relational child and youth care approach are present in any group care setting. Without this, there is the strong likelihood of physical and emotional risk for children.

This study highlights the issue of meeting the needs of individual children within a group care setting. It is crucial to note this is not a one-size-fits-all option and this group setting is not for all children. Children were clear about their need to feel safe and secure, and what feelings they have when they did not feel safe and secure. It is recommended that careful attention is paid to the group mix and the milieu, so that risks associated with children “getting lost” and exposure to “risky” behaviours are minimised for all children (Meadowcroft, 2009; Schroder *et al*, 2014; Bleach & Robertson, 2009). All of the children need to be guided and supported within a culture of care, wherever that might be.

Assessments associated with meeting individual needs within a group, the likelihood of coping within the environment and ascertaining the group mix is not an exact

science. This is an art that must be guided by principles of the best interests of the child and the children. The risks to all children are too great should these decisions be guided by a focus on quantity or outputs, and not on a quality therapeutic experiences for each child in receipt of respite care. It is also imperative that consideration is given to the retention and support of appropriately skilled staff to provide these children with consistent trusting relationships over the course of time.

The views of children who use respite care in a one-on-one setting was outside the parameters of this study. However, it would be beneficial for future child-centred research to be carried out so that their views about these experiences and the links to building resilience can be added to our evidence-based service-planning decisions.

This study suggests that the availability of respite support in times of need and in a planned capacity gave children and families the sense of someone 'having their back' and providing vulnerable parents, carers and children with periodic stress relief. The cumulative findings suggest that the children and their parents/carers clearly believe that access to a child-centred family-focused service when they need it is crucial to their family wellbeing. Group respite care needs to be included in the range of important options for vulnerable children and families, including those with emotional and behavioural vulnerabilities, so that children are provided with opportunities for positive experiences and developmental growth whilst parents and carers are also supported to access further services and promote family resilience.

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Appendix One

Participant Information For Adults and Children

Introduction

Edwina Poynton is the Service Development Manager at Cholmondeley Children's Centre and a post graduate student studying for a Masters in Science degree in Child and Youth Care Studies at the University of Strathclyde in Scotland. As a requirement for this award she is carrying out a research project.

Purpose of this Project

The aims for this project

- to gather information from you and your child/ tamariki about your experiences of the respite care and education service that you use at Cholmondeley
- to gather information about how Cholmondeley may have helped you and your family/ whanau and the effect this may have had on your child/ tamariki and your family/ whanau wellbeing
- to hear about how Cholmondeley can do things better for children and families/wha nau.

You do not have to take part?

- Your participation is entirely voluntary, that is it is your choice. You and your child/tamariki do not have to take part in this study. This will not affect your ongoing use of the service at Cholmondeley Children's Centre.
- If you agree to take part in this project you and your child/ tamariki can withdraw at any time without having to give any explanation. This will not affect your ongoing use of the service at Cholmondeley.

What will you do in the project?

As part of this research you will be asked to meet with Edwina. She will ask questions about your experiences of Cholmondeley.

During the interview you will be asked

- to reflect and report on your experience of Cholmondeley
- to describe how your involvement with Cholmondeley has affected you, your child/ tamariki and your family/ whanau
- The interview will take place in your home, at Cholmondeley or at another place where you feel comfortable such as a marae or your child/ tamariki's school. The choice is yours. The interview will take between one and one and a half hours.

What will your child/ tamariki do in the project?

Your child will be asked to meet with Edwina

During the interview your child will be asked

- to reflect and talk about their experience of Cholmondeley
- to describe how their involvement with Cholmondeley has affected them, their family/ whanau and their relationships
- the interview will take place in your home, at Cholmondeley or at another place where you and your child/ tamariki feels comfortable such as a marae or your child/ tamariki's school. The choice is yours.
- your child/ tamariki can be interviewed alone or with you, their siblings and/ or family/ whanau present. The choice is yours and your child/ tamariki's. The interview with your child/ tamariki will take up to thirty minutes.

Children/ tamariki aged 8 or above

Your child/ tamariki may also be asked to be included in a focus group. This group will consist of a small number of other children/ tamariki. The group will be asked questions about their experience of staying at Cholmondeley by Edwina

Why have you been invited to take part?

You and your child/ tamariki have been invited to take part because your child/ tamariki has stayed at Cholmondeley for respite care and we are interested in hearing about your experience of the service.

What happens to the information in the project?

- Any personal information that is collected about you or your family/ whanau will be kept anonymous, that is all names and identifying information will be changed. Your privacy and wishes will be respected at all times.
- The information you share will be treated as confidential. The exceptions to this are if I am made aware of, or suspect on reasonable grounds that a child/ tamariki, you or another person have been harmed or are likely to be harmed or that criminal activity has taken place or is likely to take place.
- Your information will be stored in a locked cabinet in a locked office at Cholmondeley and/ or in a locked cabinet in Edwina's home. You will have access to any of your information at any time.
- When the project is completed, that is when the dissertation has been written, all gathered information will be destroyed through a confidential waste service.
- The findings of the research project will be shared with you through a written report.

Please advise them to take time before they make a decision about whether they or their family/ whanau wish to be involved with this project.

What happens next?

If the parent/ carer would like further information and/ or agrees to take part please tell them the following:

- Edwina will be in touch to arrange a time to meet with you.

If they choose not to be involved thank you for your time

Appendix Two

SCHOOL OF SOCIAL WORK & SOCIAL POLICY



Participant Information Form – Adult

Introduction

My name is Edwina Poynton. I am the Service Development Manager at Cholmondeley Children's Centre and a post graduate student studying for a Masters in Science degree in Child and Youth Care Studies at the University of Strathclyde in Scotland. As a requirement for this award I am carrying out a research project.

Purpose of this Project

The aim for this project is to gather information from you and your child/ tamariki about your experiences of the respite care and education service that you use at Cholmondeley. The aim is also to gather information about how Cholmondeley may have helped you and your family/ whanau and the effect this may have had on your child/ tamariki and your family/ whanau wellbeing. It also aims to hear about how Cholmondeley can do things better for children and families/whanau.

Do you have to take part?

Your participation is entirely voluntary, that is it is your choice. You and your child/tamariki do not have to take part in this study. This will not affect your ongoing use of the service at Cholmondeley Children's Centre.

If you agree to take part in this project you and your child/ tamariki can withdraw at any time without having to give any explanation. This will not affect your ongoing use of the service at Cholmondeley.

What will you do in the project?

As part of this research you will be asked to meet with me. I will ask questions about your experiences of Cholmondeley.

During the interview you will be asked

- to reflect and report upon your experience of Cholmondeley
- to describe how your involvement with Cholmondeley has affected you, your child/ tamariki and your family/ whanau.

With your permission the interview will be recorded using a sound recorder. The recording will then be transcribed (written down). You do not have to answer all the questions and you may stop the interview at any time.

If you do not wish for the interview to be sound recorded that will be ok. Written notes can be used alone.

The interview will take place in your home, at Cholmondeley or at another place where you feel comfortable such as a marae or your child/ tamariki's school. The choice is yours. The interview will take between one and one and a half hours.

What will your child/ tamariki do in the project?

During the interview your child will be asked

- to reflect and talk about their experience of Cholmondeley
- to describe how their involvement with Cholmondeley has affected them, their family/ whanau and their relationships

With your and your child/ tamariki's permission the interview will be recorded using a sound recorder. The recording will then be transcribed (written down). Your child/ tamariki does not have to answer all the questions and you or they may stop the interview at any time.

If you or they do not wish for the interview to be sound recorded that will be ok. Written notes can be used alone.

The interview will take place in your home, at Cholmondeley or at another place where you and your child/ tamariki feels comfortable such as a marae or your child/ tamariki's school. The choice is yours.

Your child/ tamariki can be interviewed alone or with you, their siblings and/ or family/ whanau present. The choice is yours and your child/ tamariki's. The interview with your child/ tamariki will take up to thirty minutes.

Your child/ tamariki may also be asked to be included in a focus group. This group will consist of a small number of other children/ tamariki. The group will be asked questions about their experience of staying at Cholmondeley by me.

The focus group will take place at Cholmondeley. Transport will be provided.

Your child/ tamariki will be encouraged to only talk about what they feel comfortable talking about.

The group discussion will be sound recorded. The recording will then be transcribed (written down).

Why have you been invited to take part?

You and your child/ tamariki have been invited to take part because your child/ tamariki has stayed at Cholmondeley for respite care and we are interested in hearing about your experience of the service.

What are the potential risks to you in taking part?

Whilst you and your child/ tamariki will not be asked about personal information you may choose to talk about your circumstances or personal story. This may cause you upset and distress. Should this happen you will be supported to seek advice and support regarding this.

If your child is involved in the focus group there is a possibility that the information that is shared in this group discussion will be repeated by other children as there is no guarantee of confidentiality within this group. Every effort will be made to guide the conversation away from personal information that may lead to your child/ tamariki sharing something that they may later regret. They will be supported throughout and following this process.

What happens to the information in the project?

Any personal information that is collected about you or your family/ whanau will be kept anonymous, that is all names and identifying information will be changed. Your privacy and wishes will be respected at all times.

The information you share with me will be treated as confidential. The exceptions to this are if I am made aware of, or suspect on reasonable grounds that a child/ tamariki, you or another person have been harmed or are likely to be harmed or that criminal activity has taken place or is likely to take place. In this event I will follow the Cholmondeley Children's Centre child protection policy and procedure and inform the appropriate agencies.

Your information will be stored in a locked cabinet in a locked office at Cholmondeley and/ or in a locked cabinet in the researcher's home. You will have access to any of your information at any time.

When the project is completed, that is when the dissertation has been written, all gathered information will be destroyed through a confidential waste service.

The findings of the research project will be shared with you through a written report.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

Cholmondeley Children's Centre is committed to the principles of the Aotearoa New Zealand Privacy Act 1993

Thank you for taking the time to read this information – please ask any questions if you are unsure about anything that is written here.

What happens next?

Please take time before you make your decision about whether you or family/ whanau wish to be involved with this project.

If you choose not to be involved thank you for your time.

If you are happy for you and your family/ whanau to be involved you will be asked to sign a consent form that confirms that you have a clear understanding of the information in this sheet. Your child/ tamariki will also be asked to sign their own form confirming that they have understood what the project involves. Following this I will be in touch to arrange to meet with you and your family/whanau for an interview. You will be asked about the location that suits you best for this to happen. You will be invited to have a support person, Kaumatua or whanau with you if you so wish.

Once again thank you for your time.

Researcher Contact Details:

Edwina Poynton
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Floor 6, Lord Hope Building
141 St. James Road
Glasgow
G4 0LT

Telephone: +44 141 444 8648

Email:

Supervisor Contact Details:

Graham McPheat

University of Strathclyde

Floor 6, Lord Hope Building

141 St. James Road

Glasgow

G4 0LT

Telephone: +44 141 444 8682

Email: graham.mcpheat@strath.ac.uk

In addition you can contact the following:

Shane Murdoch

CEO

Cholmondeley Children's Centre

6 Cholmondeley Lane

Governors Bay

Christchurch

8971

Telephone: +64 3 329 9832

Email: shane@cholmondeley.org.nz

This investigation was granted ethical approval by the ethics committee of the School of Applied Social Sciences at the University of Strathclyde.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Iain Macleod

Convener, Ethics Committee for the School of Applied Social Sciences

University of Strathclyde

Floor 6, Lord Hope Building

141 St. James Road

Glasgow

G4 0LT

Telephone: 0141 444 8648

Email: iain.mcleod@strath.ac.uk

Appendix Three



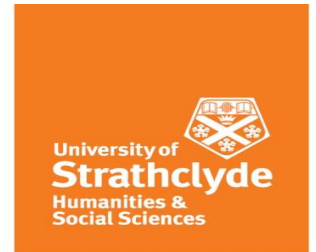
Interview Schedule for Children/ Tamariki

Questions:

The initial questions asked of the children will be aimed at the research question of their experience of using the service. The second group of questions will be aimed at ascertaining the impact of service involvement on child and family wellbeing and resilience. The final question will be focussed on what could be done differently to make the service a more positive experience for service users.

- How many times have you been to stay at Cholmondeley?
- Tell me about some of the things that you do when you stay there.
- What are the things that you most like about going to Cholmondeley?
- What are the things that you like least about going to Cholmondeley?
- What are the staff like? Do you have one that you particularly like? What is it about them that you particularly like?
- Thinking about before you first came to Cholmondeley and now, what do you think has changed for you?
- How do the things that you do or learn about yourself at Cholmondeley help you:
When you are at home?
When you are at your own school?
When you are with others?
- What would you tell other kids who are thinking about going to stay at Cholmondeley?
- What do you think Cholmondeley could do differently or more of to make it a better experience and space for kids?

Appendix Four



Interview Schedule for Adults

Questions:

The initial questions asked of the parents/ carers will be aimed at the research question of their experience of using the service. The second group of questions will be aimed at ascertaining the impact of service involvement on their child and family wellbeing and resilience. The final question will be focussed on what could be done differently to make the service a more positive experience for service users.

- How many times has your child/ tamariki been to stay at Cholmondeley?
- What led you to making the decision to use this service?
- Tell me about some of the things that your child does when they stay there.
- What are the things that they say they most like about going to Cholmondeley?
- What are the things that they say they least like about going to Cholmondeley?
- How has the experience of letting them stay at Cholmondeley been for you?
- What made it easy, if anything?
- What made it difficult, if anything?
- Thinking about before you started using Cholmondeley and now, what do you think has changed for you?
- Have you noticed anything you didn't notice before or any changes in your child and/ or family/ whanau since they have been coming to stay?
- How do the things that your child/ tamariki does or learns at Cholmondeley help them and/ or you:
 - When at home?
 - When they are at school?
 - When they are with others?
- What could Cholmondeley do differently or better to make it a better experience for your child/ tamariki, you and your family/ whanau?
- What would you tell other parents/ carers who are in a similar situation as you and who are thinking about a stay at Cholmondeley?

Appendix Five



Informed Parental/ Guardian Consent for Child to take part in Research Project

I, _____, understand that Edwina Poynton, Service Development Manager at Cholmondeley Children's Centre is carrying out a research project as part of her study as a student on the MSc Child and Youth Care at University of Strathclyde, Scotland.

I understand that Edwina is solely interested in my child's experiences of Cholmondeley for the purpose of this study.

I consent to all processes of evaluation including recording of personal information and note taking.

I consent to my child/ tamariki being interviewed

_____ [please sign here]

I give consent for my child/tamariki to be involved in a child's focus group (group discussion)

_____ [please sign here]

I consent to my child/ tamariki being recorded

_____ [please sign here]

I consent to my child/ tamariki making their own video diary about their experience of Cholmondeley

_____ [please sign here]

I understand that any information my child/ tamariki gives will be used in the dissertation (research project) and that this will be submitted to the University of Strathclyde. I also understand that the dissertation will be available to Cholmondeley, its board members, stakeholders, and staff.

I understand that my child/tamariki will not be identified in any information produced as part of this process and information will be kept confidential. I further understand that if my child/ tamariki tells the researcher (Edwina) something that makes her worried that the child/tamariki (or someone else) is not safe, she will talk to someone who can help.

I understand that my child/tamariki's participation in this is completely voluntary (my choice).

I am aware that I can withdraw consent for them to take part at any time up until such time as a draft is produced. Should I wish to withdraw, any material provided up to this point will be destroyed.

My consent is based on the fact that my child/ tamariki understands they can withdraw from this research at any time.

I understand that if my child/tamariki doesn't take part, or if either of us wants to stop at any time, for any reason, this will in no way affect any continuing involvement with Cholmondeley.

I also agree that the material from the dissertation can be used in any reports and other forms of publication and dissemination upon further request by Edwina.

As a parent or guardian of: (child/ tamariki's name) _____,

I (parent or guardian's name) _____, am satisfied that all my questions have been answered about the process of the research project and I give my permission for the child/tamariki named above to participate in this.

Signed: _____ (Parent or Guardian) Date: _____

To be completed by the Student/ Researcher

I, Edwina Poynton, Student, to the best of my knowledge, have clearly described the purpose of this evaluation and the procedure to be undertaken. I have also answered any questions required clearly and accurately.

_____ demonstrated their understanding of their rights in the following way:

Confidentiality (demonstrate participant's understanding)

Anonymity (demonstrate participant's understanding)

Revelation of harm (demonstrate participant's understanding)

Use of information (demonstrate participant's understanding)

Signed: _____ Date: _____

Edwina Poynton

Appendix Six

SCHOOL OF SOCIAL WORK & SOCIAL POLICY



Research Information and Consent for Younger Children/Tamariki

Kia ora

I would like to talk to you about how you find coming to stay at Cholmondeley.



BUT I will only talk to you if you want me to!

Before you decide if you want to talk to me or not, I will explain to you what will be happening.

I will speak with you on your own if that is OK with you and OK with your parents or carers.

I will also speak with you and other children who live in your home in a group if that's OK with you and them.

I will speak with you in a place where you and your parents or carers feel comfortable in like your home or where, your school or your marae. The choice is yours.



I would like to record what you say.

BUT only if that is OK with you. If it is not OK to record you I will write things down instead.



I will not talk with anyone else about what you say to me.

BUT if you say something to me about you or someone else being hurt I may have to tell someone else. This is so that we can keep you and other people safe.

Before I would do this I would speak with you about the best way to do it.



If you ever want to stop talking with me you can just tell me and we will stop.



When I have talked with you and other children who stay at Cholmondeley I will write a

report about Cholmondeley Children's Centre BUT I will not use your name.



I will share the report with you and your family/ whanau when it is finished.

If all of this seems OK to you and if you feel happy about talking with me, put a circle around the YES at the bottom.

If you don't want to talk to me, put a circle around NO

THE CHOICE IS YOURS!

No one will be mad with you if you don't want to do it.

And you can still come to stay at Cholmondeley if you need to!



YES



NO

Please write your name here: _____

Thank you for your time.

Tu meke!

Edwina

Appendix Seven



Consent Form

Name of Department:

Social Work

Title of the Study:

Respite Care with a Difference

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.
- I understand that I can withdraw my data from the study at any time.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.
- The only exception to this would be if information is disclosed related to serious harm or immediate danger, in which case the researcher would need to pass along this information



- If this should happen, the researcher would discuss this with me at the time.

- I consent to being a participant in the project
- I consent to being audio and video recorded as part of the project Yes/No
- I consent to be audio recorded Yes/No
- I consent to be video recorded Yes/No

(PRINT NAME) _____

Hereby agree to take part in the above project

Signature of Participant _____

Date _____

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