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Relationships Matter:

Caregiver Experience of Contact/Access Planning Practice and Outcomes for Permanency

A thesis presented in partial fulfilment of the requirements for the degree of
Master of Social Work at Massey University, New Zealand.

Kristin Nielsen-Vold

2019

ABSTRACT

When children are removed from parental care and placed out of home it is generally expected that birth family contact will occur. This commitment to birth family contact is based on beliefs about its psychological and emotional importance for children and is protected and enshrined in national and international policy. Literature clearly outlines, however, that birth family contact is one of the most complex and contested areas of practice for social workers and is often difficult for caregivers. This research set out to examine how caregivers in New Zealand experienced social worker practice in relation to contact planning. The aims of this research were to: critically explore caregivers' experience of social work practice in regards to contact planning for children progressing to their permanent care; and identify processes and practices that were helpful for caregivers, pre-permanency, which supported quality outcomes post-permanency. To achieve these aims, a qualitative approach was utilised involving six semi-structured interviews of seven kin and non-kin caregivers.

Research questions included:

- How did caregivers' experience social work practice in regards to contact planning?
- What processes and practices were helpful for caregivers to support post-permanency outcomes?
- What recommendations do caregivers have to improve quality contact outcomes post-permanency?

A rather disheartening picture of social work contact practice emerged with caregiver experiences generally ranging from dissatisfying through to distressing. Several key findings were identified by caregivers in this research including, exclusion from decision-making processes, lack of information, limited support, lack of assessment, and limited relational practice by social workers. The findings of this research echo similar research both in New Zealand and internationally in relation to social work contact practices and the experiences of caregivers. Given this consistency of experience for caregivers, additional factors were examined to help provide explanations for the ongoing issues for caregivers, including organisational practice and culture. Recommendations were made which focused on contact experiences, assessment processes, training, policy, and the importance of relationship, to strengthen practice in this challenging area of work and improve caregiver experiences.

ACKNOWLEDGEMENTS

Firstly, I need to acknowledge the incredible support of my husband Peter along with the understanding and patience of my two children Joshua and Abigail. Thanks Peter for the endless proof reading of the material.

Heartfelt thanks are given to the amazing participants in this research who gave so freely of their time and so willingly shared their experiences.

A special thanks to my two research supervisors, Dr Traicee Mafile'o and Dr Kathryn Hay who offered amazing support, guidance and academic wisdom and without whom I probably wouldn't have made it.

Thanks also to colleagues, other professionals and organisations in the field for supporting this research and the recruitment of participants.

Thank you also to Angie for transcription of the interviews and for the incredible support helping to edit and put together this research.

I want to also acknowledge the support and service provided by the staff at the Massey University Library.

A final thanks to Open Home Foundation, where my whole interest and passion in this area was sparked.

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CHAPTER 1: INTRODUCTION

The aims of this research were to explore the experiences of caregivers in relation to social work contact practices and examine those processes helpful or enabling of quality outcomes. This first chapter provides definitions of contact and permanency along with an overview of permanent care in New Zealand, the legal mandates for permanency and developments in this arena.

Background

In recent years there have been significant increases worldwide in the numbers of children and young people placed in statutory care as a result of parental/familial maltreatment and abuse (Gobind, 2013; Tarren-Sweeney, 2008). Current statistics from Oranga Tamariki (New Zealand's government Ministry responsible for the care, protection and wellbeing of children and young people) note there has been a rise in the number of children requiring out of home placements over the past two years (Oranga Tamariki, 2019). These increases appear to be consistent with figures for children globally (Gobind, 2013). In New Zealand, there is an overrepresentation of Māori children in the care system (Fernandez & Atwool, 2013). Oranga Tamariki statistics to 30 June 2019 revealed that Māori children make up 59% of children in care. Those children identified as both Māori/Pacific increase the numbers a further 9%. Therefore the total percentage of children in care who identify as Māori was 68%. Pacific children made up a further 6% of those in care. According to Oranga Tamariki there has been an increasing trend over the past few years towards placing children unable to live at home with whānau/family. For children who are unable to be placed with whānau/family more culturally-matched placements are occurring (Oranga Tamariki, 2019).

Children who have been removed and placed in care following state intervention often have a range of psychological, emotional and physical problems resulting from their early care and protection experiences (Cooke, 2014; Harden, 2004; Steinhauer, 1991). Following children's removal from parental care an entrenched principle of care and protection practice, specially protected within legislation and policy, is for familial contact to be established as soon as possible (Delbabbro, Barber & Cooper, 2002; Harkin & Houston, 2016). It is generally considered that birth family contact helps establish stability and continuity for a child

(Tilbury & Osmond, 2006). When a child is placed outside of their birth family, and in a new home, they are removed physically from them; however, thoughts and feelings about their family are not removed emotionally or psychologically from the child's mind (Neil & Howe, 2004).

At the dynamic centre of all arrangements for children in care, however, are caregivers. These are people, kin or non-kin, tasked with caring for a child or young person temporarily, until they can return home, or permanently if a return home is not possible. In New Zealand a child is a person under 14 years and a young person is a person over 14 years and under 18 years (Oranga Tamariki Act, 1989). Caregivers not only have to meet the often-complex needs of children placed in their care, they are also required to support birth family contact to varying degrees. For caregivers, keeping children connected to their birth families is one of the most difficult responsibilities they must perform and is frequently problematic (Cleaver, 2000; Sanchirico & Jablonka, 2000; Tansley, 2014).

The contact experience is where the child's two families intersect and is, therefore, a difficult arena, a significant source of conflict and one of the most contentious areas of practice social workers face (Atwool, 2008; Atwool, 2010; Beek & Schofield, 2004). For social workers, professionals and families, questions about the nature, type, purpose, desirability, and frequency of contact are major considerations. Social workers play the pivotal role in preparing and supporting contact and face the difficult task of finding the appropriate balance between the needs and wants of various parties whilst keeping the child's needs paramount (Neil & Howe, 2004; Sydney and Price, 2014).

A difficulty for practitioners, however, is that the issue of contact is not well supported in research and clear practice guidelines. Atwool (2013) notes that despite the difficulties with birth family contact this practice domain has received little attention. In general, this area is seen to be burdened by an unhelpful lack of coherent empirical theory and guidelines and that, "making judgements on the quality and nature of contact remains a mixture of art and science, possibly balanced more towards art" (Triseliotis, 2010, p.59). Complicating the issue further is that the evidence bases that do exist, to help inform contact, often result from research and practice in other fields, including family law and adoption, which involve quite different issues and circumstances (Taplin, 2005). However, despite all the known complexities surrounding contact there still remains an almost universal belief that contact is

beneficial for children (Atwool, 2013). Not only is the research and evidence base around contact insufficient to help inform social work practice, the contact issue suffers from limited research into the specific experiences of caregivers in maintaining birth family contact (Osborn & Delfabbro, 2009). Hashim (2009) outlines the gaps that exist in this area of research, most notably, the lack of information about perceptions of caregivers which is considered significant given their pivotal role in contact visits. This lack of information is surprising as the success and long-term sustainability of placements are significantly connected to caregiver disposition and attitudes (Osborn & Delfabbro, 2009). Given the needs of permanently placed children and the known difficulties with familial contact, it is essential that the issue of quality contact is addressed and assessed by social workers prior to permanent care orders being made.

Research Aims

The aims of this qualitative research were to:

- 1) Critically explore caregivers' experience of social work practice in regards to contact planning for children progressing to their permanent care; and
- 2) Identify processes and practices that were helpful for caregivers, pre-permanency, which supported quality contact outcomes post-permanency.

Research Questions

- How do caregivers' experience social work practice in regards to contact planning?
- What processes and practices are helpful for caregivers to support post-permanency outcomes?
- What recommendations do caregivers have to improve quality contact outcomes post-permanency?

Permanent care involves a legal process enabling kin or non-kin caregivers to become a child's permanent caregiver (Oranga Tamariki, 2019). This research uses the terms pre-permanency and post-permanency to describe the periods of time before and after caregivers obtain legal orders in respect of the child in their care. During the course of this research the Children Young Persons and Their Families Act (1989) was changed to the Oranga Tamariki Act (1989) and the latter has subsequently been referred to. Organisational name change also occurred from Child Youth and Family to the Ministry of Vulnerable Children Oranga Tamariki and then in 2018 to Oranga Tamariki Ministry for Children. In this research it is henceforth referred to as the Ministry.

Reflexivity

Reflexivity is seen as the ability to examine self and any biases impacting the research and is viewed as a continual process as opposed to a one-off experience (Padgett, 2008; Salzman (2002). Yin (2016) notes that qualitative research demands and deserves disclosure about a researcher's traits and roles which might impact or affect a study and its outcome. This includes any advocacy positions or roles, formal or otherwise, in connection to the area being researched. To assist in this reflexive process, I have utilised research supervision and discussions with colleagues, along with keeping a reflective journal throughout the various stages of the research.

From the outset, it is important to note that my interest in this particular area of research developed from working as an analyst of permanency case work, where I had the opportunity to see a number of trends and practice patterns. A significant issue colleagues and I repeatedly identified was birth family contact for permanency which was frequently problematic and at times a barrier for caregivers taking permanent care orders for children. Given the importance of children achieving permanency within appropriate timeframes, issues surrounding how social workers plan, manage, support and assess contact, was considered particularly crucial and subsequently became the impetus for this study.

My reflexive positioning also acknowledges that I hold particular values in relation to advocacy and support for caregivers. This has developed not only from my own work in care and protection and in permanency analysis but also from my early familial experiences of

being part of a ‘fostering family’. These experiences have shaped how I perceive caregivers and caregiving, and, in relation to this research, the strong belief that caregivers need to be well supported and seen as partners in the care and permanency decision-making journey.

The following section provides a context for this research and outlines the meaning and definitions of contact and permanency along with New Zealand’s background for permanency. The legislative frameworks for practice and the permanency legal options for caregivers are also discussed. The issues of contact, for permanent caregivers, within these legislative domains are noted. Finally, some contemporary permanency developments in New Zealand are outlined.

Definitions

Contact

Contact arrangements, also known as access and visitation, are seen as intentional forms of direct or indirect communication between children and their non-custodial parents, and a range of other significant people, such as siblings and extended family (Bullen, Taplin, Kertesz, Humphreys & McArthur, 2015; Quinton, Rushton, Dance & Mayes, 1997). Direct contact includes face-to-face visits or, in some cases, over-night stays with the parent (or other family) no longer providing the primary care. Indirect contact can involve phone calls, social media, texts, gifts, cards, letters, videos and Life Story Books (Bullen et al., 2015; Prasad, 2011; Sen & Broadhurst, 2011; Taplin, et al., 2015). As Bullen et al. (2015) caution, the line between indirect and direct has become slightly more blurred with the advent of ‘Skype’ and other such digital communication mediums.

Supervised contact is established when there are concerns about risk and safety for the child and the abuse that led to the child being placed in care. In these situations, interactions and communication between children and the birth family are closely monitored by an approved person, relative, social worker or agency (Taplin et al., 2015). The Oranga Tamariki Practice Centre (2019) outlines specific examples of when contact supervision is required, including severe physical or sexual abuse, emotional harm when a child is put down or scapegoated or any situation where safety is compromised. Supervised contact can also be in place when a

parent is incapacitated, physically or intellectually, and is unable to provide care for the child in an unsupervised capacity (Mossman, 2004).

At times supervision of contact may not be sufficient to ensure safety, wellbeing and security for a child and contact needs to be suspended or terminated. Situations warranting contact cessation can include court orders in force, a child refusing contact, parental behaviour, abuse or neglect during contact, lack of parental commitment, or repeated violations of the contact terms (Mossman, 2004). In addition, contact suspension or termination may be required when a child has experienced trauma, disordered attachments or suffered extreme maltreatment, emotional or sexual abuse (Howe & Steele, 2004; Wilson & Sinclair, 2004). Mossman (2004) also states that contact termination needs to be reviewed when birth families are unable to emotionally support the child's new permanent home and engage in destabilising behaviours including: undermining or exhibiting anger or disloyalty towards the caregivers in the child's presence; focusing on their needs rather than the child's; or being at pains to destroy the placement.

Permanency

Permanency as a concept originated in the 1959 American study, *Children in Need of Parents*, which identified significant numbers of children drifting in care as a result of inadequacies in finding permanent homes and no proper care plans (Cooke, 2014). There are a range of meanings associated with permanency including: emotional dimensions of stability and security; lifetime relationships; a sense of belonging; and legal and physical permanence (Biehal, 2014; Maluccio, Fein & Olmstead, 1986; Tilbury, & Osmond, 2006). Children require a sense of belonging and identity in a care arrangement where they can form a secure understanding of the future. Stable and nurturing caregivers can help bolster and develop children's resilience to better handle the challenges presented throughout life. This can help ameliorate the negative and damaging impacts and effects of previous instability and exposure to abuse and/or neglect and helps improve outcomes for children in relation to health, education and social development (Jackson & Gibbs, 2016; Oranga Tamariki, 2017; Osmond & Tilbury, 2012; Tilbury, & Osmond, 2006).

Options for permanency outcomes in care generally include: family preservation; return home (reunification); transition to independence; and permanency with kin or non-kin care

(Tilbury, & Osmond, 2006). This research focused on the latter permanent care process and the contact literature explored, in the literature review, also focused on contact rationale for permanency with kin or non-kin. The terms permanency and permanent placement refer to the process where children in care are placed in new homes with caregivers who will provide love and nurture through to adulthood, and this is considered a fundamental aspect of the State's care of children (Cook, 2013).

Permanent Care: The New Zealand Context

In New Zealand, the ways in which permanent care is provided for a child has undergone significant changes. In previous years adoption was a permanency option for those children requiring alternative care arrangements. *The Adoption Act* (1955) is the legislation in New Zealand which offers to a child or young person the greatest legal security and protection in their new family arrangement (Smith, 2012). However, in New Zealand adoption was not embraced as enthusiastically as was the case in other countries (Atwool, 2008). In addition, there has been a drastic decline in domestic adoption in part due to changes in societal attitudes around illegitimacy and single parenthood and the increased availability of abortion, leading to changes in social work practices (Cooke, 2014; Loxterkamp, 2009).

In New Zealand, furthermore, the legal relationship between the child and birth family, despite any issues, maltreatment or abuse, appears highly valued and privileged. The *UNCROC Fifth Periodic Report* by the Government of New Zealand (2015), notes that Oranga Tamariki seldom use adoption orders as adoption severs the legal relationship between child, birth parent(s) and birth families. Judges have sometimes refused to make adoption orders, considering instead that the child's interests would be better served with orders under the *Care of Children Act* (2004), given it does not extinguish legal relationships between the child and their birth family (UNCROC Fifth Periodic Report by the Government of New Zealand 2015). Subsequently, despite the certainty and security provided for a child (and caregivers), via adoption, this is no longer a part of permanency thinking and practice in New Zealand (Cooke, 2014; Smith, 2012).

The preferred legal options for those children unable to remain or be reunified with birth family includes permanency with kin or non-kin caregivers via application for orders under the *Care of Children Act 2004* or the *Oranga Tamariki Act 1989* and these are now discussed

along with other legal frameworks such as the *United Nations Convention on the Rights of the Child* and the *United Nations Guidelines for the Alternative Care of Children*.

Legislative Frameworks for Contact

The legislation for children in care in New Zealand is the *Oranga Tamariki Act* (1989). It is the mechanism which provides the mandate for social worker intervention and through this legislation there is a clear framework for decision making (Atwool, 2010). The Act emphasised the devolvement of decision-making, from the state to the family, which in many respects epitomised the social nature of the general deregulation occurring at this time (Bartlett, 2007). The Act resulted from the government listening to those most affected by social service legislation and practice and utilised concepts from indigenous Māori culture (Bartlett, 2007). It subsequently radicalised how decision-making occurred for children, young people and their families through a clear shift towards the involvement of, and consultation with, whānau/family (Atwool, 2010). In line with this, the *Family Group Conference* (FGC) model was introduced into the statutory child protection and youth justice systems as a family decision-making mechanism (Dyson, 2007). This legislative model required families to partner with social workers and other key players in the decision-making process for children and young people and required the Ministry to include and, wherever possible, be led by the families (Dyson, 2007).

In relation to contact, several key elements are found in the principles of this Act, notably in sections 5 and 13. These include: informing family; involvement and participation of the family; where possible maintaining family relationships; and removal of a child only if there is a serious risk of harm (Oranga Tamariki Act, 1989). The Act's legislative framework for contact is also found in Principle 5 which states that the relationship between the child or young person and their family should be maintained and strengthened, wherever possible. As Mossman (2004) notes, decision-making around placement and contact has to take these significant relationships into account.

United Nations Convention on the Rights of the Child (UNCROC)

Additional legislative frameworks that help guide practice in relation to both permanency and contact, include the *United Nations Convention on the Rights of the Child (UNCROC)* and the *United Nations Guidelines for the Alternative Care of Children*. In 1989 the United Nations adopted UNCROC and this was ratified by New Zealand in 1993. As Cooke (2014) states, “it does not override domestic law but creates obligations under international law and requires domestic law to be interpreted so as to accord with it” (p.182). The provisions of UNCROC have been reflected explicitly in New Zealand law with sections 5 and 13 of the Oranga Tamariki Act being compared with the Convention (Cooke, 2014).

On the 20th November 2009, the United Nations General Assembly endorsed the United Nations Guidelines for the Alternative Care of Children (guidelines) in honour of the 20th anniversary of UNCROC. These guidelines, focusing on alternative care for children, were developed following recognition of gaps in relation to the rights of children in various policies and practices, and provided a comprehensive rights-based framework, which Atwool (2010) considers New Zealand, is generally, consistent with. For children who are unable to live with their parents, or are at risk of separation, the guidelines outline how they should be cared for. If followed, they help ensure that all children enjoy the rights written down in UNCROC and other international laws (Save the Children, 2017).

The guidelines state that efforts need to be made to keep children in, or returned to, the care of the family. When this is not possible other appropriate and permanent solutions need to be found (Guidelines for the Alternative Care of Children, 2009). In relation to contact, UNCROC protects the rights of children, separated from their birth families, to have personal relations and direct contact on a regular basis with both of their birth parents, unless this is not in the best interests of the child (Article 9). However, it has been identified that the concept of rights, outlined in UNCROC, produces some tensions (Kelly & Mullender, 2000). These rights are determined for children where a safe family context is assumed and, as such, does not necessarily reflect some of the more complex familial experiences of conflict and abuse which many children are exposed to (Bullen et al., 2015; Kelly & Mullender, 2000).

Legal Options for Permanency

In New Zealand, there are two main legal pathways to achieve permanency with a child or young person. These include orders under the *Care of Children Act* (2004), often referred to as the acronym COCA, or order options under the *Oranga Tamariki Act* (1989) including the recently introduced *Special Guardianship*. As Cooke (2009) outlines, these two legal frameworks enable the transition for a child to move from one family to another. How these legal options relate to the issues of birth family contact, are also identified.

The *Care of Children Act*, 2004 replaced the *Guardianship Act* of 1968 and includes provision for custody (now termed day-to-day care), guardianship and contact with non-resident parents. When foster parents agree to progress permanency for children and young people, they have primarily been encouraged to apply for parenting and guardianship orders under this act. When these orders are granted, custody and guardianship orders held by the Ministry are discharged. However, the birth parents can (and usually do) remain as guardians (Atwool, 2010; Jackson & Gibbs, 2016). A Parenting Order can also be used to ascribe contact arrangements for birth relatives (Jackson & Gibbs, 2016).

Unlike adoption, orders under the *COCA* (2004) require the child's new family to work with the birth parents, "as a result of their shared guardian status" (Cooke, 2009, p. 4), unless there is a sole guardianship order in favour of the caregivers. However, as Ward (2005) notes, this is rarely granted in New Zealand. When permanency is achieved under the *COCA* (2004), the birth family, as 'eligible persons' defined in the act, are able to make applications under s47 (1) for a parenting order for contact (Cooke, 2009). Furthermore, the right to make such applications has no limitations (Cooke, 2009). This legal right to challenge has implications for permanent caregivers. Worrall (2005), in the research report commissioned by *Grandparents Raising Grandchildren*, outlined anecdotal feedback indicating that many caregivers experienced legal challenges to their custody and guardianship status.

As Atwool (2008) outlines, however, securing legal permanency via the use of guardianship orders is not necessarily straight forward and has some tensions. Ward (2005) came from the U.K. to review New Zealand's use of guardianship orders and to explore those factors which made guardianship a successful concept. Twenty kin and non-kin guardians were interviewed with five key issues identified, including: fear and cost of legal challenges; confrontation with

the birth families (particularly in regard to contact arrangements); lack of a buffer provided by the agency; economic impacts; and poor quality social work planning and advice (Atwool, 2008; Ward, 2005).

A measure of permanency can be achieved for children and young people, with caregivers taking s101 and 110 orders (custody and additional guardianship) under the *Oranga Tamariki Act* (1989). ‘Permanent’ care within this route can also offer a transitional period, enabling caregivers to develop confidence before progressing to applications under the *COCA* (2004). This confidence can at times be related to the ongoing management of birth family contact arrangements. However, caregivers who take orders under this act are no longer considered ‘permanent’ caregivers under the recently introduced legal definitions and are not eligible for supports from the newly created *Permanent Caregiver Support Service* (Permanent Caregiver Support Service, 2017). Unlike ‘permanent caregivers’ they can, however, still have Services Orders to support the care needs of the child or young person in their care.

However, in July 2016, New Zealand followed England’s lead with the implementation of *Special Guardianship* into the *Oranga Tamariki Act* (1989) - sections 110-113 (Jackson & Gibbs, 2016). This was an alternative means of securing custody and guardianship for permanent caregivers and the children in their care. The objective, according to Cooke (2014, cited in Jackson & Gibbs, 2016) is to “enhance legal and subjective placement permanence through the provision of greater security to the permanent care arrangement whilst maintaining a child’s relationship with their birth parents” (p. 329). This is notable in relation to the inherent tensions and issues mentioned previously for caregivers. There is increased security for children and caregivers via this order as it provides guardians with day-to-day care until the child reaches 18 years of age. Further, it allows the ongoing roles of guardians to be specifically based on what is best for the child and enables the Court to determine which guardianship rights will be shared between the special and existing guardians and what rights (if any) will be held exclusively by the special guardian (Oranga Tamariki Practice Centre, 2017). A caregiver with exclusive guardianship rights still has to inform the other guardians when they have exercised those rights. Despite the Court being able to provide exclusive guardianship rights, the Ministry’s starting position is always that guardianship rights are shared with the birth parents/other guardians (Oranga Tamariki Practice Centre,

2017). The order must specify the contact along with other rights, including any terms or conditions that apply to those rights.

Contemporary Developments in Permanency

Permanency outcomes have been a focus for the Ministry for a number of years and can be seen in the CYFS previous 2006 permanency policy. However, in 2010 a new policy, Home for Life (H4L), was announced, which had a renewed focus on achievement and timeliness of permanency for children and also aimed to provide a range of financial and other support to caregivers (Jackson & Gibbs, 2016). There were a number of issues raised by professionals and caregivers in regards to the previous H4L policy. Some of these concerns related to the limitations of the 3-year support package. This was notable given that many issues for a child may not have been known at the time permanency was achieved, but evidenced later, well past the 3-year support package timeframe (Cooke, 2014; Jackson & Gibbs, 2016). A significant barrier, however, was that of the limited legal security and protection for caregivers.

The Special Guardianship legislation is therefore considered a pathway to help address some of the inherent short comings of H4L (Jackson & Gibbs, 2016). Subsequently, various amendments were made to the *Oranga Tamariki Act* (1989) and were implemented from July 2016. This saw the emergence of new forms of support to permanent caregivers (Cooke, 2014) along with new definitions of permanent caregivers. *Appendix A* provides an overview of how a permanent care arrangement is now achieved including ‘permanent carer’ definition and supports. The general supports available to caregivers, prior to and once they obtain permanency, are similar to those outlined in the previous Home for Life policy including, for example, the baby care start-up package, payment of legal fees and the \$2500 payment. The notable differences, however, are the introduction of the Permanent Caregiver Support Service and the 12-month support plans, which are reviewed annually with caregivers.

Permanent Caregiver Support Service

From July 2016, the Chief Executive of Oranga Tamariki Ministry for Children imposed a new duty, that of providing financial and other supports to permanent caregivers. The provision of these supports for permanent caregivers, is coordinated by a non-government (NGO) service; the aptly named Permanent Caregiver Support Service (PCSS) have delegated responsibilities from the Chief Executive (Permanent Caregiver Support Service, 2017). A 12 month support plan is developed for caregivers who require this, which outlines any specific services and supports needed for the first 12 months following the discharge of the Chief Executive's orders (Oranga Tamariki Practice Centre, 2017). These plans can also outline provisions and services that might be required for permanent caregivers in relation to the issue of contact; such as supervision and other related costs. Any supports required following those 12 months, are negotiated directly between the Permanent Caregiver Support Service and the permanent caregiver (Oranga Tamariki Practice Centre, 2017). For a more detailed understanding of the criteria for assistance for permanent caregivers, see Appendix B.

Summary

The process of 'how we do' permanency has undergone significant changes in New Zealand, notably, since July 2016, with the introduction of the Permanent Caregiver Support Service and also the Special Guardianship legislation. How either and or both of these developments might impact on contact for permanent caregivers is yet to be fully ascertained. The permanency landscape of New Zealand, as outlined in this introduction, perhaps highlighted some of its murkiness and tensions. It is within this milieu that social workers and caregivers also have to grapple with the difficulties and intricacies of contact between the child and birth family. It is to these issues and context that the literature review concerns itself and focuses on.

Thesis Structure

The thesis is structured as follows:

Chapter Two reviews the literature and relevant research related to this topic. The chapter is divided into two sections: the first explores theory and rationale for contact; and the second examines those factors which are seen to contribute to more successful contact experiences.

Chapter Three discusses the methods and methodology utilised for this research. Research reflections and limitations conclude this chapter.

Chapter Four presents the findings or voices of the caregivers. This chapter has three sections. The first provides a general overview of participants and contact arrangements. This is followed by the key themes identified by participants including: contact experiences; ‘just told’; lack of information; limited support; and relationships matter. The chapter also outlines caregiver views of helpful social work practice along with recommendations and key messages.

Chapter Five analyses the findings in relation to the literature reviewed in Chapter Two. Also examined here are factors which are seen to contribute to the issues identified by caregivers involving; paradigm gap; managerialism; and workload and clarity. An implication for practice is highlighted here.

Chapter Six provides a summary of the findings and concludes with future research recommendations and practice and policy recommendations.

CHAPTER 2: LITERATURE REVIEW

The aim of this research was to explore caregiver experiences of social work practice in relation to contact planning. This literature review, therefore, examines the theory and relevant research in order to outline what is already known about the research area and to justify and position the research questions. The review provides both a background to the research and a platform to help establish how the research will contribute to the field (Bryman, 2016). The first section explores the theory and rationale that underpin contact planning for permanency, including: attachment; psychological wellbeing and identity. Contact for family reunification was not included in this review due to the focus being contact when children are not returning to birth family care. In the second part of this review, attention is paid to social work practices which contribute to more successful contact outcomes, including: understanding purpose of contact; assessment; training and support; relationship; the intersecting world and consultation.

Contact Theory and Rationale

The following section outlines the main theory for contact, attachment, and other rationale for contact when children are not returning to birth family care, including, psychological wellbeing and identity.

Attachment Theory

Attachment is generally described as a tie, emotional bond or enduring relationship between a child and others, notably an infant and primary caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). Children develop secure attachments when they are in relationship with a primary caregiver who provides sufficiently sensitive, responsive, loving, attuned, consistent and available care (Howe & Steel, 2004). Attachment theory is considered one of the most popular theories for those working in the field of child protection (Barth, Crea, John, Thoburn & Quinton, 2005). For children in care, this theory has: recognised the impact on development of close social relationships; helped outline the possible risks associated with multiple caregiving; and assisted caregivers to understand the lack of close relationship they may experience with children who have been subject to adversity prior to placement with

them (Barth, et al., 2005). Attachment theory in relation to contact is often considered when a return home goal is in place, although the theory can be incorporated into various aspects of practice and planning (Mennen & O'Keefe, 2005).

Maintenance of birth family contact is seen to help alleviate the separation distress experienced by the child and enables their healthy development to continue (Prasad, 2011). For young children frequent and prolonged visiting patterns with birth parents are seen as essential for attachment relationships and vitally important for children removed under three years of age who are understood to experience stress and anxiety which may be particularly harmful (Haight, Black, Mangelsdorf, Giorgio, Tata, Schoppe, & Szewczyk, 2002; Haight, Kagle & Black, 2003; Scott, O'Neill & Minge, 2005). For Lucey, Sturge, Fellow-Smith and Reder (2003) ongoing contact between children and a birth parent, who was an attachment figure, is important as denying contact may threaten security and identity for a child.

Some literature has highlighted links between the maintenance of a child's attachment with birth parents and the development of later attachments with others including caregivers. The research of Milan and Pinderhughes (2000) found that children viewed their caregivers more positively and formed stronger attachments when they had a positive representation of self and their birth mothers. U.S. research by McWey and Mullis (2004) found that those children, with reunification goals, having frequent and consistent contact had stronger attachments than those experiencing less contact. These authors noted that a child may be unable to form attachments with others if they cannot continue attachment relationships. They concluded that if contact is one of the only ways to preserve attachment and provides the child with the capacity to form new attachments throughout their life, then it needs to be well considered in case planning (McWey & Mullis, 2004).

Other research in contrast indicates greater complexities for children. Poulin's (1985) study found that children strongly attached psychologically to their birth families were those most adversely affected by long term care with ongoing contact for this group strengthening their birth family attachment and increasing loyalty conflicts. Similarly, Leather's (2003) U.S. research concluded that frequent contact was associated with stronger ties to the birth family; however, loyalty conflicts could emerge making it more difficult to develop ties to the foster family. Atwool (2013) rightly questions whether separation for children with strong

connections to their birth family is in their best interest and whether the preferable option is to provide enhanced interventions to support the birth family's ability to care for the child.

Where the issue of attachment and contact decision-making appears more complex is when there may be little to no attachment between parent and child. A significant number of children who enter the care system do so as a result of parents being unable to meet their care and/or protection needs along with poor, insecure or no attachments to their families (Mennen and O'Keefe, 2005; Taplin, 2005; Schofield & Beek, 2005; Steinhauer, 1991). Furthermore, maintaining dysfunctional relationships through contact might hinder more functional relationships from developing (Prasad, 2011; Scot et al., 2005). Contact for children, with poor, disorientated or disorganised styles of attachment, particularly without the benefit of any accompanying therapeutic work, may have a negative impact and be more harmful (Cleaver, 2000; Haight Kagle and Black, 2003).

The issue of attachment is complicated even further once a non-return home decision has been made for a child. It is contended that the relationship focus needs to shift instead to the 'attachment' between the child and the caregiver. Browne and Maloney's (2002) research concluded that contact should be minimised, particularly if it is likely to be disruptive or superficial, to enable the development of a healthy and uncomplicated attachment with the caregiver. Similarly, Barnardos Australia (2013) recommend that contact visits with birth families need to decrease to enable attachment between the child and their new family, with visits at an appropriate level to support this. However, Barnardos also recognise the situation may be different for older children and state that any pre-existing attachments with birth parents need to be acknowledged.

What is recommended is an assessment of any attachment strength between a child and their parent/s (Sinclair, Wilson and Gibbs, 2005; Taplin, 2005). For Taplin (2005) this must involve standardised assessments by professionals as opposed to contact observations by supervisors. This is additionally important given there can be confusion and lack of understanding by social workers about the concept of attachment (Taplin, 2005).

In general, attachment theory is important and assists and guides care and protection practice. However, the issue of attachment for children in care appears complex and assumptions cannot be made around the maintenance of attachment as a basis for frequent contact for all

children (Prasad, 2011). Further, as Mennen and O’Keefe (2005) note there is limited research on attachment behaviour for children in care and a far greater understanding is required around the ways in which parental separation, abuse and placement impact attachment. This is particularly important for those children who achieve permanency with or without attachment relationships with one or both parents.

Psychological Wellbeing

The widespread view is that, in general, contact between a child and their birth family is beneficial for children’s wellbeing and has a positive effect (Cantos, Gries, & Slis 1997; Howe & Steele, 2004; Triseliotis, 2011). Most children continue to want contact and some remain constantly hopeful of a return home (Atwool, 2008; Wilson & Sinclair, 2004). Furthermore, the desire for contact appears strong even in situations where children have experienced maltreatment and abuse at the hands of birth carers (Cantos, et al., 1997; Sanchirico, & Jablonka, 2000).

Research has demonstrated positive connections between birth family contact and children’s psychological wellbeing and functioning (Milham, Bullock, Hosie and Haak, 1986; Weinstein, 1960). McWey, Acock and Porter (2010), examining the impact of continued contact with biological parents upon the mental health of children in foster care, found that contact frequency (with the birth mother) was marginally associated with lower levels of depression and lower externalisation of problematic behaviours. Similarly, data produced from Fanshel and Shin’s (1978) longitudinal U.S. study also highlighted a connection between lack of parental visitation and emotional turmoil for children.

However, other research indicates familial contact does not necessarily produce positive outcomes or the same level of benefit or psychological wellbeing for all children (Schofield, Beek, Sargent & Thoburn, 2000; Osborn & Delfabbro, 2009). Fanshel and Shin’s (1978) research also revealed that children visited more frequently, appeared to cope less in the foster care environment and found it difficult to manage the emotional confusions of having two sets of parents. For Barber and Delfabbro (2004) the relationship between contact and a child’s psychosocial adjustment is complex. Their research showed that children in direct contact with birth parents, after two years, displayed significantly poorer psychological adjustment. Research has also shown that for some children, birth family contact is

experienced as distressing (Gean, Gillmore & Dowler, 1985; Macaskill, 2002; Wilson & Sinclair, 2004). For Macaskill (2002) what occurred, at times, during contact was considered further emotional abuse. Osborn and Delfabbro (2009) recommended further research occur particularly for those children with greater behavioural and emotional maladjustment than the children in their study. This would be important when permanency is achieved for those children with significant and challenging needs with varying contact arrangements in place.

For others a degree of caution is suggested around seeing a direct relationship between children's emotions and behaviours following contact with the actual contact experience itself. A U.K. study by Monck, Reynolds and Wigfall (2003) suggested caregivers were especially sensitive to signs of distress in the children and tended to attribute this to birth family contact per se. Whilst contact can be unsettling for many children there are potentially a range of other factors which may impact on children's wellbeing including: long car journeys; strange environments; disruptions to routines; the familiarity of those who take the child to contact; and also a child's ability to pick up on caregiver's anxiety or mistrust of contact, and subsequently experience similar emotions (Monck et al., 2003; Trisleotis, 2010).

One group where particular attention and assessment may be required is adolescents. Moyers, Farmer and Lipscombe (2006) argue that much of what informs the issue of contact does not make a distinction between issues for young children as opposed to those of adolescents. Their British study, involving caregivers, young people and their social workers, indicated that contact was problematic for the majority of the young people and significantly impacted on placement outcomes.

Another group of children for whom contact, particularly direct contact, may be more problematic are those children who have experienced trauma, disordered attachment, extreme maltreatment, sexual and/or emotional abuse. For these children cessation of contact is recommended with certain family members or for a period of time to ensure they do not experience re-traumatisation and assist them to feel secure (Howe and Steele; 2004; Wilson and Sinclair, 2004).

The research examined here suggests that contact alone does not necessarily contribute to positive psychological outcomes for all children to the same degree. As such, arrangements

for children based on assumptions about its psychological value, or otherwise, could range from unhelpful through to unsafe.

Identity and Cultural Connection

Knowing their origins and who their parents are is an enshrined fundamental right for all children (Ainsworth & Hansen, 2017). Contact is seen as a means to maintain links and cultural connections, support self-esteem, assist with personal and familial identity and history, sustain positive relations with birth families and help children manage their dual identities (Ainsworth & Hansen, 2017; Bullen, Taplin, Kertesz, Humphreys, & McArthur, 2015; Beek & Schofield, 2004; Smith & Logan, 2004; Thoburn, 2004; Wilson & Sinclair, 2004).

The issue of contact to enable identity and connection is particularly important for children in permanent care who are not returning to birth family. For these children, regardless of the permanency goal, their roots and heritage belong to them (Maluccio, Fein & Olmstead, 1986; Scott, et al., 2005). It is recommended that when children are unable to have contact with birth parents attempts are made to establish contact with other safe birth relatives who can help provide information and a cohesive narrative to children about their familial history (Boyle, 2017). Boyle's systematic review also found that caregivers "were more positive about contact with grandparents than birth parents" (p. 30). Notably, these family members were at times integrated into the caregivers' extended family. Importantly, this 'collaborative approach' helped support children's dual identity. Kiraly and Humphrey's (2012) Australian research indicated that extended family members, including aunts, uncles, cousins and grandparents were frequently noted by children as important and sometimes more so than the parents.

The development and understanding of cultural identity is considered crucial for children of indigenous cultures. Lack of cultural connection is seen to produce greater negative outcomes including poorer mental health and wellbeing (Tilbury and Osmond, 2006). Thoburn's (2004) research found links between birth family contact and increased ethnic and cultural identity and pride which was important for those children placed outside their ethnic or cultural group. This has particular relevance in New Zealand due to the over-representation of Māori children in care, many of whom are not placed with kin caregivers, despite the legislative

emphasis (Atwool, 2013). For children and young people who have experienced adversity, positive connection to cultural identity is seen as an important protective factor and helps support resilience (Atwool, 2013). The issue of cultural identity is made more complex due to the diverse and multiple expressions of identity. Children in the care and protection process, like the population at large, are likely to have “cultural identities” (Keddell, 2007 p.54). The *Oranga Tamariki Act* (1989), however, presumes cultural identity to be singular and Keddell (2007) rightly queries how this will be traversed for those children who identify with multiple cultural groups? This presents opportunities and challenges for practitioners and caregivers in relation to maintaining contact for this purpose.

Birth family contact can also provide an opportunity for children to understand the reasons they were removed and placed in care - including parental limits and ability to provide care (Bullen & Taplin et al., 2015; Kenrick, 2010; Prasad, 2011; Sen & Broadhurst, 2011; Taplin, 2005). However, this is not necessarily a natural outcome of contact itself; but would instead need to be purposefully and intentionally built into the contact arrangements by practitioners, including for example life story books. When children experience a lack of information about their family they can begin to fantasise their past and what they do not know. These fantasies can unsettle or undermine the child’s ability to accept their permanent placement and can also lead to alienation, relationship and identity issues, particularly in adolescence, with the new family and beyond (Turkington & Taylor, 2009).

Some form of ongoing contact with birth parents is essential for children and young people’s sense of self and identity. If birth parents cannot or elect not to be involved then attempts should be made to establish safe direct or indirect contact with other relatives who can help maintain connections and provide much needed familial information. This is particularly important for children of indigenous cultures. Having explored the theory and general rationale for contact, the following section identifies social work practices which can support quality and positive contact experiences.

Factors for More Successful Contact

The aim for children entering into alternative care with kin or non-kin is to achieve permanency through to adulthood. However, despite best intentions this option may fail as a

result of placement breakdown (Biehal, 2014). Placement breakdown is rarely the result of one single factor and is most often caused over time by various interactive processes. One such risk factor is that of birth family contact and it is imperative that practitioners attempt to mitigate those issues which can be anticipated and addressed. Factors which can help promote more successful contact outcomes are discussed in the following section and include: understanding purpose of contact; assessment; training and support; relationship; the intersecting world; and consultation.

Understanding Purpose of Contact

Successful contact outcomes can occur when social workers have a clear understanding of the purpose of any ongoing contact between children and birth parents and when that purpose is made overtly clear to all parties (Lucey, et al., 2003; Mossman, 2004; Selwyn, 2004; Smith & Logan, 2004). Clarity around contact purpose is important as it can help provide understanding and rationale for associated frequency. An example of contact purpose and frequency is provided by Smith and Logan (2004). They state that if contact is about providing opportunity for identity development, then it does not need to be as frequent and subsequently as obtrusive on children and their new family's ability to develop and sustain their own sense of identity. Alternatively, when contact purpose is for reunification then it is generally set at a more frequent level to develop relationships and support a successful return home (Mossman, 2004). Mossman (2004) cautions however, that if the primary purpose of any on-going contact is only for identity and there are a raft of other problematic issues then this needs to be considered carefully as any on-going contact "may prove to be not only counter-productive, but injurious" (p.5).

When the goal becomes permanency with kin or non-kin then the contact purpose generally focuses on the child's development of security in their new home (Barnardos, 2013; Mossman, 2004). Barnardos (2013) also warn that unrealistic contact plans can put a child's placement with caregivers at risk. Contact arrangements need to ensure a balance between the caregivers' desire to claim the child and the needs of the child to feel like they belong in a new family, along with maintenance of some form of meaningful relationship (or connection) with birth families (Selwyn, 2004). Contact frequency, therefore, needs to attempt to balance these factors and be focused on children's needs, safety and well-being.

The purpose of contact in relation to frequency may need to be considered differently for those children who achieve permanency at an older age and have meaningful connections established with their birth family. For Mossman (2004) the purpose of contact in such situations is to enable the child or young person to “...maintain contact with the biological family to know their roots and to understand and appreciate the place of their biological parents in their life” (p.9). In general though, there needs to be congruence between the permanency goal and ongoing contact arrangements (Cooke, 2009).

At times there may be occasions when contact does not serve a clear and child-focused purpose and in these instances suspension or complete termination of contact is appropriate. Situations warranting contact cessation include those previously discussed involving serious abuse and maltreatment of a child or parental behaviours which attempt to sabotage, undermine or are non-accepting of the permanent placement (Derrick, 2004; Howe & Steele, 2004; Mossman, 2004; Wilson & Sinclair, 2004).

Contact, whatever its purpose should always benefit the child, promote emotional stability and feelings of safety and is only likely to meet a child’s needs if it involves relationship with a birth family member who has some positive meaning for them, or significantly, the potential to build one (Lucey, et al., 2003; Carvalho & Delgado, 2014).

Assessment

A critical factor for contact planning is that of clear and robust social worker assessments. Children and young people do not experience quality, safe or enjoyable contact by chance (Wilson & Devaney, 2018). A number of factors need to be considered with robust assessment seen as the key social work practice (Wilson & Devaney, 2018). However, contact assessment and associated decision-making for social workers is recognised as a difficult area with little in the way of policies or research to guide social work practice or recommendations around what criteria should be utilised to support decision-making (Thompson, 2019; Triseliotis, 2010). In part, this is connected to the number of variables involved and familial complexities which means that decision-making also needs to occur on a case-by-case basis (Thompson, 2019).

Subsequently, when assessing and developing contact plans, social workers need to ensure there is case specificity and the avoidance of generalised approaches (Atwool, 2013; Boyle, 2017; Cooke, 2009; Sen & Broadhurst, 2011; Triseliotis, 2011; Wilson & Sinclair, 2004). A helpful viewpoint is provided by Selwyn (2004) who states that what is required is for practitioners to move “beyond generalisations of whether contact is harmful or beneficial, and to consider for which children, in which circumstances and by which means, contact should be promoted or ended” (p.162). Given this, there is the need to avoid potentially unhelpful social work practices involving one-size-fits-all mentalities, general rules of thumb or simplistic formulae for contact planning (Leathers, 2003; Neil & Howe, 2004).

An important area of contact assessment is that of birth family history. This includes, dynamics, quality of relationships, birth parent/child pre-care characteristics and the success or otherwise of previous interventions (Selwyn, 2004; Sen & Broadhurst, 2011). The views of children, where appropriate, are also important when assessing contact. Research has shown that children and young people have diverse views in regards to contact mode and frequency and desire a degree of agency with contact arrangements, including: who they do and do not want contact with; and differentiated contact arrangements with different family members (Atwool, 2010; Kiraly & Humphrey, 2012; Selwyn, 2004; Wilson & Sinclair, 2004). Assessment also needs to view children, even if placed in sibling groups, as individuals who may require individual plans (Lucey, et al., 2003; Selwyn, 2004). Children and young people have very different experiences of their birth families, including relationships within, roles held, levels of maturity and differing experiences of abuse (Selwyn, 2004).

Assessment of contact also needs to take account of the developmental needs of the child and also the ways in which these may change over time (Beek & Schofield, 2004; Mossman, 2004; Prasad, 2011; Sen & Broadhurst, 2011). The caregivers in Atwool’s (2010) research identified issues including inflexible arrangements and the impact this had on children as they got older and wanted to participate in sport and other activities. This inflexibility in arrangements often led to children missing out on their new family’s trips and events which were not seen to be in the child’s best interests.

Additional areas for assessment include the contact experience itself and associated domains, such as: birth family support of the caregivers; parental behaviours and responsiveness; the perspectives of caregivers and their capacity to manage contact; cultural considerations;

geographical, practical and financial considerations; therapeutic needs; and the overall needs of the placement (Mossman, 2004; Cherry, 1994 & Hess, 1988 as cited in Scot et al., 2005; Sen & Broadhurst, 2011).

In summary, contact arrangements require robust social worker assessments of a range of issues and in particular be attuned to the voice of children along with the specific and unique needs of the child, their new family and birth family.

Training and Support

One of the most significant social work practices for successful contact is for caregivers to be well informed, trained and supported with contact arrangements (Logan & Smith, 2004; Neil, 2004; Sen & Broadhurst, 2011). Caregiver support and training is important due to difficulties that can occur in the contact arrangements, the behavioural issues that children can present prior to and following visits or the emotional complexities when engaging with birth families. Research both in New Zealand and internationally has highlighted, however, that caregivers do not receive adequate or appropriate support with contact, despite having to manage complex contact issues with birth families (Atwool, 2010; Murray, Tarren-Sweeney, & France, 2011; Morrison, Mishna, Cook, & Aitken, 2011; Sanchirico & Jablonka, 2000). Contact support for caregivers involves more than just receiving the relevant practical or logistical information about the contact arrangements - such as transport, parameters, venue, and frequency. In addition, caregivers need support and training to understand and manage their emotional responses, anticipate issues that can emerge and how they can appropriately respond (Logan and Smith, 2004; Tilbury & Osmond, 2006).

Contact support is particularly significant for kin caregivers. In contrast to non-kin, these caregivers can experience additional complexities which emerge from their natural pre-existing familial histories and dynamics (Bullen, Taplin, Kertesz, Humphreys, & McArthur, 2015). The often-dual nature of the family relationships, such as being both caregiver and parent, can be particularly difficult to manage and may produce loyalty conflicts (Boetto, 2010). Kin caregivers require specific training and support to help address issues such as conflict resolution, grief and loss and support with contact (Boetto, 2010). Research also highlights that grandparent caregivers, in particular, can experience complex and difficult familial relationships, role-identity issues and high levels of anxiety and stress (Backhouse &

Graham, 2012; Dunne & Kettler, 2007). Backhouse and Graham (2012) identified the need for practice to address the complex experiences for these caregiver roles.

Generally, quality contact outcomes are more likely to develop when caregivers receive appropriate support and training to help understand and manage children's behaviours, anticipate issues and work through their own emotional responses. Kin caregivers in particular require additional support to help them deal with the added complexities of familial relationships and dual or multiple roles.

Relationship

Our sense of self and everything learnt about life, and being human, is seen to occur in the context of relationship (Megele, 2015; Saleebey, 2013; Trevithick, 2014). Social work occurs through the medium of warm, empathetic, supportive relationships considered to be the key to effective practice generally (Buckley, McArthur, Moore, Russ, & Withington, 2019; Coady & Lehmann, 2016; Howe, 1998; Megele, 2015; Ruch, 2004; Trevithick, 2003). The significance of relationship is highlighted in emerging indigenous perspectives. Mafile'o (2019) outlines that relationship, as a principle, is embedded within a mode of thinking and operating inherent to Pacific culture. Similarly, relationality is central to a Māori worldview. Māori regard both the intrinsic value of a person along with the contribution they make to the wellbeing of the group and as such Māori highly value relationship - one to another (Mead & Grove, 2001, as cited in in Montgomery, 2009). These core beliefs in turn determine a person's relational and social obligations and commitment to the whānau (family), hapu (extended family) and iwi (tribe) (Montgomery, 2009).

For work with caregivers specifically, there needs to be a relationship of trust between caregiver and social worker which involves collaborative and respectful relationships (Fuentes, Bernedo, Salas & García-Martín, 2018; Geiger, Piel, & Julien-Chinn, 2016). Positive and quality relationships between social workers and caregivers are required to help support placements and contact specifically, given its unique demands and to assist caregivers meet the challenges associated with caring for children who have suffered maltreatment and neglect (Buckley, et al., 2019). Research generally shows that caregivers express greater satisfaction when they are respected, seen as professionals, considered part of the team, involved in decision-making and their opinions are valued (Geiger, Piel,

& Julien-Chinn, 2016; Hudson and Levassuer, 2002; Morrison et al. 2011; Neil, Beek & Schofield, 2003).

Relational practice also requires practitioners to extend their focus to relationships and systems around the child. Social workers need to provide caregivers with appropriate training and support to manage contact as well as maintain positive relationships with the birth family (Beek & Schofield, 2004; Luu, Wright and Cashmore, 2019). Attending to birth family relationship is found to be particularly significant for kin caregivers who experience greater emotional complexity given their pre-existing relationships, familial dynamics and roles (Bullen, Taplin, Kertesz, Humphreys, & McArthur, 2015; Thompson, 2019).

Research indicates there are specific interpersonal and professional skills valued by caregivers that contribute to more effective working relationships (Geiger, et al., 2016; MacGregor, Rodger, Cummings, & Leschied, 2006). However, it is also recognised that effective relational practice can be impacted by systemic factors outside of individual practitioners and their personal qualities. For many, significant contributors to limited relational practice, not only with caregivers but also for clients and other service users, is that of managerialism and the adversarial risk-averse culture within child protection (Buckley, et al., 2019; Harlow, Berg, & Chandler, 2013; Keddell, 2014). Caregivers can experience the effects of the conflictual or adversarial nature of care and protection as staffing shortages, significant power differentials, complex relationships, exclusion from decision-making, role confusion, high staff turn-over and pressure on the workforce (Buckley, et al., 2019; Lonne, Parton, Thomson, & Harries, 2009; Withington, Burton, Lonne, & Eviers, 2016).

Relationship-based practice is critical and involves more than the development of collaborative and respectful relationships between practitioners and caregivers. It extends into contact planning practice that is attuned to relational systems and relationship support for caregivers and birth families - which has particular significance for kin caregivers. The following section builds on this concept by exploring the value of an intersecting world between caregiver and birth family and how this might support or benefit contact experiences.

The Intersecting World between Caregivers and Birth Family

The intersecting world for contact can include direct or in-direct communication, collaboration or engagement between caregivers and birth families and develops best when there is a positive relationship or at least respectfulness between the parties. Research indicates that the contact experience works better when there is some degree of overlap or collaboration between caregivers and birth families (Beek & Schofield, 2004; Boyle, 2017; Morrison et al., 2011). It is also identified that this overlap can help reduce anxiety for children or ease loyalty conflicts (Beek & Schofield, 2004; Jamal & Tregeagle, 2013). Beek and Schofield (2004) suggest that efforts should be made to develop positive relationships between the two families.

For some, the benefits of this intersecting world go as far as recommending contact occurring in the caregiver's home. Barnardos' Australia (2013) practice paper on child welfare decision-making considers this the ideal when it is safe for it to occur. Of note, however, is this requires the development of trust between the parties, which involves a significant relationship role again for social workers. However, others caution that contact occurring in the caregivers home can not only be inappropriate due to parental behaviours or attitudes but can be emotionally difficult for parents. Caregivers in Cleaver's (2000) study were resentful of the opportunities children had in the caregiver's home and felt greater scrutiny by caregivers. Of note is that the children expressed satisfaction with contact at the caregiver's home. Contact in the caregiver's home would need to be carefully assessed and skilfully addressed by practitioners with all parties.

Recent Scottish research from Sen and McCormack (2011) has indicated a general decline in carer involvement in contact; notably where contact occurs in the caregiver's home. The authors rightly queried that if caregivers had no involvement in parental contact they were unlikely to meet the birth parents at all, other than possibly at formal review meetings which do not always enable positive interactions between the parties. Sen and McCormack's research had a number of practice considerations which included: clear and thorough assessment of caregiver's involvement in contact; and importantly, the need for caregivers to be partners in the planning and arranging of contact.

The development of an overlapping world between caregivers and the birth family, where safe and appropriate, can support quality contact experiences. A number of factors do need to be carefully considered and highlighted was the significant role for practitioners in this process.

Consultation

A critical factor for contact planning is consultation with caregivers; those people who will be responsible once permanency is achieved for managing any agreed contact either directly through supervision or monitoring, or indirectly via contact preparation, managing logistics or transportation, and the general impact on their familial life and routines. Consultation with caregivers cannot be overstated given the knowledge they have about the child and that they are the ones who have to prepare children for contact and support them emotionally afterwards (Wilson and Devaney, 2018).

Caregiver consultation is important because often their views on what is manageable can be at odds with social workers and other professionals involved, notably given they are at the dynamic centre of the arrangements. Macaskill's (2002) research concluded that professionals' expectations were often unrealistically high in regards to the degree of contact that could be tolerated between children and birth families. However, research indicates that caregivers views generally are not valued and they are not consulted with or excluded from decision-making (Atwool, 2010; MacGregor, Rodger, Cummings & Leschied, 2006). For caregivers in Atwool's (2010) research, one of the greatest concerns expressed was the lack of consultation around the impact of contact on the child.

Other research indicates that consultation with caregivers can occur but is often not sufficient enough. Australian research by Osmond and Tilbury (2012) highlighted that caregivers' views, in regards to permanency planning, were often restricted to particular issues. The authors contended that the views and knowledge held by the caregiver is particularly valuable and should be actively sought by social workers.

Research also highlights that positive contact outcomes can develop when there is consultation between social workers and caregivers (Neil, Beek & Schofield, 2003; Nesmith, Patton, Christophersen, & Smart, 2017; Schofield, et al., 2000). Neil, et al. (2003) found that

when arrangements were not child-focused and did not involve consultation, contact experiences were unsatisfactory or distressing for the child and caregiver. In general, their research suggested that caregivers need to have a clear understanding that they are major stakeholders in decision making, including the issue of contact.

Caregiver consultation in regards to contact arrangements is essential, given their role and understanding of the child, yet research indicates that they are usually not included or consulted with. Morrison (2011) rightly states, that caregivers may feel undermined in their parenting role when they are not consulted around the child's contact arrangements.

Summary

Outlined in the literature review were the three main purposes of birth family contact, when children are not returning home: attachment, psychological wellbeing and identity. The literature is far from unanimous in regards to the related benefits of contact irrespective of its purpose. Highlighted instead was the complexity of the contact arena and that children and their caregivers can experience a range of positive and/or negative contact outcomes. Logan and Smith (2005) sound a note of caution and state that the research around the claimed benefits or otherwise of contact remain somewhat inconclusive. Quinton et al. (1997) similarly state that the present knowledge bases surrounding contact are not at a level of sophistication to enable confident assertions to be made about the benefits of contact irrespective of family circumstances and relationships. It is therefore concluded, that any social work contact planning based on assumptions about the benefits and value of contact for children is likely to be problematic. A critical element identified however, was the role that social workers play in this demanding area of practice (Austerberry, et al., 2013). Outlined, for practitioners, was the importance of robust contact assessments, consultation, relationship, training and support for caregivers along with greater case specificity which recognises the unique needs of individual children, caregivers, birth families and importantly the child within their new family. The following section outlines the methods and methodology of the research undertaken.

CHAPTER 3: METHODOLOGY / METHODS

The focus of this chapter is on the method and methodology of this qualitative research. Methods refers to the techniques and procedures utilised in the analysis and gathering of data (Cohen, Manion & Morrison, 2007). Methodology involves examination of the ideas, theories, philosophies that underpin, encompass or essentially hold the research in place (Carey, 2012). Methodology should assist the understanding of not only the product of enquiry but the very process itself (Carey, 2012; Cohen et al., 2007). Included here in this section is the philosophical positioning, research methods utilised, ethical considerations and limitations of this research.

Philosophical Positioning

Theoretical Perspective

The theoretical perspective utilised in this research was constructivist/interpretivist as this was seen as an appropriate fit for exploring with caregivers their subjective experiences in contact planning for permanency. The constructivist paradigm does not assume an objective reality but proposes that human experience can only be understood as a subjective reality (Morris, 2006). There is not, therefore, an objective truth waiting to be found, instead meaning occurs as a result of our engagement and interactions with the realities of our world. Meaning is seen to be sifted through people's prior experience as they build or construct their understanding of the external world – or interpret it (Rubin & Rubin, 2012). For constructivists, there are many possible interpretations from any single research project and the researcher is likely, at best, able to offer one of many possible interpretations of a participant's understanding of events (Carey, 2012). This approach stresses the importance of relationships and the impact of contingent factors such as knowledge, learning, tradition and culture upon people's perceptions and understandings of what constitutes reality (Carey, 2012).

Interpretive constructionists understand that people look at matters through distinct lenses and reach somewhat different conclusions. Multiple or conflicting versions of the same event can be true at the same time (Rubin & Rubin, 2012). In this position research can assume

multiple realities depending on the various perspectives of an observer and it is possible that the perspectives of the participants may differ dramatically from that of the researcher. However, for those who engage in qualitative research the prospect of multiple realities is seen as an opportunity, not a constraint. In fact, a common theme underlying many qualitative studies is to demonstrate how participants' perspectives may diverge dramatically from those held by outsiders (Yin, 2016). These aspects of interpretive constructivism were considered significant for this research given the known complexities of the issue of contact and how it is traversed, viewed and experienced by caregivers. It was important also to acknowledge that the perspectives of caregivers may have differed from my own, notably as an outsider in the process.

Whilst there are differing interpretivist theories, each share various common qualities or themes. These include a tendency to: try to understand the diverse and unique social worlds of research participants; concentrate upon the individual and the personal strategies of research participants; stress the centrality of participant's responses to external stimuli (symbols, knowledge, language, etc.); capture participant's subjective meaning of their own world; empathise with and, therefore, try to better understand research participants; allow participants to take a lead role within the research process rather than be directed by the researcher (Carey, 2013).

These elements of constructivism were also seen as having an appropriate fit and particular appeal as they resonate with social work thinking in terms of client empowerment, practitioners as partners, clients having expertise and other general strengths based practices (Saint-Jacques, Turcotte, & Pouliot, 2009). This also included wanting to enable the participants to have active involvement in the research process along with capturing their subjective experiences in their own words.

Research Design

Qualitative Approach

A qualitative approach has been utilised due to its ability to enable the researcher to conduct an in-depth study of the participant's experiences and views. This was important to enable the

researcher, along with the participants, to gain a richer understanding of their unique and individual experiences and views in relation to contact planning and its impacts. As Creswell (2013) notes, qualitative research is utilised when we want to have respondents share their stories and we want to gain a more detailed understanding of the phenomena being studied by talking directly with those involved.

Qualitative inquiry delves into and focuses on: how people understand and construct their worlds; how they make sense of and interpret their experiences; what meanings they attribute to their experiences; examination of social and institutional practices; barriers and facilitators to change; and the possible reasons for the success or failure of interventions (Merriam & Tisdell, 2016; Starks & Brown Trinidad, 2007). A critical aspect is understanding the question or phenomena of interest from the participant's perspectives, not the researcher's - the emic or insider perspective, as opposed to the etic, or outsider's view (Merriam & Tisdell, 2016). This research sought to explore with the participants not only their experiences of contact, and how they made sense of the contact 'journey', but also the practices that might have been significant or had impact on them; with the focus on those aspects that were helpful, enabling or challenging in the process.

As Lincoln and Guba (2013) note, the methodology appropriate to constructivism must be one that delves into minds and meaning making. The qualitative, interpretive research paradigm defines the methods and techniques most suitable for collecting and analysing data. Given qualitative inquiry has its focus on meaning in context, a data collection instrument is required which has sensitivity to underlying meanings when gathering and interpreting data (Merriam & Tisdell, 2016).

Data Collection

The method selected to collect the data for this research, therefore, was *semi-structured interview*. The interview was chosen as the research sought to unpack areas such as personal experiences, emotions, feelings and private matters, all of which, as Carey (2013) notes, are likely to produce rich details. The semi-structured interviews contained a combination of both pre-planned and unplanned questions; and standardised and open format questions. This format allowed discretion to create new questions in response to the participant's answers, the

ability to unpack or expand on answers that were a little unclear and for participants to have greater freedom to answer the question in their own words (Carey, 2012; Carey, 2013; Walliman, 2016).

The interview method was considered the most appropriate for exploring meanings in context, gathering the rich material and data and providing an authentic and meaningful account of the experiences with the participants. As Collins (1998, as cited in Willis, 2007) states, interviews are not fact finding endeavours, instead they are “negotiations between people who are creating understanding through the conversation” (p.137). In qualitative interviewing participants can be empowered to point out important features of the phenomenon or encouraged to reveal experiences that were not anticipated by the researcher (Elliott & Timulak, 2005). Caregivers in this research were invited to contribute thoughts or wonderings that were not covered by the interviewer to help ensure they had the opportunity to share all they wanted or needed to. This was consistent with values in relation to strengths based social work practice such as empowerment, working in partnership and ‘clients’ (or participants) as experts (Saint-Jacques, Turcotte, & Pouliot, 2009).

Sampling and Recruitment

For this research, purposive sampling was utilised to recruit participants. The logic of this approach was in the selection of in-depth “information rich cases that best provide insight into the research questions” (Emmel, 2013, p. 33). In purposive sampling the process of participant selection is a deliberate one which is based on their ability to provide the information required (Padgett, 2008). For qualitative research, in contrast to quantitative, sample selection is generally small, purposeful and non-random (Merriam & Tisdale, 2016). The focus of this research was caregiver experience of contact planning prior to permanency and the impacts (if any) of this post permanency. The criteria for participation in this research was:

- Participants were kin or non-kin caregivers;
- the participants needed to have achieved permanency in the past seven years (since 2010) with orders in their favour via the Care of Children Act (2004) or the more recent Special Guardianship (Oranga Tamariki Act, 1989) - with one or more children;

- the child/ren were previously in the care of Oranga Tamariki (previously Child Youth and Family) or another non-government service prior to going to permanency;
- there was a contact plan or regime in place prior to permanency and/or an expectation the caregivers would manage contact post permanency;
- the caregivers currently or previously managed some aspect of contact post permanency (acknowledging the possibility that some contact plans may have broken down).

It was intended that participant recruitment would occur through advertising with two fostering-related organisations. Advertising was considered an appropriate means of recruitment due to it being less likely to involve coercion (Padgett, 2008). These organisations were emailed with a general introduction and overview of the research (Appendix C). They had also been contacted prior to this as part of gaining ethics approval. The consent form and information sheet was also attached for any potential participants to review (Appendices D & E). However, this recruitment method did not yield any participants; with the researcher unclear as to whether the information was not able to be disseminated easily to members or whether this was simply not an effective means of recruiting participants. Eventually, and instead, snowball sampling was utilised which involved identifying a participant who fit with the criteria and asking them to recommend others (Tracey, 2013).

Interview Process

Data collection, as noted, occurred through the use of semi-structured interviews. This research involved six interviews with seven participants; including both kin and non-kin caregivers to contrast and compare their experiences. As Yin (2016) notes, ensuring the visibility of divergent views and experiences is important for study. This number was considered suitable as it was sufficiently large enough to maximise information (Yin, 2016) and to examine the various experiences in terms of any similarities and differences but small enough to enable a more in-depth study of the caregiver experiences.

Recommended participants were contacted by the researcher and were informed of the overall aims of the research and parameters. Those who fit the criteria and were interested in

participating were emailed a copy of the information sheet and the consent form. The potential interviewees were advised there would be follow up a week later so they had time to review the information sent to them. Interview times were then made with those who verbally consented to participating. The researcher took additional copies of the information sheet and written consent forms to the interviews. The consent forms were either collected from participants or completed with them prior to the interview commencing. An additional 'interview' occurred with a caregiver who thought she met the criteria, however, when conversation began with her, prior to formal interviewing, it was evident that this participant was significantly outside of the criteria. The inability to formally interview her as a result of this, was explained to the participant who was very understanding. However, her story was listened to, which was a particularly distressing one, and advice, support and information was provided - which was able to be given due the knowledge base from the researcher's previous role.

The remaining interviews ranged from sixty to ninety minutes in duration (see Appendix F for interview schedule). Four of the six interviews evoked a number of emotional issues where caregivers shared experiences that were distressing and concerning. Some of what was shared was difficult and supervision processes were well utilised to manage this along with use of the reflective journal. The interviews were audio-recorded and handwritten notes were also taken, which the participants were advised of, to help identify and summarise key points and other non-verbal cues evidenced in the interview process. A transcriber was contracted to undertake the transcription of the research and they signed a confidentiality agreement to ensure the privacy of the participants was maintained (Appendix G) - participants were also advised of this. It was acknowledged that the use of outsiders for transcription could limit the close relationship between the researcher and the data (Padgett, 2008, p.136). However, to help alleviate this the researcher ensured that there was ongoing familiarity with the material, which involved continual re-reading and immersion within the data.

Following data transcription, participants were emailed copies of their transcripts for them to review and make amendments. In addition to this two participants, as a result of their feedback, were contacted by the researcher and both verbally contributed additional information they felt had not been conveyed during the interview process. These notes were attached to the written transcripts. The transcription release authority (Appendix H) and a return envelope were sent in hard copy. These were all signed and returned by participants.

All names and identifying information were disguised in the public presentation of the research; however, this information was retained in the transcripts (Padgett, 2008).

Data Analysis

Data analysis is essentially about making sense of the data produced and is the process utilised to answer the research question. It involves consolidation, reduction and interpretation of what participants have said and the researcher has read (Merriam & Tisdale, 2016). For this research, the data was analysed using thematic analysis which involves a focus on the identification of patterns and themes (Carey, 2012). The patterns, attitudes, behaviours and experiences that emerged from the data were examined, combined and catalogued by the researcher to formulate themes and sub-themes (Carey, 2012).

Due to transcription occurring with an outsider the data was read repeatedly, over several weeks, which enabled an intimate and thorough awareness of the transcripts. The audio-recordings were also listened to on several occasions to ensure authentic connection to the participants' narratives. For Saldaña (2011), data intimacy helps accelerate analysis as you take "cognitive ownership of your data" (p. 95). Significant details, new insights, patterns, categories and interrelationships are clearer the more intimately connected you are to the data (Saldaña, 2011).

The transcripts were printed out and worked on manually for categorisation of the data. Category construction, according to Saldaña (2011), "is our attempt to cluster the most seemingly alike things into the most seemingly appropriate groups" (p. 91). Key words, thoughts, phrases or ideas were initially identified and highlighted on the transcripts. Reflections, wonderings or further questions, were noted on a separate journal as the data was repeatedly read through. This was a lengthy process involving constant review, and the use of supervision, to ensure that the research question and aims were addressed. Different colours were also used on the printed transcript copies when identifying themes and sub-themes. This helped make sense of the data visually and ensure relevant connections. Themes included extended phrases or sentences that summarised the apparent and underlying meanings of the data (Saldaña, 2011). A multi-page spreadsheet was developed where categorisation of the themes and sub-themes along with other connected data were recorded – colour highlighted phrases and sentences were cut and pasted here also. This process also served as a back-up in

the event of loss or corruption of the physical data. This analytic approach served to generate the most sufficient answers to the research question and present the research findings (Saldaña, 2011).

Ethical Considerations

The ‘social’ nature of qualitative research produces ethical implications, as was the case with this research, particularly when data gathering occurs via contact with participants (Carey, 2012). The unique challenges within qualitative research involve both the nature of the relationships developed along with, at times, the sensitive subject matter disclosed (Padgett, 2008). It is essential therefore, that ethical issues are anticipated and identified, although unforeseen issues may emerge at any time in the research process (Padgett, 2008).

This research met the requirements for Massey University’s *Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants*. The committee was advised of the proposed participants, recruitment methods, consent and collection, storage and disposal of records (please see Appendix I for the ethics approval letter). The committee sought clarification around several issues: The first involved potential debriefing support for participants (outlined further below); they also wanted to know how ethnicity data would be utilised along with ensuring a more formal process of consultation with Māori. The committee were advised that ethnicity data would be utilised to help provide a general context for the research. Also, given the small number of participants involved in this qualitative research, due care was taken not to generalise the reporting. The researcher also engaged in consultation with cultural advisors at various stages of the research process, given the identified interest for Māori communities.

Informed Consent

Informed consent means participants agree to research involvement only after being made aware of the purpose, methods and general procedures along with benefits and any associated risks (Reamer, 2001; van den Hoonaard & van den Hoonaard, 2016). The participants for this study were all provided with an overview of the aims, goals and participant procedures of this research and given full information about what might occur with any findings following

completion of the interviews (Carey, 2012; Padgett, 2008). Participants were also advised of the researcher's identity along with her current and previous roles. Explicit consent was obtained prior to the audio-recording interviews and participants were advised that they could withdraw all, or a section of, a recording (Padgett, 2008).

Voluntary Participation

For van den Hoonaard and van den Hoonaard (2016), voluntary participation involves participant consent that does not result from inducements, coercion or undue influence. Those involved in this research did so voluntarily and were also assured that they could withdraw from the research process at any time. Respondents, as noted, were eventually recruited via snowballing and were not coerced or tricked into participating in this research (Carey, 2012).

Privacy

As Padgett (2008) notes, the assurance of privacy to participants is vital, particularly in qualitative research where there is not the same safety in numbers as operates in quantitative research. Participants in this research were guaranteed that their privacy, along with the privacy of the children and birth families connected to them, would not be breached. No identifiable information was contained in the thesis and the caregivers were assigned a number in relation to the order of their interview. Furthermore, it was important to ensure that there was no identification in the research of the location of the participants, where it may have been possible to discern a participant's identity (June & Berg, 2017).

Particular attention was paid to the privacy of the children and birth families, as neither of these groups had agreed to participate in this research. No identifying names of the birth families or children were included in the research. When reference was made to these parties in the research they were simply referred to as the child or young person, birth mother, birth father or birth family. Any other case-specific information shared by the caregivers, which might have been identified by others, was carefully considered before it was included in the research. In addition, the locations of the families were also not identified in the research to assure privacy. Attention was also paid to the Ministry and non-government organisations

associated with the caregivers, along with any specific social workers who were not identified in this research.

Caregivers were advised, however, that breaches to confidentiality could not be guaranteed should they disclose abuse or maltreatment of a child in their care during the course of the interview; this was clearly outlined to participants. As Padgett (2008) outlines, reporting of abuse of a child is required for a registered practitioner who is also engaged in research. Caregivers were also advised that whilst the researcher would make all attempts to assure and protect confidentiality pro-actively, it is not possible to provide an absolute guarantee of confidentiality where information is recorded (Massey University Code of Ethics, 2017).

Data Management

The data was stored and managed responsibly. This included: identifier codes on data files; the lists of participants and their corresponding identifier codes kept separately in a locked cabinet; copies of transcripts also kept in a locked cabinet; and participant names and addresses were not stored on hard drives (Bryman, 2016; Holmes, 2012). A specific hard drive was also utilised to store information in the case of possible loss or corruption of data on the computer; this was only accessible by the researcher. The information form also outlined the agreement for the safe disposal of records and how this would occur. Participants were advised that the records would be kept for 5 years and then deleted from all computer records, including other storage devices, and paper copies which would be shredded.

Participant Respect

Respect was accorded to all participants to partially compensate them for their time participating in this research (Padgett, 2008). A gift voucher was provided to participants as a token of goodwill and participants were thanked for their involvement in this research. Carey (2012) identifies this as a significant ethical aspect within social work research given the more sensitive nature of the work and the potential vulnerability of those involved. Respect was also accorded to participants through the sharing of a copy of the summary of the findings following examination.

Harm to Participants; Debriefing and Support

The research questions involved personal experiences where it was acknowledged, that emotional or sensitive issues might have been raised during the interview process. Taking on the permanent care of a child is considered a significant and major life event for those involved. The issue of participant wellbeing had been raised for review by the Massey Human Ethics Committee who wanted to ensure that any debriefing support was not provided by the researcher. Subsequently, two fostering organisations were contacted and they agreed to provide additional support for participants, if required. Prior to the interviews commencing the researcher discussed with the participants that the interview may raise emotional issues for them. They were also informed that the researcher was unable to provide any debriefing, if required, at the conclusion of the interview. The importance of their own support networks and the option of connecting with those organisations who agreed to provide support were outlined. Only one participant became visibly emotional to the point that the recording needed to be paused. The participant attended to their own wellbeing and agreed to resume the interview as opposed to re-scheduling. No participants identified the need for further debriefing support with the organisations.

Bias

A significant reason for positioning my research in the constructivist/interpretivist paradigm, were the issues of bias objectivity and neutrality. The researcher's experiences, in the field of permanency, had already produced some awareness and wonderings about what might or might not occur for caregivers in the permanency journey, in relation to contact planning. Further, some practice thoughts and values were already held about this issue. Merriam and Tisdale (2015) note that it is important to identify any subjectivities or biases; monitoring these throughout the research process and providing clarity around how they might impact and shape the interpretation and collection of data. May (2001) states further, that the entry of experiences and values into the research process is not something that is shameful nor can they simply be eliminated. Instead, it is suggested that a critical exploration of values, and their relationship to the research, is necessary in order to provide justification for valid social research. This issue was significant as the researcher's role, as earlier mentioned, involved overseeing and managing a team of social workers who specifically advocated for caregivers

in preparation for permanency; with contact at times a difficult issue. For this reason, this issue was clearly outlined in the reflexive positioning at the outset of this research.

Research Integrity and Validity

Due to the greater flexibility in qualitative research, as opposed to other kinds of research, it is important to demonstrate how research has been conducted fairly and accurately (Yin, 2016). Research evaluation criteria, as proposed by Yardley (2000), was outlined in this research including:

- Rigour and commitment - substantial engagement with the subject matter and depth/breadth of data analysis;
- sensitivity to context - relevant literature, participant's perspectives, ethical issues;
- coherence and transparency - research methods and data transparency along with reflexivity;
- importance and impact - having a practical impact for practitioners and enriching theoretical understandings.

Research validity here was sought through informal member checking. Here participants had the opportunity to review the transcripts in order to ensure that the researcher had captured what they wanted shared and to provide the opportunity to identify errors or incorrect interpretations (Lincoln and Guba, 1985). Some of the participants took this opportunity to both clarify and add to information from their initial interviews.

Research Reflections

Due to the initial issues in recruitment, significant delays developed in the research journey. Even when the snowball sampling was established, the recruitment process was extremely slow and by the time the last interview had been completed it was felt that momentum had been lost and continuing on was difficult. However, what essentially drove ongoing commitment to the research were the participants themselves. Many of the participants expressed gratitude at being listened to; being able to share their story; for others to know of their experiences and hopefully see practice changes. For some participants the interview process was itself described as cathartic.

Research Limitations

A significant limitation of this research was that it only focused on the views and experiences of caregivers and did not include children, social workers or birth families. However, the nature of this research precluded the involvement of other such participants as it would have made the project too large in scale. A further limitation is that those recruited and willing to share their stories were those who perhaps had more challenging experiences. The nature of the recruitment method also produced a limitation in that there was a geographical constraint that had hoped to be avoided by recruitment nationally. However, it is important to note that not all the caregiver experiences came from the same region, despite the fact that all the participants were now residing in the same geographical area. A further limiting issue, identified by Tracey (2013), is that snowball sampling can develop one type of group or demographic due to participants possibly recommending those with similar views or experiences. In some ways this was mitigated through the creation of two snowball groups. As such, participants were not just recommended from one group.

A final limitation is that the qualitative nature and small sample size of this research does not allow for generalisability. Creswell (2013) states that the purpose of qualitative research is not to generalise information but instead illuminate the specific and particular. This research sought to explore the specific contact planning experiences of a group of caregivers in New Zealand. However, as Yin (2016) outlines, human experiences or events can be seen as “...either completely unique or having some properties that are relevant and potentially applicable to other situations” (p.19). Proposed in contrast to these either-or assertions, is to aim for what is termed a limited form of generalisability. This limited positioning recognises both the specificity, particularity and uniqueness of these local situations but accepts that some transferability to findings is possible; “depending on the degree of similarity between sending and receiving contexts” (Lincoln & Guba, 1985, p. 297; Yin, 2016). Research findings can therefore, be seen to have a degree of transferability, quality and applicability without being generalised in a statistical way (Padgett, 2008). Willis (2007) likewise notes, that interpretivist research can be considered and utilised in contexts outside of those in which it was conducted. Findings, however, are not generalised ‘laws’, instead they are local

truths where the user then determines what appears applicable and what is not in a new context.

Summary

This chapter has provided an overview of the methods and methodology encompassing this research into caregiver experiences of contact planning pre-permanency and the impacts post permanency. The nature of this particular study required a process that was able to fulfil its purpose and help answer the question (Crotty, 1998). The methodology selected and outlined was considered appropriate for this. The following chapter will therefore present the findings from the interviews completed with the participants.

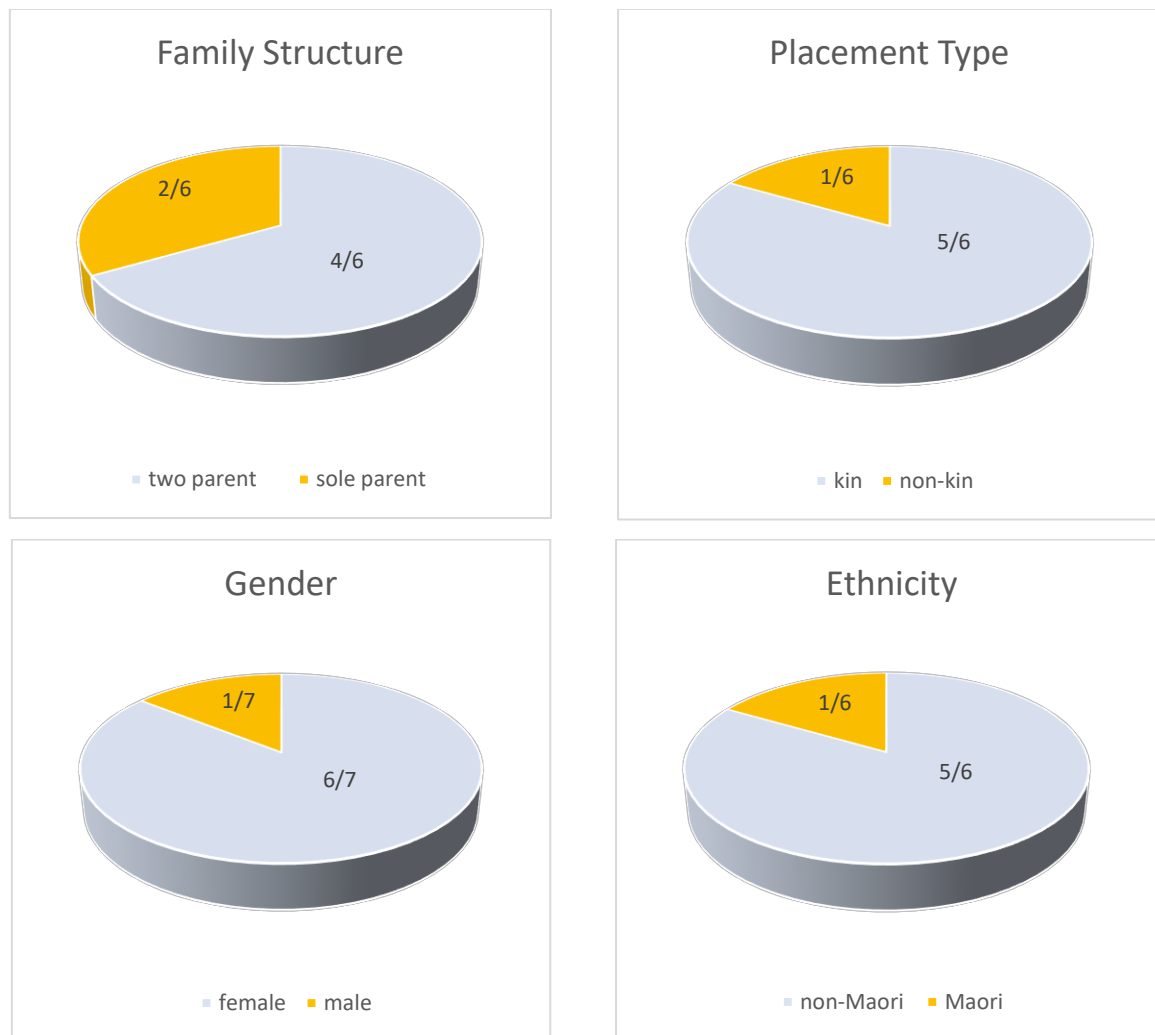
CHAPTER 4: FINDINGS

This research sought to explore how permanent caregivers experienced contact planning practice and how they perceived this impacted outcomes for permanency. The aims were to critically explore caregiver experiences of social work practice and to help identify those processes and practices which were considered helpful and may have contributed to quality contact outcomes. This chapter begins with an overview of the participants and their contact arrangements before and after permanency was achieved. This is followed by discussion of the themes including: the contact experiences; just told; information; limited support; lack of assessment and relationship matters. The final section outlines helpful social work practice identified by participants along with caregiver recommendations and key messages.

General Information about the Participants

The research participants represented a broad cross-spectrum of the community as a whole. There were six interviews, with seven interviewees; one interview involved both the husband and wife. The gender of the remaining five interviews were all female. Two of the six interviews were sole-parent households; four being two-parent. Two of the six interviewees involved kin placements; four being non-kin. Only one participant identified however, as New Zealand Māori with the remainder being New Zealand European. Figure 1 below displays visually the participant overview.

Figure 1: Participant Overview



Whilst the participants were from one geographic area, not all the social work experiences were from the same region. The majority of children permanently placed with the caregivers were in the custody of Oranga Tamariki Ministry for Children and one child was in the custody of a non-government organisation (NGO).

Five participants had children placed with them either from birth or at around one year, although one of these participants also had older children placed with them as part of a sibling group. The remaining participant had a young person placed with them.

Five of the six participants had previously parented and raised their own or other children who were now older teenagers or young adults. Only one of the participants achieved

permanency with a young person; the remainder achieved permanency with children between 1-10 years in their care.

The participants have been identified in the findings as *Participant 1* through to *Participant 6* which indicated the order of the interviews and was intended to help maintain caregiver privacy. Due to interview 4 involving a couple their respective comments have been identified as participant *4A* or *4B*.

Contact Pre-permanency and Post Permanency

Only half of the participants had ongoing contact with birth parents post-permanency. Two of these involved children in kin placements and the third involved post-permanency contact, set at fortnightly. For one of those participants, where post-permanency contact was still occurring, the parents had limited physical contact. Tables 1 and 2 below outline the pre-permanency and post-permanency contact arrangements for all the participants.

Table 1: Pre-permanency Contact Frequency and Mode

<i>Pre-permanency contact frequency</i>	<i>Pre-permanency contact mode</i>
Participant 1: Contact - no physical contact - video conferencing twice weekly for mother and once a week for father	All parental contact supervised by caregiver
Participant 2: Inconsistent / infrequent for both birth parents	Birth mother's contact supervised by caregiver
Participant 3: Fortnightly contact with immediate family	Contact unsupervised
Participant 4: Weekly - fortnightly - no contact	Contact supervised by caregiver
Participant 5: Monthly - four times a year - monthly - and weekly at times.	Contact unsupervised
Participant 6: Fortnightly contact with birth parents	Contact supervised by a Ministry worker

Table 2: Post-permanency Contact Frequency and Mode

<i>Post -permanency contact frequency</i>	<i>Post-permanency contact mode</i>
Participant 1. Video conferencing twice weekly for mother and once a week for father; four times per year physical contact - mother	All parental contact supervised by caregiver
Participant 2. Inconsistent / infrequent for both birth parents; messenger chat utilised more by mother	Birth mother's contact supervised by caregiver
Participant 3. No contact with birth family – ad hoc contact with some extended family members	No contact with birth family. Wider birth family contact managed by caregiver in consultation with child
Participant 4. No contact	No contact
Participant 5. No contact	No contact
Participant 6. Fortnightly contact with birth parents	Contact supervised by a Ministry worker

Research Themes

The following section outlines the themes identified in this research including, contact experiences, just told, information, limited support, lack of assessment and relationship matters.

Contact Experiences

The first theme identified was that of contact experience. Several sub-themes emerged from this including caregiver commitment to contact, lack of parental commitment and contact issues.

Caregiver Commitment to Contact

Commitment to contact with birth families and understanding the importance of this was strongly voiced by all the participants. Participant 5 worked hard to make contact happen and saw this as an essential role for a caregiver. In the initial years of contact they had provided all the transportation for contact to occur and at times paid for the birth mother to attend events with the children. Another participant had wanted to allow more contact with the parents when the child first came into their care, but were discouraged from doing so: “We

were being more generous than they (social worker) wanted us to be, that was when they told us we needed to put a cap on it”. (Participant 1)

Ongoing contact, along with connection with the birth family, was considered positively:

It can mean that you have contact with the parents, obviously it's not always going to work out well but you can get to know the parents and thereby get to know a bit more about the kids. (Participant 6)

For some participants there was a sense of juggling their lives to make contact between the children and their birth families work, even if this involved disruption to their own life. Often there were significant logistical demands set with contact which caregivers juggled hard to make work. One participant had children at school and at kindergarten with a contact time set at 2:30pm during the school week. The caregiver described this period of time as “pressure-cooker”. (Participant 6)

Another participant noted they had tried to facilitate contact between the mother and child as much as possible:

We... tried to accommodate her as much as we could... it was fortnightly at some stage... and she would text and say it doesn't suit today, will it suit tomorrow? So I pretty much juggled our life to suit her as much as possible. (Participant 4A)

Another participant likewise noted:

Yeah, it gets frustrating when you're trying really hard to make sure they keep in touch but you're the one doing all the work and they're not. (Participant 2)

The caregivers here all demonstrated both an understanding of the importance of contact between children and birth families but also a commitment to making contact happen. Lack of birth family commitment was a frustration and is discussed in greater detail next.

Lack of Parental Commitment

Whilst there was commitment to contact for the caregivers there was a corresponding frustration for the majority of participants about the lack of parental commitment. Participant

5 said, “I tried to keep contact and then it got less and less and less and then her mother just said, ‘I just disown you (child)’, in 2015”.

Participant 2 experienced inconsistent contact with both parents, which was considered frustrating. However, there were no issues identified when contact did occur. Keeping the father involved was particularly difficult:

He lives in the same town, he’ll come in and he’ll go ‘oh yeah I had a busy night last night so I forgot to come around’ or ‘my phone has died’ ... all sorts of excuses.

(Participant 2)

For one participant, contact between mother and child just stopped and there is now no contact occurring (with the father not having been involved at any stage):

We bumped into her... I text her every so often to see if she’d like to see her son but there is no, no replies... as a home-for-life person we’re supposed to keep the parent in the loop but when you get no response, it’s sort of, what do you do? (Participant 4A)

Participant 6 had a fortnightly contact regime in place but parental inconsistency at times was still evidenced:

They always miss accesses around New Year’s, before Christmas they’re good but in between, randomly, we’ll have a no-show. (Participant 6)

For the majority of participants parental commitment to contact appeared to occur across a continuum, from partially to mostly inconsistent through to half of the birth parents eventually ceasing all contact with their children.

Contact Issues

A range of issues, in relation to contact, were identified by many of the participants, including the lack of parental commitment previously discussed. Some, however, identified direct and negative impacts on children and/or on them as caregivers. The impact of contact on them as a caregiver was captured well by Participant 5 who noted, “You’ll hear this very common thing, a lot of us foster parents just say ‘oh god’; it’s just awful the day after the day or whatever”. *(Participant 5)*

One participant felt the children were often forced to see birth parents and wondered why contact was always insisted on because the children always appeared worse off after the visits:

It's messy because the consequences for those children after the visits was just awful, so... visits were just like, 'oh God', it's going to ruin a day of our weekend, a quarter of the month was ruined by the emotional stuff from the contact. (Participant 5)

Another participant emotionally recalled their experiences with a child who usually became overwhelmed before and after contact experiences. They noted that one day:

He was running around the car and over the fence and everywhere... and fell to pieces crying, it was breaking his heart so the resource worker wouldn't take him and rang up the social worker, and the social worker came out and...said 'well, he's still going,... went away, brought his grandmother back here and forced him into the car and took him away for access. That was not in the best interest of that child. So it kept going...he should never have had to go on access if he didn't want to go, if it was distressing him that much he should not have had to go. And the family and the social workers made that decision". (Participant 3)

However, once permanency was achieved it was noted that:

There is no access, none of them bother even ringing... He has an auntie that will ring me... and ask to come over and I allow that; that's ok. I'll ask (child), 'Do you want auntie to come over for a coffee and a visit?' And he'll go, 'Yip'... and I'm fine with that. (Participant 3)

For Participant 6, the frequency of arrangements became more difficult when parents did not turn up to contact:

It's too hard for the girls and then the emotional aftermath would only just be gotten over before the next access would occur; and then one of the hardest things we had to manage is the girls expectation that access was occurring and then the parents not turning up at the last minute.

The dynamics and emotional impact of contact when a birth parent enters into a new relationship was identified as an issue. Having a third party involved in the contact

arrangements who was described as violent and having significant mental health issues was difficult for Participant 1 to manage. They also faced the prospect of the birth mother challenging the existing contact arrangements:

Mum is wanting more, to the stage where her new boyfriend is threatening to get in a lawyer because she wants more access and more phone calls and more of everything she can get. (Participant 1)

For many of the participants the contact arrangements not only impacted negatively on the children but had ripple effects for the caregiver and the child's new family.

Just Told

No participants felt they had significant input into decision-making around contact planning and this was regardless of how they had found the whole experience and what contact arrangements occurred. Further to this, the words 'just told' featured in many of the interviews. A number of participants stated negative views about the lack of consultation with social workers or feeling like they had no control. One participant expressed this as:

It was just almost like my very experience foster parenting, point of view and my experience of living with these children...wasn't really taken into the whole thing. (Participant 5)

Participant 3 stated they were not asked anything, not involved in any of the decision-making and that the social workers, "did not care what I thought". For this participant there was, "no team about it... it was them and I was basically having to do as I was told... all the decisions were made and I was just told."

Another participant noted:

No, we never got given any choices about any of that sort of thing, we were told what we had to do... the arrangements we were told to make was not to let them have more than four visits a year and one video call a week. (Participant 1)

One participant said that they were asked if the day and time suited. However, they would have appreciated input in terms of pre-planning contact:

I like to plan ahead, I like to know that a weekend in two months' time we're going to be doing this and low and behold a contact date came up. (Participant 5)

Decision-making, particularly in regards to frequency and rationale, was never discussed for another participant. They noted their lack of involvement in discussions around contact has now placed them in a difficult situation with parental contact post-permanency:

We did manage to get it (contact) to fortnightly but apart from that discussion we would've appreciated to get it less frequently than fortnightly sooner than waiting until we had permanency. And now we have this odd jump where we go from fortnightly to four times a year is a bit of a... we're going to need quite a long transition time for that. (Participant 6)

For these same caregivers there was also no consultation with social workers in regards to the logistics of contact arrangements which was particularly challenging:

There were four children... no vehicle... to transport four children, so we had to do all the drop offs and pick-ups for access... when they first came to us we had weekly access, we had doctor's appointments, we had a social worker in our home, and both my husband and I work part time... but the practical logistics of getting children, and the timing didn't work so we had some kids at kindy and some kids at school, and some kids at home, and physically, we actually couldn't make the appointments and the access, and everything... it was just chaos. (Participant 6)

For two of the participants, however, this sense of simply being told was not considered an issue. For one participant this appeared largely due to the mother ceasing all involvement with the child. When asked about the decision-making processes that occurred the participant stated:

I don't remember any specific interaction with the social worker about that. Looking back now I get the impression that we'd been through the process before and so they were less hands on. (Participant 4A)

Participant 2 stated that decisions were made by the Ministry and that was the arrangement they wanted to stick to because of the parents. The participant had wanted to have, what they considered, a fairer contact regime for the mother; however, this was denied by the Ministry.

The overall experience for caregivers was one of exclusion from significant decision-making around contact. Instead, caregivers were generally ‘just told’ what the arrangements would be.

Lack of Information

The need for more information in relation to contact emerged strongly as a theme that was organised into two sub-themes including *general* and *familial* information.

General Information

The majority of participants identified that social workers did not provide them with relevant information about contact in terms of: expectations; guidelines; what should or should not be happening; and how to manage difficult situations or complex emotional outcomes for the children. Two participants though did receive information about how to manage aspects of contact. For one participant this occurred through a social worker from a different organisation, who was contracted to work with them, and their advice and support was valued:

We learnt quite a lot working with her and a lot of that behavioural stuff and for me it was fabulous having someone who actually, she was independent of (the Ministry) and she was very experienced. (Participant 6)

The second participant was provided with some advice from the social worker on what they could and could not do as far as the (birth) mother was concerned. This same caregiver though would have appreciated more information from the social worker as to why they made the contact decisions that they did. The importance also of caregivers being provided with information about what occurs at contact for children was identified by Participant 6.

More generic information to support caregivers around the issue of managing contact was recommended:

Caregivers need to sound out... what's supposed to happen and being very clear on the process and what is appropriate and what isn't. I guess there is still a part of me

that is unclear about what is appropriate in an access... there is a lot of uncertainty about what should or shouldn't be happening. (Participant 4B)

This was echoed by Participant 1, when talking about managing contact:

We were so unsure of what our rights were and things like that...we didn't know if we were doing the right thing, we weren't sure how long we were supposed to do it for, we weren't sure how much involvement we were supposed to get in on. (Participant 1)

Knowing what to say to children about contact would have also been helpful:

I think knowing how to deal if a child does not want to go and see their parent at contact is a really big issue because they have a trust relationship with us and yet we're handing them over to a person that they may not necessarily trust for whatever reason... I find that difficult to know how to communicate to a child that I'm putting them in an emotionally unsafe situation and letting that happen when we are very conscious about emotional safety and the fact that part of the reason they were removed was because of an emotionally unsafe environment, and I guess the other things are dealing with 'no show' at access and how that's managed. (Participant 6)

The contact experience can also feel harrowing. When faced with difficult emotions displayed by the child, before and after contact, one caregiver stated they were not provided with information to support the child but were instead told they would be spoken to about their discipline:

Later I got rung and told that they were, another social worker was going to come and talk to be about my discipline with (child) and that I'm not doing it properly and came and growled at me for the way I handle my son. (Participant 3)

Familial Information

Significant familial information was either lacking or not provided to caregivers which could have assisted contact arrangements or alternatively led to lack of safety. As an example, one participant had agreed initially, as part of facilitating contact, to having the parents of the child live at their home. However, information about the birth father including a history of gang involvement and rape was not relayed to the caregiver:

We didn't know about his background... but (the Ministry) knew everything and nobody told us about any of that until I brought it up with them, which in my book is really wrong because he was coming near our own children.... I just think they need to be more open to their carers and stuff like that around backgrounds. (Participant 1)

Another participant felt that the social worker should have shared more information with them about the birth parents and wider family, noting:

I think there wasn't enough communication about all the 'nitty gritty', it was like they were almost scared to say 'this is what she's come from and this is what you're going to have to deal with'. It would've been good to know some of that. (Participant 2)

This lack of familial information could have led to safety issues for the child:

I think it was really important that... I knew what the situation was with (the mother's) family... as in the family dynamics was really important, we could've gone 'oh well, we can just let him go with his mum's auntie so-and-so and then find out that no actually that was detrimental to him so we should've been told a bit more about things' ... if somebody is seriously going to be taking on a small child or young child and they're going to have to deal with these situations they need to know what they're walking into because we sort of went in with big blinders on. (Participant 2)

The issue of social workers sharing significant information, prior to contact, about what has been happening with birth families was also raised:

I guess... information sharing like if one of the parents has been taken into custody that week or is in a really foul mood about something else, we have had a few instances where a child has gone to be with her parent but the parent has just received news that another child, not to do with us, that they have been removed from their care... or removed from another partner's care, and...then still has had access with our child and all of that anger and emotional frustration, although it's not taken out on the child, is transferred to the child and it's extremely stressful for a child to be put in that situation. (Participant 6)

Participants highlighted the need to be provided with more information around contact by social workers. Important issues identified included information to support the child along

with significant familial information to assist caregivers with contact and help ensure safe and quality contact experiences.

Limited Support

Many of the caregivers expressed a sense of dissatisfaction with social worker support generally, along with support specifically related to contact. Only two of the six participants noted support from their respective social worker. For one of these participants though, support overall was seen as quite limited or varied depending on which social worker they had. However, this lack of support was not considered a major issue largely due to not feeling it was necessary and the mother eventually ceasing involvement. The other participant felt they did receive some social worker support as they were told by the social worker if there were any issues (with the family around contact), just send them in the social worker's direction.

For another participant, support was eventually obtained when the Ministry made a referral to an independent social worker and when they sought additional support outside the Ministry:

The real support for me came from the other social worker. And then anything to do with... I was going to say like behavioural-wise we have a friend who is a child psychiatrist that was helpful. We kind of went outside (the Ministry) to seek help.
(Participant 6)

However, for Participant 1 there “was no real support at all”. Instead they had to chase the Ministry for any support. Their experience was described as, “we basically got dumped in the middle and left to hang”.

Participant 6 would have appreciated debriefing support and noted that:

My husband and I have worked in really stressful situations overseas in war zones... the one thing is the more critical the situation the more communication is required to make you able to cope with the situation, standard procedure in any crisis situation, and you need to debrief... I think contact's that same thing.

One participant had experienced a supportive social worker at the very beginning of their journey but did not feel any support after that time and there had been a number of social worker changes. They stated: “there was no support and I was never advised on how to deal with any of it (contact) and never have been right through”. Later they noted:

It was just basically all left to me to deal with and I think I just got used to doing it by myself and until one day I had enough and said, ‘we’ll ring if I need you, if not don’t bother ringing me’. (Participant 3)

For most of the caregivers there was no support to help manage the emotional impacts of the contact arrangements on either the child, themselves or their family. For one participant, recalling their experiences around this appeared emotionally difficult with disbelief still about what occurred. They shared their experience of trying to manage contact for a child with attachment issues. The caregiver described:

Having to watch him fall to pieces and then when he come back (from contact) he would be kicking and screaming at me... because he was angry at me because I let them go, I couldn’t do anything about it... I think that was the hardest thing. (Participant 3)

Another caregiver talked of a time when the social worker decided the children could have weekly contact over a holiday period. Significant issues developed when one of the siblings did not want to attend and this made the other one become angry and aggressive:

They (social worker) actually enabled this to happen, they didn’t stop the plan... so I rang and said these...are really emotionally just wrecking us... but nothing happened and they said, ‘if he’s like that again, just call the police because he’s getting older now and he’s got to see responsibility for his actions’. (Participant 5)

The eventual outcome of this was the breakdown of this placement for one of the siblings which the caregiver attributed, in part, to the unsatisfactory contact arrangements.

The issue of support to help manage strained familial relationships, as result of contact, was also discussed. This was a kin placement, where the caregiver had to manage the emotional complexities of having the grandchild in their care but also wanted to maintain a relationship with their daughter. The interview was paused due to the emotional impact on the caregiver:

There were an awful lot of teary moments where I just wasn't handling it because I knew I was hurting my daughter... she basically hates our guts because we did everything (the Ministry) asked of us. (Participant 1)

Participants were not provided with social work support to manage a range of issues mostly connected to dealing with the outcomes of contact emotionally on the children and on them as a caregiving family. The need for specific support was identified by a kin caregiver given the greater complexity of family relationships.

Lack of Assessment

The majority of participants identified that social workers did not assess or re-assess the contact arrangements including: effects on the child; birth family behavior; or the quality and safety of the arrangements generally. Subsequently, for some participants, this led to a sense that the contact arrangements were more about meeting the needs of the birth family.

Participant 6 stated outright that there was never a sense of assessment nor any discussions at all about the contact arrangements. Participant 3 never experienced contact being assessed by the Ministry or any other professional; instead it was seen as just what the social worker and the birth family decided. They noted:

The family is... very intimidating... and I do believe the social workers are scared...intimidated by them, and so they just let the family walk over... and do whatever it was they thought the family wanted. But not what was best for the child. (Participant 3)

Lack of assessment in relation to parental behaviour was highlighted by Participant 5. Once the children realised they could say “no” to contact there was a sort of “release” for them; however, the birth mother apparently “punished” her children emotionally for this by not attending their birthdays. The caregiver said that this was never reviewed and the mother was allowed to do this to the children, “for years, and been allowed to do it, no one ever pulled her up about that”. (Participant 5)

For two of the participants, lack of assessment was highlighted in respect to unsupervised contact. Participant 5 stated:

I was surprised they were allowed to spend time with her (mother) because she got an older boyfriend... and one day he took (young person) away by himself during the visit and, cos the social workers thought it was alright that they saw both of them together, no investigations, nothing, and we didn't know this man from whatever and I said 'these are my children, I would never allow my children to spend time with a man I do not know' and, but the social worker said it was fine, but then he took (young person) away for quite a few hours one day by himself, and I heard about it and I went absolutely berserk.

Unsupervised contact was a significant concern for Participant 3 as they were subject to verbal attacks by the birth family who never accepted the child's placement with them. Similarly, Participant 5 described parental behaviour that attempted to sabotage the children's placement, which included: emotional manipulation; telling the children that the caregiver was not very good; it was the social worker's fault the children were not in her care; or she (the birth mother) was planning on getting a home so they could return to her care. Non-acceptance of a child's permanent placement along with other destabilising behaviours by birth family indicates the need for contact to be supervised (Mossman, 2004). Participant 3 noted that occasionally the contact would go back to being supervised and then revert again to unsupervised but they were never told what assessments occurred that made it safe to return to unsupervised. One particular incident was highlighted:

Once he (the child) went on access and he was left in the car by himself with a baby for 20 minutes... My friend had watched, went round and round... watching him in the car, for 20 minutes he was left alone in the car with a baby. (Participant 3)

Participant 5 also queried how child-centred contact arrangements were assessed in terms of safety and quality:

If it was a rainy day they would wander around Warehouse for a couple hours, but the social workers thought that was an okay contact, the contact wasn't even good quality...but the social workers felt it was okay and that's what I disagree with strongly too, the contact was not good quality, it wasn't safe in any sense at all. (Participant 5)

Only one participant identified ways in which they felt the contact arrangements had been assessed by the social worker. Participant 2 felt there had been some assessment of the

mother which formed part of the social worker's recommendations around contact. However, they also noted that the social worker did not share this information with them which was highlighted as an issue in regards to information sharing.

The majority of participants highlighted lack of assessment as an issue not only in terms of the quality and safety of the actual contact experience but in terms of parental behaviours and the impacts on the children and young people.

Relationships Matter

Woven throughout the narratives and identified themes was the limited relationship between the caregivers and social workers. Lack of relationship was rather poignantly captured by Participant 5 who noted that in the "last few years of fostering no one has said they would come for a coffee and ask me about how I am going". Participants also identified lack of relationship support with birth parents and the wider birth family, changed familial relationships within caregiver families and the need for relational thinking.

Lack of relationship or any sort of engagement or communication with the child's social worker was noted for several participants. For example, one participant said they never talked with social workers about the impact of contact on the child:

The (contact) supervisor and ourselves will share information as necessary if something happens to a child but we've never actually had that through (the Ministry) it's been something.... like if there's been a distressing situation or something for the child then we've heard that from the supervisor not, there has never been a discussion that I can recall around that. (Participant 6)

For Participant 1 there was simply no communication or engagement with the social worker at all:

No... we actually felt like we were in the dark a lot of the time. I was constantly texting or ringing to find out all sorts of things to do with anything you know the communication was pretty skint... nobody seemed to be interested, to put it politely.

Participant 3 similarly noted:

If they had just come and discussed it, and we talked about it and we decided together, not as them just coming and saying this is what's happening, you have to let him go (to contact).

Only one participant felt they had a relationship with a social worker (of note is that there had been several social worker changes for them since). They stated:

(she) was excellent support and encouragement and we felt genuinely cared for, and she certainly wasn't pushing us to go Home for Life. (Participant 4A)

Several participants identified the need for social workers to attend to issues of relationship with the birth and wider birth family. Participant 6 wanted the children to have a positive relationship with the birth parents and more information on how to facilitate this so that the children do not hold them in opposition. This caregiver recommended more round-the-table discussions with social workers about contact:

I think having a relationship with the parents is actually really important and the access is an opportunity to see the parents... we all have a vested interest in the children and I think that it's important that you know that about each other.
(Participant 6)

For one participant there was the need for social workers to talk with caregivers about relational long term needs and issues around contact for children and birth families:

Thinking long term...what's the goal of this; we've kind of set our own goals saying we want her to have a positive relationship with her birth mum and her extended whānau...so what would the ideal outcome of this situation when the kids have their own choice about how much they interact with (birth parents) like we still want them to show some respect to their parents but yet understand how all of this has kind of come about. So we're very big on being honest about it. But that's a discussion I haven't really heard. (Participant 6)

The need for caregivers to be supported to think beyond just the relationships with the birth parents was also identified:

We focused too much on (child) and his mum and dad and didn't think beyond those relationships to the more extended family... definitely really feel out and think

broader than just that tight little group, and more than just 'how's he going to fit in our family'. (Participant 2)

A broadening of social worker relationship focus was outlined by other participants. Three participants identified the need for social workers to attend to caregiver needs and their family relationships when contact planning. Participant 2 stated that contact planning should not only focus on the child and the (birth) parents and their needs but also everyone else who is in the home. Participant 1 stated:

No, not at all. Nothing to do with us was ever, like our other children or anything like that; nothing was ever discussed on any of our thoughts or feelings on anything.

Similarly, for Participant 3:

Start listening to caregivers, and listen, completely listen to them... and do what is best for the child not what they (social worker) think is best but what is best for that child... and take everything into account instead of just one person. (Participant 3)

The need for social workers to attend to issues of relationship within caregiver families, particularly kin caregivers, was outlined by one participant. They stated they received no social work input to understand and manage difficult familial relationships that emerged. The recording had to be paused as the caregiver became emotionally distressed when they shared about the changed relationship they now had with their daughter. For this family there was a sense of grief; of feeling as though they lost their daughter in this process. The caregiver strongly felt there was a need for kin caregivers to be informed around the ways in which their relationships with family members will alter and probably never be the same again.

In general, the themes identified here paint an overall picture of caregiver marginalisation or exclusion from decision-making or even discussion throughout the process. The following section therefore presents the participants voices in regards to practice considered helpful followed by their recommendations and key messages.

Helpful Social Work Practice

This next section outlines social work practices that were considered helpful. Unfortunately, this research found very little in the way of helpful social work practices, specifically relating to contact planning. There were though, aspects of general practice that were identified as positive. For one participant the family group conference process was helpful. However, the caregiver also identified that these meetings were not easy:

I think family group conferences are really good with the family turning up, but that didn't happen very much... it was hard to get us all together in the same room.

(Participant 5)

A useful Home for Life booklet was noted by another participant:

They gave us this really cool book that showed us...all the different ways that the situation of being a foster child or a Home for Life child could affect them as they get older... it was a great wee book. (Participant 2)

Participants from interview 4 talked about the general support they received from one social worker (as they had experienced a number of social workers) and noted:

She was brilliant and you'd ring her and you'd get an answer back the same day, not many do that and she was just full of life. (Participant 4A)

Only two participants identified helpful social worker practices specifically in regards to contact. Participant 2 noted:

(the child's) social worker was great because she'd already developed a rapport with (the mother) so she was able to mediate between us and her as far as...contact went.

For Participant 6, contact support and advice was eventually gained when the Ministry referred them to an independent social worker with an NGO who had experience in the permanency field.

Several participants expressed an awareness of issues that likely impacted on helpful practice which in turn led to a certain reluctance to criticise social workers. Such issues included

knowing that the social workers were really busy or that there were ongoing social worker changes that led to less support and poorer or confused communication:

It was quite chaotic and the means of communication were quite chaotic and our social workers were extremely overstressed with caseload, they were just overwhelmed, so it didn't feel right to be bothering them all the time either, even if they were part of the... should have been part of the... they were just simply too busy.
(Participant 6)

Another participant stated:

To be nice she did really try but it was her first time, and she really didn't know what she was doing... she was sometimes quite confused about things herself, wasn't quite sure what was going on and always having to answer back to somebody else who I never talked to. (Participant 1)

In summary, whilst caregivers identified some helpful social work practice, there was little identified that was specifically related to contact planning. For one caregiver, the most valuable support occurred when they were referred to a social worker in a different organisation. Caregivers did recognise that practice was impacted by staff turn-over and caseload demands.

Caregiver Recommendations and Key Messages

This final section provides some of the key recommendations and messages from participants in terms of contact but also related issues not covered in the interview questions. For the participants in interview 4, an assessment from a professional or expert in regards to contact arrangements would have been helpful in relation to what is considered appropriate for children's long term health and wellbeing along with some general guidelines. They also recommended that caregivers get, "proactive about asking how access (contact) is going as far as the social workers are concerned". (Participant 4B)

Social workers establishing natural birth family contact (such as birth parents attending children's sports and other events) was recommended by Participant 5. This caregiver did not support set contact times now as, for them, it created inflexibility and disappointments for children when parents don't turn up. For this participant it was about, "when the child wants

the contact not when they are conveniently available because the parents can conveniently be unavailable”.

Making training more accessible for working caregivers was also recommended. Participant 6 had observed an unspoken expectation by social workers that caregivers were not working; in that they could drop things easily, be available and importantly, that training/support was often available when they were working.

Having supervised contact with birth parents and particularly when it is supervised consistently by the same person was seen as positive:

Supervision, as I said, has been extremely positive and for us having supervised access takes away a huge amount of worry or concern, and...the supervisor having a relationship with the children and the children trust her. (Participant 6)

The need for contact to be supervised when there is a family history of abuse was recommended by one participant:

From the get go, it should've been supervised right through and never stopped due to their history, her own history of her children and right through it should've been well and truly supervised. (Participant 3)

Another participant recommended that caregivers needed to be firmer in decisions and rules for contact and asking social workers for family information:

Lay down the ground rules for anybody who wants contact with the child ...basically if you are going to have a routine, stick to the routine... be assertive in the sense of asking what the family situation is and not just the parents but the extended (family). (Participant 2)

Participant 6 outlined difficulties accessing appropriate information. They recommended greater organisational structure and communication from the Ministry and felt that, “in general there is a lot of information out there and there is no information out there”. They also noted:

The information is quite hard to actually find in a 'black and white' way, and contact has been a bit like that, like we didn't know that we could ask for contact to be less frequent, and we didn't know that we could be part of that. (Participant 6)

Aspects of this were echoed by Participant 2:

It would've been good to know the step-by-step process of how everything was going to work in the stages because we were sitting there going 'so what do we do next?', 'when do we do this?' ... we got a feeling that they kind of thought 'oh you should know how this works'. (Participant 2)

Sadly, one participant's recommendation, as a result of their experiences, was that people do not become caregivers:

I would never recommend foster parenting to anybody and yet I thought it was the most wonderful thing you could do. It really flipped me the other way. (Participant 5)

Another participant recommended that caregivers need to stand up to social workers when required and stated, "don't let them bully you, be strong and stand up for what you believe in and what you think is right" (Participant 3). Finally, Participant 5 said, "I would've liked it to be more child centred, in fact the whole experience should be child centred, what the child needs and wants". (Participant 5)

Summary

The results reveal that all the caregivers involved in this study were committed to contact arrangements and understood the importance of this for the children in their permanent care. Parental behaviours and lack of commitment to contact were identified as issues to varying degrees. What emerged in these findings was that caregiver attitudes towards contact were at times affected or re-shaped by social worker practices, or lack of practices, for the worse. Additional themes of this research included: just told; information; limited support, lack of assessment and relationships matter. Of particular note was that none of the participants were significantly consulted or involved in discussions or decision-making about contact and this was regardless of whether this was the Ministry or an NGO and regardless of the contact experiences. The following chapter will review these findings in relation to the literature and consider possible factors impacting on contact practice.

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this research was to critically explore caregivers' experiences of social work practice in regards to contact planning and also to identify processes and practices that were helpful for caregivers and supported quality outcomes. The literature review began by examining the knowledge bases surrounding contact purpose and those social work practices considered essential and supportive of quality contact experiences and outcomes. To explore the research questions, qualitative interviews were completed with six kin and non-kin caregivers who had achieved permanent care outcomes for children. The aim of this discussion, therefore, is to review the research findings and discuss the significance of the findings in relation to the relevant literature. The first section reviews the themes including, the contact experiences, just told, information, limited support, lack of assessment and relationship matters. Section two discusses factors that are seen to contribute to practice issues and relationality, including the paradigm gap, managerialism and role burden and clarity, concluding with a recommendation for contact practice.

The Contact Experiences

The caregivers in this study communicated a clear understanding of the importance and purpose of ongoing contact between children and their birth families. The caregivers were not only supportive of contact but were also committed to ensuring it occurred, despite issues with parental commitment. This is consistent with the research findings of Tansley (2014), Atwool (2010) and Collings et al. (2019). Like Tansley's research, the caregivers demonstrated contact commitment even if it involved financial and personal cost to themselves.

The findings also indicated that the majority of caregivers were either open to relationship or an intersecting world with the birth parents, with the majority also supportive (or had previously been supportive) of parental contact within their home. However, this openness to contact occurring in the home can be accompanied by risk, as highlighted by two caregivers. Despite this they remained open and supportive of this type of contact with family and

extended family. This finding was in contrast with the work of Sen and McCormack (2011) who noted a decline in caregiver openness to contact with birth families and notably contact which occurred in the caregiver's home. These authors state that without any overlap caregivers may never meet or know birth parents. It is possible that in New Zealand there is a greater acceptance for this type of contact occurring due to historical, and cultural factors and/or a lack of alternative professional contact venues.

However, this intersecting and open world was not without difficulties which were due in part to lack of assessment and/or monitoring of contact, unchallenged parental behaviour and information not provided to caregivers about the birth family. Where safe and appropriate, the research suggests that this intersecting world can be beneficial for children with positive contact outcomes when there is a more collaborative and positive approach between caregiver and birth family (Morrison, Mishna, Cook & Aitken, 2011; Boyle, 2017). This generally requires assessment by social workers and intentional social worker support to assist this occurring (Barnardos, 2013; Sen & McCormack, 2011). However, for the caregivers in this study, as outlined in the findings, the necessary social worker assessment and support was notably missing.

The caregiver narratives which expressed emotionally problematic contact experiences for children were consistent with existing knowledge bases indicating contact can be detrimental or harmful for some children (Boyle, 2017; Cleaver, 2000; Howe & Steele, 2004; Schofield, et al., 2000; Wilson & Sinclair, 2004). Of note was the difficult contact arrangements, described by the caregiver with two adolescents in her care, which was seen to contribute to the placement breakdown for one of the siblings. The contact experiences here involved a birth parent who was rejecting, unreliable and manipulative. These same issues were outlined in Moyer, Farmer and Lipscombe's (2006) research of teenagers in long term foster care where the majority of participants continued to have poor contact outcomes involving rejecting and unreliable adults who were also neglectful towards them. Like Moyer's research, it was also evident, in this research, that the young people struggled to understand and cope with the experiences and so the caregiver was left to try and assist them to work the issues through whilst the difficult contact continued. Thompson's (2018) research findings, on the views of special guardians, suggested that there needs to be a re-focusing on contact planning in terms of quality and the management of possible threats including parental unreliability or poor behaviour.

The accounts of the caregivers in this research outlined contact experiences that ranged generally from: dissatisfaction, as a result of lack of consultation or birth family information; difficult to manage, due to parental no-shows, parental behaviour and children's behaviours; through to distressing for caregivers and for children. These findings have likewise been outlined in other research (Collings, Conley, Spencer & Luu, 2019; Murray, Tarren-Sweeney, & France, 2011).

Support

There were several key issues, in relation to support, identified by caregivers in this research. The first included support to help manage some of the difficulties experienced in relation to children's behaviour before and after contact, including the impact of parental non-attendance at contact, along with support to manage parental behaviours in and around contact. This finding regarding support for caregivers was consistent with other research that indicated caregivers do not receive appropriate or sufficient support to manage contact (Murray, Tarren-Sweeney, & France, 2011; Morrison, Mishna, Cook & Aitken, 2011; Sanchirico & Jablonka, 2000; Selwyn, 2004). Similar findings were also outlined in Tansley's (2014) research highlighting the essential support role that social workers play in helping caregivers facilitate and manage contact. In general, the literature and research indicates that contact experiences are more positive and satisfactory for all parties when there is support provided for caregivers along with training (Fuentes, Bernedo, Salas, & García-Martín, 2018; Sanchirico & Jablonka 2000; Sen & Broadhurst, 2011).

Contact support was a significant issue for the kin caregiver whose contact experiences created emotional stressors resulting in damage to the relationship with her daughter. Kin caregivers, can experience greater difficulties than non-kin caregivers managing contact given the complexities surrounding their pre-existing relationships, family dynamics and dual or multiple roles (Boetto, 2010; Bullen, Taplin, Kertesz, Humphreys, & McArthur, 2015). Kin caregivers require additional and specific support and training to help manage contact issues given the difficulties in familial relationships, including conflict resolution, grief and loss (Boetto, 2010; Hunt, Waterhouse & Lutman, 2010).

Notable throughout the majority of caregiver narratives, was a distinct lack of social worker engagement with them throughout their permanency journey, contact issues aside. Of particular interest, was that none of the participants indicated support alternatively from their agency's specialist caregiver social workers which the organisations involved would have had. The role of these social workers is to recruit, train, review and support caregivers. Lack of reference to these social workers presented questions that this research was unable to answer. Namely, what role these social workers play when caregivers are seeking permanency or whether the caregivers did not see this as their role and consequently did not expect or seek support from them? However, discussions around support were general enough for participants to identify if they felt they had received support from them. It is important to note though that caregiver liaison roles were not explicitly raised by the researcher. This lack of reference to caregiver liaison social workers was in contrast to research by Murray, Tarren-Sweeney and France (2011). Their participants identified the greatest support came from caregiver liaison social workers along with other carers. Fernandez and Atwood (2013) likewise stated that these social workers are highly valued by caregivers; however, the authors note that their role is limited as they are not the social worker for the child and they carry large caseloads. This may well provide some answers in regards to their lack of reference by participants in this research.

Two participants in this research did mention contracted out support by social workers from different organisations. This support was generally considered helpful and particularly so for one caregiver who received valuable advice and support around contact issues. However, this support did not specifically help address many of the issues occurring directly with the contact and this is likely due to decision-making resting with the child's social worker.

The findings of this research add to existing research highlighting that caregivers are often not adequately supported. Whilst important for all caregivers, this has particular significance for kin caregivers who can experience additional complexities including changed familial relationships and associated grief and loss and at times also the complete loss of pre-existing relationships.

Information

Caregivers outlined a number of concerns about the lack of information sharing by social workers including: information about the contact arrangements; advice on how to manage contact; information on how to deal with children's behaviour or emotional reactions before and after contact; general birth family information or changing issues within the birth family; and, importantly, information about what occurred at contact. This was consistent with other research where caregivers stated they did not feel they were provided with sufficient information about the child's familial history or given information around contact arrangements and changed circumstances for the birth family (Austerberry et al., 2013; Fuentes et al., 2018).

Caregivers in this research voiced concern about the lack of information and training provided in regards to supporting children emotionally prior to and following contact. This was also found in the research of Collings et al., (2019) where participants felt they received insufficient training and education on how to support the child or manage problems as they developed.

Also raised by participants in this research was the need to be informed about what happened at contact for the child, along with issues for the birth family that might impact contact visits. The importance of caregivers being provided with salient information about what occurs at contact visits was also captured in the research of Morrison et al., (2011). For these caregivers the lack of information provided did not allow them to assist children to help manage their reactions and feelings.

It is reasonable to expect that caregivers will be provided with appropriate information about how to support and manage contact for children, know what occurs at contact for children and be aware of significant birth family information.

Lack of Consultation

For the participants in this study there was an overall absence of consultation around most, and in some instances all, aspects of contact, with the phrase 'just told' featuring strongly.

Atwool's (2010) research into children in care likewise evidenced that there were considerable variations in the degree to which caregivers were consulted or involved in decision-making. The point of difference with the findings of this research was that none of the caregivers had any significant say in the contact arrangements – although for two this was not perceived of as an issue. This was likely due to the contact with the birth mother ceasing for one participant and contact being less problematic for the other participant. Of note in Atwool's (2010) research, was the lack of consultation expressed by caregivers in relation to the impact of the contact arrangements on the child. This was outlined by participants in this research when children's physical, emotional or psychological needs, resulting from or connected to contact, were not addressed in consultation with caregivers. What is known is that when there are greater levels of consultation with caregivers, there is likely to be more positive and successful contact experiences (Logan & Smith, 2004; Morrison et al., 2011). Conversely, as demonstrated in the U.K. research of Neil, Beek & Schofield (2003), when contact is not child-focused and excludes consultation it ends up unsatisfactory or distressing for both the child and the caregiver; again this was consistent with the findings in this study.

Interestingly, Smith and Logan (2004) note that contact preparation/consultation with caregivers needs to involve more than information in regards to the general logistics, including venue, parameters, frequency, and transport. Whilst this is an essential element, caregivers also require preparation around the more complex and often emotional impacts of contact. However, the research here indicated that the majority of caregivers were not even prepared or consulted around the rudimentary aspects of contact including the logistics of the arrangements, regardless of whether these worked for them or not. As Morrison et al. (2011) state, caregivers can feel undermined in their parenting role as a result of a lack of consultation around contact and this was seen in the experiences of caregivers in this research.

Consultation with caregivers, those ultimately responsible for making it work and providing the necessary emotional support for children before and after, is critical. Consultation is not only good practice it can also assist the very experience of contact for a child and their caregiver.

Assessment

Another key finding of this research was the identified lack of social worker assessment of contact, at all stages of the journey for participants. For the caregivers there was no sense that the contact arrangements were assessed for the child's development, their needs or in terms of quality, suitability or safety. Caregivers in this study reported not only a lack of response from social workers to children's distress around contact experiences but also that their practical daily needs were completely overlooked - for example, the case of the caregiver who had to disrupt a child's schooling to meet contact demands. For some caregivers this led to a sense that the arrangements were more about meeting the needs of the birth family than those of the child. This is consistent with other research findings where caregivers queried whose rights and interests were served in the contact when children's needs were overlooked, or distress and trauma indications, both during and post visits, minimised (Collings et al., 2019). Selwyn's (2004) research likewise highlighted difficulties with contact, for children and caregivers, as a result of assumptions by social workers about the benefits of contact without sufficient social worker assessment.

The findings also evidenced a lack of assessment of birth parent behaviour both at contact and towards the caregivers themselves. For two of the participants, parental behaviour at contact was a significant concern which also involved non-acceptance of the children's permanent placement. However, the literature clearly indicates that social workers need to carefully assess parental behaviours and attitudes, not only generally and towards the child but also in support of the permanent placement (Mossman, 2004). As Selwyn (2004) states, social worker assessments of contact are imperative particularly in relation to issues of safety and risk along with understanding pre-existing familial relationships and dynamics.

Relationship Matters

The importance of relationship was another key finding in this study. This included: relationship with the social worker; the birth parent/s; the birth family; and wider systems and relationships for the caregivers. What was notable throughout the majority of caregiver narratives was a distinct lack of social worker engagement with them throughout their permanency journey, contact issues aside. Possible additional explanations for this are

discussed later. However, the literature clearly indicates that social workers need to develop and maintain respectful relationships with caregivers (Fuentes, Bernedo, Salas & García-Martín, 2018; Geiger, et al., 2016). This is not only as part of good or ethical practice but also because such positive relationships can help enhance the contact experience itself (Boyle, 2017; Nesmith, Patton, Christophersen, & Smart, 2017).

In addition to relational issues with social workers the participants experienced a lack of focus on relationships with birth parents, the extended birth family and wider relationship systems. This finding was partially consistent with the work of Thompson (2019). Thompson found that practitioners focused on caregiver's ability to manage contact; however, less attention was paid to the relationships between the birth parents and caregivers who were primarily kin. However, unlike Thompson's research, the majority of participants in this study were not even supported in terms of contact management let alone having relational issues with birth families attended to.

Other research has also highlighted that social workers often fail to think and operate relationally and systemically as a result of focusing only on the child, as the client, and their experience of contact (Neil, 2007). Subsequently, other relationships, such as the caregiver, tend to be neglected or ignored. Caregivers and adults, within this framework of thinking, are therefore not seen as contact participants in their own right (Neil, 2007). Caregivers in this research wanted practitioners to be aware of their own and their wider family needs when planning contact. Similarly, the findings from Austerberry, et al. (2013) highlighted that caregivers particularly valued social workers who gave consideration to the interests and needs of all parties impacted by the contact plan. Wilson and Devaney (2018) note that whilst contact practices need to be child-centred and in children's best interests, and wellbeing, myopic interpretations of this are not helpful. Instead, social workers need to recognise that children exist within multiple and complex systems and relationships which require cooperation in order to provide optimal experiences for children (Bullen et al., 2017; Fuentes et al., 2018; Wilson & Devaney, 2018).

However, whilst participants in this study indicated a lack of attention to wider relationships, it did not appear that this occurred as a result of social workers focusing exclusively on the needs and experience for the child. In contrast, the findings here highlighted that contact plans were often not in the best interest of the child or focused on their needs. It appeared

instead, that the lens was simply but firmly on contact for the sake of contact with little else considered, assessed, or at times even well thought through. Wilson and Devaney (2018) concluded that contact practice has been “informed by promoting legal rights without sufficient consideration of the relational aspects of making contact work for each of the involved parties” (p.288). Relationship-based practice and relational thinking are essential when working with caregivers and in promoting positive contact outcomes. Research recommends that there needs to be a greater focus on improving and maintaining relationships with relational thinking given a much higher practice priority (Delgado, Pinto, Carvalho & Gilligan, 2019; Geiger, et al., 2016; Nesmith, et al., 2017; Thompson, 2019).

In general, the themes identified in this study echoed those of other similar research in this field - limited support, training and information for caregivers, difficult relationships with social workers, lack of relationship and consultation and marginalisation of caregivers within the child protection system (Maclay, Bunce & Purves, 2006; Murray, Tarren-Sweeney & France, 2011; Sanchirico & Jablonka 2000; Tansley, 2014).

Factors Impacting Social Work Practice and Relationship

There are a number of factors which are seen to impact contact practices for social workers. It is acknowledged that this area of work lacks helpful guidelines, coherent theory, is not well supported in research, and divides researchers (Atwool, 2010; Schofield, et al., 2000; Triseliotis, 2010). Austerberry et al. (2013) states that social workers often lack a clear evidence-base of what type of practice would actually be most effective. All this combined with the nature and complexity of the work, makes practice in this field more difficult. This may also help explain the lack of assessment experienced by the caregivers along with the general support caregivers stated they required.

This research adds to and strengthens the findings of previous research, both nationally and internationally, evidencing ongoing issues for caregivers in regards to support, consultation, assessment and communication. Many of the same issues were, for example, highlighted in Atwool’s (2010) New Zealand report into Children in Care. Subsequently, it appears there has been little in the way of change to social work practice over the past nine years. Of note though, is that over the past decade, in New Zealand, there has also been a renewed focus on

permanency planning and support for caregivers via the previous Home for Life policy and the more recently introduced Permanent Caregiver Support Service. However, despite these initiatives there appears to have been little in the way of social worker practice change with caregivers. If social work practice has continued unchanged despite the introduction of new policies and services and the introduction in New Zealand of a new statutory organisation, *Oranga Tamariki, Ministry for Children*, then potential answers around practice must be sought elsewhere. A conclusion reached therefore is that wider issues are impacting on practice and relationality. Three factors were identified as impacting on practice and relational engagement with caregivers: the paradigm gap; managerialism; and workload and role clarity.

Paradigm Gap

Caregivers inhabit a peculiar status – they are not the client, as is the child or connected service user such as the birth parents, requiring specific interventions or models of practice. As such, a paradigm gap exists for practice with caregivers in the care and protection world. There seems to be good reason for this, albeit one that has potentially done a disservice to caregivers, which may provide clues as to the absence of relationship experienced by the participants in this research. Research indicates there are ambiguities in the relationship between caregivers and social workers (Hudson & Levasseur, 2002). For Hudson and Levasseur, these ambiguities may not be completely solvable but they do point to possibilities to help alleviate some of the associated vagueness, including caregiver entitlement to agreements, around mutual expectations. If it is fair that organisations have expectations of caregivers then this needs to be reciprocated, including respect for their role and participation in decision-making (Hudson & Levasseur, 2002). Maclay, Bunce and Purves (2006) also highlighted the need for caregivers to be viewed as equal team members; however, these authors noted their ongoing exclusion from partnership with professionals. Lonne et al., (2009) in their book *Reforming Child Protection*, which examined child protection practice across Western countries, go further and explicitly state that caregivers are not clients. These authors recommended an array of reforms of the child protection world; however, caregivers are not included in their overall framework as they are not seen as service users. Instead they argue that caregiver roles are similar to practitioners and subsequently they should be seen in that light and be an acknowledged part of the care ‘team’. Lonne et al. (2009) note that:

Many carers have suffered from being conceptualized as services users within a professionalized discourse with one central actor—a professional child protection practitioner (2009, p.95).

The findings of this research strongly indicated the central actor in the contact arena was the child's social worker with the caregivers seemingly unable to even obtain supporting or cameo roles; relegated instead to bit parts, occasional walk-ons or bystander scenes. At the same time, the aforementioned authors also acknowledged the difficulty of simply seeing the caregivers as part of the team as often they require resourcing and support in order to carry out their care roles, including contact support. Whilst it is agreed that caregivers do require specific supports and resourcing as a part of their role, this should not detract from viewing them as partners, as this is not really any different to that which is required by social workers and others working in care and protection. Whilst working with caregivers as partners presents some challenges with fit, caregivers should have an equitable partnership (Lonne et al., 2009).

Generally, caregivers want to have their opinions valued, be seen as respected members of the team and have a clear sense of being “major players” in regards to decision-making around contact (Geiger et al., 2016; Neil et al., 2003, p.416).

Managerialism

Managerialism is seen as a significant contributor to the lack of relational practice, not only with caregivers but also for clients and other service users (Buckley et al., 2019; Harlow, Berg, & Chandler, 2013; Turney, 2012). It is seen to have eroded a professional identity in social work that should value the centrality of relationships and distracted social work from its fundamentals of relationship-based engagement (McAuliffe et al., 2015; Rankine, 2017). For Howe (1998), relationship based practice was impacted by managerialism, manual writers, guideline authors, advocates of defensive practice and those who believe that people are best served by, “trained functionaries working in highly structured organisations and not by educated professionals practising reflectively in organic, free-thinking teams” (p.48).

A consequence of managerialism is that social work has become compliance and crisis driven, risk-averse and characterised by outcomes, targets, standard-setting, performance indicators, audits legal and administrative requirements, bureaucracy and procedures (Lonne, et al., 2009; McAuliffe et al., 2015; Rankine, Beddoe, O'Brien & Fouché, 2018; Ruch, 2004). For Keddell (2011), the identification and management of risk has become “one of the most ubiquitous organising constructs of child protection” (p.1254). The conflictual or adversarial nature of care and protection produces greater relationship complexities with significant power differentials. Caregivers internationally experience systemic and relational issues along with power differentials and exclusion from decision-making at all levels (Withington, Burton, Lonne & Eviers, 2016). This was evidenced, for caregivers, in the findings of this research.

Caregivers experience the effects of the conflictual or adversarial nature of care and protection as staffing shortages, high staff turn-over and pressure on the workforce with the recruitment of inexperienced workers (Buckley, et al., 2019). Scattered throughout the caregiver narratives in this research were the recurring issues of staff shortage or turnover, including frustration with new staff who were perceived as not really knowing what they were doing and appeared answerable to someone else making decisions. This finding was consistent with the Australian research of Collings et al., (2019) where caregivers expressed frustration at the high degree of staff turnover along with recruitment of inexperienced social workers.

The risk dominated nature of child protection has developed in part also as a result of intense media scrutiny which has an impact on organisational culture along with a high degree of uncertainty, insecurity and volatility (Gilbert, Parton & Skivenes, 2011). Miller (2017) notes that social workers in child protection face inherent tensions given the well-publicised risks which creates fear for practitioners and, in turn, contributes also to high staff turnover. New Zealand research by Staniforth and Beddoe (2017) highlighted that social workers were made visible in media portrayals in proportion to the extent of their failures. These workforce issues have significant implications for both service quality and outcomes as relationship-based practice relies on effective and experienced staff (Buckley et al., 2019). There is, however, growing recognition that current practices are not workable and for social work values, practices and relationship-building to be reclaimed to both withstand

and transcend the procedural, legalistic and dominating effects of managerialist discourses (McAuliffe, et al., 2015; Miller, 2017; Russ, Lonne & Darlington, 2016).

Workload and Role Clarity

Caregivers in this research expressed awareness that social workers were extremely busy or over-burdened with caseloads and, at times, this made them reluctant to approach social workers for support. Clearly it is difficult, if not impossible, to engage relationally and meet the required practice demands in regards to contact planning when there are significant time and prioritising constraints. This has been outlined in other research noting the impacts of generic caseloads for social workers and the difficulties of prioritising and balancing practice demands (Atwool, 2010). For practitioners, this often means there is not spare capacity to provide the additional contact support required for caregivers in challenging situations (Austerberry, et al., 2013). Geiger et al.'s (2016) research also revealed that caregivers were consistently aware of the systemic barrier of an overwhelmed system.

However, other research suggests there may be additional explanations for this issue. Thomson's (2007) Australian study also found that social workers often felt overwhelmed with high caseloads and considerable stressors. Of interest, however, is that the social workers in Thomson's study saw themselves as the child's social worker and as such felt uncomfortable when caregivers sought support from them as they did not consider it their role to provide support. A role dissonance was experienced by workers given the difficulties balancing the competing demands on them; not just from caregivers but from children, young people and parents. Lonne et al. (2009) go further and suggest that it may be extremely difficult, or even impossible, for social workers to simultaneously provide the required levels of support to all parties within the contact triangle. This is significant given the findings of this research and also the noted lack of reference to support by the caregiver liaison social workers.

A lack of relationship-based practice and thinking was experienced by the participants of this research which then transferred into other practice domains including assessment, consultation, communication and support. What is likely however, is that quality relational social work practice, is more easily carried out when there is congruence with organisational

culture and policy (Hudson & Levasseur, 2002). As Miller (2017) states it is crucial that relationship based practice starts in leadership and notes that:

The responsibility for embedding thoughtful, relationship-based practice essentially rests with management as messages from senior leaders provide the context within which practice strengthening occurs (p.198).

Practice Implication: Re-thinking Contact Planning

Establishing relationship and partnership with caregivers is seen as critical to improve issues of support, communication, consultation and, importantly, enhance contact assessment. By developing and maintaining effective and quality relationships with caregivers, social workers should begin to recognise caregivers as contact participants in their own right with individual needs, relationships and systems that need to be taken account of. By failing to attend to relationships, not only for caregivers but all parties, social workers will never be able to develop appropriate and well-assessed contact plans that help translate into quality contact experiences.

A significant practice implication is whether responsibility for contact planning should sit with only the child's social worker; particularly when working with more complex or difficult birth family dynamics. This is contended in light of both the wider factors potentially impacting practice and relationality and the difficulties of contact work generally. Figure 2 below outlines the relationships and systems for social worker contact planning and highlights the complexities of this arena including all the systemic, support and relational issues, identified in the literature and by caregivers in this research. This diagram is not intended however, as a practice guideline for social workers; that would be beyond the scope and capacity of this thesis.

Figure 2: Relationships and Systems for Social Worker Contact Planning



This graphic clearly illustrates what the research and literature has highlighted - namely that the contact arena is complex, multifaceted and difficult for practitioners to navigate (Atwool, 2008; Atwool, 2010; Beek & Schofield, 2004; Tansley, 2014). There are multiple relationships to support and invest in to ensure appropriate contact assessment and planning. However, as Selwyn (2004) states, social workers need to complete in-depth assessments of each specific situation and once it has been determined that contact is safe, appropriate and of benefit to the child, ensure that all involved receive the support they require. Achieving this though requires experienced, skilled social workers who are able to invest considerable time and build appropriate relationships with all parties. As such, it may be important for organisations to consider how they do contact planning as the work may simply be too

difficult for one social worker (Lonne et al., 2009). This would also open space to explore the role of caregiver liaison social workers along with the input of other professionals and caregivers when contact assessment and planning occurs.

Summary

In conclusion, the findings of this research have painted a rather disheartening picture of social work practice in regards to issues of contact assessment and support, consultation, relationship and communication with this group of caregivers. However, these findings were consistent with and added to existing knowledge bases around the lack of support, marginalisation and, at times, exclusion of caregivers from participation and decision-making. Positively, all of the caregivers exhibited an understanding of the purpose of contact and needs of the child and had worked hard, despite issues overall with social work practice and parental commitment, to ensure that it occurred. The majority of participants also displayed an openness to contact in their home and/or a desire to have more open relationships with birth families, where safe to occur. However, at times, caregivers were not provided with appropriate social work support and information and contact assessment was absent. Given this research added to and strengthened existing research, indicating lack of partnership and support for caregivers, attempts were made to explore factors, outside of simply individual practitioners, which might be impacting practice and relationality. Subsequently, it was contended that organisational and paradigm issues may affect practitioners working in this field. A significant implication for practice was examined including whether the demands of this work require critical organisational re-thinking. The conclusion therefore, will outline recommendations for future research along with specific practice and policy recommendations.

CHAPTER 6: CONCLUSION

Introduction

This qualitative constructivist/interpretivist research sought to critically explore the views and experiences of six kin and non-kin caregivers in regards to social work contact planning practice. The aim was to identify processes and practices that were helpful to caregivers and supported quality contact outcomes post permanency. Semi-structured interviews were completed which provided the opportunity to explore in-depth with participants their subjective experiences of contact planning.

This chapter will present a summary of both the key findings along with those issues identified as impacting practice. Possible future research is outlined and the chapter concludes with a range of practice, organisational and policy recommendations.

Unfortunately, this study did not answer the research question in the way intended, as there was little social work *contact practice* experienced as helpful. However, analysis of the participants' responses in terms of what was absent, alongside their stated recommendations for what would be helpful, was utilised to help answer and address the research question.

Key Findings

The caregivers in this study all had a clear understanding of the rationale for, and benefits of, contact for children and young people. They evidenced a strong commitment to birth family contact, and this occurred despite issues with birth family commitment and with social work practices. The participants were also all receptive to, or had a relationship with, the birth families and many hosted contact with the birth family in their own home. For some participants however, this positive view of contact appeared challenged or changed, to varying degrees, as a result of social work practices. Subsequently, participants were led to wonder whether children's needs were being served by the contact arrangements and questions emerged in regards to either the type or value of contact for some children.

The phrase '**just told**' featured throughout many of the interviews in relation to the overall experience of lack of consultation. The majority of participants had no significant say in the contact arrangements including venue, frequency, nature of the contact, time that contact occurred, how it would occur - nor around the value of the contact and whether it should be occurring at all. Caregivers also outlined a lack of **information** from social workers. Negative outcomes or potential safety issues as a result of not being provided with essential information about the birth family were identified. For caregivers, the required communication varied and included: information about contact generally; dealing with children's emotional reactions before and after contact; birth family history; information about changing circumstances for the birth family, particularly prior to a contact visit; and pertinent information about what occurred at the contact visit.

Limited support was also identified by the majority of participants. This involved support to help manage children's behaviours both before and following contact but also parental behaviours, including not turning up for scheduled contact or emotional manipulation of the children. The specific and unique needs of kin caregivers was also raised, and highlighted the need for social workers to provide particular support to kin caregivers who experience a greater variety of emotional complexities given family history, dynamics and dual or multiple familial roles.

A disturbing finding of this study though was **lack of (contact) assessment** identified by participants. Caregivers noted that often children's experiences were overlooked or not analysed with regard to their developmental stage, views or personal needs which for some children included significant distress. The majority of participants also experienced contact arrangements not being assessed in terms of suitability, safety or quality. Poor assessment was also outlined in relation to lack of monitoring or challenging of birth family behaviours. Concerning parental behaviours included abuse of caregivers, birth parents not showing up for contact, non-acceptance of the child's permanent placement, and emotional and psychological manipulation of children. Participants also identified that issues of **relationship** were not attended to. This was experienced not only as an overall lack of relationship with social workers directly but also a lack of support around how relationships with birth parents and birth families might be navigated and managed. In addition, important relational issues and needs within caregiver families, particularly for kin caregivers, was also

highlighted. It was clear that poor relationships were a significant contributor to caregiver experiences of lack of support, consultation, communication and assessment.

The literature review of this thesis outlined that support, consultation, information, relationship and assessment were fundamental domains of social work practice required to help develop quality contact outcomes for children. The findings of this study however, echoed research both in New Zealand and internationally which evidenced that caregivers are often not supported and are marginalised or excluded from contact planning and decision-making throughout the process.

Practice Impacts

The findings of this research, as noted, validated the outcomes of similar research on caregiver experiences both in New Zealand and internationally. Also highlighted was the lack of practice change in New Zealand over the past years, despite the increased focus on caregiver support and permanency planning. As such, broader explanations for this were sought outside of simply individual social work practice. The area of contact practice is not only complex and demanding for social workers but is generally seen to lack helpful guidelines, theory and research (Atwool, 2010; Triseliotis, 2010). This undoubtedly contributes to the type of contact practice experienced by the participants in this study. In addition to this, three key factors were identified as impacting relationality and practice: the paradigm gap; managerialism; and workload and role clarity.

The paradigm gap highlighted the somewhat peculiar status that caregivers have currently within care and protection – being not the client, as is the child, nor connected service user such as the birth parent. This lack of a clear space for caregivers to inhabit, was considered a significant contributor to the overall lack of appropriate relationship and engagement with them throughout their journey. Instead, it was argued that caregivers need to be seen as partners with organisations, which is important given that contact planning is seen to work better when caregivers are included as part of the team. Managerialism was examined to help explain the current organisational climate which works to essentially weaken relational practice through risk-averse practice and a focus on outcomes, tasks, administrative requirements, bureaucracy and procedures. The conflictual and adversarial nature of care

and protection also impacts social work practice and retention given the significant public tensions and risks. Caregivers may experience these issues as power differentials, staff shortages, staff turnover and workforce pressures and these issues were highlighted in the experiences of the participants in this study. Workload and role clarity explored issues in relation to the competing demands on child protection social workers. Participants in this study had reported issues of high staff turnover and expressed awareness that social workers were either new and inexperienced or over-burdened in their role. However, whilst these issues were important they did not in themselves answer or address the overall lack of relationship or practice issues experienced by the participants. A significant explanation for this was the likelihood that social workers inevitably have their focus on the child; perceiving themselves to be the child's social worker with contact planning, in particular, centred on the child as the primary client. As such, practitioners may find it either too difficult to provide required support to caregivers and essentially 'be all things to all people' or simply may not consider it their role. A graphic was included to highlight the complexity of contact work for social workers and in particular the relational demands required for assessment and planning. Subsequently, it was suggested that organisations reconsider how contact planning practices occur as the work and relationships involved may be simply too much for the child's social worker.

Future Research Recommendations

There were a number of issues that were raised in this research that were both beyond its scope and at times too tangential but which could be followed up in future studies. Firstly, given that this study only involved caregivers, there is scope for research to be extended to social workers, particularly in regard to the issues of relationship based practice and partnership with caregivers. Research could also examine whether care and protection practitioners in New Zealand experience similar role demands and dissonance in terms of working with caregivers. In relation to this, future work could explore the role of caregiver liaison social workers with caregivers who are on the permanency journey, given the lack of reference to these social work roles by participants in this study.

Further research could also examine whether contact planning is beyond the capacity of the child's social worker and whether team approaches produce better outcomes particularly with

families experiencing particularly complex or difficult issues. Another research area, which was not connected to these findings, is that of the contact and general experiences of those kin caregivers who end up taking orders, instead of the Ministry, where there are care and protection concerns. This is highlighted here due to meeting with a kin caregiver who was in this position, and therefore outside the parameters of this research, but who shared a journey that was emotionally harrowing and fraught with issues. By acknowledging this here, I am attempting in some way to honour her story.

Practice and Policy Recommendations

The findings of this research point to a range of recommendations to help address significant practice issues impacting caregivers in relation to contact planning. It is essential that caregivers receive appropriate support and information and are consulted and engaged with as partners in the permanency journey. Establishing relationship is a key component of this and without it the above domains cannot be achieved nor can contact assessment ever be of a quality standard that addresses and meets the needs of children and their families. The practice and policy recommendations outlined below focus on the work of practitioners and also organisational practice and culture:

- Social work contact assessments take account not only of the needs of the child but also those of caregivers and the wider systems around the new family;
- social workers receive in-depth training around contact planning and assessment work;
- unsupervised birth family contact is seriously re-assessed when issues of caregiver abuse, on-going manipulation of children or non-acceptance of the permanent placement, is present;
- there is a greater range of contact experiences considered for children dependent on their needs, histories and familial behaviours as opposed to focusing on physical/direct contact regardless of issues present;
- if safe and appropriate, greater consideration is given to alternative forms of direct contact for children and birth families centred around children's activities and events;
- support needs of kin caregivers are addressed in relation to the particular issues they face in terms of familial dynamics, dual or multiple roles within the family, and grief and loss;

- consideration is given to more caregiver training opportunities in evenings or other appropriate times, as many people work during the day, and alongside this ensuring childcare provision is considered;
- organisations ensure that caregivers are consulted and included as partners with social workers and be part of the organisational team;
- organisations reconsider how contact planning and assessment occurs, particularly in light of the relational and systemic demands for the child's social worker. This could include a greater role for Caregiver Liaison Social Workers and other professionals involved in supporting caregivers;
- consideration is given to the development of 'expert' roles, particularly within the Ministry, to help provide essential advice, training and support to social workers and sites in regards to contact planning and assessment. This is particularly relevant given the issues in relation to high staff turnover and recruitment of inexperienced workers;
- relationship-based work is strengthened and modelled by leadership in care and protection organisations to ensure that this is embedded strongly within social work practice;
- organisations continue to develop reflective supervision processes that enhance social work knowledge and skill bases and help ensure relationship skills are paralleled in practice;
- that there is more involvement of caregivers in decision-making at policy level;
- Oranga Tamariki Ministry for Children practice centre policy on caregiver support for maintaining contact/connections, is reviewed with a focus on caregiver needs and appropriate social work support.

The researcher acknowledges that issues pertaining to contact planning will at times be outside the control of social workers given that decision-making can often occur in the family court. However, it is suggested that both despite this and because of this, there is an even greater need for social workers to ensure that quality individualised contact assessments occur. This needs to include robust rationale and recommendations which can be clearly outlined in court reports.

Summary

Overall, the findings of this research strengthen and add to existing bodies of research which indicates that caregivers are often marginalised and excluded from contact planning and do not receive the appropriate support, information, training, and consultation the literature considers vital for quality contact outcomes. Further highlighted were issues for caregivers around the absence of contact assessment and relational practice. By including a wider analysis of potential organisational issues and general practice gaps, it is hoped that this research contributes to this knowledge base to strengthen this area of work. Also recognised is that the experiences of caregivers, in regards to the issue of contact, have not been well explored in research (Hashim, 2009; Osborn & Delfabbro, 2009). The intention of this study has been to contribute to addressing this gap, particularly within the New Zealand context, and give *voice* to the experiences of these caregivers.

This research began in the introduction with a quote by Triseliotis (2010) that, “ making judgements on the quality and nature of contact remains a mixture of art and science, possibly balanced more towards art ” (p.59). Whilst this remains true to a certain degree, it is hoped that this research will at the very least support sounder judgements.

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APPENDIX A

Permanent Caregiver Support Service

Definition Permanent Caregivers

A caregiver who has had a child/young person placed with them permanently by Oranga Tamariki Ministry for Children (previously CYF) or an approved social service provider may be eligible for financial and other assistance. To be eligible a caregiver must meet the definition of a *permanent caregiver* in the Oranga Tamariki Act 1989.

A *permanent caregiver* is a caregiver who:

- has had a child or young person placed with them permanently by Oranga Tamariki Ministry for Children (previously Child, Youth and Family) or an approved social service provider; **and**

Either:

- [has legal orders as a 'special guardian' or,](#)
- [has parenting and guardianship orders](#)

In addition to caregivers who fit under the definition of 'permanent caregiver' in the Act a caregiver without any legal orders may be eligible for financial and other assistance where:

- a child or young person was placed with them by Oranga Tamariki Ministry for Children (previously Child, Youth and Family) permanently and
- there was agreement that the permanent care arrangement did not need any legal orders once custody orders to the Chief Executive were discharged.

Note: Caregivers with [section 101 custody orders](#) under the Oranga Tamariki Act 1989 for a child or young person placed with them permanently do not meet the definition of 'Permanent Caregiver'. They are not entitled to financial and other assistance from the Permanent Caregiver Support Service but can continue to be supported where required through a [section 86 Services Order](#) or a [section 91 Support Order](#).

APPENDIX B

Permanent Caregiver Support Service: Criteria for Assistance

Financial and Other Assistance

A permanent caregiver is responsible for the reasonable day to day care costs of a child in their care. Sometimes there are needs that a child in care has that result from the child's earlier care and protection experience or relate to a specific extraordinary need. In these situations permanent caregivers can access individually tailored support - financial or non-financial - to help them meet the needs of the child into the future.

The Permanent Caregiver Support Service social workers are available to talk through specific requests for assistance from caregivers and plan with them.

Assistance **must** be provided under the legislation (s388A (2) of the Oranga Tamariki Act 1989) where the need:

- arises as a result of the child's:
 - care and protection needs or
 - extraordinary health needs or
 - extraordinary education needs or
 - extraordinary developmental needs **and**
- is more than what is reasonable to expect the caregiver to fund **and**
- cannot be met by existing sources of support and is unlikely to be provided otherwise **and**
- is reasonable to be provided by the Chief Executive **and**
- the provision of assistance is consistent with any general or special directions given to the Chief Executive in writing by the Minister.

*Assistance **may** be provided where the need doesn't fit the above criteria by the exercise of a legislative discretion also delegated to the Permanent Caregiver Support Service. Any assistance provided under discretion would be to help the permanent caregiver to care for the child or young person. A decision made under this discretion is not reviewable.*

APPENDIX C

Email to organisations

Dear

My name is Kristin Nielsen-Vold and I am a Masters student enrolled in research at Massey University. The research I am engaged in is focused on how caregivers experience social worker practice in regards to contact/access planning, assessment and support; and how this work impacts when permanency is achieved. The title of this research is: *Caregiver experience of contact planning practice and outcomes for permanency*.

I was in communication earlier this year with your organisation about this research and it was agreed that caregivers could contact someone at your organisation for any support they might require should the interview process raise any emotional issues for them. I do not envisage that there will in fact be issues; however this was required for ethics approval which has recently been granted. The ethics approval number is on the information sheet provided.

I would appreciate the opportunity to be able, with your support, to recruit eligible participants for this research from within your organisation. If agreed, your assistance would involve having the attached *information sheet and consent form* forwarded electronically (or any other way you consider appropriate) to your members for their consideration. There may be some of your members who would really value having the opportunity to share their experiences and perspectives on this issue.

The information sheet provides detailed information about the purpose of this research, criteria for participation and what would be involved for participants.

Also attached is the official letter of request to your organisation on Massey letterhead.

If you would like more information about this research before submitting this to your members, please feel free to contact me via the contact details below.

It would be greatly appreciated if you could advise me of whether this research request has met with your organisation's approval and you have agreed to submit to your members.

Thank you for taking the time to read through this proposal and I look forward to hearing from you.

Yours faithfully
Kristin Nielsen-Vold



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APPENDIX D

Participant Consent Form

Project Title

Caregiver experience of contact/access planning practice and outcomes for permanency.

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

My participation in the project is entirely my choice;

I am free to withdraw from the project at any time without any disadvantage;

I wish/do not wish to have my recordings returned to me?

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

Full Name - printed



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APPENDIX E

Participant Information Sheet

Caregiver experience of contact/access planning practice and outcomes for permanency.

INFORMATION SHEET

Researcher Introduction

My name is Kristin Nielsen-Vold and I am a student at Massey University. This project is being undertaken as part of the requirements for the Masters in Social Work. I have previously worked for Oranga Tamariki (Child Youth and Family) and Open Home Foundation and am currently employed as a hospital social worker. The hope is that this research will contribute to a greater understanding of caregiver's experiences in regards to social worker practice in this area.

Project Description and Invitation

This is an invitation to take part in this research and thank you for taking the time to review this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate, thank you. If you decide not to take part there will be no disadvantage to you of any kind and thank you for considering this request.

The purpose of this research is to explore caregiver experience of social work practice in regards to contact/access planning, assessment and support and its impacts once permanency was achieved.

The criteria for participation in this research is:

- participants are kin or non-kin caregivers;
- participants are not currently providing care for children in the care of Oranga Tamariki or Open Home Foundation;
- participants achieved permanency in the past seven years,
- the child/ren in their care were previously in the care of Oranga Tamariki (previously Child Youth and Family) or another non-government organisation prior to achieving permanency;
- there was a contact plan in place or an expectation caregivers would manage some aspect of contact post when permanency was achieved.

All participants will be partially compensated for their participation in this research and will be provided with a \$20.00 gift voucher as a token of goodwill. Participants will also receive a copy of the summary of the findings which will be emailed to them after the examination of the thesis. This research, when concluded, will also be available in the Massey University Library.

Project Procedures

This project involves semi-structured interviews combining planned and unplanned questions. The interviews may occur in-person (depending on location) or via Skype and in this situation you will need access to a computer with a working internet connection. The interview will be no more than around 1 - 1½ hours duration. If required, and agreed, an additional interview can be arranged. You will be provided the opportunity to review your transcript, prior to data analysis, in order to identify any errors or challenge incorrect interpretations. The researcher may also seek clarification from you following the interview, if this is required, when the interview is being transcribed.



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You can decide not to take part in the project at any time and without any disadvantage of any kind. You can also request that the recorder be turned off at any time during the interview. Given this research topic may involve emotional issues you are able to take time out or re-schedule, if necessary. If further debriefing is required at the conclusion of the interview and personal supports are not available you are able to seek support from either Fostering Kids or Grandparents Raising Grandchildren. You also need to be advised that should you disclose, during the course of the interview, that you have abused or maltreated a child in your care, the researcher is obliged to report this matter to Oranga Tamariki, Ministry for Children.

Data Management

Interviews will be audio recorded and handwritten notes will also be taken by the researcher throughout the interview. A transcriber will complete the transcription and they will sign a transcriber confidentiality agreement to ensure that your confidentiality is maintained. All names and identifying information will be disguised in the public presentation of the research; however, this information will be retained in the transcripts. The data will be safely stored and will only be accessible by the researcher. Personal identifying information (audio-tapes) will be destroyed at the conclusion of the project. However, any raw data on which the results of the project depend will be retained in secure storage for five years, after which they will be destroyed. Please note that the researcher, as outlined, will make all attempts to assure and protect confidentiality pro-actively. However, it is not possible to provide an absolute guarantee of confidentiality where information is recorded.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study at any stage;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*

Project Contacts

Student researcher
Kristin Nielsen-Vold

Research Supervisor 1
Dr Tracie Mafle'o

Research Supervisor 2
Dr Kathryn Hay

Please feel free to contact myself or my supervisors should you have any questions about the project.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 18/03. If you have any concerns about the conduct of this



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research, please contact Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 356 9099 x 85094, email humanethicsoutha@massey.ac.nz.

Once again thank you for considering participation in this project.

Kristin Nielsen-Vold
Student researcher

APPENDIX F

Interview schedule

Outline of interview with caregivers

Introduction: Outline purpose of project using Information Sheet.

Respond to any questions participant may have. Negotiate timeframe for the interview.

General statistical questions:

- *How long the child/ren have been in their care?*
- *What were the specific contact arrangements that were agreed before permanency?*
- *What are the current arrangements happening now?*
- *What was your family situation when you agreed to permanency (e.g. sole parent/ 2-parent household)?*
- *Ethnicity of caregiver.*

1. What do you remember about the contact decision-making processes that occurred when it was decided that (child) would live permanently with you?

Prompts:

- *How did you participate in contact decision-making?*
- *How was your expertise as a caregiver utilised in the planning and discussions around contact?*
- *How were your views about contact for permanency sought, valued and included by the social worker?*
- *Was there a sense of 'partnership' with the social worker in the decision-making/what did that look like?*

2. In what ways do you recall contact being assessed for permanency?

Prompts:

- *Did you participate in any social worker assessment of contact for permanency/ what did that look like?*
- *How did you know that the best contact decisions and arrangements were made?*
- *Were other professional assessments/ opinions sought?*

3. How did you experience being supported or trained to manage the contact?

Prompts:

- *What were the expectations of you in relation to the contact arrangements?*
- *Did you feel you were supported adequately/ if not why/ what more did you need or would have been helpful?*
- *How did this help you with the contact arrangements?*
- *How did any support/training help you with birth family relationships?*

4. What (if any) were your greatest challenges or barriers with the contact arrangements before permanency was achieved?
Prompts:
 - *What might you have liked to have seen happen differently in regards to contact management/planning before you went to permanency*
5. Tell me about the things that the social worker did that you found to be the most helpful in regards to the contact?
Prompts:
 - *What made this particularly helpful and why?*
 - *How did this assist with contact?*
6. What were your experiences of contact once you achieved permanency?
Prompts:
 - *How did you end up managing the contact arrangements post permanency?*
 - *Is there anything that has been particularly challenging/ why?*
 - *Is there anything that has worked well/ why?*

Are there any other parts of your experience of contact that you would like to share or expand on?

Prompts:

- *What key advice about contact preparation might you give new caregivers seeking to take permanency with children?*
- *What key messages might you give to social workers about contact assessment and planning prior to permanency?*



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APPENDIX G

Transcriber Confidentiality Agreement

Caregiver experience of contact planning practice and outcomes for permanency.

CONFIDENTIALITY AGREEMENT

I (Full Name - printed)

agree to keep confidential all information concerning the project

.....

.....

.....

..... (Title of Project).

I will not retain or copy any information involving the project.

Signature:

.....

Date:

.....



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APPENDIX H

Transcript Release Authority

Caregiver experience of contact planning practice and outcomes for permanency.

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature:

Date:

Full Name - printed

APPENDIX I

Ethics Approval Letter

Date: 24 April 2018

Dear Kristin Nielsen-Vold Re: Ethics Notification - SOA 18/03 - Caregiver experience of contact planning practice and outcomes for permanency.

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Human Ethics Southern A Committee at their meeting held on Tuesday, 24 April, 2018.

Approval is for three years. If this project has not been completed within three years from the date of this letter, re-approval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

A handwritten signature in blue ink, reading "B7 Finch".

Research Ethics Office, Research and Enterprise Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 350 5573; 06 350 5575 F 06 355 7973 E humanethics@massey.ac.nz W <http://humanethics.massey.ac.nz>