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“Someone to walk with me”:
Supporting caregivers who look after children
with mental health problems in statutory care

A thesis presented in partial fulfilment for the Degree of Doctor
of Philosophy at Massey University
School of Sociology, Social Policy and Social Work

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Errata

Pg 24, line 13, add M to DHDS – should read “DMHDS”

Pg 57, line 24, insert “of” between “source” and “emotional”

Pg 86, line 27, insert “of ” between “establishment” and “service”

Pg 94, final line replace “ is” with “are”

Pg 113, line 5, add “s” to “suggest”

Reference List – note Friesen B (1993) should read

Friesen, B. J. (1993). Creating Change for Children with Serious Emotional Disorders: A national strategy. In T. Mizrahi & J. Morrison (Eds.), *Community Organizations and Social Administration: Advances, Trends and Emerging Principles* (pp. 127-146). New York: Haworth Press.

Abstract

The role of support to caregivers in strengthening care outcomes was explored for a group of children and young people with mental health problems in the care of the Department of Child, Youth and Family Services. Four studies were integrated in a mixed methods design. In the first study a survey of 237 social workers established that informal support and caregiver factors were regarded as more effective than formal support services to caregivers in strengthening care outcomes for this group. Social workers described poor access to mental health services and deficiencies in their support to caregivers looking after children and young people with mental health problems. In the second study a focus group of caregivers viewed effective support as constituting a number of factors, including, informal support from caregiver networks, boundary setting by caregivers, training and support in managing behaviours and participation by children and young people in school or work. The role of religious beliefs, religious networks and respite care, in strengthening care outcomes was emphasised. Caregivers identified poor levels of support from Child, Youth and Family social workers and from mental health services. In the third study, a composite construct for measuring positive care outcomes for children and young people with mental health problems was established by a group of Child, Youth and Family experts, using a Delphi process. In the final study, case history data for a large group (n=1071) of children and young people with mental health problems in care of Child, Youth and Family were explored in a multivariate analysis. This analysis utilised, as independent variables, those factors identified by social workers and caregivers in studies one and two. The composite criterion designed in study three was employed as the dependent variable in this study. Multiple regression procedures provided some evidence for the role of religiously affiliated care and respite care in strengthening care outcomes for this group. The implications of these findings for Child, Youth and Family are discussed.

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Chapter One

Introduction

This thesis is concerned with finding pathways to wellness for children and young people with mental health problems who are in the care of the New Zealand statutory child welfare service; The Department of Child, Youth and Family Services (Child, Youth and Family). As a group, these children and young people are viewed as having intense needs and persistent problems.

Children and young people in statutory care are expected to have high rates of mental health problems due to their experience of significant trauma and disadvantage. Low levels of problem recognition by social workers and limited access to services, however, mean their mental health needs often remain unmet. Rather than establishing pathways to wellness statutory care for children and young people with mental health needs, across jurisdictions, appears to exacerbate problems, as agencies struggle to maintain stable and suitable placements with experienced caregivers.

The significance of this research

In Britain (Mental Health Foundation, 2002a) and the United States (Landsverk, 2001) children and young people with mental health problems who are involved with child welfare services have received recent research attention. In New Zealand their needs are less examined. In 1999 Child, Youth and Family identified for the first time that approximately one quarter of young people who were involved with the service had moderate or serious mental health problems (P. M. Wells & Smith, 2000). This research focused on prevalence of problems. Analysis of the care arrangements or outcomes of social work interventions for this group remains unexplored. Similar research gaps are noted in Britain, where outcome studies have concerned the foster care population as a whole rather than pathways specific to children in care with mental health problems. In the United States however, more information is becoming available on outcomes for those children involved with systems of care initiatives (M. H. Epstein, Kutash, & Duchnowski, 1998).

Cowen (1994) has described five pathways to psychological wellness in children. These include forming wholesome attachments, acquiring appropriate competencies, engineering settings which promote adaptive outcomes, fostering empowerment and acquiring skills to cope with life's stressors. For children in child welfare systems, especially those who cannot return home, establishment or reestablishment of wholesome attachments is commonly

sought through placement in care with a healthy family. Families caring for these children encounter many difficulties; however, the capacity to manage child behaviour remains key to the ability to maintain ongoing care. Caregiver recruitment and retention problems are shared by most statutory child welfare jurisdictions including Child, Youth and Family. These difficulties are particularly serious for children with mental health problems. Although this group are identified by Child, Youth and Family as at risk (Child, Youth and Family, 2002a) specific strategies to support their caregivers have not yet been developed in New Zealand.

Research questions

The purpose of this research was to explore support for caregivers who are looking after children and young people with mental health problems on behalf of Child, Youth and Family. In particular the research sought to better understand the role of support to caregivers in strengthening care outcomes for this group of children.

Four main questions were asked.

- What do Child, Youth and Family social workers consider are effective supports for caregivers looking after children with mental health problems?
- What do Child, Youth and Family caregivers perceive as the kind of assistance, which will help them to better manage the care of these children?
- What do Child, Youth and Family social work experts consider to be the range of positive care outcomes which are of interest for children and young people who have mental health problems and who are in care?
- What do the case history data, relating to a group of children and young people identified with mental health problems suggest about the relationships between caregiver supports and positive care outcomes?

The concept of family resilience within a family strengths framework underpins this exploration. A family strengths approach assumes that effective coping and positive outcomes exist within an arena of child welfare provision commonly described in terms of persistent difficulty. This perspective suggests that families who provide care to this group will have internal strategies, including informal support systems, which enable them to surmount the challenges of providing care (Friesen, 1989; Saleebey, 1997; Walsh, 1998). Although Child, Youth and Family are currently evolving a strengths based practice model (Child, Youth and Family, 2002e), the extent to which caregiver competencies are understood by Child, Youth and Family social workers is of interest and at this point is largely unknown.

Methodology

For this research a methodology was required which would elicit and consider different perspectives on support, as well as incorporate an exploration of outcomes derived from case history data. A mixed methods framework allows a researcher to combine different research methodologies within a single inquiry design. The rationale behind mixing methods is that qualitative and quantitative paradigms are useful approaches and strength can be drawn from linking these methodologies (Greene & Caracelli, 1997).

The research design encompassed four separate studies whose findings are integrated. In the first study, a survey was used to investigate the way in which Child, Youth and Family social workers perceive the care of children with mental health problems and to identify those caregiver supports regarded as effective. A second study used a focus group methodology to gain insight into caregivers' experience of looking after children with mental health problems on behalf of Child, Youth and Family and their views of effective support. Findings from both studies were utilised in the subsequent analysis of outcomes derived from case history data. The third study employed a Delphi process, which is a structured group discussion technique (Linstone & Turoff, 1975). This enabled a paper-based discussion by Child, Youth and Family social work experts to be used to construct a composite outcome criterion to measure positive care. This construct was employed as the dependent variable in the last phase of the research. The final study comprised a multivariate analysis of case history data for a large group of children (n=1071) identified with mental health problems who were in the care of Child, Youth and Family. The purpose of this study was to explore the relationships between supports to caregivers and care outcomes for this group. This analysis employed as independent variables, those effective supports identified by social workers and caregivers in studies one and two.

Background

Statutory child welfare provides the context for this research, which in New Zealand falls under the auspices of the Children, Young Persons and their Families Act (1989a). This legislation contains unique cultural requirements, which are reflected in this research. Maori, the indigenous people of New Zealand, hold values, beliefs and practices, which underpin this legislation and statutory social work processes. Indigenous models for conceptualising mental health are also becoming more widely known and have influenced this research. Rather than relying on overseas outcome measures, a New Zealand approach to thinking about wellness for children in statutory care was needed, reflecting both the legislative principles and indigenous approaches to mental health.

Interface between agencies

The interface between the statutory child welfare organisation and New Zealand child and adolescent mental health services is an important part of the context of this research. In the United States children with severe emotional and behavioural problems are eligible for a broad range of services under systems of care initiatives (Stroul & Friedman, 1996). While poor access to mental health services for children and young people in statutory care is noted in Britain (Richardson & Joughin, 2000) and in the United States (Leslie, Landsverk, Ezzet-Lofstrom et al., 2000; United States General Accounting Office, 2003), the situation in New Zealand may be worse. Children whose behavioural problems are solely attributable to abuse or neglect are unable to access ongoing treatment from specialist mental health services (Ministry of Health, 2002b). More specific access problems and service gaps exist for children with conduct disorder, those who are in the custody or guardianship of Child, Youth and Family and those in residential care (Child, Youth and Family, 1999a; Ministry of Social Development, Child, Youth and Family, & The Treasury, 2003).

Terminology

There are a variety of ways to describe mental health needs. A range of terms is used in the literature including mental disorders, mental health disorders, mental health problems and mental illness. For the purposes of this thesis the term mental health problem is adopted. The Mental Health Foundation (2002b) in Britain defines a mental health problem as:

“a level of symptoms of mental ill health that have led to impairment in day to day life”

(Mental Health Foundation, 2002b p.7). This is an inclusive term, encompassing all those affected by poor mental health to a level which affects their lives and causes problems, whether or not they have been formally diagnosed with a disorder. This is appropriate in the context of this thesis given the gaps in mental health services and access problems noted for children in statutory care. While the more inclusive term mental health problem is adopted in this thesis, *mental health disorder* was employed in those studies involving Child, Youth and Family staff and caregivers in order to remain consistent with the terminology used by the organisation at the time.

The term social worker is used throughout this research to refer to those people designated as such within the Children, Young Persons and their Families Act (New Zealand Government, 1989a) who are able to carry out the statutory functions laid out in this legislation. These people are, in every case, employees of Child, Youth and Family. Caregivers in this research refers to those people who have been approved by Child, Youth and Family to provide care

for a child or young person who is subject to the care and protection provisions of the legislation. In some cases these people may be wider family members, in others, they are people with no prior connection to the child or young person. While caregivers in New Zealand are reimbursed for the provision of care they are not employees of Child, Youth and Family. Many identify themselves as Child, Youth and Family caregivers and others are affiliated to New Zealand non-governmental social service organisations such as Barnardos. The term “in care of Child, Youth and Family” refers to the range of care arrangements constituted within the provisions of the Children, Young Persons and their Families Act (New Zealand Government, 1989a). Some of these arrangements are long term and involve formal transfer of custodial and guardianship responsibilities to the Chief Executive of Child, Youth and Family. Others are short term, informal care arrangements established through family group conference plans or temporary care agreements.

Thesis outline

This thesis is divided into two parts. In the first part there is a discussion of the attribution of child mental health problems and the support networks and services used by families. It includes a review of children and young people with mental health problems involved with Child, Youth and Family, the support arrangements for their caregivers and measurement of care outcomes. In the second part of the thesis the methodology of the research is described and four studies are presented, along with a chapter containing the conclusions of the research project as a whole. An outline of the thesis structure and the content of each chapter is provided below.

In Part One, following this introduction, the second chapter reviews the controversy surrounding attribution of child mental health problems and considers the prevalence of these problems. The place of family in explanations of the emergence of mental health problems is discussed and the contribution of family to positive outcomes amongst children at risk is examined. Finally, the concept of family resilience is outlined within the context of family strengths, which is a key social work theoretical and practice perspective.

Chapter three considers the experience of families looking after children and young people with mental health problems, outlining the challenges they commonly face. The nature of informal support to these families is reviewed along with formal mental health services available to support caregivers in New Zealand. The relationship between service providers and families is discussed including the negotiation of support services between representatives of the service provider and caregivers. Finally, the level of family participation in service design and delivery in New Zealand is examined briefly.

Chapter four considers children and young people with mental health problems who are involved with Child, Youth and Family. The legislative and organisational context is examined and the interface between child welfare and mental health services is reviewed. Prevalence of child mental health problems in child welfare services is discussed including what is known about this group in New Zealand. Finally, initiatives by Child, Youth and Family to address the needs of children with mental health problems are reviewed.

In chapter five the support provided to caregivers looking after children and young people with mental health problems in care of Child, Youth and Family is considered. The chapter begins with an overview of foster care and kin based care then follows with a discussion of the current pressures on the care system. The challenges of caring for children with mental health problems in a child welfare context are discussed. The supports offered by Child, Youth and Family to kin and non-kin caregivers are examined.

Chapter six considers approaches to the measurement of outcomes amongst children and young people with mental health problems who are looked after within child welfare systems. The development of outcome measurement across child welfare jurisdictions is described and an outline of key measurement issues is provided. The domains commonly used to measure outcomes for children in care are reviewed briefly along with those developed within systems of care services in the United States. Finally, the state of outcome specification in Child, Youth and Family is assessed in respect to the requirements of this research.

In Part Two the research questions and methodology are outlined in chapter seven. The gaps in the existing body of findings reviewed in Part One are re-iterated briefly and the key questions are identified. Mixed methods as a research approach is described along with the advantages of combining methodologies. The mixed methods design for the research is outlined in the final part of the chapter and an overview of each of the four studies is provided. A full account of each study methodology is given in the first section of each of the following four study chapters.

Chapter eight details the first study, which aimed to identify social workers' views of the nature of care provided for children and young people with mental health problems and their perspectives on effective support to caregivers. The survey methodology employed is described, along with its strengths and weakness in respect of the aims of the study. The results of the survey are discussed including their potential to be incorporated as independent

variables in the fourth study. The limitations of the study are identified along with the conclusions of the chapter.

Chapter nine outlines the second study. This aimed to explore, in depth, caregiver perspectives on looking after children with mental health problems on behalf of Child, Youth and Family. The focus group methodology is described and the results are contrasted with the views of social workers established in the first study. The findings are also discussed in terms of their inclusion as independent variables in the fourth study. The constraints around the findings are reviewed along with the conclusion of this part of the research in the chapter.

Chapter ten presents the third study, which aimed to develop a construct for measuring positive care specific to children with mental health problems in Child, Youth and Family care. The Delphi process is outlined as a method for conducting a paper-based group discussion amongst experts from within Child, Youth and Family. The construct produced is described in the results section of this chapter, along with its potential for inclusion as the dependent variable in the subsequent study. The limitations of the findings are considered as part of the conclusion of this study in this chapter.

Chapter eleven details the fourth and final study in which outcomes are derived from an analysis of case history data. This analysis aimed to explore the relationships between supports to caregivers and strengthened outcomes for a large group of children and young people with mental health problems in Child, Youth and Family care. The chapter also includes a description of the nature of this group, as this had not been investigated in previous research. The findings section of this chapter presents the results of a stepwise linear multiple regression using the independent and dependent variables constructed in the earlier three studies. The limitations of the study are presented along with the results in this chapter.

Chapter twelve provides a wider discussion that links the findings of the four studies in order to arrive at the conclusion of the research project as a whole. These results are outlined in the first part of the chapter, followed by a set of policy implications suggested by the findings. The limitations of the research are reviewed in the final section of the chapter along with some suggestions for future research.

Chapter Two

Children and young people with mental health problems and their families

Introduction

This thesis explores support to caregivers and care outcomes for children and young people with mental health problems who are in the care of the child welfare service in New Zealand. To do this an understanding is needed of child mental health problems and the role of families in respect of these problems. This chapter considers the attribution of mental health problems in children and young people and controversy surrounding diagnosis. It begins with discussion of the classification of child mental health problems and presents an overview of the prevalence of these problems. The construct of family is reviewed briefly along with its place in explanations of the development of child mental health problems. The role of family as a contributor towards resilience in children at risk of developing mental health problems is then examined. Finally, the concept of family resilience is explored, within the context of the family strengths perspective in social work.

Attribution of mental health problems in children and young people

Child mental health is described as the ability to develop psychologically, emotionally, intellectually and spiritually. This involves the capacity to initiate, develop and sustain mutually satisfying personal relationships and the ability to be aware of others, to empathise and use psychological distress as a developmental process rather than it hindering future development (National Health Service Health Advisory Services, 1995). Mental health is an integral part of a child's development and its promotion is a key concern for families, in particular early recognition of problems in order to establish patterns of recovery.

The attribution of child mental health problems in New Zealand is predominantly made using the DSM diagnostic framework (American Psychological Association, 2000). Eligibility for specialist child mental health services in this country depends on attribution of disorder using the framework and on establishing severity of the condition (Ministry of Health, 2002b).

DSM IV defines mental disorder as:

a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

(American Psychological Association, 2000 p.xxxi).

The need to delineate between non-disordered and disordered behaviour is emphasised particularly determining whether symptoms are an expected reaction to an immediate social context or event (American Psychological Association, 2000).

Diagnosis is controversial

Attribution of mental health problems amongst children and young people is controversial. Throughout history, as Millon (1991) contends, it has been difficult to identify from within the range of human behaviour those aspects which are true manifestations of mental problems. Criteria, such as the DSM IV framework exist only as tools to guide observation and are therefore controversial (Millon, 1991). This point is illustrated by Singh (2002) in respect of the symptoms of Attention Deficit Hyperactivity Disorder (ADHD). The diagnosis of ADHD within DSM IV relies on clinical judgements in respect of dimensions of intensity and pervasiveness. Evolution in the diagnostic criteria for ADHD saw emphasis in symptomology shift from hyperactivity to inattention between early and later versions of DSM. This change in diagnostic emphasis supported a 57% increase in children meeting ADHD criteria (Baumgaertel, Wolraich, & Dietrich, 1995). Serious concerns have been raised by some researchers about the implications of making a diagnosis of ADHD, for increasing numbers of children in the United States, in the face of such clinical uncertainty (Baughman, 2003).

Contextual factors will also affect the interpretation of behaviour and the attribution of disorder, particularly for children, where there is inherent ambiguity in behaviour. Although DSM IV attempts to account for cultural bias, by describing cultural variations and urging consideration of cultural factors in assessment, Durie (2001) warns that professionals interpret spoken and body language of clients through their own culture and these barriers may result in a misapplication of diagnosis. Scheff (1999) argues further, that most people experience the popular symptoms of mental illness at some time in their life and disorder attribution may be used to label those in society without power. For children and young people a mental health problem may act as a label and ultimately a social control strategy for

behaviours, which do not fit conventional expectations. Again using ADHD to illustrate, some have argued that the diagnosis is used to medicalise the failure of normal boys in a competitive world with an oppressive culture of masculinity (Kindlon & Thompson, 2000; Pollack, 1998). Barkley (1990) identifies an interaction between the use of medication in respect of ADHD and expectations of social contexts such as the classroom.

Methodological problems in DSM IV

Other researchers have focused on the methodological problems of DSM IV such as the derivation of categories based on information obtained from self report (Kagan, Snidman, McManis, Woodward, & Hardway, 2002) and other construct problems (Richters & Cicchetti, 1993; Wakefield, 1992a, 1992b, 1997). Kagan et al.; (2002) for example, argue the inappropriateness of assigning unitary constructs to what are in reality likely to be heterogeneous categories. A useful overview of the methodological problems present in the two predominant classification systems DSM IV and ICD –10 is provided by S.Scott (2002).

Pertinent to this research is concern that DSM IV criteria do not adequately distinguish mental disorder from non-disordered reactions to living (Wakefield, 1997). The resulting over inclusiveness of DSM IV has been discussed with particular reference to young people with antisocial behaviour (Kazdin, 1995; S. A. Kirk, Wakefield, Pottick, & Hsieh, 1999; Moffitt, 1993; Richters & Cicchetti, 1993; Wakefield, 1997). In 1993 Richters and Cicchetti argued that Tom Sawyer and Huckleberry Finn manifest sufficient anti-social behaviours to warrant a diagnosis of conduct disorder, however, the biographical details in the story “*seem to offer a compelling explanation for the behaviour of Tom and Huck as normal boys living and behaving under very abnormal circumstances*” (Richters & Cicchetti, 1993 p.6).

For children and young people subject to statutory child welfare intervention this distinction is important. Children growing up in adverse family environments, where there is abuse and neglect, may exhibit behaviours which could be viewed as normal adaptation to detrimental environmental factors. The attribution of disorder in these cases remains controversial. This debate is reflected in the service specifications of New Zealand child mental health services. While a diagnosis within DSM IV with severity establishes eligibility for child mental health services, certain restrictions apply, which limit access to services for those with problems attributable to adverse social environments. For example, children and young people with conduct disorder as a sole diagnosis are excluded from New Zealand specialist mental health services (Child, Youth and Family, 2001i; Ministry of Health, 2002b) as are children with mental health problems arising from abuse or neglect. The implications for families caring

for children and young people and for Child, Youth and Family are discussed in the following chapters.

Negative impact of attribution of disorder

Any caregiver, whether a natural parent or delegate, must consider the disadvantages of diagnosis for a child or young person. Stigma and the loss of self-esteem, which accompanies the attribution of disorder, are significant risks. Wahl (1999) suggests media portrayal of those few with overwhelming mental health symptoms is a principal mechanism by which people with mental health problems are viewed as frightening, irresponsible and extreme. Those coping well with mental health problems usually remain unknown and invisible. For a broader discussion of stigma and labelling of people with mental health problems see Link, Phelan, Bresnahan, Steuve, Prescosolido (1999) Hinshaw & Cicchetti (2000) and Sartorius (1998).

Generally, it is envisaged that where there are undesirable behaviours, the attribution of child mental health problems, may lead to greater acceptance and tolerance. However, evidence suggests that diminishing blame may not necessarily follow and stigmatisation is a likely outcome of diagnosis for children (Hinshaw & Cicchetti, 2000). Young people with a mental health diagnosis are at risk of developing damaged self esteem, as even children of school age have been recognised as possessing stigmatising attitudes (Richardson & Joughin, 2000). Families identify stigma as a major problem, reporting shame, self-blame and mistrust (Lefley, 1992; Wahl & Harman, 1989). This is discussed further in the next chapter. Those children and young people in statutory care with mental health problems risk the double stigmatisation, of having a mental health disorder and of being in care (Lindsey, 2000).

Despite the risks associated with stigma, attribution of disorder is likely to be a mixed experience because diagnosis remains an important route to accessing mental health services, resources and support. For example, Kutchins and Kirk (1988) considered the attitudes of social workers in the United States to the use of DSM III and discovered a complex interaction within their perspectives between diagnosis, treatment and reimbursement, which has not been previously well recognised or understood.

Linking eligibility for child mental health services to diagnosis and severity, however, may also produce incentives for families to reconstruct and present qualifying aspects of behaviour with negative consequences. Parents may deny valid coping strategies and down play functional behaviour of their children and young people. The process of deconstruction whereby a whole person is fragmented to obtain a fit with diagnostic criteria has negative

effects that are discussed further by both Saleebey (1997) and Goldstein (1997). In particular pathological definitions can create pessimistic expectations and reinforce beliefs that those with problems will not move beyond their present condition (Graybeal, 2001). For young people and those who look after them and educate them, these negative expectations can become self-fulfilling (Lindsey, 2000). Further, while a mental health diagnosis may mean entry to mental health services there can be problems thereafter gaining access to other essential services, such as schooling (Richardson & Joughin, 2000).

Indigenous models of mental health problems in New Zealand

Not all conceptualisation of mental health problems in New Zealand fall within the DSMIV framework. Cultural requirements within New Zealand child welfare legislation suggest that indigenous models of health and well-being should contribute to discussion of outcomes for children with mental health problems. Several indigenous models derived from Maori cultural frameworks and research are in use in this country, see for example Te Wheke (Jackson, 1988; Pere, 1991) and Te Whare Tapa Wha (Durie, 1994, 2001).

When considering the cause of any disease Maori people make reference to wider spiritual, social and environmental contexts. Durie's model Te Whare Tapa Wha (Durie, 1994) which has prominence in the literature describes this. It emphasises four components, which need to be in balance to sustain positive health. These are illuminated more fully in an outcomes design for Te Whare Tapa Wha (Kingi & Durie, 2000b). Within the model, positive Maori health consists of te taha waiorua (reflecting personal spiritual wellness, dignity and respect and individual fulfilment), te taha hinegaro (closest to western mental health constructs involving individual feelings, thoughts and behaviours, it involves motivation, cognition and management of emotions), te taha whanau (based on the need for reciprocity and collective identity and includes the health of family life, its relationships, mutuality and social participation) and te taha tinana (the physical aspects of health and the inter-relationship between this state and mental health) (Kingi & Durie, 2000a).

In Te Whare Tapa Wha (Durie, 2001) strong whanau (families), who are conceptualised as those with a sense of mutuality, reciprocity and active participation of members, are linked to improved wellness of individual members of the collective. The pattern of supportive extended family networks Durie (2001) acknowledges, may not be true for all whanau, many of whom are now too loosely connected to be helpful. However, whanau remain a potential strength for those planning and implementing child health and welfare services. Models of health intervention based on these understandings enhance the identity and strengths of whanau and work towards empowerment (Durie, 2001). While spirituality (wairuatanga)

differs according to tribal tradition, absence of a separation between spiritual and non-spiritual is also important and integration of spirituality is part of Maori quests for social reform (Nash & Stewart, 2002). The concept of whanau, spirituality and Maori mental health models are discussed further throughout this thesis.

Although indigenous models of wellness are in early stages of discussion, they are beginning to underpin some analyses of mental health problems in this country and approaches to service design and delivery (Durie, 2001; Health Funding Authority, 2000a). Ruwhiu (2001) for example, explains the importance of the Maori concept of mana (power or prestige) for those who are involved in helping people experiencing trauma, pain, loss or grief and outlines mana building strategies. Joyce (1994) describes establishing a therapeutic relationship, which is underpinned by spirituality. These models have not yet been specifically applied to child mental health problems (Kingi & Durie, 2000b) but practitioners increasingly describe their use to enrich CAMHS approaches (Waetford, 2004). In this thesis they provide a fresh perspective from which to consider the relationship between wider family processes and child mental health which is at the core of this research.

Prevalence of child and adolescent mental health problems

Dealing with child mental health problems is a part of the lives of many families both overseas and in New Zealand. Caregivers will likely be required to manage these problems for a sustained period of childhood and adolescence.

Prevalence in overseas jurisdictions

Considerable variation exists in prevalence rates for child and adolescent mental health problems both internationally and in New Zealand. Early studies in the United States established prevalence rates of around 10- 12%, for example Costello (1989) found rates of 9.1% amongst Pittsburgh 11 year olds and 10.8% in 12–18 year olds. Research during the 1990s elevated prevalence rates of serious mental health problems in children and young people such that in 1996 a prevalence range of between 9% and 19% was viewed with confidence (Friedman, Kutash, & Duchnowski, 1996). Others estimated serious emotional disturbance (SED) to be between 11% and 26% (Quinn & Epstein, 1998). In the United States the Methodological Epidemiological Catchments Study (MECA) estimated 21% of United States children and young people between 9 and 17 years had a mental health disorder with minimum impairment with 11% having significant impairment (US Surgeon General on Mental Health, 2000).

Children and young people with severe mental health problems have aroused the most concern. The characteristics of this group were described by Friedman et al. (1996), using six separate studies of populations. The overall picture is of a group of children and young people with severe problems in a range of domains, impairing social, educational and behavioural functioning. The diagnoses show a high prevalence of disruptive behavioural disorders and mood disorders and a high incidence of co-morbidity of problems. Older males (between 12 and 17 years) are significantly over represented in the group (Friedman et al., 1996).

Similar prevalence rates and population characteristics are reported in Britain. The Mental Health Foundation (1999) and Meltzer, Gatward, & Ford (2000) have studied prevalence of mental health disorder in the general child and adolescent population. In the 5–10 year old group Meltzer et al. (2000) found 10% of girls and 6% of boys had a mental health disorder at any given time, rising to 13% of girls and 10% of boys aged between 11–15 years. Amongst families with high unemployment rates, those in poverty and those with a greater number of children, rates rose to 15%–20%. Higher figures from the Mental Health Foundation (1999) suggest that 20% of children and young people experience mental health problems, or a significant level of disturbance. Both sources identify conduct disorder, depression and ADHD to be the common disorders (Meltzer et al., 2000; Mental Health Foundation, 1999).

Prevalence rates in New Zealand

Recent estimates of child mental health problems in this country are drawn from two key New Zealand longitudinal studies; the Dunedin Multidisciplinary Health and Development Study (DMHDS) and the Christchurch Health and Development Study (CHDS). These studies conclude that the rate of child and adolescent mental health disorder in New Zealand may be higher than estimates based on overseas studies. Their findings have been combined recently showing consistent high prevalence of mental health disorder and co-morbidity at age 18 to 21 years (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2003).

Although the DMHDS sample is thought to be slightly socio-economically advantaged and under representative of Maori and Pacific Island peoples, (Henry, Moffitt, Robins, & Earls, 1993) prevalence data from this study have been used extensively (McGee, Feehan, & Williams, 1996). Prevalence rates of behavioural problems in the pre-school years are estimated at 5% and rise to 16% in preadolescent years. By 18 years 37% evidenced one of the principal mental health disorders, with a rate of 42% in the girls and 31% in boys (Silva & Stanton, 1996).

Following a birth cohort of 1265 children born during mid 1977 in Christchurch, the CHDS found that at 16 to 18 years 43% of the group met standardised diagnostic criteria for at least one DSM IV disorder (Horwood & Fergusson, 1998). Gender differences were found in the risk status for different types of disorder, for example, rates of conduct disorder were five times higher in males. Although the number of Maori in the sample were low, the influence of cultural factors was significant. Maori had 1.2 to 2.8 times the risk in the main disorder groups, in particular for anxiety, conduct and substance abuse disorders (Horwood & Fergusson, 1998).

Persistence of mental health problems

Along with establishing high levels of mental health problems in children and young people research suggests that these problems are likely to be persistent and caregivers will need to cope with these problems over an extended period of childhood and adolescence. In the DHDS findings, at three years 2% of children were identified as exhibiting hyperactive behaviours and another 3% were described as hard to manage. At 15 years, 75% of these children were viewed as having a significant mental health problem during one or more developmental periods (McGee et al., 1996). Friedman et al. (1996) review a number of overseas studies, which demonstrate that the presence of mental health problems will continue through childhood into adolescence. This continuity exists amongst a range of disorders, including children exhibiting both inhibited and disinhibited behaviours. Although change is detectable in children with these problems, this change is largely confined to the middle range of the distribution, for example, a child with extreme problems may improve and move towards the middle ground, but is not likely to completely lose his or her problems (Pfeifer, Goldsmith, Davidson, & Rickman, 2002).

Furthermore, problem continuity appears to be established even in the presence of provision of mental health services, although the relationship between mental health services and child outcomes has been poorly researched (Visser, Van Der Ende, Koot, & Verhulst, 1999). Studies have found considerable stability of problem behaviours amongst children and young people referred to mental health services (Stanger, MacDonald, McConaughy, & Achenbach, 1996). *"Children and young people troubled early in life remain most troubled later and most likely by similar problems, despite the wide range of intervention used in our clinic"* (Visser et al., 1999 p.12). While the efficacy of outpatient treatment has been established in clinical research settings, unfortunately real world therapy has been found to be less effective (US Surgeon General on Mental Health, 2000). However, methodological issues do mean that conclusions are difficult to reach. For example, Salzer, Bickman & Lambert (1999)

failed to establish a dose-effect relationship in child mental health services whereas Foster (2000) using the same data but different statistical techniques found increased mental health provision resulted in improved functioning.

Families of children with serious mental health problems

A significant number of families then will be faced with the challenge of raising children with mental health problems and these problems are likely to persist for a long period of time, in some cases even in the presence of mental health services. Studies in the United States find that families who care for children with severe mental health problems appear to face additional challenges in their structures and processes. Luthar & Becker (2002) have recently argued for more balance and consideration of affluent families, because most research interest has been in children of families with economic disadvantage or young people of minority cultures (C. C. Barber, Rosenblatt, Harris, & Attkisson, 1992; McLoyd, 1990; K. Wells & Whittington, 1993).

A high percentage of children with mental health problems come from families who are constituted in forms other than nuclear families (M. H. Epstein, Cullinan, Quinn, & Cumblad, 1994; Friedman et al., 1996). Histories of parental mental health problems, criminal activity and family violence are also evidenced amongst the families of children with mental health problems (M. H. Epstein et al., 1994). These families often appear to break down and be unable to manage the care and control of these children. For example, M. H. Epstein et al. (1994) and Landrum, Singh, Nemil, Ellis, et al. (1995) have reported high rates of out of home placement for this group of children and young people. In Quinn and Epstein's study (Quinn & Epstein, 1998) 88% of children and young people with severe emotional problems were previously placed out of home at least once. In a substantial proportion of United States families with children with mental health problems, a statutory agency had augmented or assumed parental custody (Landrum et al., 1995).

New Zealand research has confirmed these overseas findings. Horwood & Fergusson (1998) report that children with serious problems in adolescence are characterised by

a combination of social disadvantage, dysfunctional family circumstances, exposure to impaired child rearing environments, parental psychopathology and difficulties, impaired parent/child relationships, educational failure or underachievement and the formation of relationships with deviant peers in adolescence (Horwood & Fergusson, 1998 p.28).

In the findings of the DMHDS family variables also accounted for the difference between children with mental health problems and those without. The most significant family factors were parental disagreements on discipline and changes of the child's primary caregiver during childhood (Henry et al., 1993).

Explaining child and adolescent mental health problems

Unsurprisingly then, the family and its characteristics are central to explanations of serious mental health problems in children and young people and are important in this research.

What is family and whanau?

Family is often thought of in terms of function, in particular the nurturing of children through their development into adults and the meeting of individual needs (R. Munford & Sanders, 1999). Within developmental psychology, the family is viewed as a micro-social organisation whose members are related in some manner, and which functions to meet the social, economic and emotional needs of members, in particular training younger members for roles and behaviours in society, see for example (Werner & Smith, 1982). The nature of interdependence within families is central to the construct. Billingsley (1992), for example, includes in the term family, relationships of appropriation, meaning unions of people without ties of blood or marriage, who form a family by deciding to live and act towards each other as family. This concept of family is useful in the context of this present research as it encompasses arrangements for temporary or permanent nurture and care of children such as foster families.

Although family is a core construct within New Zealand social policy, legislation and research, diversity and change in families make it difficult to maintain a satisfactory definition of family. Social, political, cultural and economic influences shape the construct of family and its context and structure, over time. These changes are associated with increasing diversity in family structures and processes, which impact on interdependence and functioning within families (Cass, 1994). Sanson & Lewis (2001) provide an international perspective on these influences, while Briar & Gill (1998) Shirley, Koopman-Boyden, Pool, & St. John (1997), R. Munford & Sanders (1999) and Swain (1994) present New Zealand perspectives.

The impact of culture on family warrants consideration here, as indigenous constructs of family inform analyses of mental health problems in New Zealand (Durie, 1994, 2001) and underpin child welfare legislation. Culture has been variously described as systems of

meaning or cognitive schema that are shared by a group of people (Betancourt & Lopez, 1993) or as a total set of beliefs, customs or way of life pertaining to a particular group of people (Abercrombie et al., 2000). Cultural identity means sharing cultural heritage, a sense of relatedness and symbolic ties (Durie, 2001). Durie (2001) argues further that in New Zealand for indigenous Maori, identity means more than knowledge of traditions, it means access to language, the extended family network and customary land.

Cultural views influence the construct of family and the definition of family problems, such as child abuse (Boushel, 1994; Korbin, 1991, 2002). While a European construct of family has been the dominant foundation of social policy in this country since colonisation over 150 years ago, New Zealand legislation, over this time, has varied in its capacity to recognise cultural difference (Durie-Hall & Metge, 1992). The Adoption of Children Act (New Zealand Government, 1881) for example, respected Maori customary practices of child placement, however, this cultural awareness was terminated in 1955 (New Zealand Government, 1955) and forced Maori to accept a European system of adoption at odds with their values and beliefs (Bradley, 1995). Legislative change to child protection practice in 1989 attempted to introduce indigenous family constructs and processes (Ernst, 1999), which are discussed further in chapter four.

Whanau

In New Zealand whanau is the Maori construct akin in some respects to a European (or Pakeha) concept of wider family but significant differences exist in the importance of descent to the identity of members of whanau (Metge, 1995). In the same way that family is a construct that is difficult to define; Maori interpretation of whanau has also undergone change. Some using the construct emphasise descent, while others define whanau as encompassing people who behave towards each other in a family like manner with a common purpose (Durie, 2001).

Interdependence within whanau is central to the construct. Interconnectedness involves not just the living members of whanau, hapu (the wider kin grouping) and iwi (the tribal group) but also a link with the dead, kept alive by whakapapa, the oral records of lineage and connectedness (Metge, 1995). For a more detailed discussion of the strengthening power of whakapapa see Ruwhiu (2001).

Functions of whanau include support of individual members, shared up-bringing of children, management of group property and organisation of hui (meetings) where whanau problems, conflict and management matters are dealt with (Ernst, 1999). Traditionally for Maori,

parents do not possess children in the same manner as do Europeans. Children are considered as assets in the whanau and in the past were placed often with other whanau in order to strengthen kin group networks (Bradley, 1994). Within this process of whaangai (akin to shared parenting or adoption) a child knew both their birth parents and those who currently cared for them and so a wide sense of belonging was fostered. Practically speaking whaangai enabled whanau to respond to stressful situations and provide respite to caregivers while maintaining the structural integrity of the whanau.

The family in explanations of child mental health problems

Developmental psychopathology

Family features in many explanations of the development of mental health problems such as in psychodynamic theory or in family systems approaches (Lefley, 1996). As this research is concerned with children and young people with mental health problems who are involved with child welfare services, explanations which relate to family circumstances hold particular interest.

In the last two decades developmental psychopathology has provided an approach to understanding the family as the context for the development of mental health problems in children and young people (Achenbach, 1990; Capara & Rutter, 1995) and the design of interventions (Davis, Martin, Kosky, & O'Hanlon, 2000; Kazdin, 1997).

Developmental psychopathology suggests that the development of mental health problems in children and young people is a process, linked to a complex range of multi-layered influences including individual and environmental factors and the dynamic interaction between these (Cicchetti & Toth, 1998). Garbarino (1995) asks us to think of childhood as a cultural creation which protects children from the economic, political and sexual affairs of the community. When this space is eroded and children are exposed to problems which they have neither the social role nor personal power to negotiate, they are endangered.

Developmental psychopathology conceptualises such intrusion into childhood as "risk".

Within developmental psychopathology risk factors can be described as stress factors or stressful events such as poverty or divorce. Early research attempted to isolate single critical risk factors, for example poverty or low parental education. Over time results indicated this was over simplistic and variance understood in this way was found to be small (Shirk, Talmi, & Olds, 2000). Risk is now understood to be derived from a range of factors and their

interaction with one another. Cumulative risk models show multiplicative rather than additive effects, whereby rising numbers of risk factors result in further significant deterioration (Davis et al., 2000; Mackner, Starr, & Black, 1997). Within the complex constellation of influences which constitute risk are the nature of the family context, the wider environment, the stage of development of the child, individual characteristics and timing (Rolf, Masten, Cicchetti, Nuechterlein, & Weintraub, 1990). While environmental factors have traditionally received attention a new focus is emerging on the role of genetic factors, for example the high heritability (82%) of early childhood anti-social behaviour (Arseneault et al., 2003) and attention problems (75%) (Rietveld, Hudziak, Bartels, Van Beijsterveldt, & Boomsma, 2004).

Developmental trajectories

Research into risk factors has evolved to view the pattern of childhood experience as a developmental trajectory whereby outcomes of risk associated at one point in life become integrated into the following developmental stage (Ebata & Moos, 1994; Ebata, Petersen, & Conger, 1990). Of interest is the degree to which children outgrow problems or whether problems at one age mean greater risk of difficulties at another age. Currie & Hyson (1999) for example, explain how an early adverse outcome such as developmental delay can act as a risk factor for later ill health. Transition points such as entering school have also been discussed in terms of “incubating” pre-existing risk factors as well as developing new ones (Huffman et al., 2000; Mesman, Bongers, & Koot, 2001).

Interaction between family and other risk factors

The interaction between risk factors, particularly family characteristics, culture and economic disadvantage is important but difficult to untangle. A range of studies conclude that children raised in socio-economically disadvantaged families are at risk of a variety of adjustment difficulties including mental health problems (Duncan, Brooks-Gunn, & Klebanov, 1994; Felner, Brand, DuBois, Adan, & et al., 1995; D. Walker, Greenwood, Hart, & Carta, 1994). This effect occurs across cultures, for example Dressler (1985) found that chronic economic stress was the strongest predictor of depression within a black community.

Horwitz, (1984), Kessler, House, & Turner (1987) and Dew, Bromet, & Schulberg (1987) demonstrate a relationship between rising levels of unemployment and rising levels of psychological distress. Boyle (2002) shows that family home ownership is associated with lower levels of child problem behaviour, a finding consistent with other studies (Green &

White, 1997). More recently research has focused on the continuity of poor outcomes for children with low socio economic status and the emergence of mental health problems later in their life (Caspi, Wright, Moffitt, & Silva, 1998). These risks appear to depend on the developmental stage of individuals, with the greatest problems associated with accumulating experiences of socio-economic disadvantage from childhood to adolescence (Schoon et al., 2002).

Although socio-economic factors have some independent effect on child mental health it is likely that the stress of poverty, in particular the complex interaction of family background characteristics and processes accompanying it, more closely relates to poor child outcomes (Mayer, 2002). McLoyd (1990) in her review of the effects of economic hardship on black families underlines an interrelationship between economic hardship, family discord and mental health problems. Those in low socio economic positions experience frustration from a range of events which are out of their control, for example eviction or criminal assault. These frustrations produce psychological distress and discord amongst family members with consequent impact on family order (McLoyd, 1990). These family characteristics and processes, frequently associated with families who are involved with statutory child protection agencies, have become a focus for research into family as a source of risk in children's mental health.

Family characteristics and processes as a source of risk

Families where there is abuse and neglect

Of particular relevance to the children and young people at the centre of this research are families where there is maltreatment of children. A comprehensive body of research links early experience of abuse and deprivation to poor mental health outcomes in children (Glaser, 2000). The relationship between child maltreatment and mental health risk has led to a specific field of developmental psychopathology known as developmental traumatology and to claims that child maltreatment may be the single most preventable contributor to child mental illness (De Bellis, 2001). Stated broadly, child maltreatment exemplifies a pathogenic relational environment that poses substantial risk for undermining psychological wellness across a broad spectrum of adaptation (Cicchetti, Toth, & Rogosch, 2000).

The relationship between infant brain development and maltreatment is a major component of this area of research, of which Glaser (2000) and Nelson (2000) provide comprehensive reviews. Brain functions, such as emotion, concentration, impulse control, memory and

cognition have been found to alter, as a result of the experience of trauma in children (Perry, 1993). A key understanding is that babies living in deprived environments may experience a loss in the development of synaptic connections during critical periods of neural plasticity (Glaser, 2000; R. Shore, 1997; W. Singer, 1995). Secondly, impairment in the quality of the relationship between primary caregivers and their infants has been found to impact profoundly on the ability of the infant to regulate early affect and arousal (Cohn & Tronick, 1989; Glaser, 2000). Longitudinal studies show maltreated children have patterns of severe and continuing developmental delay. Deficits include lower intellectual functioning, depression, exhibiting withdrawn behaviour or behavioural problems (Aber, Allen, Carlson, & Dante, 1989), delinquency (Zingraff, Leiter, Johnsen, & Myers, 1994) and adult psychiatric and physical problems (Fancourt, 1998).

Attachment problems are also central in research linking family process risk factors to the development of child mental health problems. Attachment is described as proximity seeking behaviour by a dependent organism when there is discomfort of any sort, on the assumption that the attachment figure will reduce the discomfort and restore the child's equilibrium (Bowlby, 1988). Response to the attachment quest is thought to interact with the emerging sense of self in the infant or child. As Calvert and Lightfoot state: "*Attachment provides an internal working model for understanding oneself, future relationships and relationships with the environment. It is a primary source for learning about emotional regulation*" (Calvert & Lightfoot, 2001 p.28).

Problems of attachment and the maltreatment of children appear to interact. For example in a group of maltreated children it was found that 82% of children exhibited disorganised attachment compared with 19% in the non-maltreated group (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cicchetti & Barnett, 1991). Anxious or disorganised attachment is implicated in the development of psychological problems, although this is not always in a linear manner (Sroufe, Carlson, Levy, & Egeland, 1999). Children with poor attachment may go on to exhibit distrustful or hostile behaviour, further endangering their relationships with caregivers (Schofield, 2002). For maltreated children with attachment problems there is an increased likelihood these problems will be maintained in early school years and that disturbances in interpersonal relationships will continue as development proceeds (Cicchetti et al., 2000).

General findings have linked poor relationships between parents and their offspring with psychological problems (Zaff & Calkins, 2001). However, amongst children experiencing abuse or witnessing violence between caregivers, a stress response is observed that is linked to further harmful effects on brain development. Correlations have been found between

sustained stress, excess cortisol and damage to the part of the brain associated with memory and to other regions (Gunnar, 1998; Sapolsky, 1996a, 1996b). Children with violent parents who are the subject of inconsistent and harsh discipline over a long period of time have been found to develop negative reactions that endure (Shields, Cicchetti, & Ryan, 1994). Cohen, Adler, Kaplan, Pelcovitz, & Mandel (2002) considered combined effects of marital disruption and physical abuse on children's mental health, finding those children who had experienced both factors were 15 times more at risk of ADHD than if they had suffered either factor alone. The trauma of abuse can result in conditioned behaviour responses such as that described as post traumatic stress disorder (De Bellis, Baum et al., 1999; De Bellis, Keshavan et al., 1999).

Parents' personalities and child temperament appear to interact. Most vulnerable are those children who have a temperament described as "difficult". They are likely to have a reduced threshold response to stress and a poor ability to dampen this internally. Where these children are involved with stressed or violent caregivers they are likely to be met with irregular and sometimes violent reactions, which in turn are stressful to the child (Glaser, 2000). Moffitt (1993) describes an ensuing transactional process in the families of troubled adolescents whereby the challenge of coping with a difficult child evokes a chain of failed parent-child encounters, which negatively impact on adolescent well-being.

Socio-economic effects remain part of the explanation of behavioural problems (Wodarksi, Kurtz, Gaudin, & Howing, 1990) and delinquency (Starr, Mclean, & Keating, 1991) in maltreated children. As discussed above, parenting in poverty seems to be associated with greater stress and the use of coercive discipline. Poor caregivers are less likely to use reasoning and more likely to use physical punishment for disciplining (McLoyd, 1990). In some studies poverty has been associated with fewer expressions of affection and less responsiveness to the needs of the child (Peterson & Peters, 1985; Portes. Dunham, & Williams, 1986). These studies suggest the pressures of economic hardships may exacerbate conflict within the family. Where there is already weakness in the bonds between adult partners there is an increase in discord and dissolution (McLoyd, 1990). In some families this stress spills over into abuse and neglect of children and violence between adult family members.

Families where caregivers have mental health problems

Parental mental health problems have been an ongoing part of research into family risk factors (Goodman & Brumley, 1990; Sameroff, Seifer, & Zax, 1982). Lancaster (1999) reports that caregivers with schizophrenia have periods of adequate parenting but these are interrupted by critical times of serious problems due to disordered thought and psychiatric symptoms. Maternal depression has been linked to limitation in responsiveness (Cummings & Davies, 1999) and subsequent emotional problems in children (Field, Morrow, & Adlestein, 1993; Osofsky & Thompson, 2000; Weinberg & Tronick, 1998). For parents with substance abuse, research indicates a substantive link between these problems and negative child outcomes. For women with addictions high levels of distress and parenting stress are experienced and problematic parenting behaviours evidenced (Arellano, 1996; Chaffin, Kelleher, & Hollenberg, 1996; Harmer, Sanderson, & Mertin, 1999). M.H. Phillips & Cohen (2000) outline the risk process for children in families where there is substance abuse amongst caregivers. They draw attention to the interaction between child insecurity, family processes of shame and secrecy and conflicted emotions of children towards parents, and the effect this has on their expression of needs (M. H. Phillips & Cohen, 2000).

Quinton & Rutter (1988) provide a range of explanations for the link between poor parental mental health and emotional problems in their children. They cite possible factors as genetic transmission, compromises to child /parent interaction or more indirect impacts of the illness on the texture of family life, for example marital harmony. Rutter (1989) does however, warn that a simple causal relationship is not sustainable. Parental mental health does not always mean poor parenting, and risk is more likely to be related to psycho-social risk factors associated with the parents' illness. Other variables to consider in establishing the degree of risk include the child's age, their individual characteristics (Anthony, 1987), the presence of another protective parent or close adult who is not mentally ill and the extent to which the illness takes over all aspects of the family life (Rutter, 1989).

Family as a source of protection in the prevention of child mental health problems

While factors associated with severely adverse family environments contribute to elevated risk of mental health problems in children there are a range of processes and outcomes to be accounted for (Gaudin Jr, 1999). The long-term consequences of maltreatment are well established but are not invariant or inevitable. The family can also be regarded as a source of protection in respect of child mental health problems. Understanding the potential of this

protection, is of great interest to this research which seeks to relate support for caregivers to improved child outcomes.

Resilience in children and young people

Children in at risk environments who go on to experience positive outcomes are described as exhibiting resilience (Rutter, 1990). Rutter (1990) suggests that risk and protective factors act as two sides of the same coin; while exposure to risk can be damaging, survival and coping are also possible outcomes. Resilience can be thought of as a good outcome in spite of high risk or as sustained competence under stress or recovery from trauma (M. W. Fraser, Richman, & Galinsky, 1999). Three different hypotheses are offered as explanations for the presence of resilience. Firstly, it is suggested that a child may be immune to a risk factor, secondly, a child may compensate to maintain a level of competence and thirdly, risk can challenge an individual to achieve or acquire enhanced competence (Garmezy, 1985). Rutter (1999) underscores the range of possible psychological outcomes involved in resilience and warns against focusing on one unusually positive outcome or super-normal functioning.

Resilience involves the action of protective factors which, despite their heterogeneity, can act to buffer or mitigate against risk factors present in any situation. Protective factors can include individual characteristics possessed by the child, as well as relationships within the family and factors outside the family (Bynner, 1998, 2001). As with risk, resilience arises from a dynamic interplay of these systems, at a range of levels, from interpersonal to those of the family, the peer group, community and wider society.

Analysis of protective factors and their interaction has expanded to consider the processes that underlie the effects observed. Continuities and discontinuities mean that patterns are not necessarily set for life; for example, life events can be considered a turning point for individuals and can act as a catalytic modifier of a person's risk trajectory (Rutter, 1990). Consideration of process, the timing of experiences, the content of relationships as well as capacity, the effect of experiences and how these are perceived are all necessary to untangle resilience (Rolf et al., 1990). Protective processes can alter exposure to or involvement in risk, reduce the probability of a negative chain of events, cultivate self-efficacy, self-esteem and create opportunities (Rutter, 1990).

The multiplicity of factors and their interactive effects has made resilience research problematic and replication difficult. Methodologically research can only offer, at this stage, crude understanding of this variance (Masten, 1999). Luthar (1993) suggests that although resilience can be thought of as competence despite significant adversity or trauma, broad

definitions of resilience are less useful than specific domains for measuring the construct. Such measures of positive adaptation, or resilience, need to be comprehensive and multifaceted (McGloin & Widom, 2001) and commensurate with the risks encountered (Luthar, 1993; Rutter, 1999). For example academic achievement may be a less appropriate measure of resilience in school-based functioning for children and young people who are in statutory care than perhaps school attendance, level of inclusion or participation in a range of activities.

Protective family factors and protective family processes

A range of processes and factors within the construct of family life are of interest to researchers considering protective effects and the resilience of children and young people. Early researchers noted that warmth, emotional support, structure and positive parenting styles were associated with positive adaptation in children (Poertner & Ronnau, 1992; Rutter, 1985; Werner & Smith, 1982). Parental responsiveness, involving both nurturing and developmentally appropriate limit-setting continues to be related to positive outcomes for children regardless of other family and social conditions (Sanders, Gooley, & Nicholson, 2000) and predicts lower levels of child externalising behaviours (Rothbaum & Weisz, 1994). Kazdin's (1995) review of protective family factors in respect of conduct disorder concluded that emotionally responsive caregiving styles, parent education and social competence were associated with resilience.

Research has established the protective effect of a good mother and child relationship particularly in the first year of life (Werner & Smith, 1982). As described above the quality of attachment between parents and children in very early childhood has been found to influence later child behavioural adjustment (Greenberg, Speltz, & DeKlyen, 1993; Musick, Stott, Spencer, Goldman, & Cohler, 1987). It seems that maternal responsiveness and warmth can buffer the action of other risk factors such as maternal mental health disorders, separation and family discord (Musick et al., 1987).

The protective effects of family can involve relationships with others in the wider family system. Where parents are unable to provide positive processes, others in the family network, such as siblings, grandparents, and other family members (Kashani, Canfield, Bourduin, Soltys, & Reid, 1994) and those outside the kin system, for example, friends, neighbours, or clergy (Brooks, 1994) can offer a protective effect. For example in the presence of parental mental health problems close warm relationships with other adult caregivers are protective (Anthony, 1987; Musick et al., 1987). Muller, Goebel-Fabbri, Diamond, & Dinklage (2000) found that social support amongst a group of high-risk youth

with psychopathology was an effective buffer against family violence. In addition Osofsky & Thompson (2000) found those living in high risk environments who had positive reciprocal relationships, adequate support networks and shared parenting, could alter parenting style with positive effects on children. The role of support for families is discussed further in chapter three.

New Zealand research, although limited, has also pointed to the importance of a range of protective family related factors in promoting good child and adolescent outcomes. This includes breastfeeding and early learning experiences (Silva & Stanton, 1996) and the role of fathers as a source of resilience in families with children with disabilities (Bray, Shelton, Ballard, & Clarkson, 1995).

Spirituality as a protective family factor

A high majority of families report having a spiritual belief system. In the United States, for example, ninety five percent of married couples describe themselves as having a religious affiliation (Mahoney, Pargament, Tarakeshwar, & Swank, 2001). Amongst young people similar rates exist with 95% of those between 13 and 17 years believing in God or a universal spirit and 69 % considering themselves to be religious (M. J. Pearce, Jones, Schwab-Stone, & Ruchkin, 2003). In New Zealand, although statistics for couples are unavailable, 75% of the population claim adherence to the main Christian denominations (Michael Hill, 1994). While religious affiliation has been identified as an important aspect of many families' lives its impact on caregivers and child well-being has been less explored by psychologists (Mahoney et al., 2001) particularly amongst high risk children, young people or families, other than disabled children.

In respect of marital conflict Brody, Stoneman, Flor, & McCrory (1994) found a relationship between increased personal religiousness and improved couple communication. Mahoney et al. (1999) also determined that engaging in joint religious activities appeared to be linked to improved resolution of disagreements amongst couples. In adult studies, positive psychological outcomes as well as emotional release and renewal of purpose and strength have been associated with diverse religious and spiritual practices (Hassed, 2002; Matthews et al., 1998). Underpinning these effects, spirituality appears to link with sustenance and meaning attribution which assists in daily coping (Norman, 2000). Adolescents with active religious or spiritual lives experienced a four-fold reduction in suicide risk (Hassed, 2002), reduced drug and alcohol use (R. D. Moore, Mead, & Pearson, 1990) and were protected across a range of other problems experienced by youth at risk (Resnick et al., 1997).

Studies into the links between parental religiousness and child adjustment are comprehensively reviewed by Mahoney et al. (2001). Parental religiousness is associated with lowered levels of child externalising behaviour (Brody et al., 1994) and increased pro-social behaviour in children and young people (Lindner Gunnoe, Hetherington, & Reiss, 1999). In parent-child interaction a link between parental religiousness and greater efficacy of parenting practices has been established (Lindner Gunnoe et al., 1999; L. D. Pearce & Axinn, 1998). Wilcox (1998) found that conservative religious views in parents were associated with increased hugging and praise and in parents with increased church attendance there were high levels of physical affection shown to children. Brody et al. (1994) suggested that there was likely to be interaction between spirituality, improved marital quality, co-parenting skills and child well-being. Parental religiousness was related to less marital conflict and fewer child externalising behaviours and greater family cohesion (Mahoney et al., 1999). They warn however that the measures utilised in these studies are commonly global and there is a need for more delineation in the criteria used to explore the relationship between religiousness, parenting style and child adjustment.

Resilience in abused and neglected children

The role of protective factors and resilience has tremendous potential for researchers and practitioners interested in children with mental health problems in a child welfare context. The research suggests that while individual attributes are important they co-exist with other factors, which appear amenable to intervention and can reduce the likelihood of adverse outcomes in adolescence (Cicchetti et al., 2000; Kaufman & Zigler, 1987; Mannarino & Cohen, 1986).

An extensive body of literature has documented the negative psychological consequences associated with child maltreatment as described above. There is a smaller group of studies, which report that some maltreated children will retain their positive functioning (McGloin & Widom, 2001). Heller, Larrieu, D'Imperio & Boris (1999) in a large study of abused or neglected children found that 22% met the criterion for resilience in domains such as absence of psychiatric disorder, successful employment, educational achievement and absence of homelessness. Factors associated with resilience were high cognitive competence, self-esteem and characteristics such as flexibility, persistence and reflection. As Pagelow & Pagelow (1984) point out, resilience in abused and neglected children is significant as they often experience additional problems such as the stigma of child welfare involvement and disrupted placement patterns. These findings indicate to social workers and other professionals that there is not an inevitable pathway to mental health problems for children and young people who are neglected or abused.

An understanding of resilience amongst at risk children can provide a basis for intervention with caregivers. Studies in the early 1980s, for example, identified some aspects of addicted mothering which were protective, in particular, the normal love and concern for children (Rosenbaum, 1981; Wellisch & Steinberg, 1980), the desire to remain connected to these children (Colten, 1982) and awareness of personal deficiencies and children's needs (Luthar & Suchman, 2000). This group is usually characterised as having a high level of individual psychopathology and parenting deficiencies. Luthar & Suchman (2000) designed an intervention programme with substance-abusing mothers, using these protective factors, in particular, maternal concern for their children's welfare and awareness of parenting problems. These strengths are harnessed within the programme and used as the key motivators for change. Phillips & Cohen (2000) describe other programme designs which utilise negative life experiences such as trauma and abuse as a source of opportunity and motivation towards change, releasing individuals from personal blame and enabling them to achieve adaptive distance.

Cowen's (1994) emphasis on establishing pathways to wellness, referred to in chapter one, incorporates a resilience approach to working with children at risk to enhance child mental health outcomes. This informs a strategy for the promotion of wellness in maltreated children presented by Cicchetti, Toth & Rogosch (2000). The strategy includes concerted efforts to prevent maltreatment using psycho-educational home-based interventions, increased child protection capacity in order that the first instance of abuse is responded to with timeliness and efficacy, a focus on fostering self-determination in children and empowerment of families, and access and maintenance of services regardless of whether there is a diagnosable condition. These strategies are useful for thinking about interventions for children with mental health problems in the New Zealand welfare context. Some of these priorities are appearing in recent New Zealand social policies, (see for example Department of Corrections, 2001; Jacobsen et al., 2002) and in new models of foster care which are discussed in chapter five.

Family resilience and strengths based social work theory and practice

Thinking beyond individual resilience researchers have also come to regard families as possessing resilience in their own right. This concept of family resilience has emerged from two research paths; studies which characterise resilient families who are exposed to stress, and research which considers families in respect to the protective environment which they offer for child development (Kalil, 2003).

Walsh (1998) views family resilience as the coping and adaptive processes in the family as a functional unit and recognises that in most circumstances families are able to confront and manage difficult experiences, buffer stress and reorganise. The result of this reorganisation is short and long term adaptation both at the individual and family unit level. Family health is not taken to mean problem-free families, rather adversity is regarded ultimately as a source of family strength (Norman, 2000). Family resilience acknowledges diversity in family structure and processes, such as cultural difference, and views positive adaptation as possible in all family forms.

While there are gaps noted in the research on family resilience, particularly in New Zealand, a common set of characteristics of resilient families is identified by Kalil (2003) in a recent review. These factors include a sense of connectedness, effective communication patterns, use of coping and problem-solving strategies and spirituality or religious beliefs. Many of these characteristics have been established as protective factors within research on individual resilience as described above.

Theories of family resilience co-exist within the body of social work theory, known as family strengths (Saleebey, 1997). In the family strengths perspective there is a view of families as possessing strengths and resources rather than problems and a reorientation from deficit and dysfunction in order to search for potential repair and growth (Weick, Rapp, Sullivan, & Kisthardt, 1989). As Saleebey states : *The environment continually presents demands, stresses, challenges and opportunities. These become fateful, given a complexity of other factors-genetic, neurobiological, familial, communal – for the development of strength, of resilience or of diminution of capacity* (Saleebey, 1996 p.299).

Norman (2000) formally ties the concept of resilience to the emergent strengths perspective in social work practice, claiming that enhancement of resilience is the best way for social work to put the strengths perspective into practice. Strengths based practice in social work has emerged from practice-based research with families, drawing policy from the realities in which families live, face challenges and thrive (R. Munford & Sanders, 1999; O'Neil, 2003).

Weick et al. (1989) summarise the main assumptions of the strengths perspective. These include: individuals have the capacity for good, strengths enable growth, individuals will do their best and that while human behaviour is complex and hard to predict clients will know what is best for them. As a practice model family strengths social work rests on empowerment, avoidance of blame, developing motivation in clients and evolving a co-operative relationship between client and worker (Blundo, 2001; Russo, 1999). Family expression of coping strategies may be hard for social workers to recognise or assign value

to because of the pervasive problem focus which social work has traditionally had (Saleebey, 1997). However, collaboration and dialogue are thought of as the way in which work can proceed, requiring openness and appreciation of the viewpoints of others. In Australia, family strengths practice models have received particular attention, most notably the development of a competency-based, solution-focused practice framework at St Lukes (D. Scott & O'Neil, 1996) building on strengths based therapies such of those of White & Epston (1989).

Most family strengths models rely on an in-depth assessment. This underpins the identification of strengths and goals for intervention, as well as facilitation of the helping relationship (Dunst, Trivette, & Deal, 1994; Early & GlenMaye, 2000; Poertner & Ronnau, 1992). Through this assessment the social worker and the family form a partnership in defining problems, goals, strategies and success, as is described, for example, within a New Zealand social service using this approach (R. Munford & Sanders, 1999). Within this perspective the strength of individuals is enhanced within their communities of interest. Membership and connection is emphasised in order to foster a sense of belonging, for example, linking with other parents in a cultural or recreational context.

Resilience frameworks for this research

This chapter has discussed a range of resilience frameworks, which are useful when thinking about families who care for children and young people with mental health problems. Developmental psychopathology, although originally focused on families as a source of risk, has become interested in the identification of the potential of caregivers to protect and enhance child mental well-being. Even amongst children who have been abused or neglected, researchers find resilience. From this comes recognition of the potential for families of these children to make a positive contribution to their outcomes. Within social work theory an orientation to resilience and positive adaptation is embodied within the family strengths perspective. Similarly, in New Zealand, Maori models of health outlined above, provide indigenous wisdom on the protective role of family, spirituality and the link between the mental health of individuals and wider resilience in whanau. Spirituality, dignity and identity are the basis of Maori models of health and are linked to the commonly understood manifestations of mental health, such as emotions, and to physical health (Lapsley, Nikora, & Black, 2002). These strands are intertwined with an understanding of the health of the interactions, processes and relationships amongst whanau members and the wider hapu and iwi (Durie, 2001). As an approach to the questions at the centre of this thesis, these frameworks prompt the researcher to consider the way in which most families who are

caring for children with mental health problems, possess unique coping mechanisms, which can be protective to their children.

Conclusion

Research both overseas and in this country has established that the development of mental health problems in children and young people is a common experience for many families, which will likely persist over time, despite the input of mental health services. How families are constructed in the explanations of the development of these problems has shifted from a focus on the family as a source of risk to include the potential of family to provide protection and resilience. Family processes, in particular the interactions between children and caregivers, are identified as having a significant impact on the development of resilience in children.

The frameworks discussed in this chapter suggest that it is legitimate to search for sources of positive variance in child outcomes within the context of family, amongst caregivers and their actions. Of central interest to this research is the finding that positive variance or resilience is evident amongst children who have been maltreated and that opportunities exist to design interventions around their caregiving. While research into resilience amongst high risk populations is limited, the findings to date, along with those of strengths based social work and Maori mental health models, orientate the researcher in the first instance to the experience of caregiving families. Their perceptions of need and the strategies they use to meet the challenges of care, including their use of support services become a central focus. These matters are explored in the following chapter.

Chapter Three

Caring for Children and Young People with Mental Health Problems

Introduction

The previous chapter highlighted the prevalence of child mental health disorders, the persistence of these problems and explanations of the development of child mental ill health. This chapter focuses on the experiences of families looking after children and young people with mental health problems, the challenges they commonly describe and the manner in which they manage this care. The research relating to informal support is examined together with the contribution of formal mental health services available to support caregivers in New Zealand. The relationship between service providers and families is explored, including the negotiation of support services between representatives of service providers and caregivers. The chapter reflects on progress in the United States to establish a coordinated network of individualised services for families caring for children with mental health problems. This approach is contrasted with current support service scope and design in New Zealand.

Gaps in the research

The experience and priorities of families raising children with mental health problems have been poorly studied in New Zealand. Family perspectives are more often than not missing from research initiatives, government policies, service design, delivery and evaluation. Further, those families raising children with mental health problems who experience additional stress, such as domestic violence or drug dependency have not been the subject of separate study in this country. This research does draw on a small number of government consultations that provide testimony from New Zealand families caring for children with a range of high support needs including those with mental health problems (Autistic Association of New Zealand, 2001; Carpinter, Irwin, & Rogers, 2000; Health Funding Authority, 2000a; Mental Health Commission, 2000a).

New Zealand studies are supplemented here by a growing body of overseas research detailing the experiences of families caring for children with mental health problems. The experiences of caregivers looking after adults with mental health problems has been widely researched for example by Hatfield & Lefley, (1987), Lefley, (1996) and Wahl & Harman,

(1989) whereas Friesen's (1989) study of 965 United States families caring for children with emotional and behavioural problems was among the first of its kind. Her study provides an understanding of families perspectives, along with more recent work (Bruns & Burchard, 2000; Friesen, Kruzich, Robinson, & Pullmann, 2002; Herman, Marcenko, & Hazel, 1996; Modrcin & Robison, 1991; Pullmann, Savage, & Koroloff, 2002).

There is a stronger research tradition which provides insight into the experience of families caring for disabled children (Breslau, Strauch, & Mortimer, 1982; Dunst et al., 1994; Weiss, 1991). As there are some common issues for families this research can augment studies of families caring for children with mental health problems, for example as Kutash & Rivera (1996) do in their review of mental health services.

The experience of families providing care for children with mental health problems

Families of children with mental health problems face complex issues beyond the everyday challenges of family life. Included amongst these challenges are dealing with stigma, establishing and maintaining effective relationships with professionals, managing difficult child behaviours, dealing with uncertainty and financial problems (Friesen, 1989, 1990). Weiss (1991) in her study of parents caring for children with pervasive developmental disorders outlines a similar cluster of stressors, as do families of other disabled children (G. H. S. Singer & Irwin, 1996). These issues, discussed separately below, are interactive and dynamic; deficits in one area impact on other areas and the multiplicative effect of numerous stress domains compounds family strain.

Stigma and blame

Families of children with mental health problems identify stigma as their biggest challenge (Friesen, 1989) from the general public and within their own networks. Schools have also been identified as a source of stigma both overseas (Richardson & Joughin, 2000) and in New Zealand (Health Funding Authority, 2000a). Families in this country describe their children's experience of stigma (Health Funding Authority, 2000a) reports of stigma by siblings (Carpinter et al., 2000) and by other family members (Mental Health Commission, 2000a, 2000b; New Zealand Commissioner for Children, 1999). Blame is often associated with stigma, based on misinterpretation of a child's symptoms as deficits in parenting. For example, United States parents reported that child impulsiveness was sometimes viewed as the result of parenting without limit setting (Friesen & Huff, 1996). New Zealand caregivers

report similar judgments and assumptions about their parenting (Health Funding Authority, 2000a).

Lefley (1996) suggests that a source of blame for users of mental health services may arise from the services themselves, in particular from the professional use of theoretical models that locate responsibility for dysfunction with parents. The discussion in the previous chapter highlighted the risk orientation, which many such models adopt in respect of families. Clinical practitioners working with families of children with mental health problems have been found to retain theoretical models which view family relationships as the cause of child problems, rather than a source of protection (Friesen, 1996; McManus & Friesen, 1986). A more recent study finds that while differences existed amongst professional groups, parents were still frequently blamed, despite evidence of a biological basis for many childhood disorders (Johnson et al., 2000). New Zealand families agree that a source of blame lies within the mental health services. As one parent claims:

As a parent I felt very judged, blamed and dismissed by their interaction with me. How could you let this happen was a comment made to me in relation to her overdose and her swallowing pills found at A and E (New Zealand Commissioner for Children, 1999 p.14).

Managing difficult behaviours

Children with common mental health problems can exhibit a spectrum of behavioural and communication problems (Friedman et al., 1996). These result in unpredictable developmental pathways to which their families must adapt (Modrcin & Robison, 1991). The presence of severe behavioural concerns and the family capacity to manage these problems are a significant source of stress for families of children with high support needs (Lucyshyn & Albin, 1993; Quine & Pahl, 1985, 1993; Weiss, 1991). Although child behaviour and family resources have been found to interact in the prediction of caregiver stress, child behaviour appears to be the greatest predictor of strain in families of children with mental health problems (Pullmann et al., 2002). For example, child behavioural disturbances and perceived parental control over this behaviour, amongst parents of children with ADHD, were the strongest predictors of parental stress and depression (Harrison & Sofronoff, 2002).

The impact of behavioural problems in families include demoralisation, social isolation and conflict between family members (Friesen, 1989) and the discrepancies between child capacity and parental expectation widen over time (Modrcin & Robison, 1991). The fear of making connections with others because of child behaviour is described by many parents (Friesen & Huff, 1996), as is the diminution over time, of friendship networks. In addition

physical threats from children are common, experienced by approximately half of the parents in the United States surveyed by Friesen (1989). A level of danger is also described by New Zealand families, who recount receiving cuts, bruises, broken bones and threats with knives from those in their care (Carpinter et al., 2000).

For many families, the interface between the child, the school and the wider community causes greater strain than managing child behaviour within the family (G. H. S. Singer & Irwin, 1996). New Zealand families concur that relationships between the child and the outside world generated more stress and sadness than relationships within the family (Carpinter et al., 2000). Parents report going to extreme measures to try to manage challenging behaviours including constant vigilance and seclusion (Carpinter et al., 2000).

Uncertainty and inadequate information

Despite increasing evidence of early precursors of child mental health problems and continuity of behavioural problems, early assistance for families is limited. United States families caring for children with mental health problems reported uncertainty and lack of information, leaving them with unanswered questions about how to help their child (Friesen, 1989). This uncertainty prolongs family articulation of need, delays the development of home based strategies particularly around behaviour and loses opportunities to reinforce family coping styles (Weiss, 1991). For example, caregivers of children with ADHD who received early confirmation of the disorder saw themselves as better positioned to learn strategies to stabilise family interaction and maintain child self esteem than those receiving later diagnoses (Segal, 2001).

Uncertainty is also a common response by New Zealand mental health services and provisional diagnoses are to be expected (Child, Youth and Family, 2002h). Even with a formal diagnosis parents report gaps in information available to them (Health Funding Authority, 2000a) and express anger about lost opportunities to gain support earlier (Carpinter et al., 2000). As an illustration of this, families caring for children with autistic spectrum disorders describe inadequacies in information particularly about treatment innovations available overseas, and emphasise the need for families to do their own research (Autistic Association of New Zealand, 2001). In this way New Zealand parents become key information sources, *"it was clear at the meetings that parents are a key source of advice, information and inspiration for each other"* (Carpinter et al., 2000 p.10).

Dealing with services and professionals

Families of children with mental health problems seek relationships with professionals which are honest, respectful, non-blaming and inclusive in respect of decision making (Friesen & Huff, 1996). Research into care of disabled family members also underscores the importance to service users of their interpersonal transaction with workers, which they rated more highly than technical expertise (Herman et al., 1996; Marquis & Jackson, 2000). However, these families experience parent/professional problems relating to disrespectful interaction styles, intimidation, disregard, and helping models which undermine family ability to solve their own problems (G. H. S. Singer & Irwin, 1996; Weiss, 1991).

Relationships between professionals and families caring for children with mental health problems are problematic. There are reports of erratic and unsatisfactory relationships with services and professionals, but more positive experiences with individual clinicians (Friesen, 1989). Significant dissatisfaction has been recorded by some families, including claims that they felt involved only when the aetiology of disorder was discussed, that access to child records was blocked, and that they were poorly involved in decision making (Collins & Collins, 1990; Friesen, 1996). Families feel excluded and isolated when children are hospitalised, resulting in a feeling of powerlessness (Mohr, 2000).

These problems appear worse for low income families, who are more at risk of receiving disrespect from health care providers than affluent families (Friesen, 2001b). This is an important finding for the group of families involved in this research and may contribute to understanding their service access problems, discussed in the next chapter.

Poor relationships between families caring for children with mental health problems and professionals may be partially explained by the intermittent contact parents have with mental health services. Overseas, families have been found to have little involvement with early intervention or middle level services, tending to access intensive services for their children when their mental health problems become unmanageable (Friedman et al., 1996). In this way crucial relationships are under-developed. Once in intensive services families find it difficult to participate in planning and care, for example, 79% of parents reported restriction on contact with their children who were living in residential services (Friesen et al., 2002).

New Zealand families have reported lack of respect from mental health services. They describe a loss of dignity, being viewed as a part of the illness and of being invited to meetings but not being asked to contribute (Mental Health Commission, 2000a, 2000b).

Families have reported that when they express stress to professionals they are patronised (Carpinter et al., 2000) and their experience is not acknowledged (Autistic Association of New Zealand, 2001). As one New Zealand family recalled: *“the staff person told me they had invited the nurse along to tell me about mental illness. I told them I knew about mental illness because I had lived with my daughter for many years”* (Mental Health Commission, 2000b p.13).

Inability to obtain appropriate services

Families raising children with mental health problems report difficulties accessing services including unavailability of services, lack of knowledge of services, inappropriateness of services (Frank, Greenberg, & Lambert, 2002; Friesen, 1989) and differing eligibility requirements (United States General Accounting Office, 2003). In the United States specific service gaps include respite care, financial assistance and support groups for parents and siblings (Friesen & Huff, 1996). Finding and sustaining suitable arrangements for schooling for children with mental health problems also causes families considerable stress (Friesen, 1989). Reluctance of service providers to recognise children's mental health needs is noted as a continuing problem for some families in the United States (United States General Accounting Office, 2003).

New Zealand parents reiterate these issues. They emphasise a lack of responsiveness in crisis services (Health Funding Authority, 2000a; New Zealand Commissioner for Children, 1999), absence of a range of crucial services such as day programs (Health Funding Authority, 2000a), school support and respite care (Carpinter et al., 2000; Health Funding Authority, 2000a), absence of residential services, poor staff training and advocacy and inadequate planning (Health Funding Authority, 2000a; New Zealand Commissioner for Children, 1999). Families singled out parent support groups as a key support service that was underdeveloped in this country (Health Funding Authority, 2000a).

New Zealand families caring for children with autistic spectrum disorders who are able to access respite care through disability services, report low levels of satisfaction with this care. Difficulties finding caregivers have led many families to not use respite care only to have these hours deducted the following year (Autistic Association of New Zealand, 2001). In addition these families noted that there are insufficient anger management, self-esteem and social skills and behavioural support programs available. As a result 30% of families looking after a family member operate their own home based programmes to meet learning, social and recreational needs (Autistic Association of New Zealand, 2001). Difficulties which schools in New Zealand have in coping with children with mental health problems and

consequent pressure on families are also described (Carpinter et al., 2000; New Zealand Commissioner for Children, 1999).

Culturally inappropriate services

The focus of this research is on families caring for children and young people with mental health problems who are involved in child welfare services. This group has high representation of families from minority cultures, who are likely to face extra challenges in obtaining appropriate support services. As child rearing, child development and mental illness are all experienced in culturally specific ways the values and practices of the cultural majority tend to shape mental health services (Takeuchi, 2001). In the United States there is evidence that some ethnic minority groups are reluctant to seek services and delay contact with professionals (Bui & Takeuchi, 1992). Later studies have continued to confirm that race affects both over and under service utilisation patterns amongst families of children with mental health problems (McCabe et al., 1999). Cultural awareness amongst those providing services has been found to impact both on the services received and engagement of families in service systems (N. N. Singh, McKay, & Singh, 1998).

In New Zealand Maori identify mainstream mental health services as dominated by a western medical model, which is pessimistic about recovery and assumes an ongoing need for medication and services (Mental Health Commission, 2000b). The basis of the counselling model used in many mental health services separates the individual from the family. As described in chapter two, this is not congruent with Maori concepts of well-being where understanding about health is derived from the relationships between people and their wider systems (Durie & Hermansson, 1989).

Maori caring for whanau members with mental health problems report difficulties accessing support services, including gaps in information about treatment and resources and poor follow up (Mental Health Commission, 2000b). Durie (2001) identified that for a group of whanau involved with a former New Zealand health institution, over half had their relatives placed in hospital against their wishes and were excluded from practice decision making. High rates of admission of Maori to psychiatric hospitals and ineffective treatment approaches are also reported (Woodward, 2001). The needs of whanau have not initially been recognised in service design although as chapter two indicated new moves are being made to address the needs of Maori in New Zealand mental health services.

Balancing family and work lives

Families caring for children with mental health problems describe disrupted and difficult family patterns (Friesen & Huff, 1996; Kutash & Rivera, 1996). Similar problems are recorded in families of disabled children. Siblings report increased stress, greater caregiving and household responsibilities, loss of time with parents, changed nature of play and stigma (Breslau & Prabucki, 1987; B. Gibbs, 1993). These problems are also described in New Zealand, particularly the strain in balancing attention to siblings and to the child with problems (Carpinter et al., 2000).

Overseas families with children with mental health problems experience financial pressure due to high medical costs, work discontinuity and the need to supplement services (Friesen, 1989, 1996). In New Zealand, even where medical care is subsidised, parents are often dependent on government income assistance and are unable to afford technology which would assist them, such as mobile phones (Carpinter et al., 2000).

Many caregivers of children with mental health problems also undertake paid work in order to relieve financial strain, enable services for their children to be obtained (Brennan & Poertner, 1997) and find a source of support (Friesen, 1989). Management of work and family life is stressful however, (Brennan & Poertner, 1997). In the United States it is estimated that 5%–10% of employed parents care for a child with a mental health problem (Rosenzweig, Brennan, & Ogilvie, 2002). These families recount a number of difficulties, including the need to take time off work to provide care or to attend planning meetings for their child (Brannan, Heflinger, & Bickman, 1997; Brennan & Poertner, 1997). The quality of childcare for children with mental health problems is scarce, expensive and lacks flexibility. This group of children are more likely than other children to be in lower quality care, to change their childcare arrangements and be dismissed from childcare (Ama, Berman, Brennan, & Bradley, 2002).

In New Zealand parents explained that participation in work gave them respite from providing care, stimulation and rebuilt self-esteem; however, many were unable to sustain work because of the needs of their child (Carpinter et al., 2000). The absence of adequate day programmes in New Zealand, for example, means that when children are too unwell to go to school their parents must care for them at home (Carpinter et al., 2000; New Zealand Commissioner for Children, 1999). These requirements will make it difficult for some parents to maintain ongoing employment although the extent of this has not been studied in New Zealand.

Fatigue

Parents of children with mental health problems report that persistent stress and fatigue affects both their health and coping capacity (Carpinter et al., 2000; Friesen, 1989). Problems are exacerbated by conflict between child ability and parental expectations, the long-term tenure of parenting and the constant need to adjust to unanticipated change and challenge as parents (Modrcin & Robison, 1991; Segal, 2001; Weiss, 1991). Responsibility for care in families with children with high support needs has traditionally fallen on the primary caregiver (Dyson, 1997). In Friesen's research although shared caregiving was reported by a high majority of families this level was much reduced amongst single parent respondents (Friesen, 1989). Families in New Zealand do not report a high level of shared parenting and caregivers who were in relationships described themselves as sole parents with respect to caring for their child (Carpinter et al., 2000).

Disintegration of the family unit

The ability to manage difficult child behaviour influences the perception of parents about their ability to provide ongoing care, both overseas (Bromley & Blacher, 1991) and in New Zealand (Carpinter et al., 2000). Breakdown of family care and subsequent out of family placement is a common indicator of stress in families (G. H. S. Singer & Irwin, 1996) and a frequent feature of families with children with mental health problems (M. H. Epstein et al., 1994; Landrum et al., 1995).

The loss of custody accompanying most out of home placements further undermines the integrity of the family. One quarter of United States parents of children with mental health problems surveyed said that relinquishment of custody of children had been suggested as a means of gaining access to services (Friesen, 1989). Landrum et al. (1995) also found that in a substantial proportion of families a statutory agency had augmented or assumed parental custody. This trend has continued with a significant number of parents placing children in child welfare or juvenile justice systems in order to obtain mental health services (United States General Accounting Office, 2003). Ervin (1992) notes similar patterns in families with children with neurobiological disorders.

As residential care packages are not yet an established part of New Zealand child mental health services there are no ready data about the patterns or number of out of family placements of children with mental health problems or relinquishment of custody in order to access services. Estimates would need to be made across the breadth of child welfare and

education settings where out of family placement of these children is likely to be occurring in New Zealand.

New Zealand families caring for children with high support needs and behavioural problems have commented on the circumstances which might lead them to relinquish care. These parents did not identify any single common factor that would trigger this crisis but reported depleted coping skills, rising demands of those being cared for and atrophying social networks (Carpinter et al., 2000). Similar patterns of loss of coping are described in families looking after children with high support needs overseas (Dunst et al., 1994) particularly in relation to aging of caregivers (J. A. Cook, Lefley, Pickett, & Cohler, 1994).

Managing the care of children with mental health problems

Positive aspects of care

Despite all these difficulties, caring for a child with high needs remains a variable experience for families particularly where there is support for primary caregivers. For many this care, although challenging, is described as fulfilling and children are viewed as making a positive contribution to the family (G. H. S. Singer & Irwin, 1996; Summers, Behr, & Turnbull, 1989). Positive feelings about children with high needs are expressed by siblings and caregivers, who acknowledge the learning and growth they have experienced in their caregiving role (B. Gibbs, 1993; Kosonen, 1996). This evidence has led to an appreciation of reciprocity in family dynamics and the way in which cognitive maps of families inform caregiver evaluation of their experiences (Grant & Ramcharan, 2001).

Religiousness may also play a part in the positive response of some individuals to serious family stress (Mahoney et al., 2001). Amongst parents of disabled children with religious practices personal gains from parenting are noted (Haworth, Hill, & Glidden, 1996; Skinner, Bailey, Rodriguez, & Correa, 1999) along with increased family cohesion (Weisner, Beizer, & Stolze, 1991) and reduced parental stress (Friedrich, Cohen, & Wilturner, 1988). Findings suggest that spirituality appears to buffer negative effects of stress particularly when child problems are not perceived as being under parental control. However, where difficulties are thought to be the responsibility of the parents (such as behavioural problems) there may a negative effect of religiousness on parenting functioning (Pargament, Smith, Koenig, & Perez, 1998; Strawbridge, Shema, Cohen, Roberts, & Kaplan, 1998).

For families of children with mental health problems positive experiences are also noted. In Friesen's (1989) study, while a minority of all parents identified positive effects on family

life this percentage was elevated to one third in the group of parents who had support of a partner. For these families involvement in religion was not associated with blame and was rated as almost as helpful to parents as involvement with other parents of children with problems. Support of religious networks was identified by family members across all income and educational levels (Friesen, 1989).

Positive experiences along with challenges are noted in testimony of parents of children with high support needs in New Zealand (Pepperel & Wane, 2002). Religiousness however, was reported as a mixed factor, with some describing religion as a support and others seeing it as a source of judgement (Carpinter et al., 2000).

In summary, although amongst caregivers looking after children with mental health problems stress is well established, there is evidence that the experience is not overwhelmingly negative particularly where parents are well supported. Families can bounce back from challenges of providing care to such an extent that for families with good support networks intervention may be unnecessary (Dunst et al., 1994).

Meeting family needs

There is a core set of needs which families caring for a child with mental health problems tend to have. These needs include emotional support, accurate information about diagnosis, prognosis, treatment and services, behavioural management support, respite from providing care, transportation, assistance with household tasks, financial and life planning (Friesen, 1996). Some of these needs are likely to be continuous and stable while others will emerge at different stages of the family life cycle (G. H. S. Singer & Irwin, 1996). Before family members can effectively carry out therapeutic or educational interventions identified needs of families should be met (Dunst et al., 1994) otherwise families are likely to experience additional stress and negative feelings.

The role of front line workers in defining need and negotiating support services

The ability of a family to manage the care of children with extra support requirements has been linked to individual caregiver resources, the family's internal needs and the support of the extended family network (Slater & Wikler, 1986), along with more formal support services. For this present research, which explores support to those providing care in a child welfare context, the process by which support needs are defined and negotiated is also of

interest. While research on help seeking by families is undeveloped (Broadhurst, 2003) the relationship between caregivers and social care agency representatives has been found to influence the way service provider and family perception of support needs interact (Twigg & Atkin, 1995).

Need is defined as an individual judgement of the discrepancy between actual states or conditions and what is considered normative, desired or valued, from a help seeker's rather than a help giver's perspective (Dunst, Trivette, & Deal, 1988). While needs-based criteria used in some service designs are important they exist in a context, the influence of which has been less understood. Needs based criteria are filtered through assumptions about relationships and situations which influence the nature of help families receive (Twigg & Atkin, 1995).

Dunst et al. (1988) considers the processes involved in identification and articulation of need, describing the way in which perception of need is bound up with a caregiver's values and awareness, as well as knowledge and access to resources. In order to recognise need there must be awareness that there are resources that will reduce the discrepancy between what is and what should be. This need recognition occurs whenever something (for example a resource) is identified as a form of aid or assistance that will reduce the perceived discrepancy (Dunst et al., 1988). In many cases people do not perceive needs if they see no way in which resources can be procured to meet them (McKillip, 1987; Reid, 1985). For New Zealand families caring for children with mental health problems where resources are very limited, perception and articulation of family need is likely to be reduced. These resource constraints are described in greater detail later in this chapter.

The relationship between the service provider representative and the caregiver, which is the nexus of identification of need and provision of support services, has also received attention. Twigg and Atkin (1995) describe a "negotiated response" in which the expectations and assumptions of caregivers shape the response of service providers. In this model significance is placed on the understandings, values and belief systems of both service providers and caregivers about care, support and the role of caregivers. This approach helps to explain why some caregivers can refuse help or see it as intrusive, while others will regard the same support as an entitlement. In other cases caregivers appear to require permission to articulate their needs (Twigg & Atkin, 1995).

While front-line workers often have discretion to allocate extra resource to caregivers this is commonly exercised in a situation of funding constraint. In this context responses have been found to be occasional and rarely initiated as workers tend to wait for approaches from

carers. The values, knowledge and expectations of caregivers then become key factors in determining whether they will seek out extra support services (Twigg & Atkin, 1995).

Twigg & Atkin (1995) describe three principal clusters of caregiver response to the stress of providing care, which are important in structuring their expectations of support. These are boundary setting, engulfment and symbiosis. Boundary setting enables caregivers to detach from the caregiving situation, set clear boundaries as to their role and responsibilities and make a separation between themselves and the person cared for. Engulfment is described as the overwhelming of caregivers by their situation and demands so that *"they had no energy with which to pursue help and find it difficult to adjust to accepting any assistance that was offered"* (Twigg & Atkin, 1995 p.11). The response of symbiosis encompasses caregivers who gain from their role and do not want responsibility taken from them. They are happy to accept support as long as this help is not so extensive as to threaten their role of caregiver (Twigg & Atkin, 1995).

The provision of support services then is based on a negotiation involving both service provider and caregiver perceptions and expectation of need. These in turn relate to values about the nature of care, caregivers' response to providing care and knowledge of service availability.

What is family support?

The process of supplying resources (practical, emotional, interpersonal) to families (R. Munford & Sanders, 1999) or more broadly creating permanent socio-environmental conditions designed to maintain family caregiving (G. H. S. Singer & Irwin, 1996) is known as family support. Family support should be contextualised in terms of the changes to the social construct of the family, which were referred to briefly in the previous chapter. Family support is a way of strengthening family members so that they can cope with the challenges of such changes (Pinkerton, Higgins, & Devine, 2000). Family support exists both as a policy objective, and a form of social work practice. However, the wide variety of family support programmes and diversity of definitions make it difficult at times to link these to child welfare policy objectives (Pinkerton et al., 2000).

For the purposes of this research, family support is defined in respect of families with significant stress or disadvantage. Drawing from the research on resilience Gilligan (2000b) discusses family support as *"mobilising support for children's normal development in adverse circumstances... in all the contexts in which children live their lives"* (Gilligan, 2000b p.13). Within this perspective, the objectives for family support include sustaining

children's normal development and sense of belonging. Importantly the goal of family support is also to contribute towards keeping a child in the family by preventing deterioration in family relationships whereby the child or other adults see it as necessary for the child to leave the family. While family support can occur naturally through the informal support system of kin and friends it also is commonly planned and delivered by professionals or paraprofessionals as formal family support (Gilligan, 2000b).

Family support for families caring for children with mental health problems

Family support for those caring for children with mental health problems, has been described similarly as a range of formal and informal services of varying intensity that are defined and determined by families (Kutash & Rivera, 1996). The goal of family support is to maintain the integrity of families looking after children with mental health problems, ensuring they can continue to live together achieving a balanced life (Friesen & Wahlers, 1994). Flexibility and breadth of support is a defining element of family support, the “whatever it takes” for a family to care for a child or adolescent who has an emotional, behavioural, or mental disorder (Kutash & Rivera, 1996). Support can take the form of aid, that is, practical services and material benefits. It also includes affirmation which promotes positive self-esteem and validates identity providing caring, affection and nurturing (House, 1981). The Federation of Families for Children’s Mental Health describe a range of services within the scope of family support including family self-help, advocacy groups, education, in-home and out-of-home respite care, cash benefits and other forms of assistance with food and housing (Kutash & Rivera, 1996).

Within many family support services in the United States the needs of the child with mental health problems and his or her family are expected to dictate the type and mix of services provided (Lourie, Stroul, & Friedman, 1998) thus strengthening parental roles (Weissbourd & Kagan, 1989). For this group of families there is an emphasis on the individualisation of services, responsiveness and decision making with the family (Kutash & Rivera, 1996). In situations where children are in out-of-home placements, Friesen points out that family support can assist families to maintain close involvement when children are placed out of home and help when they return (Friesen, 1996).

The contribution of family support

Family support has been linked with improvements in child and family well-being across a range of populations. Specifically improvements have been noted in child psychopathology (Kashani et al., 1994), child temperament, (Affleck, Tennen, Allen, & Gershman, 1986), child behaviour and development, (Crnic, Greenberg, & Slough, 1986), caregiver attitudes to children (Colletta, 1981), family well-being (S. Cohen & Syme, 1985; Patterson & McCubbin, 1983) and satisfaction with parenting (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983). The buffering effect of family support in periods of stressful parenting, (Crockenberg, 1981) and during life crises (Moos, 1986) has also been noted. In these times those offering support can augment the role of the primary caregiver and assist in meeting child needs when there are limitations or disruptions in parenting.

Specific to children and young people with mental health problems, family support can offer additional protective effects, enhancing a child's social skills, improving self esteem and buffering negative effects of stigmatisation and withdrawal. Support may enhance the caregiver-child relationship in such a way as to assist in preventing the development of further emotional and behavioural problems (R. A. Thompson & Ontai, 2000).

Gilligan (2000b) reviews a number of studies that suggest that gains from family support can be demonstrated over periods of 7 to 23 years. Summarising the findings of three separate reviews he suggests family support can make a difference particularly where there is a multi service approach, intensive, long term contact, specialist assessment, and where parental networks are strengthened and support groups exist for skill building and socialisation (Gilligan, 2000b). Family support interventions are included in the large meta-analysis of outcomes of programmes designed to prevent the development of mental health problems in children and adolescents (Durlack & Wells, 1997). This review established the effectiveness of such programmes in both reducing problems and significantly increasing competencies. R. Munford & Sanders (1999) confirm these findings in the context of New Zealand family support services, emphasising the importance of the integration of families into their communities so that they can effectively access and utilise community support.

Informal family support

As this research aims to understand the role of support to those providing care in a child welfare context the delineation of formal and informal sources of family support is important. Formal family support includes professionals and agencies who provide formally organised assistance through a range of services to families such as those described above,

whereas informal support includes individuals and social groups who are accessible to the family and who provide support as part of daily living (Dunst et al., 1994).

Informal family support is often described as the social network of the family, those people outside the household, who engage in activities and affective or material exchanges with members of the immediate family (Cochran & Niego, 1995). The common natural helpers are members of the immediate and extended family, friends (close or distant), workplace colleagues, current or former neighbours, local businesspeople and community leaders (R. A. Thompson, 1995). Clergy and others associated with the church or spiritual communities of caregivers are often cited as members of the informal network for children with mental health problems and other complex health needs (Barbarin & Chesler, 1984; Friesen, 1989).

Across cultures informal family support systems vary. Within a Maori perspective, for example, support systems are based on whanau roles and responsibilities which are founded on tikanga, Maori law, and kawa, being regulatory processes and practices (Ruwhiu, 2001). Variability in informal support can also be influenced by a range of other matters such as access to technology, mobility and availability of time to nurture relationships (R. A. Thompson, 1995). While neighbours are commonly cited as part of informal networks, some studies suggest that in large urban areas this may now be restricted, with neighbours having a transitory and only minor role in the support system of families (Bulmer, 1987; Lerner, 1990a, 1990b).

Family members as the main source of informal support

For families caring for children with a range of high support needs, including mental health problems, family members are the main source of informal support notably spouse, grandparents (Friesen, 1989), and siblings (Kosonen, 1996; G. H. S. Singer, Powers, & Olson, 1996). New Zealand studies reveal similar experiences where family members were seen as a source emotional support, highly available and possessing intrinsic knowledge about the child (Autistic Association of New Zealand, 2001; Mental Health Commission, 2000a, 2000b). There are some qualifications however, within the New Zealand material. While parents of family carers are seen as supportive, families also recounted times when stigma and blame prevented them from turning to their own parents. Evidence was also given of extended family support diminishing over time (Carpinter et al., 2000; Health Funding Authority, 2000a).

There are a number of reasons why families may act as a better platform for support than others in the informal support network. Kin based ties are more permanent, less likely to turn

over (Cochran, Larner, Riley, Gunnarsson, & Henderson Jr, 1990) and have an obligatory element to them (R. A. Thompson, 1995). Internal family support also enables the family to use its own resource to strengthen its boundaries and maintain family integrity. As a New Zealand family describes: *"Rose's sister also has guardianship over Rose's child and this meant that we could keep her in the family. That was important to us"* (Mental Health Commission, 2000a p.12).

The centrality of family members in the provision of informal support may however, be under pressure with changes in family structure. Increasing numbers of single-parent families and rising participation of women in the workforce mean that it is likely that members of the informal family network, such as friends, families and neighbours will be working and less available to offer support (Karp & Bradley, 1991). In addition, physical distance separates members of the nuclear family from their relatives, and places of work are distant from the family environment (Disney, 1994).

Informal support as a target for intervention

Even where formal resources, specifically designed to deal with problems, are made available, families have a preference for using their informal supports (Salisbury & Intagliata, 1986). In some cases formal services can exacerbate stress, for example as reported by caregivers in receipt of intensive home help services (Johansson & Ahlfeldt, 1996). Based on an appreciation of family preference and a greater understanding of the protective effect of family support, informal support has become a focus of interventions to strengthen family care of children with high needs (Weil, 2000). Some argue that informal networks are so powerful they should be the principal form of intervention, *"family needs should be met by promoting the use of informal rather than formal support sources"* (Dunst et al., 1988 p.32).

Consideration of the informal network has been built into some assessment scales for working with families, developed in the United States, for example the Family Resource Scale (Early, 2001). These are strengths based tools to determine the level of resources available to caregivers to support them in their role. These measures inform need identification and intervention plans established with families. The goals of such interventions vary but include mobilising and enriching existing informal networks, modifying some networks and introducing new network members, through support groups (Barrera Jr & Prelow, 2000).

Limitations of Informal Support

While interventions aimed at enhancing the informal support structures of families with children with mental health problems feature in the United States (Kutash & Rivera, 1996) there are some limitations to this. Friesen (1989) for example, documents high levels of parental fatigue, which can compromise the ability of caregiver parents to extend their networks. Cochran & Niego (1995) add that when there is conflict or overload in the informal support network it can add stress to a carer's life.

For families of children with mental health problems and additional serious problems such as domestic violence and poverty, the contribution of wider family members may be depleted and in some cases they are inappropriate sources of support. While research in this area is very limited, R.A. Thompson (1995) has considered the potential of informal family support in families to influence child outcomes where children are at serious risk. R.A. Thompson (1995) links the nature of the informal network, its homogeneity, strength of ties and size to the kind of support offered and the degree to which these networks can assist in changing parenting behaviours. Korbin (1989) agrees that a wide range of friends and family providing unconditional support do not necessarily have a protective effect on the children in their care.

For some families with children with mental health problems whose caregivers have multiple, serious issues such as drug dependency, interventions aimed solely at increasing informal support may be insufficient to build constructive relationships and enhance child and family well-being. Most informal networks are unlikely to be able to fundamentally challenge poor caregiving, and the likelihood is that helpers in these networks will be overwhelmed by the same issues with which they are trying to assist (R. A. Thompson & Ontai, 2000).

Formal support services to families caring for children with mental health problems

It is apparent then that caring for children with serious mental health problems has a major impact on families. The needs of these children are extensive and it is beyond the reach of many families and their informal networks to meet these needs (Friedman et al., 1996). For most families, their informal support systems are central, however, formal services alongside these will be important in meeting needs and maintaining family integrity. As described above, formal family support services for those looking after children with mental health problems are designed to meet the emotional, social and basic needs of families in order that they are assisted to remain together and achieve a balanced life for all members (Kutash &

Rivera, 1996). Formal family support services vary in their type, target population and intensity both in the United States (Kutash & Rivera, 1996; Stroul & Friedman, 1986), in Britain (Z Kurtz, Thornes, & Wolkind, 1994) and within New Zealand (Mental Health Commission, 1998a, 1999; Ministry of Health, 1998, 2002b).

The systems of care approach

In 1982 Knitzer summarised the service deficits for families caring for children with mental health problems in the United States. These included a lack of family advocacy, poor levels of support services and coercion of parents wanting support from public agencies (Knitzer, 1982). Disparities existed whereby families of children with disabilities were eligible for a wide range of support services such as respite care, cash assistance, or homemaker services, for which families with children with emotional disorders did not qualify (Friesen, 1993). In 1994 these deficiencies were addressed with the establishment of the Child and Adolescent Service System Program (CASSP), designed to develop and co-ordinate a range of formal services to assist children and adolescents with severe emotional disturbance and their families (Friesen & Huff, 1996). The approach sought a balance which recognised that while more was needed than the traditional mental health service response of a 50-minute visit, hospitalisation was excessive (Karp, 1996).

A continuum of formal support services, known as “Systems of Care” was developed, which is now internationally recognised as an appropriate way to meet the complexity of needs within families caring for children with mental health problems (M. H. Epstein et al., 1998; Kutash & Rivera, 1996). A systems of care approach is defined as: *“a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely disturbed children and adolescents”* (Stroul & Friedman, 1986 p.3).

The services within a system of care include social services, educational services, vocational and mental health services (Lourie et al., 1998). Within mental health services both non-residential and residential services are described. Non-residential services include home-based services, respite care, self-help mentoring arrangements or groups, financial assistance, home support, intensive therapeutic services, recreational programs and training (Kutash & Rivera, 1996). A key component is the family-driven principle, which underpins the development of individualised, wrap around care packages for families (Karp, 1996). This model has been widely applied in 50 states in the United States during the 10 years since CASSP's inception (Lourie et al., 1998).

While access problems are common in mental health services across jurisdictions (Leaf, Alegria, Cohen, & Goodman, 1996; Mental Health Foundation, 1999; Offord, Boyle, Szatmari, & Rae-Grant, 1987) the systems of care approach in the United States appears to have resulted in some improvement in the number of families taking up services. In 1993 between 70 and 90 % of all children who were classified as having a severe disorder were not receiving mental health services (Costello, Burns, Angold, & Leaf, 1993). A 70% increase in children receiving formal mental health services since 1986, in the United States, is attributed to the implementation of the systems of care approach, although the improvement may not be evenly distributed amongst deprived population groups (Pottick, Isaacs, & Manderscheid, 2002).

The establishment of systems of care interventions has not been fast nor without challenges. There is variability in how programmes are implemented and in the rates of success with individuals (Ungar, 2003). Systematic reviews of implementation issues and progress in achieving improvement in child outcomes within systems of care are available (M. H. Epstein et al., 1998; J. S. Walker, Koroloff, & Schutte, 2003). The necessary conditions for implementing collaborative individualised services envisaged in the systems of care model are described in the latter review. These conditions include extensive change requirements at the team, organisational and systems level.

Mental health services for families in New Zealand

The conditions facing families with children with mental health problems in the United States identified by Knitzer (1982) resemble problems apparent in New Zealand today. New Zealand does have a well-established and separate child and adolescent mental health service. However, lack of co-ordination of services across sectors and under funding of mental health services has created gaps in the type of services provided, with poor access to information, services and a paucity of family support services (Health Funding Authority, 2000a; Mental Health Commission, 1998b, 1999, 2001; Ministry of Health, 1995, 1997b, 1998).

Access to specialist mental health services (CAMHS)

Specialist community based mental health services known as Child and Adolescent Mental Health Services (CAMHS) in New Zealand can be accessed for children and young people with serious mental health disorders, suspected psychiatric disorders or psychological disorders (Ministry of Health, 2002b). The danger in using diagnosis as an entry criterion is

that it may stigmatise and act as an incentive to understate adaptation, as was noted in chapter two. Where children have emotional or behavioural problems without a formal diagnosis or where these problems relate to family circumstances, such as post traumatic stress families cannot access ongoing child and adolescent mental health services (Child, Youth and Family, 2001i).

Due to poor information systems, no accurate data are available from New Zealand mental health services on which to base estimates of access rates (Mental Health Commission, 1999). The Christchurch Health and Development Study reported that amongst those who meet the criteria for at least one psychiatric disorder at 16–18 years, less than one quarter had sought treatment. The reasons given for low access rates were a perception amongst young people that their problems could be self-managed (Horwood & Fergusson, 1998). Similar findings from the Dunedin Multidisciplinary Health and Development Study conclude that overall rates of help seeking by families are low. For adolescents the majority of those with disorders had not sought any help (McGee et al., 1996).

Inadequate co-ordination of services

There is no comprehensive systems of care approach for families with children with mental health problems in New Zealand. Formal support to such families is provided across three principal jurisdictions, the health, education and child welfare sectors. Each sector refers to a block of service responsibility specifically funded by central government. The Ministry of Education, through Group Special Education, provides learning support during school hours to individuals in schools, principally through teacher assistance and behavioural support (Child, Youth and Family, 2001i). Child, Youth and Family provides a range of generic family support programmes to families and communities in need and individualised services to children, young people and their families who meet a statutory definition of being in need of care or protection (Child, Youth and Family, 2002a). The Ministry of Health provides funding for primary health services through general practitioners as well as specialist mental health services for children with severe mental health disorders through Child and Adolescent Mental Health Services (Ministry of Health, 1998). CAMHS although community based, follow a clinical model, as one CAMHS worker explains:

those of us in CAMHS are out and about in the community less and because we work to an appointment system with other disciplines we cannot respond immediately and spontaneously to some child and youth mental health needs (Bagnall, 2002 p.25).

Funding restrictions, regional decision making and variation in government policies and programmes have fragmented coverage so that a lack of co-ordination is the common experience for most families caring for children with mental health problems (Mental Health Commission, 1999). Without formal needs assessment or service co-ordination, the point of entry often determines the pattern of services to families and the amount and type of assistance provided. While the three sectors may be jointly providing services to families there is no formal mechanism for co-ordination for most families. Co-ordination is viewed as the responsibility of all who work with the child or family (Ministry of Health, 1998). Making Links (Ministry of Health, 1997b) was an early attempt by the education, health and child welfare sectors to agree case leadership assignment but this has not been well implemented at the local level (Mental Health Commission, 1999).

Under-funding of New Zealand child mental health services

New Zealand child mental health services are seriously under-funded (Mental Health Commission, 1998b, 1999, 2001; Ministry of Health, 1995, 1998). In 1995, access benchmarks for CAMHS were recommended at 5% of the child and youth population (Ministry of Health, 1997a). Despite an increase in prevalence estimates in New Zealand since 1995 (Horwood & Fergusson, 1998; Silva & Stanton, 1996), under-funding has meant that service access benchmarks have been subsequently reduced to 3% (Ministry of Health, 1998). Within this, half of one percent of children between 0 and 9 years are expected to present with severe mental health needs, 2.2 % in the 10–14 year age bracket and 3.1% of the 15–19 year age group. These now represent the CAMHS access levels established for New Zealand (Ministry of Health, 1998) although under-funding means that even these access levels are not reached (Mental Health Commission, 1999).

In a review of services in 1999 actual provision for children and young people was reported at around 25% of these recommended benchmarks and gaps in services for children and young people exceeded those for any other age group (Mental Health Commission, 1999). While the addition of a further 208 clinical positions has seen a 65% increase in CAMHS in recent years under-funding in children services is still very serious. In 2003 the Mental Health Commission reported that despite growth in funds access to service remained relatively unchanged and that services were still well below benchmarks, for example respite care services were at 33% of benchmark (Mental Health Commission, 2003). Although workforce problems are cited as an explanation for this stasis, there have been questions raised about the level of priority given to some service development (Child, Youth and Family, 2004b; Mental Health Commission, 2003).

Gaps in mental health services in New Zealand

Services for children and young people with severe behavioural problems

In the United States children with severe emotional and behavioural problems are eligible for a broad range of services under the CASSP systems of care initiative. Eligibility for specialist child mental health service in New Zealand, however, is less established for children with emotional and behavioural problems and those with conduct disorder. This gap has been consistently documented since 1995 (Child, Youth and Family, 1999a, 2001f; Interdepartmental Working Party, 1995; Ministry of Health, 1995; Ministry of Social Development et al., 2003). These reports detail ongoing debate amongst government agencies about responsibilities for the care, treatment and support of children and young people with serious behavioural problems and conduct disorder, and the consequent failure to establish services. As this service gap has a significant impact on families involved with child welfare services it is discussed in more detail in the following chapter.

Gaps in the range of mental health services for families

The development of child and family mental health services in the United States has attempted to ensure a continuum of care offering a full range of services to families, although gaps are still noted in the provision of key services (Friesen, 1996; Quinn & Epstein, 1998). In New Zealand the actual range of services being funded is still very limited (Mental Health Commission, 1999), see appendix 1. By contrast New Zealand disability support services offer a full range of family support services including needs assessment, service co-ordination, home support, respite care, residential care, shared care and behavioural support in the home (Ministry of Health, 2003). CAMHS own staff express frustration at these mental health service gaps, identifying the need for more residential therapeutic care options, specialist 24 hour crisis services and programmes for those with mild to moderate needs currently excluded from CAMHS (Bagnall, 2002). The following review outlines the key service gaps in child mental health services in New Zealand.

Intensive family support services

Intensive family support or family preservation is a key intervention described overseas that aims to strengthen a family's capacity to manage child mental health problems. While acknowledging that many studies did not involve comparison groups Kutash & Rivera's (1996) review concludes that these services have been in some instances effective in averting

out of home placement of children with mental health problems. Similarly the report of the U.S. Surgeon General on Mental Health (2000) indicates that the majority of studies show marginal gains with some services significantly more effective.

In New Zealand while some intensive family preservation programmes are offered to at-risk families they are not targeted to families caring for children with mental health problems. Family Start, for example, has recently begun for families at serious risk of breakdown but this is focused on families with babies and very small children (Child, Youth and Family, 2002a). Family Start is not part of the formal mental health services but has been funded under a specific joint arrangement between the health, education and welfare sector. Unfortunately, there is no substantive evaluation available yet to ascertain the programme's effectiveness, in particular in relation to the development of child mental health problems.

Therapeutic care

There are very few specialist therapeutic care placements or residential services for children or young people under 17 years within New Zealand mental health services, despite this care type appearing in service typologies of CAMHS, see appendix 1. The Ministry of Health indicated a low level of interest in developing this type of child mental health service arguing:

There are ongoing questions about whether more residential services are needed, whether such provision is the province of health, education or social welfare and whether residential services are in the best interests of the child or young person and their family and whanau (Ministry of Health, 1998 p.35).

In New Zealand families with children with mental health problems are therefore likely to access short term and longer term out-of-home placements via the provisions of the child welfare services rather than through the health sector. The extent to which this happens is not easily determined. Child welfare provisions require a formal declaration that a child is in need of care and protection before most interventions can proceed. This potentially stigmatises families seeking this support through child welfare. In New Zealand both temporary relinquishment of custody and longer term formal transfer are required under child welfare statute (New Zealand Government, 1989a sections 139, 140, 101 and 110). The practice of requiring parents to relinquish custody of their children with high support needs in order to gain access to out-of-home placements has caused concern in the United States (Ervin, 1992; Friesen & Huff, 1996) most recently in 2003 (United States General Accounting Office, 2003).

Respite care

Respite care is the service most frequently requested by families of children with high support needs (Bruns & Burchard, 2000; S. Cohen, 1982; Sherman, 1995). It is noted as a key component of mental health family support services (Friesen, 1996). In children's mental health services the goal of respite care is stated broadly as aiming to stabilise and enhance care so that a family can remain the major service provider for their children (Burns & Friedman, 1990). While families require access to a wide range of respite care options to meet the spectrum of child needs, across time and circumstances, there is parental preference for in-home services, as these are least disruptive to the child and can be monitored (Pollock, Law, King, & Rosenbaum, 2001).

Research on the effectiveness of respite care for families caring for children with mental health problems is limited. However, a relationship between respite care, reduced out of family placement and decreased caregiver strain has been established (Bruns & Burchard, 2000). Rimmerman (1989) in a small study looking at respite care for children with developmental problems found that mothers with respite care showed lower stress levels and more positive views than those in the comparison group. Sherman (1995) also noted that a reduction in hospitalisation of children with high support and medical needs was associated with family utilisation of respite care. Despite these findings, gaps in respite care are commonly noted in United States systems of care (Friesen, 1996; Pullmann et al., 2002) although successful programs are also reported (Jivanjee, Simpson, & Gettman, 2002).

In New Zealand respite care services for children with mental health problems is at 33% of the benchmark (Mental Health Commission, 2003). Respite care, in the context of New Zealand mental health services is crisis orientated, intended to reduce the need for inpatient care. It is viewed as short term, and treatment provided for children and families is expected to resolve the need for ongoing respite care (Ministry of Health, 2002b). Despite recorded family demand (Carpinter et al., 2000; Health Funding Authority, 2000a) regular respite care is largely unavailable to New Zealand parents caring for children with mental health problems (Mental Health Commission, 1999). In contrast ongoing respite care, known as carer relief, is a readily accessible family support service for families with disabled children in this country (Ministry of Health, 2003).

Behavioural support programs

As described earlier caregivers' perception of their ability to manage child behaviour influences demand for out of family placement. In this way effective behavioural support is a key mental health service. Behavioural support programs are designed to improve child behaviour in the home and the community. In addition they aim to enhance family capacity to support a child, manage their behaviour, thus strengthening the family as a whole (Lucyshyn & Albin, 1993). Behavioural support is commonly carried out in the home with family members and the wider family support network. Best practice behavioural support emphasises partnership with professionals and includes respecting family perceptions, collaboration over goals, building trust and joint problem solving (Lucyshyn & Albin, 1993).

Clinically significant improvements have been established leading some to suggest behavioural support is a promising treatment in child mental health (Kazdin & Weisz, 1998), particularly for younger children with less severe problems (N. M. Curtis, Ronan, Heiblum, Reid, & Harris, 2002). Parent groups also using these approaches have had some success (Cunningham, Bremner, & Boyle, 1995). Limitations are noted, however, in respect of the demands on parents, poor level of training available to those wanting to adopt this approach and the extent to which treatment effects are maintained over time (Kazdin & Weisz, 1998).

Behavioural support programs are part of home based family support strategies in overseas mental health services (Kutash & Rivera, 1996) and are part of New Zealand disability support services. They are not a formal mental health service purchased in New Zealand, however, some clinicians provide behavioural management advice and there are some Parent Management Training programmes being offered by some mental health services (N. M. Curtis et al., 2002). This suggests that behavioural support programmes may have an increasing place in New Zealand mental health services as they evolve in the future.

Maori mental health services

Recent developments in child and mental health services in New Zealand include the integration of Maori mental health conceptual models as described in chapter two, such as Te Whare Tapa Wha (Durie, 1994, 2001). Informed by these models, whanau-based strategies have been incorporated into the health framework for Maori mental health services and child mental health services (Health Funding Authority, 2000a; Ministry of Health, 1998). There are goals both to enhance mainstream CAMHS to become more culturally aware and to provide a greater number of specialist services for whanau (Health Funding Authority,

2000a). For example tribal elders or kaumatua are employed by many CAMHS to provide cultural leadership and advice (Waetford, 2004).

Durie (2001) argues that attempts to introduce a Maori perspective into mainstream mental health services, through cultural advisors and ceremonies, have often been incomplete and unsatisfying. More recent emphasis is on development of dedicated services for whanau caring for those with mental health problems, known as Kaupapa Maori services (Health Funding Authority, 2000a).

The cultural considerations that underpin Kaupapa Maori mental health services include whanau participation in services, use of Maori language, observation and adaptation of Maori protocols known as tikanga Maori, use of cultural and recreational activities such as toi Maori (arts and crafts), incorporating karakia (prayer), rongoa (indigenous plant remedies) and involvement of tohunga or traditional healers (Durie, 2001). As there is a close link between mental health problems and cultural factors, cultural and clinical assessment in Maori based services are integrated in a coherent way. While these services are still being developed, problems are noted in respect of the numbers of qualified staff available and inconsistencies in contracts for Kaupapa Maori services (Briggs & Cromie, 2001).

A distinguishing feature of Kaupapa Maori Services is the participation of whanau in mental health services. This involvement is valued for strengthening whanau, and providing opportunities for whanau to contribute to the development of effective services and the review of outcomes (Kingi & Durie, 2000a). Amor (2002) describes these concepts in operation within a Kaupapa Maori mental health service, utilising a Te Whare Tapa Wha approach to work alongside whanau to achieve jointly planned outcomes. Further illustration of whanau participation in Maori mental health services can be found in Waetford (2004).

The relationship between families and service providers

While participation of whanau is central to the delivery of developing Kaupapa Maori mental health services, it is less established in mainstream child mental health services in this country. Parents of children with mental health problems, such as the speaker quoted by Friesen in 1996, have long argued for the value of their contribution to child mental health services "*... we live with these kids. We know what it feels like. We need your help but you need ours too.*" (Friesen & Huff, 1996 p.45).

Friesen & Huff (1996) and Stroul & Friedman (1996) describe the reconceptualisation that has taken place in the design, delivery and evaluation of mental health services for families in the United States, involving a view of the family as a source of strength rather than a cause of problems. Using a family strengths approach the orientation of systems of care services is to anticipate that parents have experience and insight to offer professionals, which they cannot obtain elsewhere. The extent to which mental health services involve families can include families as partners in treatment, as service providers in their own right, as advocates, policy makers, evaluators and researchers (Friesen & Stephens, 1998). The developmental process by which some systems of care services have come to effectively engage with families as partners has recently been extensively reviewed (Center for Effective Collaboration and Practice, 1998) and are discussed further in the final chapter of this thesis.

What do families view as successful mental health services

Friesen & Huff (1996) warn that family members may have different views about services than those who provide and administer them. They may identify different priorities for systems reform, which are complementary or innovative. The experience of families using mental health services in the United States has identified the features which characterise successful services (Worthington, Hernandez, Friedman, & Uzzell, 2001). These are services in which families are fully engaged, where providers listen carefully and respectfully to family priorities, and address their highest priorities first and promptly. Services are sought which can address the needs of the entire family, designed based on a family's own identified strengths and needs, as well as their criteria for success. Families want services that promote and strengthen their connection with communities. Providers, both individuals and teams, who demonstrate genuine caring, persistence and creativity in meeting families' needs are valued most. Services need to be fully accessible to families, offered 24 hours a day, seven days a week. Successful services are flexible, provide additional supports not typically found in the usual approaches to service provision and offer opportunities for family empowerment, independent problem solving and skill building (Worthington et al., 2001).

Current assessment models within New Zealand child mental health services are not of a family strengths design. Rather they are described as a clinical review of the nature and history of presenting problems, developmental and health status of child, educational, peer and family relationships and functioning of the child or young person's family (Ministry of Health, 1998). While there are no formal mechanisms to enable family participation in the design and planning of mainstream child mental health services in this country, consultation

with families is a service standard for CAMHS (Ministry of Health, 1997c). This requirement, although in an early form may mark a beginning point from which family participation can grow.

Conclusion

This chapter has considered the challenges facing the many families who are caring for children with mental health problems. Variability is noted with some families viewing their experience of providing care as one of growth and learning. Informal supports, particularly by other family members have been found to make the greatest contribution to those looking after children with mental health problems. However, it is expected that there will be limitations in the contribution of informal support networks particularly amongst families who experience significant other problems such as drug abuse or domestic violence.

For many families caring for children with mental health problems formal family support services are likely to be an important supplement to the support which their own networks can offer. Formal mental health services to support such families have a comprehensive design in the United States, known as systems of care, and aim to strengthen the families' ability to provide ongoing care. In New Zealand, under-funding and deficits in mental health services have meant significant gaps in the range of support offered to families.

Research suggests that the interaction between service providers and caregivers is important in any identification of family support needs and the negotiation of a service response. This makes the involvement of families in planning, delivery and evaluation of mental health services a significant matter. Family involvement has progressed in the United States but is yet to emerge in New Zealand. A notable development however, is in the area of Kaupapa Maori mental health services, which integrate whanau into service provision and evaluation. This service model offers both an appropriate delivery to Maori and an alternative conceptual approach to mainstream mental health services in respect to the involvement of family.

For most families under-funding of mental health services in New Zealand has meant serious gaps in respite care, behavioural support, day programmes and care services. The experience of families suggests that these service deficits are likely to undermine their capacity to manage behaviours, balance work and family responsibilities and ultimately offer continuing care to their children. In this context statutory child welfare services are likely to be meeting some of these gaps in mental health services for New Zealand families. The extent to which this happens is examined in the next chapter.

Chapter Four

Children and Young People with Mental Health Problems who are Involved with Child, Youth and Family

Introduction

This chapter considers the group of children, young people with mental health problems who are known to be involved with Child, Youth and Family. The organisational and legislative context for New Zealand statutory child welfare services is considered and the interface between child welfare and mental health services is reviewed. Prevalence of child mental health problems in child welfare services is examined using both international research and New Zealand studies. Initiatives taken by Child, Youth and Family to meet some of the needs of this group are reviewed in the last part of the chapter.

The organisational context of statutory child welfare in New Zealand

The Department of Child, Youth and Family Services

The Department of Child, Youth and Family Services administers the Children, Young Person's and their Families Act (New Zealand Government, 1989a). This Department, along with a range of non-government organisations, provides services to meet the requirements of this legislation. The scope of statutory child welfare social work is broad. It includes child maltreatment investigations and risk assessment, powers to uplift children for safety reasons, family group conference co-ordination and participation, and the provision of care, custody and guardianship to children who are subject to agreements, plans and orders made under the 1989 Act (Child, Youth and Family, 2002b). Child, Youth and Family employed approximately 989 staff in the social work and supervisor employment class in 2002 (Child, Youth and Family, 2002a). Thirty-one and a half psychologist and therapist positions provided specialist assessments, consultation and therapeutic services to clients with mental health problems and support to their social workers, although coverage across the country was uneven.

Statutory child welfare services

There is broad agreement that statutory child welfare services, both internationally (Downey, 2002; Lord Laming, 2003; Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000; Waugh, 2000) and in New Zealand (Child, Youth and Family, 1999b, 2000e; Connolly, 2001; Ministry of Social Development et al., 2003), face increasing pressure, scrutiny and change. Rising child maltreatment notifications and increasing numbers of re-referrals have led to questions about the effectiveness of statutory interventions (J. Gibbons, Conroy, & Bell, 1995; Hetherington, 1999; Pecora et al., 2000; Tilbury, 2003). *"The data paints a picture of families being reported again and again to child protection agencies because they do not receive the help they need to maintain adequate care for their children"* (Tilbury, 2003 p.6)

In this country patterns of pressure on statutory child protection services are similar to those overseas. Child welfare services in New Zealand are delivered within a social context of high unemployment levels in some communities, widening economic inequality and increasing levels of self reliance expected of communities and families following restructuring of welfare services in the 1990s (Connolly, 2001; Dalley, 1998). In addition public sector reforms, in particular the Public Finance Act (1989b) require that statutory social work be specified in terms of activities within certain output classes, which some suggest impacts negatively on preventive work (M. O'Brien, 2001).

Commenting from within Child, Youth and Family, the Chief Social Worker identified that the outcomes of statutory social work practice were subject to affordability constraints, the delivery of quality social work supervision was compromised and there was pressure from the demands of implementing new information systems (Pakura, 2001). Child, Youth and Family also faced a long period of scrutiny about its poor cross-cultural practice, in particular the alienation of Maori children from their whanau and the over-reliance on residential care (Department of Social Welfare, 1984; Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1986).

Pressure on the service has been linked to a continued increase in numbers of care and protection notifications. During the 1980s approximately 2000 notifications a year were received, rising to 11,000 in 1992 and to 23,246 in 1997 (Connolly, 2001). In the year to June 30 2003 there was a 15% increase in notifications on the previous year with 31,781 notifications received, the biggest increase recorded by Child, Youth and Family (Child, Youth and Family, 2003a). The inability of Child, Youth and Family to investigate every case has caused considerable public concern (Child, Youth and Family, 2002a), although some social workers in the organisation suggest it may be inevitable (Sharland, 2002).

Working and managing in statutory child welfare services

Not surprisingly social workers practising in statutory child protection agencies experience their work as *"complex, overwhelming, multi-disciplinary and multidimensional. Ethical, moral and emotional issues abound."* (Goddard, Saunders, Stanley, & Tucci, 1999 p.254). Child, Youth and Family's submission to a Ministerial Review in 2000 added budgetary issues to these concerns (Child, Youth and Family, 2000e). They identified that fiscal imperatives mean that costly interventions were no longer contemplated unless they could be accessed within existing contracts. Despite this, New Zealand legislation requires that services to children, young people and their families are provided without regard to the limitations of available funding. Child, Youth and Family argue that this is a fundamental contradiction for the Chief Executive who must also ensure that departmental expenditure is managed within the regime of the Public Finance Act (1989b) (Child, Youth and Family, 2000e). Doolan (2003) also claims that the conjunction of state sector and child welfare reforms stymied the development of a range of complementary services envisaged within the Children, Young Persons and their Families Act (New Zealand Government, 1989a).

In 2003 a further review of Child, Youth and Family took place known as the First Principles Baseline Review (Ministry of Social Development et al., 2003). This review sought to enable the Department to move forward on a sustainable basis within resource constraints, while meeting its performance targets and demonstrably achieving outcomes (Child, Youth and Family, 2003a). It included recommendations to develop a demand management approach to dealing with the pressure of rising notifications along with workload management procedures (Ministry of Social Development et al., 2003). Despite this review Child, Youth and Family remained unable to manage the demands on services with notifications rising to 43,414 in the year to June 2004 (S. Cook, 2004).

Strengths based practice in statutory child welfare services

In the face of rising demand, increases in problem complexity and shrinking resources, many statutory child welfare jurisdictions have sought to move away from reliance on risk orientated processes (Berg & Kelly, 2000; Turnell & Edwards, 1999). In the United States Schene (1999) argues for including greater accountability for care management, using evaluation of outcomes and strengthening community capacity to protect children. Similarly in Canada Barter (2001) believes current child protection systems were not designed to deal

with the contemporary realities and suggests strengthening communities as a new orientation for child welfare systems.

In Britain a number of legislative and policy reforms have required agencies to work together to develop integrated solutions to social problems (Webb & Vulliamy, 2001). A modern relationship-based child welfare system using principles of trust, authority and negotiation has been recently advocated (A. Cooper, Hetherington, & Katz, 2003), which is similarly strengths-focused. The approach includes provision of a confidential space to families, where there is time to negotiate and work on problems without the immediate threat of child protection action (A. Cooper et al., 2003).

In parts of Australia statutory investigation has been separated from family support in order to better manage rising demand for services (Parton & Mathews, 2001) and there is new emphasis on preventive services (Peltola, 2002). Ways are sought for communities to contribute to improved family and child well-being, in order that adversity can be coped with at all levels (Tomison, 2001). This includes broadening the roles of primary services to work with vulnerable families so services are accessed without recourse to statutory child protection (D. Scott, 2003).

Part of the reorientation within statutory social work practice includes utilising, rather than ignoring, family resources and strengths. These practice models draw directly from the conceptual framework of resilience and family strengths described in chapter two. They require building relationships with families, in order to identify their goals and the resources within their own family systems likely to be useful in achieving these outcomes (Turnell & Edwards, 1999). At the practice level, attention of statutory social workers is drawn to their use of language, the importance of their relationships with families, the nature of their questions and the degree to which clients' experiences and resources are incorporated into the social work process (Berg & Kelly, 2000; Turnell & Edwards, 1999).

In New Zealand too, there is growing recognition that Child, Youth and Family cannot act alone to achieve better outcomes for children

In essence, the Department sits within a continuum of social services that are provided and needs to actively work with the wider community of families, community providers and Government agencies to maximise collaboration and partnership in the delivery of social services (Child, Youth and Family, 2002f p.4).

Following the recommendations of the Ministerial review in 2000 (Brown, 2000) a project was launched to initiate the development of a strengths based practice platform for Child, Youth and Family. This project, while still in development, has reported positively on the feasibility of this task and is now under a staged implementation (Child, Youth and Family, 2002e). While Child, Youth and Family has recently launched strengths based practice many argue that the 1989 legislation had already introduced this approach (Sharland, 2002), seeking to establish family-led rather than professionally-led solutions to family problems (Connolly, 2001).

The legislative context - The Children, Young Persons and their Families Act (1989)

All statutory child welfare services in New Zealand are carried out under the auspices of the Children, Young Persons and their Families Act (1989a). The antecedents to this law were multifaceted, involving both a desire to develop more culturally appropriate practice and a concern to increase awareness and reporting of child abuse (Ernst, 1999). The embedding of family and in particular Maori constructs of whanau, hapu and iwi have led to claims the new law marked a shift away from mono-cultural child protection practice (Cockburn, 1994) and have raised international interest (Marsh & Crow, 1998). Three key features of the legislation are the family group conference decision making process, the separation of juvenile justice and care and protection procedures and the partnerships sought with community organisations (New Zealand Government, 1989a).

Meeting mental health needs within the Children, Young Persons and their Families Act (1989)

The definition of a care or protection concern is provided within section 14 of the Act (New Zealand Government, 1989a). Broad in scope, it includes a range of conditions that may be generated when families have insufficient support services to manage the care of children with mental health problems. Section 14 defines children whose behaviour is such that they are a danger to themselves or to others, as in need of care or protection, as are children of parents who are no longer willing or able to control or provide care for them (New Zealand Government, 1989a).

The gaps in mental health services in this country were discussed in the preceding chapter. Key deficits in respite care, therapeutic out of family care, day programmes and behavioural support programmes, and the exclusion from services of those with conduct disorder or severe behavioural problems were identified. Child, Youth and Family have argued that the

inclusive nature of the 1989 legislation has meant that child welfare services have become a means of supporting families who may well have had their needs met by health services if sufficient support had been available (Child, Youth and Family, 1999b; Ministry of Social Development et al., 2003). The Ministerial Review of Child, Youth and Family in 2000 (Brown, 2000), went so far as to describe the area of child and adolescent mental health as one of grave concern. Child, Youth and Family was described in this review as the agency of last resort, due to gaps in services and poor access to existing mental health services (Brown, 2000).

The legal framework enables ongoing provision of support services by Child, Youth and Family to meet the needs of families of children with mental health problems who are unable to receive services within the health sector. The implications of this were fully explained by Child, Youth and Family to the incoming government in 1999 (Child, Youth and Family, 1999b). Included was reference to a Crown Law Opinion highlighting the overlapping jurisdiction of the Children, Young Person's and their Families Act and the provision of health services. This opinion *"opposed 'reading down' the definition of care and protection to exclude the challenging behaviour of an intellectually disabled person"* (Child, Youth and Family, 1999b p.46) thereby making Child, Youth and Family potentially responsible for meeting these health needs.

Child, Youth and Family considered that in the light of this opinion there was likely to be legal support for ongoing service provision by the organisation to meet gaps in mental health services for clients. Action to resist providing these services was considered unlikely to succeed because of the nature of the Children, Young Persons and their Families Act (New Zealand Government, 1989a), (Child, Youth and Family, 1999b). Further discussion of the implications of the 1989 Act for meeting health service deficits took place within the First Principles Baseline Review (Ministry of Social Development et al., 2003).

International patterns of child welfare services meeting mental health service gaps

A similar picture of involvement of child welfare services to meet health needs exists overseas. Cohen, Harris, Gottlieb & Best (1991) identified that in the United States parents were using child welfare systems to meet the need for co-ordinated mental health and disability support services. Friesen (1996) agrees arguing that child welfare services often associated with the protection of children from abuse and neglect are used differently by some families with children with mental health problems:

many families whose children have serious emotional disorders become involved with it as a way of gaining access to publicly funded residential treatment, group homes, or therapeutic foster care programs (Friesen, 1996 p.267).

Recent testimony to the United States Senate (United States General Accounting Office, 2003) refers to an estimated 12,700 children and young people involved in child welfare and juvenile justice systems in order to receive mental health services, a figure that is regarded as an under-estimate. Factors which influenced whether parents placed children in welfare systems to receive mental health services include limitations in health insurance coverage, shortage of mental health services, difficulties accessing mental health or educational agencies, differing eligibility requirements across programmes and misunderstanding about the responsibilities of agencies to meet children's mental health needs (United States General Accounting Office, 2003).

The consequences of using the child welfare system to meet family need for health services can be serious. Along with the stigma of welfare involvement there is also intrusion into the natural custodial authority of families. In Friesen's 1989 survey of families caring for children with mental health problems, 25% had custody relinquishment suggested as a way of accessing services (Friesen, 1989). A survey of jurisdictions in the United States found that 62% of states required that in order to access services for children with a serious mental health problem, custody was transferred for fiscal, treatment and liability rationale (R. Cohen et al., 1991). Where provision of out of family care is arranged privately in circumstances where families have resources to pay for this care, custody is not relinquished (Blankenship, Pullmann, & Friesen, 1999).

In New Zealand a similar position exists, as was described in chapter three. Residential care is not provided for under mental health services; respite care is limited and therefore out of family care tends to be arranged through welfare provision. All care services provided under the Children, Young Persons and their Families Act (New Zealand Government, 1989a) require some transfer of custodial responsibilities. Any informal, temporary care is strictly time limited under this law.

Prevalence of mental health problems amongst children and young people in child welfare services

Discussion in chapter two linked the development of child mental health problems to adverse family processes, in particular, child abuse and neglect. Additionally, with gaps in mental health services, access problems and the nature of child welfare legislation, it is not

surprising that child welfare services experience high rates of mental health problems amongst their clients.

International prevalence rates

Prevalence rates for mental health problems amongst children and young people in foster care, derived from studies conducted in the 1980s, range between 29% and 48% (McIntyre & Keesler, 1986; Moffatt, Peddie, Stulginskis, Pless, & Steinmetz, 1985) with some studies showing higher rates, for example over 60% (A. H. Thompson & Fuhr, 1992). Pilowsky's (1995) review of the research between 1974 and 1994 concluded that overall there is a higher rate of mental health disorder in the foster care population than would be expected, even when the data is controlled for deprivation factors. The research cited has certain limitations. Studies failed to use standardised instruments for measuring psychopathology, others did not utilise control groups from similar backgrounds of deprivation and cohort sizes and ages varied (Pilowsky, 1995).

Since Pilowsky's (1995) review was published, further attention has been paid to the rates of mental health problems amongst foster care populations. In the United States studies for this group of clients agree prevalence rates of mental health disorder are around 40% and behavioural problems are approximately 60 % (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Landsverk, 2001; Schneiderman, Connors, Fribourg, Gries, & Gonzales, 1998). Parents, social workers and caregivers have all been found to under-report problems, 37% of foster parents or social workers reported emotional problems in foster children when assessment established an 84% rate (Halfon, Mendonoca, & Berkowitz, 1995).

In Britain, although fewer studies have been conducted, a similar prevalence picture emerges. High rates of mental health problems were found amongst children in care in Oxfordshire with 67% of children in the care of the authority having mental health problems (McCann, James, Wilson, & Dunn, 1996). Utting's (1997) report into children in care stated that up to 75% of children in care had mental health problems (Utting, 1997).

Information about prevalence is generally drawn from the foster care population and so the level of mental health problems amongst children involved with welfare services but remaining in family care is less understood. This is a significant gap in the research particularly for jurisdictions such as New Zealand where legislation supports interventions to enable children to remain in family care.

Prevalence rates in New Zealand

In the last 10 years Child, Youth and Family has reported on the level of mental ill health amongst children and young people involved with the service. In 1994 a single study within a large Child, Youth and Family residence found 80% of residents had some level of clinical anxiety or depressive disorder (Child, Youth and Family, 1999b). In 1997 a survey of conduct disorder in Auckland identified that there were 82 Departmental young people with severe childhood onset, conduct disorder (Werry & Tashya, 1997).

In 1999 more formal studies of prevalence of mental health problems within Child, Youth and Family became available. Utilising subjects within the Christchurch Longitudinal study; Smith & Beautrais (1999) reported that over 80% of young people with histories of contact with welfare services had at least one mental health disorder compared with rates of 40% amongst those without welfare contact.

In the same year, Child, Youth and Family conducted a nationwide survey into the prevalence of mental health problems including drug and alcohol disorders amongst children and young people who were involved with the organisation but not necessarily in its care (P. M. Wells & Smith, 2000). The research was limited to those children and young people who had a Child, Youth and Family social worker allocated at the time of the inquiry. Children or young people with a diagnosed mental health disorder were included, as were those who were in assessment. Also included were children and young people for whom social workers suspected there would be a condition able to be diagnosed. This approach to identification is supported by research which suggests that social workers are able to appropriately distinguish between behaviours which are likely to be symptomatic of disorder and those which are a normal response to environmental factors (S. A. Kirk et al., 1999). The research included demographic, clinical and service uptake variables (P. M. Wells & Smith, 2000).

Based on these data it was estimated that 22% of young people involved with Child, Youth and Family were likely to have a moderate or severe mental health problem (P. M. Wells & Smith, 2000). The most common age group was between 14 to 20 years. Fifty percent of those identified with mental health problems were European, 37% were recorded as Maori and 5% as Pacific Island. Sixty seven and a half percent were recorded as male and 32.4 % as female.

Alcohol and drug disorders accounted for 30% of the primary diagnoses of the group. Conduct disorder and oppositional defiance disorder together accounted for 11%, ADHD/ADD a further 10% and severe behavioural disorders were recorded at 8.6%.

Depression and suicidal behaviour accounted for 7% of disorders and 6% of clients were recorded as having Post Traumatic Stress Disorder. The most frequent service provided to this group was individual or family therapy, which was confirmed as being accessed by 25% of the group. These data however, did not distinguish between therapy services provided by the local CAMHS, private counsellors and Child, Youth and Family specialist services staff. The second most common service type was residential care (including 24 hour supervised living arrangements), which accounted for services to approximately 9% of the group. Family support services such as respite care and home support were provided at very low levels (P. M. Wells & Smith, 2000).

Since this research was completed, Child, Youth and Family reviewed arrangements for a small group of 36 young people with mental health problems who were cared for by way of individualised support packages in 2000 (Calvert, 2000). While the children and young people reviewed had multiple disorders, 34 out of 36 had the diagnosis of Post Traumatic Stress Disorder. The review demonstrated the intensity of need and on going gaps in mental health services for this group.

Mental health needs within the Child, Youth and Family client group continue to be reported in an ad hoc manner. In a review of problems presenting amongst low urgency child maltreatment notifications, child and family mental health problems were common. In 10% of cases child mental health problems were indicated in the first intake information presented to Child, Youth and Family. Substance abuse was represented in 10% of child problems and in 20% of caregiver problems (P. M. Wells, 2002). In a recent survey of children and young people in residences for care and protection rather than for offending matters, 80% of this group were assessed by health professionals as having mental health needs (Ministry of Social Development et al., 2003).

Mental health and young offenders

There is less information available about the prevalence of mental health disorder amongst the juvenile justice or youth justice population, as they are known in New Zealand. Estimates of mental health problems amongst this group in the United States have tended to be around 70% - 90 % with high levels of co-morbidity (Atkins et al., 1999; Coccozza, 1997; Nordness et al., 2002; Teplin, 2001). In Britain estimates of mental health problems amongst young offenders in custody are slightly lower, ranging from 46% to 81% (Mental Health Foundation, 2002b). For example, Bhatti, Vostanis, Lengua, Rothery & Cope (1996) found that 50% of those attending a youth treatment centre reported mental health problems

requiring assessment. Many young offenders have entered the youth justice system without these needs being assessed or treatment being received (Wasserman et al., 2003).

In New Zealand, while comprehensive research into the prevalence of mental health problems amongst the youth justice population has not been carried out, there is awareness of these problems. Using the Christchurch Health and Development Study data, D. Smith & Beautrais (1999) found high rates of alcohol and drug disorders in the Child, Youth and Family youth offender population, and other mental health problems (D. Smith & Beautrais, 1999). In 2000, Child, Youth and Family reported the results of an informal survey into substance abuse problems amongst those in residences (predominantly youth justice facilities), establishing a prevalence rate of 61% (Child, Youth and Family, 2001h). Like overseas, concern about the lack of mental health assessments and treatment for young offenders in Child, Youth and Family residences are noted (Ministry of Social Development et al., 2003).

Families where caregivers and children have mental health problems

While the 1999 survey of prevalence in Child, Youth and Family did not attempt to gauge the level of mental health disorder amongst parents, later work investigated this. This research indicated that amongst children and young people identified with a mental health problem approximately 60% also had a parent with a mental health problem (Child, Youth and Family, 2001d). In the review of 36 children and young people with mental health problems, in 23 cases of 36 there was a parent with a formal diagnosis of mental illness or a severe drug and alcohol problem (Calvert, 2000). The number of parents with borderline personality disorder and other Axis 2 diagnoses and the difficulty accessing services for these clients through adult mental health services were noted (Calvert, 2001). This is not surprising, as serious gaps and treatment deficiencies in adult mental health services for people with borderline personality disorder have been identified in New Zealand (Krawitz & Watson, 1999).

Response to children and young people with mental health problems in welfare systems

Meeting the needs of this group and providing effective support to their caregivers places demands which most child welfare jurisdictions have found difficult to manage. Social care professionals in Britain (Downey, 2001; Richardson & Joughin, 2000) and the United States (Dore, 1999; Landsverk, 2001) have recorded increasing pressure on child welfare services to respond to the rising level of mental health needs of children and young people. Issues

identified across jurisdictions include poor levels of social worker recognition of problems (Dore, 1999), inconsistent assessment of children entering care (Simms & Halfon, 1994), poor levels of treatment (Graziano & Mills, 1992) and limited care options (Morton, Clark, & Pead, 1999; Richardson & Joughin, 2000).

In one British survey (Downey, 2001) four out of five social care professionals believed that in the last five years there was a higher prevalence of those suffering severe emotional and behavioural problems. More than half felt insufficiently qualified or experienced to work with children and young people with these mental health problems. Most sought to increase early diagnosis, interventions and support for families as the priority for service improvement (Downey, 2001). In another British study of social workers' views on mental health needs of children in care, it is suggested that 80% of foster children require treatment from a mental health professional (J. Phillips, 1997).

Children with mental health problems can require intensive and expensive forms of care, which absorb a large amount of system resources and not surprisingly their care is associated with social worker burnout (Dore, 1999). Social workers are now closely involved with the use of psychotropic medication. Many are uncomfortable with this, claiming that they have had insufficient information, training or informed discussion of therapeutic or toxic effects (D. Cohen, 1988).

In the United States the difficulties in developing an adequate response to this group have been described as system reactivity and their effect as iatrogenic (Nugent & Glisson, 1999). An absence of mental health services exacerbates system reactivity such that untreated mental health issues result in problem escalation, making it more difficult to provide adequate services and stabilise care. Variability in treatment levels for this group have been found to relate to care and protection problem type. Children who have been physically or sexually abused are more likely to receive treatment services than those involved with welfare services for reasons of neglect (Garland, Landsverk, Hough, & Ellis-Macleod, 1996). The impact of these placement patterns on caregivers is discussed in greater depth in the following chapter.

The impact of managing mental health issues on Child, Youth and Family

The capacity of Child, Youth and Family to manage the mental health problems of those in care and support their caregivers effectively is central to this research. Child, Youth and Family has outlined the impact of child mental health issues on the organisation in a number of reports (Brown, 2000; Child, Youth and Family, 1999b, 2002a, 2002c; Maharey, 2002)

and most recently within the Baseline review process (Ministry of Social Development et al., 2003). These documents explain that the cost of therapeutic services has driven up departmental budgets (Maharey, 2002) and the time which children are spending in care is increasing because of their multiple behavioural and family-related problems (Child, Youth and Family, 2002c). Typically these children are involved with a number of agencies and their care needs require significant co-ordination (Child, Youth and Family, 1999b), so overhead costs are high and casework is complex.

As Calvert (2000) states: *"Child, Youth and Family Services' care facilities (Institutions, Family Homes and Foster Homes) have become the de-facto residential mental health services for children and young people"* (Calvert, 2000 p.5). Social workers involved with children and young people with the highest levels of mental health needs are identified as lacking the skills, training and support to cope with this group (Brown, 2000; Child, Youth and Family, 1999b) *"social workers and their supervisors face extreme and intolerable pressure attempting to manage this group of young people without access to information, clinical training, specialised advice and services"* (Calvert, 2000 p.5).

Child, Youth and Family seeking a safe environment for a young person with a severe mental health problem often use residential care (Child, Youth and Family, 1999b). In these circumstances staff report they are unprepared to manage this role, particularly where monitoring medication is required, where there are few specialist treatment services available and where staff do not have specialist supervision (Hassan, 2002). Once admitted to a residence or a specialist group home, young people are very difficult to discharge because there are few support services in the community (Child, Youth and Family, 1999b).

Access to mental health services for children with mental health problems who are involved in child welfare services

Children with mental health problems in the care of child welfare services experience difficulties accessing mental health services. In Britain 71% of social work professionals reported access problems and under-diagnosis is anticipated because of the lack of services (Downey, 2002; Richardson & Joughin, 2000). Children's services inspectors recorded unacceptably long waiting times for CAMHS and noted that social workers viewed CAMHS as unresponsive particularly for families reluctant to seek or accept help (Department of Health, 2002; Valios, 2002). Slow response times, exclusion of particular categories of children, lack of treatment post assessment have all been noted as problem areas (Z Kurtz, Thomes, & Bailey, 1998). Social workers can sometimes be reluctant to refer clients to child mental health services due to unease about waiting times and concerns about inappropriate

clinical settings (Richardson & Joughin, 2000). These problems extend to young offenders where 75% of youth justice managers report difficulty accessing CAMHS (Audit Commission, 1999).

In the United States reports about access to mental health services for children in foster care appear more mixed. Glisson (1996) found that only 14 % of children entering state custody actually received mental health services although the majority had significant mental health problems. Landsverk (2001) however, found that children in foster care are high users of mental health services although the use of evidence based treatment is low. Kortenkamp & Ehrle (2002) similarly reported that children involved with the child welfare system were more likely to receive mental health services than children in parent care.

The greatest concern is held for those with the most severe problems. In the United States children's services appear to compete to avoid providing services to those with the most severe mental health problems, resulting in service rejection and placements further from home to obtain services (Nugent & Glisson, 1999). Paradoxically the research suggests: *"The best way for a child in state custody to receive the most services is for that child to not have any problems in psychosocial functioning"* (Nugent & Glisson, 1999 p.56). Problems with funding, in particular with Medicaid coverage, insensitive or untrained staff, absent or inadequate mental health services are all noted for this group (Risley-Curtiss, Combs-Orme, Chernoff, & Heisler, 1996; United States General Accounting Office, 2003). Recent research by Lau & Weisz (2003) indicates even when services are accessed, treatment outcomes for children with a history of maltreatment are worse than for other groups. They conclude that the mental health needs of this group are not well addressed in community mental health clinics in the United States.

In New Zealand problems accessing CAMHS have been described for some time (Child, Youth and Family, 1999b; Cockburn, 2002; Health Funding Authority, 2000b; Ministry of Social Development et al., 2003). Calvert (2000) succinctly summarises the key access issue for Child, Youth and Family clients, which involves controversy over attribution of child mental health problems where there are significant contributing life circumstances, arguments referred to in chapter two. She states:

The CYPFS client group is especially vulnerable to being excluded from health sector services because mental illness, in their case, is often a reaction to their life circumstances. This remains a controversial area within child and adolescent mental health (Calvert, 2000 p.5).

Perverse incentives are described in the context of under-funded mental health services whereby priority access may be given to clients with lesser needs who do not have the involvement of a statutory agency. "*...where CYF places a child with a mental illness in a residence, then that increased level of security is sometimes a factor in clients not being provided with mental health services*" (Child, Youth and Family, 2003i p.14).

Child, Youth and Family have drawn attention to the problems accessing CAMHS in many parts of the country, especially the exclusion of children where problems were judged the result of sexual abuse, violence, anger, learning difficulties, criminal activities, conduct disorder and parenting difficulties (Child, Youth and Family, 2001i). More recently Child, Youth and Family staff noted the most serious access problems were for those with conduct disorder and those in residences, although improvement in relationships with CAMHS were also noted (Child, Youth and Family, 2003g; Cockburn, 2002).

Approaches to addressing mental health needs of Child, Youth and Family clients

The path to resolving access issues, meeting service gaps for clients and addressing staff skill shortages in Child, Youth and Family has been difficult. Efforts have included improving interagency collaboration, providing new funding, increasing social worker recognition and developing specialist programmes. These are discussed in more detail below.

Interagency collaboration

Inter-sectoral collaboration and service co-ordination initiatives have been used internationally to improve services to families whose children have mental health problems. While the systems of care approach in the United States (Stroul & Friedman, 1986) is most well known, service co-ordination approaches for children with serious emotional disturbance are described in Australia by Luntz (1994; 1996) and in Britain by Valios (2001).

Stroul & Friedman (1996) explain the structures and mechanisms that are needed to ensure co-ordination at the system level for children and families with mental health needs:

integrated, multi-agency networks are needed to blend the services provided by mental health, education, child welfare, health, juvenile justice, substance abuse and other agencies. These components must be interwoven into a coherent system with provisions for joint

planning, service development, problem solving, funding and evaluation of services (Stroul, 1996 p.265).

The identification of a case management role is as an important part of effective inter- sector collaboration and is a particular feature of individualised wrap around programmes (Burns & Goldman, 1999). A family focus is also integral to systems of care where the needs of the child and family dictate the type and mix of services (Ungar, 2003).

Interagency collaboration between CAMHS and Child, Youth and Family has received consistent attention over the last nine years (Child, Youth and Family, 1998, 1999b, 2001i; Department of Social Welfare, 1995; Interdepartmental Working Party, 1995; Ministry of Social Development et al., 2003). In 1996 a case management protocol was agreed between Health, Education and Welfare, whereby Health would be lead agent when severe mental health problems were dominant for a child or young person (Ministry of Health, 1997b). Child, Youth and Family was identified as lead agent when care and protection needs or offending behaviours were dominant (Ministry of Health, 1997b). This did not clarify what would happen where these circumstances co-existed or provide guidance on delineating between care and protection and mental health issues in the case, for example, of Post Traumatic Stress Disorder.

Given what is now known about co-morbidity of these problems (Fergusson et al., 2003) it is not surprising that such a simple determination of lead agent was unsuccessful. In 1999 the Mental Health Commission described this protocol as failing to resolve interagency co-ordination problems, commenting on this particularly in the context of significant service deficits (Mental Health Commission, 1999). In 1998, a report to the management board of Child, Youth and Family noted similarly that current initiatives focusing on interagency cooperation would be insufficient to address ongoing deficits in services (Child, Youth and Family, 1999b).

Another approach to improving co-ordination and access to mental health services has been through the establishment service liaison positions in some New Zealand CAMHS. Despite their clear intentions, a review found that these positions did not achieve their initial objectives (Gillespie, 1999). The main problem identified was the failure of the liaison service in fact to make referrals to mental health services and the slow pace of assessments (Gillespie, 1999). Child, Youth and Family staff report continued confusion over liaison positions, stating:

these are difficult positions for the incumbents as CAMHS expect the liaison person to limit the number of referrals whereas Child, Youth and Family expect more open access to CAMHS. The success of these positions seems variable around the North Island (Cockburn, 2002 p.3).

The question of service access for children and young people with conduct disorder received particular focus by Child, Youth and Family but without resolution. Chapter three described the exclusion from New Zealand child mental health services of those with conduct disorder as a sole diagnosis. This situation was the subject of a report to Government in 2001 (Child, Youth and Family, 2001i). This report described how in 1998, to plug this service gap, a specialist residential treatment programme for young people with conduct disorder was funded by Child, Youth and Family, with schooling costs met by the Ministry of Education. A contribution of funding was sought from the Ministry of Health but this was not forthcoming (Child, Youth and Family, 2001i). In 2001, after further interagency discussions Government agreed that the responsibility for children with conduct disorder lay jointly with Health, Education and Welfare sectors; however, no new services emerged and further policy work was planned (Child, Youth and Family, 2001i). In 2003 continued lack of clarity about the response to those with conduct disorder from CAMHS was noted, this time in the context of the Baseline Review (Ministry of Social Development et al., 2003). In a follow-up paper, further delineation of agency responsibilities was once again deferred for future policy work (Ministry of Social Development, 2004).

Problems establishing effective service collaboration

Child, Youth and Family is among many child welfare jurisdictions experiencing problems in establishing effective inter-sector collaboration. While some success in systems of care approaches in the United States has been identified (see chapter three) difficulties are also noted. Considerable change requirements at the team, organisational and system level have been identified and suggestions made as to how to overcome these problems (Anderson, McIntyre, Rotto, & Robertson, 2002; Koroloff, Walker, & Schutte, 2002; Ungar, 2003).

From another perspective, Glisson & Hemmelgarn (1998) question whether process-oriented service co-ordination efforts may in fact limit caseworker discretion and responsiveness at the individual level, in turn, constraining attention to desired child outcomes. Ungar (2003) too questions whether service integration can be successful when the focus is on needs and rates of service utilisation. He suggests a better basis may be to consider the relationships between parties from the standpoint of families. Ewles (2000) warns that the high profile of

alliance work means that it is easy to perceive the setting up and attending of an alliance as an achievement in its own right rather than improved practice or child outcomes.

In Britain, Webb & Vulliamy (2001) Mental Health Foundation (2002a) and Jenny Morris (2003) outline significant challenges in achieving interagency collaboration, including controlling the real costs of collaboration in terms of staff time and in realigning priorities and work practices. Case management differences often emerge in interagency work when funding is being negotiated, (Aldgate & Stratham, 2001). Others emphasise that multi-agency work underestimates necessary cultural differences which exist between different kinds of professionals (A. Cooper et al., 2003). As one professional comments: *"education and social services operate within different legislative agendas and frameworks and culturally they are worlds apart, these aren't excuses they are the context in which we have to work"* (Jenny Morris, 2003 p.23).

In New Zealand, although interagency collaboration is newer, there is concern expressed that as a single initiative it may not be enough to improve outcomes for children, particularly where there is a shortage of services (Gray, 2002) and when collaboration fails to achieve participation of community organisations (P. Walker, 2001).

In summary, service collaboration appears to make some improvement for some families but is dependent on the state and quality of existing services. Problems persist for some groups, for example, those in the United States who continue to receive their mental health needs through child welfare and juvenile justice services (United States General Accounting Office, 2003). Research into the necessary conditions for individualised service collaboration in the United States holds warnings particularly for those in the New Zealand context:

Research on systems integration sends a strong caution against relying on systems reform in and of itself, as a route to improved outcomes for children and families. These studies argue that without attention to improving the quality of services and to increasing the capacity of organisations there may be little reason to expect improved outcomes under systems of care (J. S. Walker et al., 2003 p.8).

New funding for services

The findings above suggest that growth in the range and quality of child mental health services will be crucial to achieving improvements in service access and client outcomes. In 1998, Child, Youth and Family received recognition of the deficits in mental health services for its client group and were given funding to develop services to meet these gaps (Child,

Youth and Family, 1998). Additional mental health and other services were proposed, as described in Table One below; however, these services were never established.

Table 1 Funding sought for Child, Youth and Family Services (Child, Youth and Family, 1998).

	1999/2000 \$M	2000/01 \$M	2001/02 \$M
• 10 places in a 12 month residential programme	0.900	0.900	0.900
• 20 places in a 6 month residential programme	0.900	0.900	0.900
• 10 inpatient beds (for 4 weeks @ \$14,000/week)	0.056	0.056	0.056
• 150 respite beds (for 50 days @ \$50/day)	0.375	0.375	0.375
• 4 contracts for behavioural support	0.600	0.600	0.600
• Training for family caregivers, foster parents and social workers	0.200	0.200	0.200
Total Funding Required	3.031	3.031	3.031

At this time the Ministry of Health identified that the appropriate services to develop, were respite care, wrap-around funding and intensive clinical support services (Health Funding Authority, 2000b). It was acknowledged that some children and young people who were unable to reside with their families required safe accommodation options; however, there was ambivalence about who had the responsibility for provision of this residential care (Health Funding Authority, 2000b). Therapeutic foster care was also identified as the appropriate option for this group although no specific proposals were advanced to develop this form of care (Health Funding Authority, 2000b).

Health received monies in 1999-2000 to meet service gaps for Child, Youth and Family clients; however, funding was progressively transferred from Health to Child, Youth and Family, during that year in order to continue Child, Youth and Family service provision (P. M. Wells & Smith, 2000). This money was expended in individualised wrap-around funding arrangements, which allowed packages of care to be developed for 36 young people in very intensive care arrangements within Child, Youth and Family. A review of these arrangements is provided in Calvert (2000) and P.M. Wells & Smith (2000).

The subsequent financial year 2000-2001 saw the establishment of a new inter-sector approach which continued the wrap around funding to this small group. This became known as the High and Complex Needs Strategy (HCN) (Child, Youth and Family, 2002a). This initiative was developed using pooled funding from Health, Education and Welfare administered through an inter-sector unit located within Child, Youth and Family.

The High and Complex Needs strategy marked a change in emphasis. In previous years funding for this group of clients was designated for extra mental health services and was located in Health for the purchase of these services. The new initiative, now located in Child, Youth and Family, was accessible to children and young people with any form of high and complex needs including those with disabilities. Children and young people who were not involved with Child, Youth and Family could also receive funding under the scheme. The target group of clients were described as: *"a small group of children and young people who present highly complex idiosyncratic needs and challenges that cannot be met through existing services"* (New Zealand Government, 2002 p.1).

The premise was that it was the extraordinary level of an individual's needs and their idiosyncratic nature, which necessitated intervention, rather than the significant gaps in mental health services. Families where there was a constellation of problems, amongst a range of members, could not establish eligibility because the high and complex need threshold was not met in any individual dependent member. In addition the criteria requiring persistence of problems over a year (Ministry of Education, 2000), makes early intervention difficult to secure for families with younger children or where mental health problems exist amongst caregivers rather than children.

The initiative did not address the underlying nature of the Children, Young Persons and their Families Act as a mechanism for meeting mental health service deficits. Most importantly, the significant gaps in support services for Child, Youth and Family caregivers looking after children with mental health problems, were not addressed under this strategy.

Improving recognition of mental health problems

Child, Youth and Family has continued to improve recognition of client mental health problems. The Youth Services Strategy addressed the need for improved screening for mental health problems amongst young people in 1999-2000 (Ministry of Social Policy, 1999). The strategy developed social worker recognition of young peoples' mental health needs, with screening tools for alcohol and drug problems, suicidal issues and psychological distress. It also provided for some specialist care options and rehabilitation. While it was intended to refer young people to mental health services where further assessment was indicated, access protocols to CAMHS were not negotiated at the time of the strategy. While the interim evaluation suggests the tools were not being used in all cases, due to the demands on social worker time, they were viewed positively (Preston, 2002).

Further improvement in assessment of mental health problems by social workers was recommended in the review of Child, Youth and Family in 2000 (Brown, 2000). In 2002 Child, Youth and Family completed and released guidelines to staff working with children and young people and families with mental health problems. The booklet provided an assessment framework for social workers, as well as providing information about disorders and psychotropic medication (Child, Youth and Family, 2002h).

Specialist programmes for children and young people with mental health problems in Child, Youth and Family

Calvert (2000) predicts that the significant problems in obtaining health services for Child, Youth and Family clients will persist in the short term and *"in some areas it is unlikely to ever be able to access appropriate assessment services for clients"* (Calvert, 2000 p.3).

It is likely then that Child, Youth and Family will continue to need to provide specialist programmes to meet mental health needs of clients. For example, the recent review of residential services provided by Child, Youth and Family indicates that:

Work is also needed to develop consistent systems of services across residential and community based settings and to identify unmet need for mental health services and secure funding for the purchase of specialist mental health services for residents where these are not available through public health services (Child, Youth and Family, 2003g p.5).

Child, Youth and Family have already established two specialist services to meet gaps in mental health services. Firstly, a small residential programme for those with conduct disorder is provided by a non-government organisation funded by Child, Youth and Family. Secondly, Child, Youth and Family fund an intensive case monitoring programme for clients with suicidal or self-harming behaviour, to provide support to social workers and facilitate access to child mental health services (Child, Youth and Family, 2002g).

Very recent progress has been made with the establishment of four intensive clinical support services funded by Health to trial an intensive clinical response to Child, Youth and Family clients by CAMHS (Child, Youth and Family, 2004b). This approach is similar to the CAMHS Innovation Projects in Britain (Z Kurtz & James, 2002), whereby specialist workers for children in care are located in CAMHS and, reciprocally, mental health specialists work in child welfare services. This model may have benefits as it aims to intensify the response to this group within mainstream services, encouraging mental health workers to be more responsive and supportive to this group. A preliminary review of these services in 2004

found that, although two of the services were not yet securely established, social workers valued those services that were operational (Child, Youth and Family, 2004b).

Conclusion

Children and young people in statutory child welfare services have been noted to have high rates of mental health problems, due to the association between abuse, neglect and psychological distress. In New Zealand the inclusive nature of child welfare legislation means that Child, Youth and Family is supplementing gaps in services for families caring for children with mental health problems. Like other child welfare jurisdictions Child, Youth and Family experiences pressure of rising demand for services, increased costs, complexity of client problems and difficulties obtaining sufficient skilled staff. These problems are exacerbated in respect of meeting the needs of those with mental health problems.

While Child, Youth and Family have only recently researched the level of mental health problems amongst their client group they have been documenting problems accessing adequate assessment and treatment from CAMHS over a nine- year period. Initially efforts were focused on developing additional mental health services to meet gaps, and extra funding for these was located in Health. More recently, however, the focus on mental health service gaps has been replaced by an emphasis on improving inter-agency collaboration and development of individualised services for a very small number of children with high and idiosyncratic needs. The serious gaps in mental health services for Child, Youth and Family clients remain and there is no ongoing funding path agreed to resolve these. It is in this context that Child, Youth and Family have developed a number of programmes to provide specialist services particularly for those with conduct disorder and suicidal or self-harming behaviour.

The focus of Child, Youth and Family endeavour has been to raise staff awareness about client mental health needs, improve access to assessment and treatment services and develop better inter-agency processes. The needs of caregivers looking after this group have received much less attention. In this context Child, Youth and Family caregivers are likely to bear the brunt of meeting the needs of children and young people with mental health problems with inadequate support from mental health services. What is known about their experiences and the support available to assist them is the subject of the next chapter.

Chapter Five

Supporting Child, Youth and Family Caregivers Looking after Children and Young People with Mental Health Problems

Introduction

This chapter considers the support arrangements made for caregivers who look after children and young people with mental health problems in the care of Child, Youth and Family. The chapter begins with a return to developmental psychopathology, using resilience as a perspective for considering the provision of care within a welfare context. As caregivers in this research include relative and foster caregivers, a brief overview of foster and kinship care is provided along with a description of the current pressure on the care system. The challenges of caring for children with mental health problems within a child welfare context are considered in the next part of the chapter. Finally, the supports provided by Child, Youth and Family to kin and non-kin caregivers are discussed within a family strengths perspective.

Caregivers, in respect of this discussion, are those people, who provide care within a family setting on behalf of Child, Youth and Family and who are not employed by the organisation. The issues for staff employed by Child, Youth and Family who provide care within residential settings are distinct and not within the scope of this research.

A developmental perspective

The Department of Child, Youth and Family defines foster caregiving as providing "*an appropriate family like setting in which to care for children and young persons who, for various reasons, cannot live with their own families and whanau*" (Child, Youth and Family, 2001b p.1). A developmental perspective considers the contribution this kind of care can make towards child development and resilience, contributing to their longer-term outcomes. This perspective views a placement in care as a time in which children can develop new attachments and correct negative pathways which may have begun to form as a result of previous harmful experiences. Schofield (2002) argues that foster care can be restorative, providing an opportunity for children to raise self-esteem and develop new resilience. Through foster care, a child's sense of competence and self-efficacy is given a chance to develop. This builds adaptive capacity rather than defensive or hostile reactions, leading to increased trust (Gilligan, 1997; Schofield, 2002).

A developmental perspective gives particular consideration to the age and state of the child entering care. Foster care potentially represents another disruption in caregiving for a group of children who have usually already been exposed to serious problems in their caregiving relationships, often of a frightening or threatening nature (Dozier, Albus, Fisher, & Sepulveda, 2002). Chapter two outlined the psychological consequences of long-term threats, stress and disruption to care. For infants placed in foster care, disruption to their relationships with primary caregivers often occurs at a point when they are fundamentally dependent and attached to these caregivers. However, through foster care, reorganisation of attachment behaviour has been found particularly amongst infants receiving sustained nurturance from new caregivers (Dozier, Stovall, Albus, & Bates, 2001).

As reviewed in chapter two, many factors have the potential to protect and encourage resilience in children and young people at risk of negative outcomes. Within this scope are the activities of social workers and caregivers such as facilitating purposeful contact with parents, siblings, family members and other key adults from the past. It includes facilitating positive school experience, friendships with peers, interests in culture and hobbies and finding ways to help young people to observe and rehearse problem solving (Resnick, 2000a; Resnick, Harris, & Blum, 1993)

Gilligan (1997) suggests that the focus of social workers, caregivers and policy makers is concentrated on three key sources of resilience for children in care: a sense of having a secure base, self-esteem or self-worth and a sense of self-efficacy. From a strengths perspective the goal of foster care also encompasses collaborative relationships with families of origin, both prior to and during placement, involving them in joint review of the child's needs and in reunification activities (Newberger, 2000).

The provision of care in a welfare context

In New Zealand, children whose care arrangements are part of a plan constituted within the provision of the Children, Young Persons and their Families Act (New Zealand Government, 1989a), are described as "in care". While care arrangements vary across jurisdictions, extended family or "kinship care", substitute families or "foster care", small family-like group homes (known in New Zealand as family homes) and institutions or residences are common to most countries. While a number of children and young people with mental health problems are cared for in New Zealand child welfare residences (P. M. Wells & Smith, 2000), it is anticipated that the predominant care arrangements for this group are made with extended family and foster caregivers although there is no data available to confirm this.

Kinship care

Although an agreed definition of kinship care is not present in the literature (Connolly, 2003) a common description frequently cited suggests kinship care is:

the full time nurturing and protection of children, who must be separated from their parents, by relatives, members of tribes or clans, god parents, step parents or other adults who have a kinship bond with a child (Child Welfare League of America, 1994 p.2).

Kinship care is increasingly sought as a means of caring for children in child welfare systems. In the United States, in some places, over half of children are placed in this form of care (Scannapieco, 1999) although rates now appear to have stabilised nationally at around 25% (Geen & Duerr Berrick, 2002). In Australia kinship care constitutes 24% of all placements (Hunt, 2003). In the United Kingdom rates of kinship placement are lower at approximately 10% but this form of care is still regarded as significant (Broad, 2001).

The increase in kinship care placement does not appear to have been based on consensus about the purpose of kinship care, nor are support services for caregivers clearly agreed (Gordon, McKinley, Satterfield, & Curtis, 2003). The development of standards and policy have lagged behind the increase in kinship care, which is of concern given the rapid rise in this form of care (Ainsworth & Maluccio, 1998). In New Zealand, along with poor levels of caregiver screening, standards, support and monitoring, there are also concerns about the unresolved issues within the family of origin, abuse in kinship care, lack of permanency planning and less active work with birth families (Worrall, 2001).

The motivation for the development of kinship care in welfare systems is variously described. From a developmental perspective, kinship care provides an opportunity to substitute caregiving relationships in a manner that is much less disruptive to the familiar relationships and environment of the child (Dozier, Albus et al., 2002). In this way kinship care can reduce separation trauma and its negative consequences (Crumbley & Little, 1997; McFadden, 1998). Kinship care has also been viewed as culturally safe practice (Hegar, 1999; Wheal, 2001) and as a way to reinforce child identity (Child Welfare League of America, 1994). In the United States, kin care appears to have been developed as a mechanism to cope with rising health problems amongst parents (Waysdorf, 1994). Others emphasise the desire to respect and recognise the natural willingness in families to assist their next generation (McFadden, 1998) and offset loss of family continuity and other poor outcomes associated with foster care (Hunt, 2003). Finally, kinship care may have been

embraced in response to the pressure of demand for out of home placements in the context of the financial constraints of child welfare systems (Hunt, 2003).

Who are kinship carers?

While New Zealand data are not available, a small body of overseas research suggests kin care givers in the United States (Gebel, 1996; McFadden, 1998; Scannapieco, 1999) and in Britain (Broad, 2001; Hunt, 2001) share similar characteristics. Caregivers are usually female, commonly grandmothers carrying out second generation parenting or aunts. Relative caregivers are older than non-relative caregivers, and are less well educated (Dubowitz, Feigelman, & Zuravin, 1993; Gebel, 1996). Kinship caregivers appear to have lower levels of income and home ownership (Berrick, Barth, & Needell, 1994; Ehrle & Geen, 2002). In the United States kinship caregiving families are less likely to be headed by a married couple and more likely to be from an ethnic minority (Dubowitz et al., 1993; D. L. Wilson, 1999).

In terms of role perception, research has shown important differences between kin and foster caregivers. Kinship caregivers seem to take a more active role than foster caregivers in maintaining child contact with birth families and helping children deal with issues of separation and loss (Pecora, Prohn, & Nasuti, 1999). Overall kinship carers express a strong commitment to caring as a part of the natural loving response to their family members, wishing to retain care in the family and reporting high levels of satisfaction (Broad, 2001; McFadden, 1998; D. L. Wilson & Stukes Chipungu, 1996). However, kin carers both overseas (Berrick, Needell, & Barth, 1999; Waldrop & Weber, 2001) and in New Zealand (Brudenell & Savage, 2000; Grandparents Raising Grandchildren, 2000; A. Smith, Gollop, Taylor, & Atwood, 1999; Worrall, 2001) attest repeatedly to the difficulties inherent in their role.

Outcomes of kinship care

Research on child outcomes in kinship care is limited; however, early studies indicate reason for optimism in respect of the quality of relationship between caregivers and children, especially bonding (Altshuler, 1999). Preliminary findings on health outcomes of children in kinship care suggest these are comparable to those of children in foster care (Geen & Duerr Berrick, 2002). This is interesting given that kin carers generally provide care in poorer circumstances than other caregivers (Ehrle & Geen, 2002). In respect of child safety, findings are mixed, with one study establishing a higher rate of child abuse in foster care

than kin care (Zuravin, Benedict, & Somerfield, 1993) while a later study found similarities between both populations (Benedict, Zuravin, & Stallings, 1996).

There may be some superiority of kinship care over foster care in terms of placement duration and stability (Berrick et al., 1994; Courtney, 1994; Wulczyn & Goerge, 1992). For example, the lowest rate of breakdown amongst the range of placement types for Swedish young people was in kinship care (Sallnäs, Vinnerljung, & Westermarck, 2004). Reunification rates, however, appear to be lower (Berrick et al., 1994; Wulczyn & Goerge, 1992) although some conclude that reunification is slower rather than lower over all (Geen & Duerr Berrick, 2002; McLean & Thomas, 1996). In general child well-being research is too preliminary to be conclusive, compounded by the heterogeneity of kinship placements (Leslie, Landsverk, Horton, Ganger, & Newton, 2000). Connolly (2003) in her review also draws attention to the poor level of kinship care research and methodological problems of many studies which do exist. However, Hunt (2003) does suggest that despite this, it is justified to say that outcomes for children in kinship care, appear at least no worse than those of children in foster care and in respect of placement stability kinship care has clear benefits.

Children with mental health problems in kinship care

Children in kinship care experience mental health problems both overseas (N. Shore, Sim, Le Prohn, & Keller, 2002) and in New Zealand (Worrall, 2001). There is some agreement within the studies, however, that there may be lower rates of emotional and behavioural problems amongst children in kinship care than in foster care. Rowe, Cain, Hundleby & Keane (1984) reported lower rates of problems even amongst older adolescents in kinship care using standardised scoring. Rates reported by Solomon & Marx (1995) were found to be as low as amongst children in two-parent families. Iglehart (1994), Dubowitz & Sawyer (1994), Benedict et al. (1996) and Hunt (2003) describe mental health problems of children in kin care as being in the 33%–39% range. These rates, although substantial, are below the 40 – 60% figures reported for children in foster care, as described in chapter four. While some suggest this may relate to lower rates of behavioural problems of children in kinship care at the point of placement (Landsverk, Davis, Ganger, & Newton, 1996; Rowe et al., 1984) further research is required to determine whether the superior support offered to children by kin caregivers McFadden (1998) and high levels of commitment (Hunt, 2003) are also factors. The potential of kinship care for children with mental health problems in child welfare systems is discussed further in the final chapter of this thesis.

Kinship care in New Zealand

In New Zealand, Emst (1999) and Worrall (2001) have described the emergence of kinship care within Child, Youth and Family, concluding that encouraging culturally appropriate practice and costs containment were forces driving this country's interest in kinship care. While a focus on kinship care for Maori children was in place before the passage of the Children, Young Persons and their Families Act (New Zealand Government, 1989a) (Bradley, 1994; Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1986), the new law established placement principles requiring family and extended family members to be considered as caregivers wherever this was appropriate (New Zealand Government, 1989a). The Act, however, does not use the term kinship care, referring to family, whanau, hapu, iwi and family group, the latter including a person with whom the child does not have a legal or biological relationship but with whom there is a significant psychological attachment (Child, Youth and Family, 2003f).

Child, Youth and Family claims that no other country reviewed uses kinship care to the extent that New Zealand does (Child, Youth and Family, 2003b). Consistently, between 32%-35% of all placements between July 2001 and February 2003 were made with kin (Child, Youth and Family, 2003c). This is a higher number than the most recent figures to emerge from the United States of 25% (Geen & Duerr Berrick, 2002). Limitations around the data are noted. Rates may be higher still because of the likely exclusion of children placed with people with no biological ties but with psychological attachments and children placed where board payments are not made (Child, Youth and Family, 2003b).

Kinship placements in Child, Youth and Family take place more often for Maori children than for non-Maori. In 2000 45% of Maori children were placed with kin compared to 22% of Pakeha (European) (Brown, 2000). More recently, it is reported that 50% of all Maori children in long term foster care are placed with whanau, double the rate for Pakeha children (Child, Youth and Family, 2003b). Child, Youth and Family propose to improve kinship care practice through the development of policies for assessment and support of kin caregivers, as well as research (Child, Youth and Family, 2003b).

Foster care

Foster care provides children and young people, whose immediate or extended family of origin are not able to provide care, with planned, time-limited substitute care in families with trained caregivers, while simultaneously services are provided to these children and families to help resolve their problems (Pecora et al., 2000). Foster care is designed to enable children

and young people to engage with trustworthy adult caregivers, and where necessary replace birth family members on a temporary or permanent basis in order that children or young people may form attachments and receive positive nurture and care. Pecora et al. (2000) include, as objectives, the avoidance of further harm, maintenance of family, school and other connections and the development of cultural and self identity. Carter (2002) adds that foster care should contribute to developing personal and social relationships, physical and mental health and educational achievements.

Permanency is a prominent outcome sought from foster care. Permanency involves securing for all children a family for life (Minty, 2000) or stable, enduring and guaranteed placement as an alternative and antidote to disruptions in early care (Gilligan, 1997). While many view foster care as a short-term supplementary role, emphasising the requirement to maintain family contact and work towards reunification, others, as described earlier in the chapter, focus on the role of foster parents in rebuilding attachment and self esteem. Gilligan (1997) argues that resilience rather than permanency should drive foster care practice and that preoccupation with permanence may mean a failure to devote sufficient time to achieve reintegration with birth families.

Who are foster carers?

In most jurisdictions, including New Zealand, foster care is provided by a mixture of the statutory authority and non-government organisations, including church-based social services. Internationally there are mixed findings about the characteristics of foster carers. In Australia, for example, while early research found foster carers were usually not in the workforce (Cusack & Orr, 1999) a later survey found only 20% of foster care families had no breadwinner (Australian Foster Care Association, 2001a). In this latter study, foster carers were in the 45 to 54 year age range, with a level of formal qualification above that of the general population. They were drawn from all employment types with the two largest catchments being professional and managers/administrators (Australian Foster Care Association, 2001a). In Britain, foster carers are generally female, between 31 and 55 years with their own children, in two-parent households and owning their own homes. A large number of women caregivers come from social work, nursing, child-minding and teaching backgrounds (Berridge, 1997; Triseliotis, Borland, & Hill, 1999). In the United States Orme & Buehler (2001) report a wider range of occupational backgrounds of foster families but similar two-parent structures. Many foster parents have been found to hold spiritual belief systems and report attending places of worship (M. E. Cox, Orme, & Rhodes, 2003; Kirkby, 1997; Reilly & Platz, 2003) In New Zealand, while there are 1700 foster caregivers approved (Child, Youth and Family, 2003j) there are no data on their characteristics.

Pressure on the care system

A Crisis in Care

Reviews of foster care, across jurisdictions, suggest there is set of serious and common problems leading many to question the effectiveness of foster care, viewing it as a system in crisis. Criticisms have included unacceptable levels of foster care breakdown, high turnover of social workers, loss of family contact, untimely discharge, rapid re-entry to care and poor child outcomes (Pecora et al., 2000). At the systemic level, problems include a lack of strategic approach to care, recent rises in demand for care, poor supply of caregivers and the changing nature of care (Berridge & Cleaver, 1987; M. Fisher, Marsh, Phillips, & Sainsbury, 1986; Johnstone, 2001; Kufeldt, 2002; Rowe, Hundleby, & Garnett, 1989; Triseliotis, Borland, & Hill, 1998).

In New Zealand, early reviews of foster care provided by Child, Youth and Family drew attention to persistent problems in establishing good practice, particularly planning for children in care, the need to increase involvement of natural families, poor preparation for young people leaving care and low levels of involvement of children in decision making (Mackay, 1981; G. Munford, 1994). More recently, Worrall (2001), T Ward (2000), and Yates (2001) have found a failure to establish continuity in the areas of placement, social worker, education or family contact. Those with complex histories of abuse, and with high needs, particularly adolescents with behavioural problems, are noted to have significantly worse experiences in care in New Zealand (T. Ward, 2000; Yates, 2001).

Since 2000 Child, Youth and Family has internally reviewed its own approach to foster care noting problems in developing a care strategy, pressures of supply and demand and the changing nature of care (Child, Youth and Family, 2001e, 2002c). The pressure of front-line investigative work has meant less priority on meeting the needs of children in care, and high caseloads limit social workers' ability to complete care casework (Ministry of Social Development et al., 2003). Difficulties in managing child behaviours has led to problems in obtaining sufficient caregivers. This is exacerbated by competition for carers from health and education sectors who offer higher remuneration for care of those with lower needs (Child, Youth and Family, 2002d).

The move away from institutional care

Substantive reviews of child welfare policies point to a transformation in the nature of care in the last twenty five years. Predominantly reliance on institutional care has shifted to an emphasis, reflected in legislation, on foster care as a means of caring for children (Ainsworth, 2003; J. G. Barber, Delfabbro, & Cooper, 2001; Minty, 1999; Petrie & Wilson, 1999; Preston, 1999). This re-orientation has meant foster and kin care systems need to provide the same care capacity as was met through more intense, institutional forms of care. Overseas, however, some jurisdictions have noted that during the 1990s an increasing number of children are again being placed in group care and residential settings (Farris-Manning & Zandstra, 2004).

In New Zealand a similar movement away from institutional or residential care was initiated in the 1980s (Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1986) and consolidated in the placement principles within the Children, Young Persons and their Families Act (New Zealand Government, 1989a) (Preston, 1999). This gave non-government organisations, including Iwi Social Services, the potential to develop their own community-based response to care of family or whanau, hapu and iwi members (New Zealand Government, 1989a).

"Supply" of caregivers

In Britain, United States, and Australia there is discussion of the problems maintaining a sufficient "supply of caregivers" (J. G. Barber, 2001; Department of Health, 2002; Mathiesen, Jarmon, & Clarke, 2001; Rindfleisch, Bean, & Denby, 1998; Triseliotis et al., 1999). It is likely that the shortage of caregivers has been influenced by new demographic patterns such as the changing nature of women's participation in the workforce, the need for many women to be involved in looking after elderly relatives, the changing nature of families (J. G. Barber, 2001), aging and drop-out rates amongst existing caregivers (Pecora et al., 2000) and economic pressure on families (Hernandez, 1993).

Increasing difficulty in the provision of care

There is also a perception amongst foster caregivers that the care task is growing more difficult. Foster caregivers fear they are not able to do the task, mistrust social workers, have a poor impression of children in care, dislike protracted assessment procedures and are concerned about return of children to families (Triseliotis et al., 1998). Requirements to keep

children longer, facilitate contact with birth parents, to keep records, and the perceived risk of allegation of abuse have been cited as other areas of difficulty for caregivers (Rindfleisch et al., 1998; Sellick, 1997).

Foster carers, more than kin carers, have been found to have mixed views about family contact (Butler & Charles, 1999b) where notions of good and bad families still prevail. Foster caregivers have found family contact successful in circumstances where the child wished for contact, where it appeared to benefit the child and where rapport could be established with parents. Where parents are haphazard in keeping to arrangements, where conflict exists or where parents display difficult personalities, problems arise (Waterhouse, 1992). Important to this present research, which is focused on children with mental health problems, is the link between caregiver retention problems and the increasing numbers of children and young people needing care who have complex behaviours.

Looking after children in care who have mental health problems

The rising number of children with emotional and behavioural problems, the complexity of their behaviours and the impact of these on the lives of caregivers have been noted as contributing factors to the crisis in care (Des Semples and Associates, 2001; Pecora et al., 2000; Petrie & Wilson, 1999). A developmental perspective suggests that children who have been subject to abuse and who enter the foster care system will be expected to have emotional and behavioural problems relating to the impact of earlier abuse. The move away from institutional care to foster and family placement has meant that caregivers are now managing problems which in the past, may have been treated within a residential environment. *"In some way, the foster care system has become an open air mental hospital serving many very disturbed children placing them in the 'least restrictive' environment"* (Rosenfield et al., 1997 p.454). While care aims to restore child well-being systemic issues described above mean there may be further damage for those with existing histories of harm (Mental Health Foundation, 2002a).

Placement breakdown and children with mental health problems

Children with serious emotional and behavioural problems have been identified as at risk in the care system (Blower, Addo, Hodgson, Lamington, & Towilson, 2004) especially those with conduct disorder (Berridge, 1997). Their behaviours are linked to placement disruption and breakdown across a range of studies (Barth & Berry, 1988; C. S. Cooper, Peterson, & Meier, 1987; Dore, 1999; Fein, Maluccio, & Kluger, 1990; Proch & Taber, 1985). The

strength established for this relationship (J. G. Barber et al., 2001) has led some to question whether foster care is a viable option for some older children in this group (J. G. Barber et al., 2001; Richardson & Joughin, 2000). The behaviours associated with placement breakdown have been described broadly as including sexualised behaviour, dishonesty, suicidality, fire lighting, encopresis and enuresis, aggression, destructiveness and running away (Barth & Berry, 1988; Gilbertson & Barber, 2004; Rosenthal & Groze, 1990).

Caregiver satisfaction has been found to be closely associated with feeling competent to handle behaviours of those children who are placed with them (United States General Accounting Office, 1989). Triseliotis et al. (1998) identified that children's behaviours were isolated by carers whose ceased to foster as an important reason for doing this, along with the impact of fostering on caregivers' families and their sense of privacy. When caregivers find that the challenging behaviours and the emotional intensity that accompanies mental health problems cannot be managed within their family, placement breakdown is to be expected, although caregivers feel shame and sadness when this happens (Butler & Charles, 1999a; Richardson & Joughin, 2000).

Recruiting caregivers who are able to withstand these behaviours is crucial to successful care of children with mental health problems. Small-scale, recent research has attempted to describe characteristics of those foster caregivers willing to care permanently for children with high needs (M. E. Cox, Orme, & Rhodes, 2002; Reilly & Platz, 2003) however, the findings are preliminary. In one study willing caregivers were found to be on average in their mid forties with active religious or spiritual beliefs and had fostered their high needs children prior to adopting them (Reilly & Platz, 2003). In another small study (n=142) it was also established that belonging to a place of worship was associated with a willingness to foster children with bed wetting and troubled behaviour at school (M. E. Cox et al., 2003). In Wales a study of caregivers looking after children with behavioural problems found them to be predominantly older, describing these caregivers as durable and experienced (Pithouse, Lowe, & Hill-Tout, 2004).

Behavioural problems and the experience of foster care appear to interact. Two way or interactive effects are noted between child behaviour and placement breakdown for children in care with mental health problems whereby behavioural problems are both a cause and a consequence of placement breakdown (Ackerman, 2002; Newton, Litrownik, & Landsverk, 2000). While breakdown of foster care is attributed to behavioural problems, these problems are also exacerbated by the rate of placement change (Fanshel, Finch, & Grundy, 1989; Newton et al., 2000) although the strength of this relationship has been questioned in a recent Australian study (J. G. Barber & Delfabbro, 2002). Children placed later in life seem at

greater risk of behavioural problems and this trend holds good amongst those who are adopted (Brand & Brinich, 1999).

Cumulative negative experiences are likely to follow placement breakdown. In many cases placement breakdown is accompanied by educational failure (Biehal, Clayden, Stein, & Wade, 1994; Causer, 1996), with school or training positions being hard to maintain for children with behavioural problems (Morton et al., 1999). Poor placement history is also linked to discontinuity in mental health treatment and deficiencies in management of behavioural problems (Mental Health Foundation, 2002a). The longer the initial placement is maintained the more likely a child or young person will receive mental health services (Nugent & Glisson, 1999).

These problems appear to be ongoing. Children and young people with behavioural problems experience longer periods in care (Landsverk et al., 1996; Lawder, Poulin, & Andrews, 1986) and have lower reunification rates after controlling for background characteristics and types of maltreatment (Landsverk et al., 1996). There is continuity of troubles whereby reported problem behaviours amongst children in care are predictive of risk behaviours five years later (Taussig, 2002). Re-entry into care has also been linked to the behavioural problems of children (Courtney, 1995) and the inability of parents to manage child problems with insufficient family support (Festinger & Michael, 1994). The difficulty in diverting such negative trajectories is explained by the strong influence of background factors, such as behavioural problems. The best predictor of outcomes for children in care appears at this stage to be their characteristics at the time of placement (Pecora et al., 2000).

However, within kinship care there is variance in the interaction between disruptive behaviours and placement breakdown, which as described above is of interest. Landsverk et al. (1996) found that variance in kinship placement reunification rates was not impacted on by child externalising behavioural problems in the way that foster care rates are. It is suggested that this finding may be attributed to kin caregivers not accepting children with these problems into their care. Alternatively, McFadden (1998) argues that lower rates of mental health problems amongst children placed with kin caregivers may be because of the pre-existing emotional bonds of caregivers. The recent Swedish study of youth placements concurs, finding that kinship care is protective after controlling for background variables and arguing for *"a more positive attitude to kinship care especially if increased stability in teenage placement is an important goal"* (Sallnäs et al., 2004 p.150). The relationship between child behaviours, stability and duration of kinship care is insufficiently explored for children with mental health problems to make conclusions possible. It remains a significant care option however, warranting further research.

Looking after children with mental health problems who are in Child, Youth and Family care

There is very little information available about the mental health problems amongst children in Child, Youth and Family foster care as the research base is small. In Ward's (2000) study while only one third of those in care had an established diagnosis, 91% had received mental health services at some point while in care. In over one half of the group, placement breakdown was attributed to the inability of caregivers to manage behaviour. Yates (2001) also identified serious mental health problems amongst a small group of young people leaving Child, Youth and Family care.

In Calvert's (2000) review of 36 young people with mental health problems in Child, Youth and Family care there appeared to be few non-government organisations able to provide care services for this group. All groups involved commented that meeting child needs was not possible without additional funding. In line with overseas research described above, multiple placements were a key feature of the care histories of this group, with one young person experiencing 41 placements and only two having single placements. Multiple admission to residential care was attributed to failure to maintain placements which could meet the severity of the behavioural and psychological state of the children and young people. Calvert (2000) comments on the lack of fit between care plans of children and assessments, and the absence of behavioural strategies despite the need for these identified by clinicians (Calvert, 2000).

Impact on Child, Youth and Family caregivers looking after children with mental health problems

Child, Youth and Family identify that caregivers looking after children and young people are liable to experience problematic behaviours which threaten placement stability (Brown, 2000; Child, Youth and Family, 2002h). Calvert (2000) notes the complex health and safety issues for caregivers trying to manage serious behavioural challenges, particularly the use of restraint. Reviewing Child, Youth and Family care Ward (2000) concludes that *"the traditional response of caring for adolescents in private foster homes is presently failing to meet the special needs of an increasing number of damaged adolescents"* (T. Ward, 2000 p.23)

Not surprisingly foster care agencies in New Zealand are unconfident they can support foster families sufficiently to manage the care of children with difficult behaviours. New Zealand

foster caregivers testify to the stress in trying to manage difficult child behaviours (Barnardos New Zealand, 2000a, 2000b; Child, Youth and Family, 2002d; Open Home Foundation, 2000). Kin caregivers also record stress in managing child behaviours with insufficient training and casework support (Worrall, 2001). Suggestions to deal with this situation include development of professional foster care (Open Home Foundation, 2000) increasing use of residential care (Barnardos New Zealand, 2000a, 2000b) and inpatient options (Methodist Mission, 2000).

There has been no systematic attempt to examine caregiving by Maori non-government organisations (in particular those constituted within tribal structures known as Iwi Social Services) for children with mental health problems who are involved with Child, Youth and Family. Calvert (2000) in her review of intensive care packages for a group of children and young people with these problems however, refers positively to the capacity of one Iwi Social Service providing care for a child with significant mental health problems. As with other forms of kinship care, this remains an important area for further study.

The "job" of providing care for children with mental health problems

In order better to support and train caregivers to manage the specialist requirements of children with mental health problems attempts have been made in New Zealand to describe the components of this care. Calvert & Lightfoot (2002) provide an outline of a treatment package which includes use of an integrated support network centred on the primary paid caregivers with regular respite care, specialist treatment and support teams along with behaviour management, staff training and support.

The task of caring for a child with serious mental health problems for Child, Youth and Family has been further described within a job analysis framework by Sanft (2002). Job analysis is a methodology to determine knowledge, skills, abilities and other tasks (KSAOs) for a particular job (Brough & Smith, 2003). Sanft (2002) describes 14 categories which comprise the job of providing foster care for a child with a serious mental health problem.

The first five categories are considered either desirable at the onset of caregiving, or not trainable, due to time or cost. In this way job analysis indicates those categories which should be included in caregiver selection criteria. Sanft (2002) recommends that the KSAOs form the basis of interview schedules, reference checks and pre-training selection. A particular focus is needed on the fit between the applicant's personality and the inherent or non-trainable KSAOs identified. The utility of job analysis in recruitment of kin caregivers has not been discussed. Separate consideration of its appropriateness is warranted, as kin

caregivers are likely to regard their care as a continuation of parenting between generations rather than a job.

Table 2 Foster care job analysis from Sanft (2002) p.28

Rank	KSAOs Categories	Specification and Inclusions
1	Commitment to the programme	24 hour availability, commitment to philosophy
2	Self care	Self-management, personal relationships, stress management
3	Parenting skills	Positive parenting, modelling desirable behaviour
4	Personal qualities	Persistence, resilience, sense of humour
5	Change management	Ability to work with the child's ever-changing needs and to change own patterns of behaviour
6	Behaviour management	Ability to manage high arousal states, to set and maintain boundaries
7	Teamwork ability	Work as part of a team, challenge and be challenged
8	Monitoring and observation	Sensitivity to problems
9	Policy and procedure	Adherence to Child, Youth and Family policies on foster parenting and discipline
10	Decision making, co-ordination	Critical thinking, planning, prioritising
11	Child development	Attention to the child's human development and mental health
12	Communication	Written, verbal and listening skills
13	Literacy and numeracy	High school level english and mathematics
14	Understanding of relevant culture	Knowledge of child's culture and language to a level appropriate to child

Support to Child, Youth and Family caregivers looking after children with mental health problems

Foster care agencies have struggled to provide adequate levels of support, training and compensation to those managing children with difficult behaviours (Dore, 1999), as have post adoptive services (Groze, 1996; Plenty, 2003). Much of what is understood about effective support to caregivers looking after children with mental health problems, however, is derived from general research into foster caregivers' satisfaction and retention rather than specialised studies.

As described in chapter four Child, Youth and Family effort in respect of children with mental health problems has focused on access to mental health services rather than their care arrangements. While Child, Youth and Family has considered improvements to the support offered to caregivers this has been a general approach (Child, Youth and Family, 2001e, 2002c), which has not focused specifically on those looking after children with mental health problems. While these reports acknowledged difficulties in the present system of foster care, Child, Youth and Family opt for improving social work support and training through current arrangements rather than changing the voluntary basis of care or developing an intensive therapeutic model of foster care. Support for caregivers of children with mental health problems spans remuneration, social work support, training in behavioural management, clinical support and respite care. These are reviewed below.

Remuneration

Remuneration for caregivers varies markedly across jurisdictions and a full discussion of this is beyond the scope of this thesis. In some child welfare systems care remains on a voluntary basis with remuneration only by reimbursement, whereas in other places specialist carers are employees and receive salary in exchange for the provision of specialist care. For example, in Britain tiered systems of payment exist depending on the skills required (McCurry, 1999). Payment of foster carers has received considerable attention from researchers, with mixed findings about its effect on retention and recruitment (Kirton, 2001a, 2001b). For example, Barth (2001) comments on the downside of higher reimbursement in some of the specialist foster care models, whereby children in these arrangements appear to have longer lengths of stay than those in conventional foster care (Barth, 2001). Shortage of foster parents continues to be linked to inadequate remuneration for care of difficult children (Martin, 2004).

Remuneration and the presence of other forms of support to caregivers are intertwined. Caregivers wishing to renegotiate remuneration levels may be unable to get a response if they cannot access social workers to communicate their needs. Conversely, where caregivers experience intensive social work and other forms of support such as respite care, they may feel less need for increased remuneration. It is not surprising then that combined retention initiatives, which package increased levels of payment with additional support and training appear to have been more successful than single remuneration strategies (Chamberlain, Moreland, & Reid, 1992).

In Child, Youth and Family, caregivers are not employees of the organisation and are reimbursed rather than remunerated for their care (Child, Youth and Family, 2001e). This reimbursement is by way of a weekly board payment accompanied by a clothing grant and

the meeting of extra expenses such as medical costs. The derivation of the board rate is unknown. However, Child, Youth and Family acknowledge that anecdotal inquiry suggests the payments, even though adjustable, no longer meet the actual costs of caregiving (Child, Youth and Family, 2001e) nor allow retention of caregivers in a competitive environment (Child, Youth and Family, 2000e).

There is capacity within this board payment system to recognise the extra requirements of children with high needs, including mental health problems, through the payment of an enhanced weekly board rate (Child, Youth and Family, 2002h). The decision to make this increase lies between the social worker and the supervisor (Child, Youth and Family, 2002b). The failure of Child, Youth and Family always to provide reimbursement up to a standard rate has been identified (Child, Youth and Family, 2001a). This suggests that enhanced payments available to those caring for children with higher needs may not always be made, however, no analysis of this is available.

While caregivers in New Zealand are usually not employees there are a small number who are in effect paid a wage for providing care for some children with mental health problems. These arrangements are made primarily through the non-government sector under contract for one-to-one caregiving under the Youth Services Strategy (Ministry of Social Policy, 1999). Additionally some intensive care packages have also been established under the High and Complex Needs Strategy described in the previous chapter. Calvert & Lightfoot (2002) describe these arrangements which include remuneration commensurate with the requirements of the job.

Options for increasing financial support were discussed with Government in 2001 and 2002 (Child, Youth and Family, 2001e, 2002c). The negative effects anticipated in moving from a remuneration basis to salary, included caregivers incurring employee status, loss of benefit eligibility, increased tax obligations, and liability for occupational health and safety coverage (Child, Youth and Family, 2001e, 2002c). However, there was no discussion of whether children and young people with serious mental health problems required a different care response as is suggested by recent practice developments (Calvert & Lightfoot, 2002). Child, Youth and Family opted to retain the current reimbursement arrangements, develop initiatives to improve case management, review cases for discharge and improve contact with caregivers. The number of caregiver liaison social workers was increased to provide better support to caregivers and regionally based care specialists were employed to assist in the review of children in care (Child, Youth and Family, 2001e, 2002c).

Social work support

The role of social work support to caregivers is central to a thesis concerned with caregiving in a statutory child welfare context. The provision of foster care is stressful for many caregivers. In a longitudinal study of 980 foster carers two thirds had experienced a distressing event, with consequent damage to their health and willingness to foster (K. Wilson, Sinclair, & Gibbs, 2000). Support by social workers is a key part of helping caregivers to manage this stress and is particularly important for those caring for children with mental health problems.

Social work support has been usefully categorised into physical and emotional availability of a social worker, teamwork and respect, and help both practical and with the individual child (T. Fisher, Gibbs, Sinclair, & Wilson, 2000). For caregivers looking after children with mental health problems there are additional social work support requirements, covering the need to consult about medication, schooling problems, behavioural approaches and service issues (Calvert, 2000; Child, Youth and Family, 2002h). Child, Youth and Family guidelines suggest that caregivers looking after children with serious mental health problems will need extra support, such as team planning, crisis management and respite care (Child, Youth and Family, 2002h).

Maintenance of an honest and effective working relationship between social workers and caregivers is a significant source of satisfaction (Sellick, 1997) associated with an increase in caregiver retention across jurisdictions (Australian Foster Care Association, 2001b; Triseliotis et al., 1998, 1999). Caregivers seek recognition of their love from those in their care (Butler & Charles, 1999b). For caregivers of children with mental health problems, social workers rather than children may be a key source of this recognition.

The relationship between caregivers and social workers is also the means by which caregivers participate in decision making and access other support services. Triseliotis et al. (1998), Aldgate & Hawley (1986) and K. Wilson et al. (2000) suggest that receiving adequate information, support and being involved in decision making are all linked to foster care satisfaction and retention. In particular, involvement in service planning for children in care has been found to lift levels of satisfaction amongst foster carers (Sanchirico, Lau, Jablonka, & Russell, 1998).

Contact appears crucial to the quality and maintenance of the social worker /caregiver relationship. Even at a simple level telephone contact between a social worker and caregiver have been found to increase the likelihood of continued fostering (T. Fisher et al., 2000). In

the United States (United States General Accounting Office, 1989) satisfaction was also reported to be associated with the readiness with which caregivers felt that they could contact the social worker.

Problems in the social worker / caregiver relationship

While caregivers have been found to value their relationship with social workers many feel that social workers are inaccessible and that they are on their own in the caregiving role (Triseliotis et al., 1999). Caregivers feel unrecognised and, across jurisdictions, believe their contribution is disregarded (Cusack & Orr, 1999; Waterhouse, 1992). Difficulties include infrequency of social worker visits, insufficient levels of 24 hour support and respite care, lack of clarity about entitlement and payments and insufficient listening and support (Triseliotis et al., 1999). Foster caregivers regarded information and support provided by social workers as key, particularly in respect of family contact, yet this support is infrequently received (Pithouse et al., 2004; Waterhouse, 1992).

As described in chapter three, the relationship between caregivers and social care agency representatives is central to the definition of need and the negotiation of support. Reports are made of social workers redefining need in order to shape requirements to fit resource constraints. Peltola (2002) describes child welfare social workers as *"interpreting need according to the eligibility criteria for services, in other words workers looked backwards so they examined what they could provide then assessed need according to what they thought they could provide."* (Peltola, 2002 p.47). The same dynamic is reported in respect of support to kin carers (Doolan & Nixon, 2003a).

Social workers appear unclear about the potential of their support role. Triseliotis et al. (1998) found that social workers believed external factors, such as moving house or the need to work, were the motivations for caregivers in relinquishing care. They did not emphasise the factors that caregivers saw as important, in particular, the lack of social work support, attitudes and behaviours of social workers or the activities of the foster care agency.

Other factors may contribute to the deficiencies experienced by caregivers. Cusack & Orr (1999) suggest that caregivers may feel unrecognised because of the low value given by society to children whose parents are no longer able to support them. Alternatively, Denby Rindfleisch & Bean (1999) highlight conflict between caregiver goals and agency goals for example, reunification with birth parents. Others draw attention to the diverse ways in which caregivers are perceived by social care agencies and the lack of a policy framework for caregiving across social care agency settings (Twigg, 1989).

In New Zealand, while research is limited, poor levels of caregiver preparation and support have been established for both kin and non-kin caregivers providing care for Child, Youth and Family (A. Smith et al., 1999; Worrall, 2001). These researchers noted that there was a discrepancy between the needs of caregivers for support and social worker willingness to be highly involved in placements when these were stable and long term. Similar deficiencies in the relationships between caregivers and Child, Youth and Family social workers are reported by non-government organisations (Across: Te Kotahitanga O Te Wairua, 2000; Barnardos New Zealand, 2000a, 2000b; Open Home Foundation, 2000), by caregivers (Child, Youth and Family, 2002d) and acknowledged by Child, Youth and Family (Child, Youth and Family, 2000e). Key issues include the negative perception of foster caregivers attributed to social workers, poor planning and information, lack of financial support, delays in payments, lack of social work support due to heavy caseloads, poor training, and placement shortages particularly for children with mental health problems, behavioural problems or other special needs (Child, Youth and Family, 2000e).

Given that foster carers, despite all their frustrations, express positive feelings about social workers (T. Fisher et al., 2000) there is reason to believe that improvement in this relationship is possible. Establishment of effective dialogue between agency representatives and caregivers will be central to the negotiation of adequate support (Twigg & Atkin, 1995). Simple requirements for social workers such as showing an interest in carers, being easy to contact, and being responsive are likely to bring significant improvements. Social workers who carry out their stated actions, who are prepared to listen, encourage and take account of family needs can expect to deepen their relationships with caregivers (T. Fisher et al., 2000).

Alongside this Petrie & Wilson (1999) argue for organisational structures which promote closer links between foster carers and professional social work staff, rather than contractual relationships, which may promote competition between providers. However, others are pessimistic that traditional social work support has the capacity to deal with the complexity of care situations and team approaches treating caregivers and social workers equally, are advocated (McDonald, Burgess, & Smith, 2003).

Child, Youth and Family has recognised the centrality of social work support and anticipate that additional caregiver liaison positions and joint training ventures will increase support to caregivers (Child, Youth and Family, 2002c). For caregivers looking after children with mental health problems, however, it is unclear whether liaison positions can improve contact, teamwork and provide the level of advice about child behaviour and treatment that is required. Doolan & Nixon (2003a) raise a similar question about the separation of child

social work from caregiver social work in respect of kin care in Britain, advocating for a family social work role, which encompasses both roles.

Training and support in the management of child behavioural problems

Key to assisting caregivers looking after children with mental health problems is support in the management of difficult child behaviours. A developmental perspective suggest that most caregivers may need help to recognise that children require nurturing even when their behaviours suggest otherwise and to develop strategies for dealing with alienating or avoidant behaviours (Dozier, Higley, Albus, & Nutter, 2002). Foster carers looking after older children with mental health problems require training to understand children's needs, appropriate ways of managing behaviour and methods of coping with their own needs and those of other family members (Calvert & Lightfoot, 2002; Richardson & Joughin, 2000; Valios, 2002).

Caregivers seek practical help with the specific behaviours of individual children on a regular basis. Management of challenging behaviours is a complex task. It requires a comprehensive behavioural assessment in a stable, good quality environment, strategies which target behaviours and a focus on evaluating outcomes and redesigning strategies (A. Cox & Tregeagle, 1999). Training in behavioural management is identified as important to caregivers (Chamberlain et al., 1992) but often has less impact on subsequent child behaviours than anticipated. For example, while foster caregivers in Scotland felt training helped them to understand their children better and communicate with them, they were cautious about the effect of the training on child behaviours due to the influence of other factors (Minnis, Devine, & Pelosi, 1999) as were caregivers in Wales (Pithouse, Hill-Tout, & Lowe, 2002).

The Child, Youth and Family training guide provided to caregivers contains material on attachment and coping with difficult behaviours (Child, Youth and Family, 2003d) but in-depth assessment and development of behavioural strategies exists only in respect of a very small number of therapeutic packages, see for example Calvert & Lightfoot (2002). Calvert (2000) comments that while behavioural modification was a common recommendation: *"social workers reported that they did not know where or how to access information about such programmes nor could they access professionals to develop and manage programmes"* (Calvert, 2000 p.14). Additionally, caregivers are concerned that Child, Youth and Family social workers make decisions about specialist medical or treatment needs of children with little hands-on knowledge or experience of the child (Judith Morris, 2001).

Clinical Support

Caregivers looking after children with mental health problems require access to a range of clinical support services for their children. Calvert and Lightfoot (2002), describe these clinical services as encompassing advice from professionals on medication, behavioural strategies and assessment of new problems, along with more intensive services such as in-patient care. The clinical needs of children with mental health problems and histories of maltreatment are quite specific (De Bellis, 2001). However, Calvert (2000) comments that professional knowledge by some New Zealand clinicians is deficient in the area of developmental psychopathology, in particular in dealing with the impact of severe trauma and poor attachment and managing the difficult behaviours associated with emergent Axis 2 disorders.

Social workers across jurisdictions describe a common response from mental health services whereby placements are required to be stable before mental health services can be accessed. Caregivers then are having to agree to care for children with mental health problems before appropriate clinical assessment and support is available. This is documented in Britain (Mental Health Foundation, 2002a; Valios, 2002), in Australia (McHugh, 2002) and in New Zealand (Child, Youth and Family, 2003g; Cockburn, 2002). Particular difficulty accessing mental health services for kin based caregivers is also noted (Leslie, Landsverk, Horton et al., 2000). Scannapieco & Hegar (2002) point out that kin carers need to access mental health services at parallel rates to those of foster caregivers and some relative caregivers may also be in need of mental health services themselves.

Respite care

The importance of respite care to families caring for children with mental health problems is outlined in chapter three, along with its more established place in family support services for disabled children. Respite care is increasingly viewed as a valuable part of support to foster caregivers within child welfare systems in Britain (Aldgate, Bradley, & Hawley, 1996; Butler & Charles, 1999a) and in Australia (McHugh, 2002; J. O'Brien, 2001) and particularly for those with high needs (Community Services Commission, 2000; Tregeagle & Voigt, 1999).

Aldgate et al. (1996) describe the purpose of planned respite care within a welfare context. Here it is designed to alleviate the normal rigours of parenting, provide children with relief from stressful family life, help manage child behaviour and provide a link with families living in social isolation. It also offers an alternative to admission to full-time care, provides

relief for sick parents, prevents potential child abuse and builds parental self esteem. On this basis a more substantial investment in respite care is advocated within child welfare services (J. O'Brien, 2001) in order to help caregivers cope with the emotional drains of fostering (Butler & Charles, 1999a).

Foster families looking after children with mental health problems and behavioural problems, however, may have considerable ambivalence about using respite care. Plenty (2003) reports that the informal support required for caregivers is often not sought or is not available because of the child's behavioural problems. Amongst the group of adoptive British families only 18% used respite care and only 30% had considered its use. Reluctance was based on a concern that respite care may exacerbate the rejection and insecurity that is already part of a child's history (Plenty, 2003).

Social workers can offer respite care and assist caregivers to reflect on their needs and their strengths in respect of the child they are caring for (Aldgate et al., 1996). Social workers are significant in achieving successful uptake of respite care. As Jenny Morris (2003) quotes from Jane Westacott, a Barnardos social worker: *"if you build in respite you don't get the downward spiral of people getting negative and tired and punitive towards the child. It helps keep them above that line"* (Jenny Morris, 2003 p.43).

There are no comparative data available in New Zealand about the provision of respite care to caregivers in Child, Youth and Family although gaps in respite are noted (Child, Youth and Family, 2001c; P. M. Wells & Smith, 2000). Research from 1999 showed that counselling and therapy were the predominant services being provided to children with mental health problems and home-based support and respite care was minimal (P. M. Wells & Smith, 2000). In 2001 and 2002 Child, Youth and Family reported the possibility of providing regular respite care for caregivers with very demanding children and those providing long term care, but improvements to respite care were not included in subsequent recommendations (Child, Youth and Family, 2001e, 2002c).

Caregivers own support networks

A family strengths perspective suggests the resources and networks of caregiving families will be a crucial part of the support systems of caregivers although very little research has addressed this in a foster caregiving context. In Australia foster caregivers report that they derive most of their support from families and friends rather than official sources (Australian Foster Care Association, 2001b). In New Zealand in the light of the poor support from Child, Youth and Family personal support from family, friends and informal agencies is noted as

important to caregivers (A. Smith et al., 1999). For kin caregivers personal networks, self help groups and organisations are a significant source of this support as are religious groups (Waldrop & Weber, 2001). The importance of spirituality as a source of personal support for both kin and non kin caregivers alike is noted by a number of researchers (M. E. Cox et al., 2003; 1999; Reilly & Platz, 2003).

Practice models for social work support which respect and reinforce the informal networks of caregivers are not easily found. Incorporating informal support to caregivers, Wain's (1999) concept of the caring team, places the foster family's own extended family, friends and neighbourhoods alongside the birth family and the social worker. While the network is not automatically assumed to provide support, the model suggests there will be individuals with this potential. Realising this support requires adequate recognition, imagination, attention and work (Campbell, 1999). The importance of creating an environment for dialogue, expression of need and negotiation of working relationships is emphasised by researchers interested in strengthening informal networks of caregivers (Campbell, 1999; Wain, 1999). Consideration of the personal networks are discussed as an important part of the selection and provision of ongoing support to caregivers (Campbell, 1999).

Support to kinship carers

Support to kinship caregivers requires specific consideration in respect of the care of children with mental health problems, who may demand high input to manage difficult behaviours. Kinship carers, as second generation parents, take on a more full time role which requires different skills, resources and energy (Pecora et al., 1999). While deficits in support to foster caregivers have been outlined above, research suggests that kinship carers are even less well supported than foster carers (Berrick et al., 1994; Gebel, 1996; Scannapieco & Hegar, 1997), despite having poorer health and income status (Gordon et al., 2003). Kin caregivers are likely to receive less training, respite care and are more likely to link with others in support groups (McFadden, 1998). Support is provided to kin based carers by other family members (Doolan & Nixon, 2003a) however, this leaves unmet needs for respite care, therapy and financial support (Scannapieco & Hegar, 2002). Other studies have documented low levels of agency monitoring of kinship care placements in the United States (Gebel, 1996; Iglehart, 1994). In Britain similar support disparities are noted (Doolan & Nixon, 2003a; Sykes, Sinclair, Gibbs, & Wilson, 2002), as they are in Australia (L. Gibbons & Mason, 2003).

Although research is limited, the small number of studies conducted has commented on the lack of support by Child, Youth and Family to kin caregivers (Brudenell & Savage, 2000; A.

Smith et al., 1999; Worrall, 2001). Poor levels of support for kin carers are also described by non-government organisations (Barnardos New Zealand, 2000a, 2000b; Open Home Foundation, 2000). In particular, the training, assessment and support given to whanau placements has been viewed as "not adequate" (Brown, 2000). In a survey of grandparents providing care in New Zealand, 25% received no reimbursement. Only 50 % reported that Child, Youth and Family were actively involved with them, although another 25% had some previous contact. Twenty five percent had never had a social worker involved (Grandparents Raising Grandchildren, 2000). Consistent with foster caregivers, kin caregivers describe poor responses to messages they left for social workers, lack of teamwork, over-use of powers such as the police, and a level of disrespect and disregard once children were placed (Worrall, 2001). New Zealand kin carers also report a lack of practical help, insufficiency of information about financial help, inadequate strategies to manage traumatised behaviour and a lack of respite care (Grandparents Raising Grandchildren, 2000).

Many kinship carers do not initially expect to provide long term care so are surprised at the level of intrusion which agency involvement can bring. Building supportive relationships with social workers may, as a consequence, be more difficult for kin than foster carers (Cimmarusti, 1999). In particular kin caregivers are reported to find assessment and approval processes daunting and out of proportion to the attention paid to their support when they assume care (Doolan & Nixon, 2003a). Voigt (2001) argues for a new and creative approach to supporting kin caregivers, which is different in kind from the current arrangements for foster placements. Child, Youth and Family agree that the existing support processes in place for caregivers may not be appropriate for kinship caregivers and indicate consultation is needed to develop *"a distinct policy framework for kinship care that will address assessment, support and training issues"* (Matheson, 2003 p.28).

New approaches to providing care for children with mental health problems

The pressure on foster care and the inter-relationship between severe problem behaviours and placement breakdown described above have led researchers overseas (J. G. Barber et al., 2001; Community Services Commission, 2000; A. Cooper, 2000) and in New Zealand (T. Ward, 2000) to question whether traditional foster care is effective for young people with severe mental health problems who are first placed at an older age. The viability of reunification or adoption as outcomes for this group of young people has also been questioned (Kerman, Wildfire, & Barth, 2002).

A range of specialist care services has been identified as necessary to cope with the needs of children with serious mental health problems. In the United States some of these specialist

services are described within the systems of care model, discussed in chapter three. In Britain an appropriate range of services is also called for and key gaps in residential care have been identified as a barrier to the development of more effective responses to this group (Mental Health Foundation, 2002a; Richardson & Joughin, 2000). In Australia work to establish options for young people with serious emotional and behavioural disturbances, coupled with maltreatment histories, concluded that a specialist cross programme response was required including intensive care placements (Ainsworth, 2003; Morton et al., 1999). These analyses concur that a spectrum of care options is needed which includes sufficient residential placements available to social workers looking to place children with serious mental health problems (Community Services Commission, 2000; A. Cooper, 2000; Morton et al., 1999).

Therapeutic foster care

In this context many jurisdictions have opted to develop specialist treatment foster care as an alternative to residential care. This involves specialised recruitment and training, increased remuneration and intensified support to meet the extra demands of therapeutic care for children and young people with mental health problems (Pecora et al., 2000). In the United States provision of specialist foster care, often known as therapeutic foster care is viewed as a key component in systems of care (Jivanjee, 1999b). Although therapeutic foster care is not a formal care option provided by Child, Youth and Family, its importance to the care of children with mental health problems overseas warrants a brief discussion here.

Therapeutic foster care is provided in a family-like setting by caregivers who have a family caregiving role and who also provide therapeutic interventions with the child and family (Stroul, 1989). Key features are assessment, individualised nature of care (normally only one child is placed), high levels of training and remuneration of caregivers, with intensive supervision and support of their work. There is frequent contact between the case managers and caregivers and usually extra clinical support services are available in the form of intensive behavioural specialists and counsellors (Kutash & Rivera, 1996). Some therapeutic foster care programmes emphasise involvement with birth family members; however, difficulty in finding effective approaches to include families has also been reported (Jivanjee, 1999a; Stroul, 1989). Parents participating in this form of care commonly have multiple difficulties of their own relating to mental illness, substance abuse, histories of abuse, neglect and poverty, and may require support to engage in decision making (Jivanjee, 1999a).

There have been a number of studies looking at the efficacy of therapeutic foster care. Conclusions are difficult to reach however, because of the variation in programme designs, implementation (Kutash & Rivera, 1996) and measurement issues (James & Meezan, 2002). Four studies available show that young people in therapeutic foster care made significant gains in self-esteem and adjustment and had reduced levels of aggressive behaviour, sustained over time (US Surgeon General on Mental Health, 2000). Using results of programme evaluation, Kutash & Rivera (1996) conclude that 60% to 90% of young people leaving therapeutic foster care placements go to less restrictive settings for substantial amounts of time.

In New Zealand, while therapeutic foster care has not been formally developed a partial move towards more specialist fostering for children with behavioural problems was included as part of the Youth Services Strategy in 1999 (Ministry of Social Policy, 1999). The support and remuneration offered to caregivers within this strategy (Child, Youth and Family, 1999c), while going some way towards a therapeutic care model, falls short in key aspects, such as therapeutic training, clinical support and the level of supervision for caregivers. Calvert and Lightfoot (2002) also describe care arrangements within the HCN strategy for children with severe mental health problems, which more closely follow a therapeutic foster care model. These key practice developments suggest that therapeutic foster care may eventually become a Child, Youth and Family care option in the future.

Conclusion

Many families in New Zealand face the long term challenges of providing care for a child with mental health problems. Service deficits in New Zealand and additional stresses for some families mean that Child, Youth and Family care for many of these children. However, children and young people with serious mental health problems, particularly those placed at a later age, remain at significant risk when in care of child welfare systems.

From a developmental perspective substitute care offers opportunities to develop attachment, rebuild self-esteem and ultimately foster resilience. Children with severe problems, however, have behaviours, which significantly challenge caregivers. Consequent placement instability and associated negative experiences, such as school failure, are common for this group. This experience in turn exacerbates already established problems, further threatening development.

Research into the effective support to caregivers looking after children with mental health problems in a child welfare context has been limited. Conclusions about support have been

generalised from studies across the total caregiver population despite a well established relationship between child mental health problems, management of behaviour, caregiver satisfaction and placement breakdown. It is known from these studies that the relationship between social workers and caregivers, in particular the communication of respect, provision of ongoing contact and support and involvement in planning, are crucial to caregiver retention. For caregivers looking after children with mental health problems ready access to social workers in order to negotiate practical support and clinical advice is also important in order to manage child behaviour and minimise the impact on families. A critical aspect of support is the provision of respite care, although caregivers may be reticent about seeking this help, because of disruptive behaviours of children.

Children with mental health problems are identified as a vulnerable group by Child, Youth and Family (Child, Youth and Family, 2002a) but strategies have focused on lifting access to mental health services and improving interagency relationships rather than on supporting caregivers. More general efforts to improve the support to caregivers have not been directed at the specific needs of those who look after children with mental health problems. Further research is needed to determine effective support to caregivers looking after children with mental health problems in a child welfare context and the relationship this support has to child outcomes. This research project begins to address this deficit in respect of this group in Child, Youth and Family care. The beginning point of this work lies in clarifying the care outcomes sought for this group, which is discussed in the next chapter.

Chapter Six

Measuring Outcomes for Children and Young People in Care of Child, Youth and Family

Introduction

In this chapter approaches to the measurement of outcomes amongst children and young people with mental health problems in the care of child welfare systems are considered. Outcome measurement across child welfare jurisdictions is described first, outlining some of the key measurement issues. The domains commonly used to measure outcomes for children in care are reviewed briefly, with reference to outcomes defined within systems of care models. Finally, the state of outcome specification in Child, Youth and Family is discussed as part of an assessment of the current outcome data available to this research. The chapter concludes with an outline of the gaps in information which face researchers assessing outcomes for children and young people with mental health problems in Child, Youth and Family care.

Development of child welfare outcomes

What are outcomes?

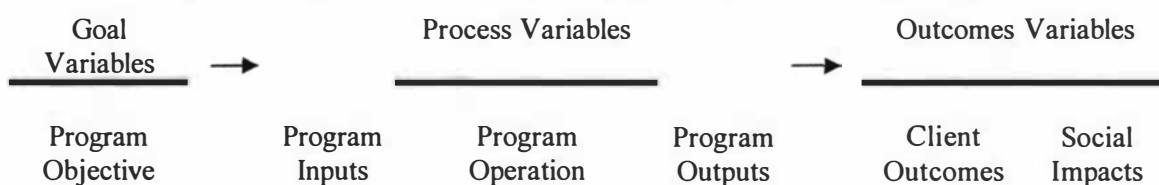
Concern about the outcomes of child welfare services is part of a general effort to describe results for those subject to welfare interventions. A flow underlines most outcome models, whereby inputs leads to processes, which lead to outputs and then to outcomes. Tilbury (2002) defines these key parts of the model as follows:

- *Inputs – resources required to provide a service such as funds and staff*
 - *Processes – the way in which a service is delivered, involving some measure of quality*
 - *Outputs – services or activities, the tangible products of an agency*
 - *Outcomes – the impact, benefit or results of the service for individuals or society*
- (Tilbury, 2002 p.137)

While these components are often identifiable in an industrial context, such as manufacturing, in a child welfare environment some components of the model are less easy

to discern. Magura & Moses (1986) assist by specifying the flow of inputs to outcomes within a child welfare system.

Figure 1 Program evaluation model (from Magura & Moses 1986)



Child welfare context

Concerns about outcome measurement preoccupy child welfare organisations internationally (Gain & Young, 1998) and some argue that for practising social workers, outcomes have always held an interest (J. Gibbons, 2001; Wood, 1978). Early research raised questions about whether casework services in a statutory context actually worked (Fischer, 1973; Gough, 1993). Attention to outcomes has continued to grow in response to pressures on child welfare services such as rising demand, renotification rates, cost imperatives and dissatisfaction with remedial interventions as described in chapter four.

Tilbury (2002) reviews motivation for the development of outcome measurement across child welfare jurisdictions. In the United States, legislative and contracting imperatives were important along with restricted budgets and increased accountability. Additionally, the perception of failure to achieve permanency led to discussions about effectiveness. In Britain, public attention has been paid to social work decision making and interventions, with a focus on the capacity of child welfare systems to make improvements in the situations of children and families. Finally, in Australia, budgeting, contracting and concerns to improve effectiveness, increased the focus on outcome measurement (Tilbury, 2002).

Growing understanding of the multiple and interactive nature of child risk and protective factors, as outlined in chapter two, has lead to an appreciation of the complexity of the circumstances in which social workers plan. Key practice dilemmas have fed the debate on outcomes, for example whether children should be protected by interventions aimed at out of family care and ultimately family reconstitution or whether in-family care solutions are preferred (Parker, Ward, Jackson, Aldgate, & Wedge, 1991). High profile cases of child deaths both in New Zealand and overseas have intensified these debates.

Benefits of outcome measurement

Outcome information can be used throughout different levels of the child welfare system. In the first instance, users, that is children, young people, their caregivers and wider families have interest in the predicted and actual effects of what are significant interventions into their lives. Social workers' interest in outcome measurement is also high. Those wanting to assess the effectiveness of their practice and learn from their experiences require ongoing information about the impact of their actions (Schene, 1999). Outcome measurement can also reinforce supervision, ensuring accountability by linking outcomes to social work activity. Given the complexity and difficulty of statutory social work practice, outcome information can enrich the spirit and maintain optimism of social workers (Parker et al., 1991).

At an organisational level, outcome measurement requires consistent information collation, allowing cross-case comparison and decision making about efficiency and effectiveness of services (Schene, 1999). Outcome data can provide social work managers with an evidence base to target resources when demand outstrips these (Potter, 1999). Rising scrutiny of individual case decision making in response to public inquiries also means that social workers require outcome information to strengthen intervention planning processes, particularly where there is cross-sector collaboration.

Development of outcome measurement

Despite consensus about the benefits of measuring outcomes, agreement on measurement approaches has been hard to obtain across child welfare jurisdictions (Gain & Young, 1998; Magura & Moses, 1986). In the United States, there has been considerable independent work by a large number of states, along with collaborative work, to develop common outcome measures for child welfare systems (American Humane Association Children's Division et al., 1998). There is agreement on the goals of improving safety, achieving permanence, enhancing children's emotional and behavioural well-being and lifting parenting skills (Gain & Young, 1998). Progress to develop measures is slow however, and while 23 states have identified specific outcomes, only 12 were reported as having developed measures for these (S. J. Wells & Johnson, 2001).

In Britain, an outcomes framework known as Looking After Children has been developed for children in statutory care (Parker et al., 1991). Using assessment and action records, this framework focuses on outcome measurement as a direct means to influence practice. It moves away from continuity of placement as the sole outcome measure and includes, as

outcomes, similar expectations that exist for children growing up in all families. Seven dimensions are identified. These are health, education, emotional development and behaviour, social, family and peer relationships, self-care and competence, identity and social presentation. These domains are interactive, and all children need to develop continually along all these dimensions to achieve long term well-being in adulthood. No weighting is provided to indicate the relative importance of the domains, although there is discussion of the potential to develop this (Parker et al., 1991).

In Australia, the Commonwealth Government recently undertook an international review of child welfare outcomes, identifying a set of preferred measures for child protection and supported placement interventions. In recognition of the poor state of measurement development, implementation of national reporting against outcomes in Australia was seen as premature. Some preliminary measures were identified and future exploration of overseas work was recommended, particularly the Looking After Children approach (Gain & Young, 1998).

Measurement issues

Conclusions about the effectiveness of social work interventions will always be limited by the complexities inherent in child welfare practice. The theoretical problems in establishing causal links between interventions and child welfare outcomes are fundamental (Parker et al., 1991). Social workers have little control over many circumstances, which contribute to child problems, and multiple, intervening factors confound efforts to make direct links between interventions and outcomes (Gain & Young, 1998). Perverse effects are likely; for example, the hazard of recurrence of abuse post case-closure increases with agency follow-up, as re-substantiation of abuse is more likely to be detected and recorded in post intervention services (Tilbury, 2003)

Clear distinction between outcomes and outputs is also required in robust outcome measurement systems (Parry, 2000). However, in child welfare systems, services, goods or processes are often confused with their impact or consequence (Huxley, 1994; Parker et al., 1991). For example, a family group conference within the New Zealand child welfare context can be mistaken for an outcome rather than an output or process contributing towards outcomes such as improved family functioning or child well-being.

Establishing appropriate levels of outcome measurement and linking these levels has been a concern. Confusion can arise because outcomes are discussed at a range of levels including individual client plans, corporate performance and public or social goals (Parker et al.,

1991). Specific levels are emphasised within different outcome systems. For example, child development against individual case plans is central to Looking After Children in the United Kingdom, whereas in New Zealand corporate performance reporting has been integral to preliminary outcome design (Child, Youth and Family, 2000b). Thus volume and timeliness measures have dominated early measurement in Child, Youth and Family.

Interdependence is expected whereby outcomes in one domain can be shown to have consequences for outcomes in another area. The Looking After Children framework, for example, acknowledges that the seven outcome domains will interact with one another (Parker et al., 1991). Further, many children and young people and their families receive multi-systemic services and outcome measurement needs to operate across different agencies and sectors (Schene, 1999). For example, measurement of child well-being draws heavily on the need for clinical data from mental health services (both adult and child services). Unfortunately, for many child welfare jurisdictions, poor cross-sector relationships mean these data are unavailable (S. J. Wells & Johnson, 2001).

Within child welfare organisations, the capacity of information systems to provide adequate data for outcome measurement is compromised. Missing data, inaccuracy and poorly defined measures are commonly encountered (Gain & Young, 1998). Consequently, many jurisdictions have begun by using case history data whilst information system improvements are made and measurement options are increased (Parker et al., 1991).

Despite these developments, social workers have felt under served by outcome measurement. In particular aggregated data provided to social workers are unhelpful and information about individual cases needs to be available (Lyle, 1997; Sladen, 1997). In response, some jurisdictions have attempted to design outcome measures which directly address the questions that social workers wish to answer (R. S. Kirk, 1993; J. Nelson & Sladen, 1993). For example, the Looking After Children framework is intended to operate as an extension of everyday case planning (Gain & Young, 1998). While this system was developed with casework considerations uppermost, it also has the potential to aggregate data where necessary and comparative analysis is possible (Parker et al., 1991).

Measurement approaches

In the face of substantial measurement complexity it is not surprising that there is debate in the child welfare literature as to the optimum approach. Within this discussion Magura & Moses (1986) usefully distinguish between case status (case history) and client status outcome variables. Case status variables measure change in the stage or phase of a case. In

contrast client status variables are defined as changes in client (child or parent's) behaviour, knowledge or resources including changes in functioning. Case status variables are often referred to as proxy variables as they substitute for client status variables when other measures cannot be readily developed. Case status variables commonly used are rates of foster care placement change, discharge from care or adoption. As Magura & Moses (1986) warn, while case status measures are useful they are only indicative of system change, or:

a transformation in the way clients are being serviced by the child welfare system. One must be careful not to conclude however, that changes in such performance indicators necessarily connote changes in client situations (Magura & Moses, 1986 p.6).

J. G. Barber & Scott (1996) outline four approaches to measuring child welfare outcomes and identify the probable error associated with each one. These are: client self report, key informant report, observation and inference from known facts, events or case history data. Self report, involves asking the individuals concerned about their feelings and behaviours whereas observation involves direct examination or study. Key informants are those people in positions of knowledge who act as sources of measurement. In respect of known events, inference is based on the case history events, which are used as proxies for measuring feelings or behaviour in the manner of case status variables. In order to deal with error, Barber and Scott recommend incorporating all measurement options into an outcomes framework (J. G. Barber & Scott, 1996).

Such multiple sources of measurement have wide support in the child welfare outcomes literature. Magura & Moses (1986), Kolko (1998) and McCroskey (1997) recommend triangulated measurement of the same indicator and advocate the use of independent assessment by clients and workers. Agreement also exists across jurisdictions about the interim use of case event data sources as proxy measures, while improvements in other measurement options are made (Gain & Young, 1998).

The timing of outcome measurement is also important. Longitudinal designs are preferred over cross sectional studies, as they offer an overview of a child's intervention history, sequence of experience and can search for risk and resilience variables (Parker et al., 1991). Appropriate points to measure are needed across the intervention continuum, spanning notification, assessment, intervention, discharge and post discharge. The poles of this continuum are often controversial. Durie (2001) for example, in discussing Maori health outcomes identifies five "clinical endpoints", arguing that even assessment, not normally considered an intervention in itself, can be considered therapeutic. Although outcome measurement in a child welfare context is usually concentrated on the period of intervention,

others argue that accurate assessment of quality of life requires post intervention measurement (S. J. Wells & Johnson, 2001).

The debate about timing is often referred to in terms of proximal and distal measurement, although both conceptual and temporal distinctions between these two poles can be found in the literature. As Gain & Young (1998) explain, proximal measures include those indicators close in time to the intervention along with measures which are closely linked conceptually, for example family functioning measurement is proximal to the outcome of programmes designed to improve family functioning. Distal measures are those more distant in time (for example, post-discharge measurement) or less immediately linked conceptually. For example, out of home placement rates as a measure of outcomes of a family support programme. Others describe choices about timing in terms of the merits of summative evaluation (focused on a fixed question about effectiveness using aggregated results) and formative evaluation (continuous, designed to influence practice) (Patton, 2002). The Looking After Children framework was designed as a formative system offering social workers information about outcomes to feed into their practice (Parker et al., 1991).

The use of standardised measurement tools, of which scales, checklist and inventories are common, is also widely discussed (Gain & Young, 1998). Standardised measurement is viewed by many as essential to the comparison of outcome data (Magura & Moses, 1986; Rapp & Poertner, 1987) and a wide range of tools have been developed to measure outcomes such as family functioning and child well-being. In the United States, for example, the use of standardised systems based on the principles of psychometric measurement is widespread, enabling direct client comparisons (Huxley, 1994). This approach is less common in other parts of the world, such as New Zealand and Australia.

Criticism of the use of standardised tools is multifaceted. Some argue that they over-simplify complex phenomena and there are methodological problems to overcome such as validity and reliability (Parker et al., 1991). Scales can be viewed as time-consuming, alienating to clients and difficult to administer skilfully, their results require interpretation and they are insufficiently endorsed by social work practitioners (Kuechler, Velasquez, & White, 1988). Measurement questions have been raised about standardised scoring approaches, for example the extent to which scales have been normed for a child welfare population (Parker et al., 1991). Items of different degrees are sometimes summated without weightings, for example within the INCADEX instrument, a checklist of 134 items indicating abuse and neglect are scored as present or absent where seriousness ranges from skin damage to dismemberment or brain damage. *"One must conclude that total, un-weighted composite scores for such items*

are not useful either for one-time case assessment or for measuring case change" (Magura & Moses, 1986 p.18).

Despite the concerns above, standardised measures are common. A modified version of a scale for measuring emotional and behavioural problems can be found in the Looking After Children framework, although it relies on subjective judgement of a social worker. On this basis, Gain & Young (1998) anticipate that standardised measurement will be a likely feature of future outcome development outside United States child welfare systems.

Multiple criteria and composite criteria

Multiple criteria are accepted when there is not likely to be a single best criterion for a construct, given its multi-dimensionality (Blum & Naylor, 1968; M. Smith & Brough, 2003). There are warnings about perverse incentives on social work practice, which results from single outcome designs (Kimmich, 1993). For example the focus on permanency as an outcome may have been at the expense of a focus on child well-being (Gilligan, 1997). Tilbury (2003) agrees, suggesting that outcome reporting can make some areas of work important and others invisible such as family support. On this basis she argues for increased use of case history data to reduce the marginalisation of family support in child protection.

As no single criterion has been found to determine success for a child or young person receiving either child protection or placement services, research supports the use of multiple criteria (Berlin, 1992; M. Fraser, 1990; McCroskey, 1997). However, outcome measures reported in this way are unsatisfactory to social work practitioners making decisions as they disaggregate the experience of child, into domains such as placement stability or length of time in care (Gain & Young, 1998) and do not indicate how these domains are to be combined when making decisions.

It is possible to aggregate criteria into a composite criterion, a global entity composed of several outcome criteria. Although the Looking After Children framework opted to take forward a set of multiple rather than a composite outcome criterion the authors concede "*it could be argued that weighting simply makes explicit and open an unavoidable process that goes on all the time*" (Parker et al., 1991 p.45).

For social work practitioners there is some utility in obtaining not only multiple outcome data such as placement stability or child safety but composite scores as well, which incorporate all domains considered integral to assessment of outcomes or decision making. This summary data has utility during case planning when an overall assessment of progress

is needed, such as when discharge is contemplated or when considering the overall effect of social work intervention. A composite criterion is also used to assist social workers in making broad client comparisons. Finally, a composite criterion can deal with some of the objections social workers have made in respect of the disaggregated, depersonalising nature of outcome measurement, tending towards the more holistic measurement, which they seek (H. Ward, 1995).

Social workers are continuously obliged to trade off possible and actual achievement, at some stage somebody has to make decisions about the relative importance of different domains. If this is done within the outcomes assessment process it has the advantage of being explicit but it also acquires a finality which may be unhelpful (Parker et al., 1991 p.45).

In other disciplines both multiple and composite approaches are recognised as valid *"The arguments about composite versus multiple criteria are usually presented as if one form of criterion information excludes the other and this is by no means the case"* (Landy, 1989 p.21).

Interestingly, Child, Youth and Family identifies the construction of a composite index, using a wide range of variables, as a goal of outcome development in the organisation (Child, Youth and Family, 2002f) but does not specify the rationale for such a composite nor how this will be achieved.

Progress in measuring outcomes across child welfare jurisdictions

Integration of outcome measurement into child welfare practice has been slower than the development of agreement about outcomes. International experience indicates that data limitations, measurement issues, lack of effective service models, intervening variables in the lives of children and poor links to practice, undermine the apparent benefits of outcome measurement (Schene, 1999). Many child welfare jurisdictions have found that while outcomes can be articulated and in some areas measured, it is another step to reorganise service delivery around these outcomes. Child welfare practice in some countries is still procedurally driven, rarely linking services to measurable objectives in casework plans that are, in turn, linked to agreed outcome domains (Schene, 1999). Barratt (2003) has reported poor mechanisms for dissemination, implementation and adoption of findings in social work, which may, in part, explain the slow integration of outcome measurement into practice.

The absence of supervisory use of outcome measurement in social work is another contributing problem. While outcome measurement has progressed, few examples exist of this data being regularly used by field social workers and their supervisors (T. D. Moore, Rapp, & Roberts, 2000). Reviewing the small body of literature, it is suggested that reasons for poor utilisation of data include, organisational cultures which do not reinforce the importance of outcomes, data overload and skill deficits in managers to interpret data and take action (T. D. Moore et al., 2000).

Outcome measurement is further undermined by the lack of availability of effective interventions. Resource constraints within child welfare systems has meant that while goals can be specified there rarely are the resources available to apply services of sufficient intensity to secure positive outcomes (Schene, 1999). Achievement, for example in family well-being domains, relies on the application of highly skilled and intensive early intervention programmes, which are undeveloped or simply not accessible in many jurisdictions.

Common outcome domains used in child welfare services

Despite the methodological difficulties described above, it is possible to identify a common set of outcome measures that have evolved, although the Looking After Children framework remains distinct. In their comprehensive review of child welfare outcome literature Gain & Young (1998) identify safety, permanency, child well-being, family well-being and consumer satisfaction as agreed outcome measures operational in many child welfare systems. For the purposes of this research, these outcomes form a core set from which to consider the measurement of outcomes for children with mental health problems in Child, Youth and Family care.

An extensive discussion of the debate around measurement options for these domains is not included here but can be found in Gain & Young (1998). An extensive table compiled by Gain & Young (1998), in which outcomes for child protection and placement services are presented separately, appears in the appendix of this thesis. These domains are summarised in an abbreviated table below and discussed briefly in the following section.

Table 3 Abbreviated table adapted from Gain & Young 1998 (see Appendix 2 for full table)

Domain Name	Outcome	Measure
Safety	The child will be safe from physical, sexual, emotional abuse or neglect	Ratio of children investigated for abuse to number reported at risk Number of subsequent confirmed abuse or neglect cases in out of home placements
	The child will remain safe from any future harm	Recurrence of abuse or neglect, recidivism after case is closed
Permanence and Stability	The child will have a permanent home	Number of confirmed child protection cases where children remain in own home with or without further support
	The child will have continuity of care	Number of different people who have acted as the child's main carer since s/he was a baby
	Length of time in a non-permanent placement will be minimised	Length of time for child in out-of-home care to achieve permanency
Child Well-Being	The child's well-being will improve or be maintained	The child is normally well and thriving Immunisation rates, medical and dental examination rates
	The child is receiving the level of care that would be provided by a reasonable parent	Amount of time attending school, school performance and educational progress Contacts with his or her birth family
		The child or young person is free of emotional or behavioural problems
Family Well-being	Improve or maintain functioning of caregivers and families	Improved application of parenting skills appropriate to child's level of development Improved parental ability to access and use formal and informal community resources
	Parent/child relationships will improve	Number of days the child is in out-of-home placements during family preservation services Increase in number of families providing regular contact
Consumer Satisfaction	Users of services will be satisfied with services received	Increase in families expressing satisfaction with services while case is open

Safety

Child protection services attempt to prevent the further abuse and neglect of a child or young person. Safety is the outcome domain used to measure the degree to which children are protected from immediate abuse and neglect in their own homes and are safe from further maltreatment (Gain & Young, 1998). Common measures include rates of substantiated maltreatment, for children with active or open case status, and recurrence of maltreatment amongst children who have been discharged or have returned home. Tilbury (2003) usefully distinguishes between renotification and re-substantiation measures in respect of the measurement of safety. Some jurisdictions also describe the measurement of reduction in risk factors for future harm, for example improvement in levels of parental supervision (Magura & Moses, 1986).

The weakness of renotification of substantiated maltreatment, as a measure of the domain of safety, has been noted in a number of places (J. G. Barber & Scott, 1996; Gough, 1993; B. Walker, 1998). In particular there is concern that not all cases of abuse or neglect are reported or substantiated and incidents reported can inappropriately include different abuse types. Even in circumstances where recurrence measures are restricted to those repeat instances of the same abuse or neglect type, lower levels of seriousness can indicate improvement rather than deterioration in a child's situation.

Permanency and stability

Permanency as described in chapter five has at its core the concept of attachment and the desirability of constituting a permanent placement for a child or young person placed either outside their own family network, within their kin network or by reunification within the family of origin. In New Zealand, as in other jurisdictions, there is a focus on achieving permanency in a timely manner, in particular limiting the time that the state is an intermediary between a family and a child to the minimum necessary to achieve change (Child, Youth and Family, 2002b). Where reunification of care is not possible within the family network, the same imperatives apply to reconstituting a new set of caregivers, who will commit to providing a permanent home for a child.

Permanency has three dimensions; support provided to enable a child to remain at home, the period of substitute care and the reunification or reconstitution of a permanent home. Measures of permanency include all three dimensions (Gain & Young, 1998). Some jurisdictions also include in permanency quality indicators about the nature of the

placements, encompassing cultural appropriateness and safety (McDaniel & Thielman, 1997). The level of restrictiveness of a placement is also viewed as a short-term measure available to consider the outcome of permanency (Gain & Young, 1998). This measure is an indicator of the degree of social inclusion that an individual child is able to experience during placement. The most obvious constraint on social inclusion occurs in care arrangements which restrict freedom, such as residences or group homes, and where the opportunity to mix with a range of peers is limited.

As discussed in chapter five, a developmental approach emphasises the capacity of new caregivers to realign attachment behaviours in children and contribute to rebuilding self-esteem. In most jurisdictions permanency includes measurement of the stability of care, in order to assess opportunities offered to children in care to develop constructive relationships with caregivers. Stability or continuity of care is often measured by the number of people who have acted as the child's main carer since entering care (Berlin, 1992; H. Ward, 1995). The length of time with caregivers, and placement counts, are also used in the measurement of stability but attention is needed to ensure that these measures do not inappropriately capture planned moves such as respite care and periods of home return.

Permanency, as an outcome, has been the subject of some controversy, particularly for older children with high needs, such as children with mental health problems, as described in chapter five. Gilligan (1997), for example, suggests that using this outcome has encouraged a process of moving to a permanent placement prematurely and resolving a care situation in the favour of foster parents when it may have been possible to continue working towards reunification with birth families. This makes the measurement of re-entry to care post permanency an important part of the measurement of permanency although agency recording deficiencies can make this difficult (Gain & Young, 1998). Others have questioned how often permanency is attainable and challenged its central place as an outcome for policy and practice with some young people (J. G. Barber et al., 2001; Courtney & Barth, 1996).

Relationships beyond primary attachment also require attention, as described in the developmental perspective on care outlined in the previous chapter. Contact with siblings, and others in the family network can be important sources of support and supplement primary attachments (Kosonen, 1996). Gilligan (1997) argues similarly that:

For effective child care planning at the individual or the aggregate level we need to be clear about the difference between ends and means, or between the final qualities, resources or circumstances with which we may wish to endow a child and the arrangements we put in place to try to secure the chosen ends (Gilligan, 1997 p.15).

For these reasons more direct measures of child and family well-being have often been pursued as outcomes in addition to permanency and stability.

Child Well-being

While agreement exists that a goal of child welfare intervention is to ensure child well-being, outcome measurement of child well-being is much less developed than safety or permanency domains. Magura & Moses (1986) identified the problems of poor measures of child well-being and constructed the Child Well-being Scales, incorporating 43 scales to measure domains such as physical health care. Gain & Young (1998) however, do not recommend their use in Australia arguing that they are experienced by social workers as either too abstract or too specific and not easily derived as meaningful.

The child well-being measures endorsed by Gain & Young (1998) are proxy measures, which have received some general international agreement. These include immunisation rates, medical and dental care, health status, age-appropriate educational progress, self-esteem measures, peer relationships, school attendance, school completion, employment status, early pregnancies and youth offending. The Looking After Children framework, described earlier, incorporated many of these child well-being measures (H. Ward, 1995). New care approaches by Gilligan (Gilligan, 1997, 2000a) and Resnick (2000b) suggest that child well-being measures also need to include protective factors associated with resilience for example, the nature of peer networks.

Family Well-being

Family well-being outcomes concern improvement or maintenance of caretaker functioning and the functioning of members of the family, along with child and parent relationship quality (Gain & Young, 1998). Family preservation outcomes similarly relate to retaining or strengthening the integrity of the family unit, particularly where child welfare services have had a care involvement. Behavioural developments within the family, such as improvement in parenting however, are regarded as better measures of family well-being than constitution of the family (Parker et al., 1991). Proxy measures frequently used for family well-being are the number of days children are placed while family preservation services are provided. Other more direct measures include improvement in parent /child interaction (Gain & Young, 1998) using family functioning instruments, such as the North Carolina Family

Assessment Scale (NCFAS) (Markley, 1997) or the Family Functioning Scale (Magura & Moses, 1986).

Consumer satisfaction as an outcome measure

In child welfare interventions, those experiencing the services usually have the most complete and direct access to information about their outcomes. Consumers therefore are often cited as an important source of data for measurement and consumer satisfaction is specified as an outcome in some child welfare jurisdictions. Consumer satisfaction involves the goal that the users of services will be satisfied with the service that they receive (Gain & Young, 1998). In some places the measures are discrete (Markowitz, 1997) and in others they constitute an integrated part of the wider measurement system, for example, Magura & Moses (1986) include a Parent Outcome Interview in their outcome framework.

Some researchers have expressed concern about whether service users have sufficient levels of reflection and articulation to report relevant information and the issue of bias is also raised (Magura & Moses, 1986). Others argue that consumer satisfaction, rather than being an outcome measure, is really a quality measure. Gain & Young (1998) for example, did not include consumer satisfaction in their final recommendations to the Australian Commonwealth Government, arguing that it was not a direct child protection outcome but rather a process or quality measure.

Outcomes measurement for children and young people with mental health problems

Specific consideration of outcomes for children with mental health problems in child welfare systems is justified given their additional vulnerability, as described in chapters four and five. Substantive work has taken place to develop outcome measures for this group within services designed to assist children with emotional and behavioural problems and their families in the United States. While it is not possible to review the full range of outcomes measured within systems of care interventions in the United States, a brief review follows of some of the outcome measures developed.

The measurement of outcomes for children and young people with mental health problems has been informed by efforts to measure the construct of resilience. As described in chapter two, resilience is established as a multi-dimensional construct which is difficult to measure. Researchers argue for the use of a comprehensive range of domains (McGloin & Widom,

2001) and multiple sources of measurement (Kagan et al., 2002; Potter, 1999). In systems of care interventions measurement across multiple domains is also endorsed, as is the integration of a number of perspectives, for example, children, parents, professionals (Lourie et al., 1998). Measurement spans a number of levels, from child and family domains to programme design and delivery.

As with child welfare services, the development of outcome measures for children with mental health problems in systems of care has been slow and there is frustration at the delays in developing measures of sufficient strength to inform programme design (M. H. Epstein et al., 1998). The absence of robust outcome measurement is noted and weak program evaluations have not always provided sufficient data to secure new or even existing funding levels (Rosenblatt, 1998).

There is a striking similarity between systems of care outcome designs and the current consensus on child welfare outcomes as described above. Outcomes identified for systems of care interventions include child and family well-being (including both symptoms and overall functioning) environment, systems infrastructure and consumer perspectives (Hoagwood, Jensen, Petti, & Burns, 1996). As such, systems of care outcome measurement commonly incorporate client satisfaction measurement, including accessibility of services (Stroul, McCormack, & Zaro, 1996).

Functional, clinical and process outcomes are all described in respect of children's mental health progress within systems of care. Functional outcomes refer to the ability of a child to lead a productive life and include measures such as school attendance, whereas clinical outcomes relate to psychological symptoms. Process outcomes relate to how services are delivered and are measured by case status variables such as length of placement (Beck, Meadowcroft, Mason, & Kiely, 1998).

Measurement of emotional and behavioural adjustment is a key component of functional and clinical assessment of child well-being, seeking to estimate variability within these domains (Clark et al., 1998). Many well-known scales are used, such as the Child Behaviour Checklist (Achenbach & Edelbrock, 1993), the Youth Self Report (Achenbach, 1995) and the Diagnostic Interview Scale for Children (Shaffer, Fisher, Piacentini, Schwab-Stone, & Wicks, 1989). The latter measures symptoms, emotions and behaviours corresponding to DSM III criteria, and individual functioning is assessed in terms of global functioning and specific behaviours. Improvements in school status, such as attendance and performance are also additional measures used to establish child well-being outcomes. Rosenblatt (1998) describes how measures such as school attendance and achievement, restrictiveness of

placement, re-arrest rates and child behaviour assessment are combined within systems of care evaluation.

Family well-being also has a central place in systems of care outcome approaches. Positive links between family participation in service design and child and family outcomes have been established (Jivanjee, Friesen, Kruzich, Robinson, & Pullmann, 2002), for example, family participation is linked with shorter stays in foster care (Landsverk et al., 1996). Based on these types of findings family involvement in service provision is integral to systems of care outcome approaches (Friesen & Stephens, 1998). Family participation measures are thus incorporated in order to ascertain the level of inclusion of family in service planning for children (Friesen, 2001a).

Maori health outcome measurement

This present research, taking place within a New Zealand context, is concerned with care outcomes amongst Maori children in care. As earlier chapters have outlined, Maori health models can contribute to consideration of outcomes for children with mental health problems. In particular, these models include many of the protective factors, which some (Gilligan, 1997, 2000a) argue should be regarded as outcomes by child welfare services. Outcome models within Maori health have been developed with a recognition that interest in outcomes extends beyond the recipient of services and those agencies who work with them, because the health of the individual, whanau and wider tribal collective are integrated. Participation in outcome measurement extends beyond the service user to the wider whanau and ultimately to hapu and iwi (Durie, 2001).

Maori outcome frameworks utilise broad domains, which include spiritual, social and cultural dimensions, see, for example, the outcome model of Kingi & Durie (2000a). The schedules of Hua Oranga contain simple measures designed to assess the quality of communication and relationships amongst whanau, levels of internal contentment, cultural self assessment and spirituality (Kingi & Durie, 2000a). Durie (2001) describes some of the difficulties in measuring wairua, with its connotations of reciprocal interchanges between people, the environment, cultural heritage and spirituality. Although these outcomes have not yet been designed for children, or those in a welfare context, many of the domains have a clear link to resilience and family strengths theories, which are increasingly informing statutory child welfare practice.

A comparison of Maori and non-Maori views of positive child outcomes was recently undertaken in New Zealand (Gray, Barwick, Martin, & Asiasiga, 2002). The investigation

established commonality between Maori and non-Maori views of outcomes, which increases the utility of Maori defined outcomes. There was agreement on the need for educational achievement, good jobs, a sense of self-worth and maintenance of respectful and supportive relationships. Differences emerged with the importance Maori attach to a sense of cultural identity and the level of involvement expected of young people in their extended family. Using a family resilience model the research concluded that there was support for the interrelated measurement of:

the family itself through its form, functioning, financial and other material resources, labour market achievement, attitudes, values and beliefs, the social, institutional, economic and community environment, a young person's personal endowment and cumulative capacities (Gray et al., 2002 p.xv).

This commonality suggests that Maori outcome measures will integrate well with those developed within the child welfare context and both can usefully inform the search for suitable criteria for this present research.

Outcome measures developed for Child, Youth and Family

Development of outcome criteria has been taking place in Child, Youth and Family since 1996. In 1989, as described earlier, not only the Children, Young Persons and their Families Act (New Zealand Government, 1989a) reformed statutory child welfare in New Zealand but the State Sector Act (New Zealand Government, 1988) and the Public Finance Act (New Zealand Government, 1989b) significantly altered the operational context of the organisation. These statutes attempted to move government departments from accounting for inputs towards defining and measuring outputs. However, the relationship between outcome and outputs still needed to be established, as Child, Youth and Family commented:

... CYF's focus needs to be upon achieving measurable outcomes for its clients, in partnership with their families and other social service providers. Hence, its formal outputs (what it contracts to government to provide) need to move away from being designed around processes to an orientation towards outcomes for clients (Child, Youth and Family, 2000a p.2).

In 1996 a comprehensive outcome measurement system for Child, Youth and Family was designed by Jim Barber and Graeme Scott (J. G. Barber & Scott, 1996). Five domains were identified in this framework. These were: promoting adequate standards of care giving, optimising child well-being, minimising risk of future harm, minimising disruption to a

child's life and ensuring cultural competence of intervention (J. G. Barber & Scott, 1996). The proposed system identified a range of data sources (self-report, observations, inference using case history data, key informants) and anticipated error associated with these. To offset possible bias, the system incorporated all data sources into its design. The outcome framework relied on the use of 7 standardised psychometric scales including Achenbach's Child Behaviour Check list, Parent/Child Conflict Tactics scales and suicide probability scales (G. Scott, 1998).

Child, Youth and Family (1999) described the response to the proposed framework as cautious and peer reviewers identified a number of areas, which needed further work and testing. However, Child, Youth and Family did not pursue this framework stating that it was considered impractical because of development work needed and the recent introduction of other new systems such as the Risk Estimation System and Youth Services Screening tools. Child, Youth and Family continued to report on what were described as interim proxies for final outcome measures (Children Young Persons and their Families Agency, 1999). These largely included performance measures of volume and timeliness, (see for example Child, Youth and Family Annual Report (2002a)).

In 1999 Child, Youth and Family identified commonality between international outcome criteria developed in the United States, Australia and those proposed for New Zealand by J. G. Barber & Scott, (1996). Child and youth well-being, safety, permanency and stability, family functioning and cultural competence were adopted as the set of internationally recognised outcome "domains" for Child, Youth and Family (Children Young Persons and their Families Agency, 1999). Based on further work in 2000, Child, Youth and Family added a final criterion, client satisfaction to complete the current set of six outcomes (Child, Youth and Family, 2000c).

Current outcome domains

Child, Youth and Family define their six outcome domains in the following way. Safety involves ensuring the safety of the child and the young person, and, in the case of youth justice, the safety of the community from reoffending. This includes physical safety, cultural safety and emotional/psychological safety. Child and youth well-being is described as improving or optimising the well-being of the child or young person. Family functioning is defined as improving or optimising family/caregiver functioning and support. Permanence and stability involves achieving permanency and stability in the child or young person's situation. Cultural and spiritual competence is described as ensuring that the child or young person is positively aware of, and draws strength from, his or her culture and spiritual

identity. Client satisfaction is achieved when the legitimate wishes and choices of the child or young person and their family are treated with respect and met wherever possible (Child, Youth and Family, 2000d).

Child, Youth and Family (2001j) argued that it was not practical at that stage to link any of the available proxy indicators (for example renotification, reoffending or stability of placements) to the formal accountability structure of output reporting: "*because the data can be interpreted in a number of ways and does not necessarily indicate a good outcome or an outcome which the department has brought about by its interventions*" (Child, Youth and Family, 2001j p.10).

It was proposed that outcome reporting be developed and enhanced systematically to the point where, within three to five years, elements of outcome reporting meet the criteria for inclusion in formal performance reports to Government. Embryonic measures identified included rates of renotification/reoccurrence, stability of placements, Family Group Conference decisions, achievement of objectives in care plans and rates of re-offending. Family functioning, cultural and spiritual identity, well-being and client satisfaction are identified as requiring further work, along with the development of a composite index encompassing a range of indicators (Child, Youth and Family, 2001j).

In 2004, Child, Youth and Family once again changed its outcome definitions. The First Principles Baseline Review report expressed concern about Child, Youth and Family's paucity of information and incapacity to measure even basic trends (Ministry of Social Development et al., 2003). This review confirmed that the interest of Child, Youth and Family now centred on two outcomes, prevention of recurrence of harm and on reducing the rate and severity of re-offending (Ministry of Social Development et al., 2003). The strategic statement for Child, Youth and Family to 2008 reflects this, describing the care and protection outcomes as follows:

To prevent the re-occurrence of child abuse, of neglect and of insecurity of care, i.e. to keep safe children who have already been harmed. To prevent the first occurrence of abuse, neglect or insecurity of care. Additional outcomes are to address the effects of harm and to restore or improve well-being (Child, Youth and Family, 2004a p.2).

Current capacity to measure care outcomes for children and young people with mental health problems in Child, Youth and Family care

This present research aims to explore the role of support to caregivers in strengthening care outcomes for children and young people with mental health problems in Child, Youth and Family care. The poor state of measurement in Child, Youth and Family and the continuous change in outcome definitions presents a challenge for research of this nature. As Schene (1999) warns: *"The discussion surrounding outcomes definitely changes when you actually have data as opposed to discussing outcomes in the abstract"* (Schene, 1999 p.7).

Although the Child, Youth and Family Annual Reports of 2002 and 2003 (Child, Youth and Family, 2002a, 2003a) identify children and young people with mental health problems as a key group at risk, at the time of this research it was not possible to measure care outcomes for this group using the agreed outcome domains. In the past, information systems of Child, Youth and Family were weak in their ability to record routinely mental health problems amongst clients. The new information system (CYRAS) introduced in 2000 does contain a field in which mental health problems could be recorded but this was used poorly by social workers (Child, Youth and Family, 2003h). In response, further improvements were made in 2003 to the level of recording by social workers, in an effort to improve reporting on mental health and other child problems (Child, Youth and Family, 2003h).

Some data, described in chapters three and four are available but these are derived from small studies and are limited in scope. Evaluation of specific interventions for groups of children and young people with mental health problems, for example, clients within the youth services strategy, focus on programme compliance, and not on child outcome data (Preston, 2002).

In summary, the key deficits facing those aiming to investigate outcomes for children with mental health problems in Child, Youth and Family include: continuous change in outcome definitions, consequent under-development of measures and specific problems in identifying the group within the information system. Variables of interest, in particular those protective factors linked with individual resilience, for example, peer relationships or school inclusion, are not yet integrated into the outcome domains developed by Child, Youth and Family. Finally, direct measurement of child and family well-being using standardised psychometric tests, which are considered integral to outcome measurement for this group are not available in Child, Youth and Family. There is value however, in proxy measurement, which is possible within the existing information system. However, proxy measures have not yet been well developed nor have estimates been made as to the likely error associated with these.

Conclusion

This chapter has reviewed the development of outcome measurement in child welfare services. While progress has been slow, internationally there is consensus about a set of core measures, which include permanence, safety, stability, child and family well-being. The domain of cultural competence which reflects New Zealand's legislative responsibilities and client satisfaction have been added to New Zealand's outcome domains. Despite these six outcome domains being agreed by Government in 2000, Child, Youth and Family have in 2004 reshaped these to focus on prevention of recurrence of child maltreatment. Not surprisingly, outcome measurement, as opposed to outcome description, has been slow to develop, although some proxy measures have been suggested. As a result outcome information about children and young people with mental health disorders is restricted to anecdotal information from caregivers and social workers and the findings of small studies.

In New Zealand, it is indicated from the small body of studies reviewed in the previous chapter that children with mental health problems are at risk of a range of negative outcomes. The picture from overseas research concurs. It appears that child welfare systems have a long way to go to secure positive pathways in care for this group. Common problems are the relationship between disruptive behaviour, caregiver response, placement instability and failure to achieve permanency. While some outcome information is available from overseas about permanency and stability, very little research has been conducted into the relationship between support to caregivers and the care outcomes for this particular group.

This present research aims to fill some of these gaps by developing a set of studies to explore the relationships between supports to caregivers and care outcomes for children and young people with mental health problems in Child, Youth and Family care. The discussion in this chapter has highlighted a range of case status variables, which are accepted internationally as proxies for these outcomes. It has also identified that a composite criterion may have utility for social workers in their assessment and decision making in respect of this group. The research aims to develop an approach to outcome measurement which is specific to the needs of this group and which utilises existing case history data as a source of proxy measurement. The research questions and the methodology adopted in this research are outlined in the next chapter.

Chapter Seven

The Research Design

Introduction

Caring for children with mental health problems is a common feature of New Zealand family and whanau life, as prevalence rates discussed in Part One indicate. While most families cope successfully with providing care, where serious other difficulties exist child welfare services may become involved. Additionally, significant gaps in New Zealand mental health services mean that some families use child welfare services to meet support needs, which fail to be met within the health sector. As a result here and overseas, there is a high prevalence of mental health problems amongst children involved with statutory child welfare services. Child, Youth and Family, like other jurisdictions, face considerable pressure to offer effective support to those who provide family-based care for this group.

This research aims to explore the role of support to caregivers in strengthening care outcomes of children and young people with mental health problems who are involved with Child, Youth and Family. In the first part of this chapter, after a brief discussion of the place of social work research, gaps in the literature are reviewed and the research questions are outlined. Following this is an introduction to mixed methods as a research approach in which the advantages of combining research methodologies are outlined. The mixed methods design of the research is described in the final part of the chapter and the four studies are introduced in turn. A full account of the methodology of each study appears in the first section of each of the next four chapters.

The place of social work research

The importance of social work research as a means of giving voice to the powerless (R. Fisher & Karger, 1997), and achieving social change, has been identified overseas (Alston & Bowles, 2003; McDermott, 1996). In New Zealand this research tradition in social work can also be found (R. Munford & Sanders, 2003b). Others consider social work research as the means to evolve evidence based practice. As Malcolm Hill (1999) argues: *“good practice ought to derive from research evidence about either the nature, cause and typical pathways of social problems or about the success of particular methods to deal with these problems”* (Malcolm Hill, 1999 p.20).

Some believe social work has been insufficiently based on evidence because research findings are difficult to integrate into practice (Cashmore & Ainsworth, 2003; W. M. Epstein, 1990; Gelles, 2000). There is concern about the tendency for practitioners to rely on colleagues rather than on evidence, about their failure to keep up to date with knowledge, and the iatrogenic effects of some social work practice (L. Gibbs & Gambrill, 1999; Howard, McMillen, & Pollio, 2003). Gelles (2000) accounts for these problems in terms of the shortage of resources in child welfare, difference in timeframes of researchers and practitioners and a tendency for social workers' interest to be in individual cases rather than in the patterns across cases. The gap between the findings and the realities of the field, along with lack of access to technology, also appears to alienate many social workers from research (Barratt, 2003).

Evidence based practice, emerging from medicine, has been described as "*the conscious, explicit and judicious use of current best evidence in making decisions*" (Sackett, Richardson, Rosenberg, & Haynes, 1997 p.2). Practice is based on findings which have the potential for replication because the methods are made explicit (Howard et al., 2003). Applying evidence based practice to a social work setting requires social workers to integrate their experience with the best available evidence, in addition to consideration of the values, preference and expectations of clients (L. Gibbs & Gambrill, 1999, 2002).

The introduction of evidence based practice into social work does not mean supplanting practice based judgments, but rather supplementing the data social workers themselves collect to evaluate their interventions (Thyer & Wodarski, 1998). Such integration requires that social work ethical codes include a client's right to evidence based treatment and the provision of training and supervision which reflects this knowledge base (Myers & Thyer, 1997).

However, there are reasons to be cautious about the prospects of complete adoption of evidence based practice in respect of child mental health problems in a statutory social work context. Researchers warn that there is not always an evidence based model established for all child problems and that those available may occur in settings, which are not appropriate (Research and Training Center on Family Support and Children's Mental Health, 2004). In addition, ways need to be found to respect family choice and keep new service initiatives supported while using evidence based practice approaches (Research and Training Center on Family Support and Children's Mental Health, 2004).

The place of evidence based research and practice in statutory child welfare services is less secure than in other services such as health care (Cashmore & Ainsworth, 2003). A range of

writers claim that there needs to be a much greater investment in child welfare research, particularly for children in care (Barratt, 2003; Courtney, 2000; Gelles, 2000), in order to evolve an evidence base for statutory social work. In New Zealand, Connolly (2002) notes that, although the country passed ground-breaking legislation in 1989, there has been little research into the effect of these changes. Child, Youth and Family has also acknowledged the need to build a greater research base for children in care (Child, Youth and Family, 2003e). Concluding a substantive review of statutory care, Connolly (2002) identified a range of studies that would assist in assessing the efficacy of statutory responses to children in care in New Zealand. Included is research, which would determine *"to what extent are caregiving families, both kin and non kin, supported and encouraged to acquire the skills and access the resources that can assist them to adequately provide for the children in their care"* (Connolly & Rathgen, 2002 p. 72).

The questions at the centre of this research fit within this area of interest, focusing on a group of children in care with particular vulnerability, due to their mental health problems.

Gaps in the research

In New Zealand very little research has been carried out in respect of the needs of families who are raising children with mental health problems as was described in chapter three. The perspectives of caregivers are missing in this country. Reports of how they manage, and their views on the impact of support deficits on child outcomes, remain largely un-explored. Overseas research reviewed in chapter three suggested that gaps in New Zealand mental health services such as insufficient respite care, behavioural support, day programmes and out of family care services are likely to undermine family capacity to manage behaviours, balance work and family responsibilities and ultimately offer continuing care to their children.

Given these service gaps, New Zealand child welfare services are likely to be a key part of providing care and support to families looking after children with mental health problems under the inclusive provisions of the Children, Young Persons and their Families Act (New Zealand Government, 1989a). Caregiving arrangements for this group are derived from the child's own extended family network, from the Child, Youth and Family pool of foster caregivers or non-government foster care organisations providing care. Overseas families looking after children with high support needs, such as mental health problems appear to rely more on their informal networks for meeting their support needs than on formal support services. Whether this preference exists for caregivers who are looking after children with mental health problems on behalf of Child, Youth and Family, is as yet unknown.

While children with mental health problems are internationally recognised as a group at particular risk within the care system (J. G. Barber & Delfabbro, 2002; Richardson & Joughin, 2000), there has been limited exploration of the vulnerability of this group in New Zealand. There is no routine identification of children with mental health problems by Child, Youth and Family. However, there is some screening of young people using tools designed for social workers within the Youth Services Strategy (Leigh, 2000) and there is improved recording of child and adult problems in the information system (Child, Youth and Family, 2003h). A survey of children with mental health problems in Child, Youth and Family was conducted in 1999 as a one-off exercise. This inquiry included all children who had an involvement with Child, Youth and Family and provided some description of this group (P. M. Wells & Smith, 2000). For those amongst this group who were looked after by Child, Youth and Family, their care arrangements and the support needs of their caregivers remain unidentified. This is a serious deficit in knowledge as most overseas research with which Child, Youth and Family would wish to make comparisons is drawn from foster care populations.

Child, Youth and Family initiatives to improve support to caregivers have focused on remuneration, training and providing caregiver liaison social workers (Child, Youth and Family, 2002c) as was described in chapter five. There has been no in-depth consideration of the perspectives of Child, Youth and Family social workers regarding support to caregivers. Overseas, however, the role of workers from support agencies in any negotiation of support to families has received attention and is viewed as critical to the successful provision of support (Twigg & Atkin, 1995).

The operational context of Child, Youth and Family was reviewed in chapters four and five and attention was drawn to the constraints of statutory child welfare work. In this environment front-line workers may have discretion to allocate extra resources but their responses tend to be occasional, and rarely initiated, as social workers wait for approaches from caregivers (Twigg & Atkin, 1995). The values, knowledge and expectations of caregivers then become factors in determining how they will negotiate a support response and whether they will seek out extra support services (Twigg & Atkin, 1995). Understanding the perspectives of both social workers and caregivers and the degree to which these perspectives are shared, assists in understanding how a support response develops.

Finally, there has been little research to analyse the role of support to caregivers in achieving positive outcomes for this group of children in care. While measurement of outcomes for children in welfare systems has progressed internationally (Gain & Young, 1998), Child,

Youth and Family do not have key measures in place to determine outcomes for children in care, and urgent improvement is sought (Ministry of Social Development et al., 2003). In considering the role of support to caregivers in strengthening care outcomes there were insufficient existing outcome criteria or analysis of outcome data available to be useful to this research.

The purpose of the research

The gaps in the existing research described above justified an exploration of support to caregivers looking after children and young people with mental health problems on behalf of Child, Youth and Family and the role of these supports in strengthening care outcomes. Four specific research questions underpinned this exploration:

- What do Child, Youth and Family social workers consider are effective supports for caregivers looking after a child or young person with mental health problems?
- What do Child, Youth and Family caregivers perceive as the kind of assistance, which will help them to better manage the care of these children and young people?
- What do Child, Youth and Family social work experts consider to be the range of positive care outcomes which are of interest for children and young people who have mental health problems and who are in care?
- What do the case history data, relating to a group of children and young people identified with mental health problems in the care of Child, Youth and Family, suggest about the relationship between supports to caregivers and positive care outcomes?

As the research was exploratory no formal hypothesis was generated. A family strengths perspective, augmented by the concept of resilience, provided a theoretical framework for this exploration. As described in chapter two, this perspective views all families as potentially having strengths or protective factors, which reinforce their resilience and enable them to withstand the shocks encountered in the course of raising children (Saleebey, 1997; Walsh, 1998). Family support research indicates that families looking after children with a range of high needs are likely to derive support and resilience from their own family networks (Friesen, 1989). Maori models of mental health, which emphasise the importance of connection and reciprocity within whanau in achieving good child outcomes (Durie, 1994, 2001; Pere, 1991), also contributed to the strengths framework of this research.

The research context

The Department of Child, Youth and Family Services

The research was conducted during the period 2000–2002. This was a period of intense pressure within Child, Youth and Family as is described in chapter four. For these reasons access to social workers was highly restricted, in terms of the time they had available to participate in any inquiry.

Research access and ethics approval

This research required Child, Youth and Family Research Access Committee Approval and approval from the Massey University Human Ethics Committee. Research Access Committee approval for this study was applied for in 1999 and granted in 2000. The Research Access Committee approval is particularly concerned with protection of privacy for individual clients of Child, Youth and Family and control of research demands on staff (Child, Youth and Family, 2001g).

Research Access Committee approval enabled the researcher to access individual social workers, supervisors and caregivers but did not allow direct access to children and young people involved with Child, Youth and Family. Access was permitted to non-identifying case records, which were part of the reporting fields in the information system. Individual case records however, were not accessible, as these are identifying. Access was also permitted to a copy of the 1999 Child, Youth and Family mental health database from which all identifying client details had been removed. Following Research Access Committee approval, an application for approval from the Massey University Human Ethics Committee was made and granted in 2000.

Ethical considerations

There were a number of ethical issues underlying this research. Social work has an obligation to the children and the families and whanau they work with, to ensure that interventions are well considered and of practical use. This is particularly true in the case of statutory social work, where interventions are often intrusive to families and whanau. Social work, however, has a poor research tradition outside universities and teaching institutions (Barratt, 2003). As described above, concern exists about the attitude of statutory social workers to research. While practising statutory social workers have been reported as

antipathetic to research, J. Gibbons (2001) suggests it is the crisis context of social work and the pressing nature of client need, which means the longer-term goals of research become subsumed. It was important to be conscious of the enormous pressures on social workers, their time limitations and likely low motivation to participate. These constraints meant choosing research methods that could elicit the most information from social workers in the shortest time.

Research access restrictions on participants were particularly problematic. Although there is increasing attention paid to involving children and young people who are in care, in research (Cashmore & Paxman, 2003; Connolly & Rathgen, 2002; Gilbertson & Barber, 2002) this was not possible within these research access constraints. While Maori models of health have contributed to the theoretical framework of this research, restrictions on access to social workers meant it was not possible to provide for separate consideration of a Maori social work perspective. These remain areas for further exploration, which are discussed further in chapter twelve.

Alston & Bowles (2003) remind us that social work research is relevant in assessing the impact of social policies and contributing to the formulation of policy. The experience of working part-time as a Child, Youth and Family policy analyst during this research however, highlighted associated difficulties. The integration as described by Alston & Bowles (2003) was not easily achieved. At the beginning of this research, Child, Youth and Family did not have a separately identified research section, although by 2002 one was established with a clear research agenda (Child, Youth and Family, 2003e). During the first two years of the research, there was no formal structure through which to connect with other researchers and opportunities for peer support were few.

As the research progressed and findings were gathered there were moments of discomfort, as some priorities for policy development appeared not to align with early research results. Feeding information from research into policy development in a timely manner was difficult. It was not always possible to disclose findings through the policy channels of the organisation without compromising the integrity of the research project. At one point it was necessary to write formally with some early conclusions to the Baseline Review of Child, Youth and Family prior to completion of the research (P. M. Wells, 2003).

In other ways being employed by Child, Youth and Family simplified many aspects of the research. Access to information was regularly eased through personal knowledge of source documents, contacts and the information system. Being a qualified social worker working in National Office is likely to have assisted in encouraging social worker participation.

However, it may also have acted as a disincentive for caregivers wanting to participate in the research as the relationship between foster caregivers and Child, Youth and Family was poor at this time (Child, Youth and Family, 2002d). On balance, however, the experience of both working for and researching within Child, Youth and Family reciprocally strengthened the investigator and policy analyst roles.

The research methodology

Throughout this research the aim was to provide practical findings which would have utility for social workers and caregivers and reflect their interests. A methodology was sought which could enhance the participation of caregivers, social workers and practice leaders within Child, Youth and Family and develop research that was meaningful to them.

Research, which takes place within an organisational context requires care so that the process causes the least intrusion and disruption to service delivery (R. Munford & Sanders, 2003a). Methodological choices were shaped by the requirement to keep demands on participants to a manageable level, while enhancing their involvement and developing practical results.

The research questions required that multiple sources of information be integrated and a mix of different types of data be achieved. Multiple sources of measurement are recommended within a range of research traditions, which inform this project. As discussed in chapters two and six researchers within the disciplines of social work, such as, Kolko (1998) Magura & Moses (1986) and McCroskey (1997) and in developmental psychopathology, for example, McGloin & Widom (2001), argue that in order to grapple with multiple domains and levels of measurement, multiple sources of information are required. Resilience research also points to the multiplicity and interactive nature of protective factors (Masten, 1999; Rutter, 1999), such that the interrelationship between variables should be part of any exploration of outcomes. To manage the diversity of data and measurement sources researchers involved with systems of care interventions for children with mental health problems emphasise the need for studies to utilise both qualitative and quantitative methods (Knapp, 1995; Lourie et al., 1998). Mixed methods research provided a methodological approach able to meet these requirements.

Mixed methods research

Mixed methods research refers to the practice of combining multiple methodologies within a single inquiry design. Mixed methods approaches are based on an acknowledgment of the uncertainty that surrounds research within the social sciences (T. D. Cook, 1985).

Uncertainty has arisen from dissatisfaction with positivist approaches, which view the world as lawfully ordered. The task of science is to search for these universal laws through empirical verification of logically derived hypotheses (Patton, 2002). This order is assumed to be deterministic so that, once the laws of the world are known, prediction will be accurate. From a positivist perspective, objects in the world have meaning independent of any consciousness of them, a position known as objectivism (Crotty, 1998). As positivism followed the natural sciences, certain research methodologies are emphasised, in particular those of quantified observation and experimentation in order to offer explanation and prediction.

A range of problems arises in applying positivist principles to research interests outside the natural world. Humans are not inert or passive nor can they readily be subjected to the isolation of stimulus and control, which classical experimentation requires (Crotty 1998). In the social sciences, perfect prediction is likely to be impossible because of the complex nature of human behaviour. The human world, it is argued, is different from the natural world: *"the world of human perception is not real in an absolute sense, as the sun is real but is 'made up' and shaped by cultural and linguistic constructs"* (Patton, 2002 p.96). Observations of human behaviour, which are broken down in a positivist framework into components in order to be measured, lose the intrinsic holism of the phenomena.

In contrast, constructivists argue that people construct their own meaning in order to understand their world. It is these constructs which provoke a response, rather than the external world itself. Thus the mental constructions of those in the world become the research focus and designs are employed which can incorporate these perspectives (Crotty, 1998).

Positivism has changed over time and some of the criticisms about the suitability of positivism to social research have resulted in modifications to the paradigm. Post positivists, for example, do acknowledge that no matter how closely the scientific method is followed the outcome of research will be neither totally objective nor certain. As Crotty (1998) describes the post positivist position:

They may claim a higher level of objectivity and certitude for scientific findings than for other opinions and beliefs but the absoluteness has gone and claims to validity are tentative and qualified (Crotty, 1998 p.40).

Debate in respect of positivist and non-positivist research traditions has tended to centre on the relative merits of quantitative and qualitative methodologies. Within the discipline of

social work, concerns of researchers about positivist approaches include its mismatch with the individual nature of reality (Mark, 1996), the loss of information within empiricist techniques (Heineman, 1981) and the search for participatory methods which are more appropriate to marginalised groups (Rothman & Thomas, 1994). Social work criticism of positivism also includes the objectifying of those people being studied and the tendency for them not to be included in decision making about research (Greenwood & Levin, 2000). A common critique of empirical methodologies is their reported failure to deal adequately with the complexities of social work practice (Reid, 1994). It is argued that for social work, empiricism is less appropriate than interpretative and qualitative methodologies (Heineman, 1981).

In social work literature the debate between those favouring positivist paradigms and quantitative methodologies and those preferring interpretative and qualitative paradigms has continued through the 1980s and 1990s (J. Gibbons, 2001). Belchamber (1997) and J.G. Barber (1996) in particular, have challenged social work rejection of the scientific method. Shaw (2003) also suggests social work research needs to regain quantitative expertise. Belchamber (1997) argues for the contribution that scientific inquiry can provide: *"a type of reality check, holding up beliefs, practice and programmes to open scrutiny"* (Belchamber, 1997 p.21).

The qualitative/quantitative dichotomy in social work is viewed by others, however, as a distraction to the overall goal of social change (R. Fisher & Karger, 1997). A perspective is emerging which views qualitative and quantitative approaches as unopposed and sees them as different phases of a process or points along a research continuum (Babbie, 1992; Crisp, 2000; DeVaus, 1995; Reid, 1994). As Patton (2002) summarises this view, qualitative designs add depth and detail to data and integrate meaning for participants whereas quantitative data can establish patterns across a range of data. Taking this approach, a range of methodological frameworks may guide any inquiry. Instead of paradigms being opposed to one another, interest has grown in the intentional use of multiple methods in order to strengthen the course of study.

Approaches to mixing methods

The intentional combination of diverse methods in order to gather different kinds of information has become known as mixed method research (Greene & Caracelli, 1997). Researchers commonly argue for this integration in order to generate more comprehensive and logical results than either an interpretive or positivist paradigm alone could provide (Greene & Caracelli, 1997). Mixed methods acknowledge that each inquiry paradigm

provides a legitimate and useful way to approach understanding a phenomenon, and that there will be strength in linking the insights from the different paradigms.

Greene & Caracelli (1997) identify three attitudes to mixing methods in research design. First there are “purists” who argue that different inquiry paradigms are so diverse in their assumptions as to human nature and knowledge that they cannot ever be sensibly mixed within a single inquiry. For others mixed methods are of “pragmatic” interest. While the philosophical assumptions which lie behind quantitative and qualitative methodologies are logically distinct, they can be mixed depending on the best fit for any given inquiry. Finally, the authors describe a dialectic position whereby the different philosophical assumptions are used deliberately to enhance understanding and revise perspectives and meaning. Unlike a pragmatic approach, where differences between methods are underplayed, in a dialectic approach, mixed methods are undertaken in an integrative manner, using the strengths inherent in each approach to establish a dialogue between paradigms (Greene & Caracelli, 1997).

Fielding & Fielding (1986) warn that mixed methodology is not pursued in the interest of determining objective truth but seeks to strengthen understanding. Its advantage is the juxtaposition likely to arise in the course of analysis and the integration of findings. There is a webbing of results, whereby findings are woven back and forth between methodologies to elaborate, deepen understanding and further test claims of significance. This is a potentially endless process, which could extend beyond any project and form the basis of an on going research endeavour.

Mixed methods and social work research

The need for social work research to move beyond qualitative and quantitative dichotomies is discussed by a number of researchers (Allen-Meares & Lane, 1990; Crisp, 2000; Rubin, 2000), and mixed methods approaches are being adopted by researchers such as Barber in Australia (Gilbertson & Barber, 2002). The family strengths perspective also promotes research methodologies which incorporate a range of perspectives, and the integration possible in mixed methods designs is discussed with interest (Norman, 2000; Saleebey, 2002). Combining qualitative and quantitative approaches meets some of the goals of strengths based social work research as it allows participant perspectives to inform the research process. For example as R. Munford & Sanders (2003b) describe, perspectives from participants as well as constituting findings can be used to direct further phases of the research.

Child, Youth and Family (Child, Youth and Family, 2003e) also view the contribution of qualitative and quantitative approaches as appropriate. In a background paper Connolly (2002) argues that the research strategy for children in care of Child, Youth and Family must *“bridge the divide between qualitative and quantitative research, recognising the value of both and promoting ways in which they could be used to respond to the range of questions confronting the state and its care responsibilities”* (Connolly, 2002 p.6).

Research design

The mixed methods design for this research

The aim of this research was to explore support to caregivers of children and young people with mental health problems in the care of Child, Youth and Family. This inquiry integrated qualitative and quantitative techniques in a mixed methods research design based on a dialectic approach to mixing methods. Within the research, quantitative design was directed by qualitative findings and the results of the quantitative analysis were further interpreted in the light of qualitative results. In this way the results were webbed in what Green & Caracelli (1997) describe as an iterative mixed methods design. Many researchers describe mixing methods in terms of triangulation. Triangulation refers to the use of multiple measures and methods to overcome deficiencies that stem from one investigation or method (Patton, 2002). Denzin (1978) offers four types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation. This study utilised data triangulation and methodological triangulation.

Incorporating multiple perspectives – data triangulation

Data triangulation requires researchers to search for as many data sources as possible which bear on the subject of inquiry. In the case of this research, there was a wide range of potential sources of data. Information could be obtained directly from participants as key informants in the care process (being children and young people, caregivers, and social workers) from administrators within Child, Youth and Family, and from individual case history records held within the information system. As described above, access constraints did not permit individual clients or their identifying case records to be included. Non-identifying case information however, was accessible. Data from caregivers, social workers, supervisors, policy makers and managers within Child, Youth and Family were all available to be integrated into the research design.

Reviews of the literature within family strengths and resilience research described in chapters two and three suggest that the perspective of caregivers receiving support will be critical to understanding the nature of effective support. Negotiated response theory reviewed in chapter three indicates that the perspectives of those with whom caregivers negotiate support, the agency representatives, will also be significant (Twigg & Atkin, 1995). For these reasons both social worker and caregivers' perspectives were seen as key data sources, in order to understand how effective support is constructed.

Incorporating multiple methods – method triangulation

As described above this research project also triangulated methods utilising both qualitative and quantitative methodologies in its design. Combining qualitative and quantitative methods or methodological triangulation is described both as, 'within method', and 'across method' triangulation (Denzin, 1978). In this study both forms of method triangulation were employed. 'Within method' triangulation employs multiple techniques within a single research method to examine data. For example, in the first study of this research design, a survey of social workers and supervisors utilised both rating scales and open comments fields, thus generating both quantitative and qualitative data. Additionally, study three employed a Delphi technique in which qualitative comments and quantitative data were combined to express group consensus and divergence.

The research also employed 'across method' triangulation whereby four separate studies using different methodologies were combined in an overall design to explore the research questions. As a result the combination of qualitative and quantitative methods supplemented one another and offset traditional areas of weakness within single method approaches.

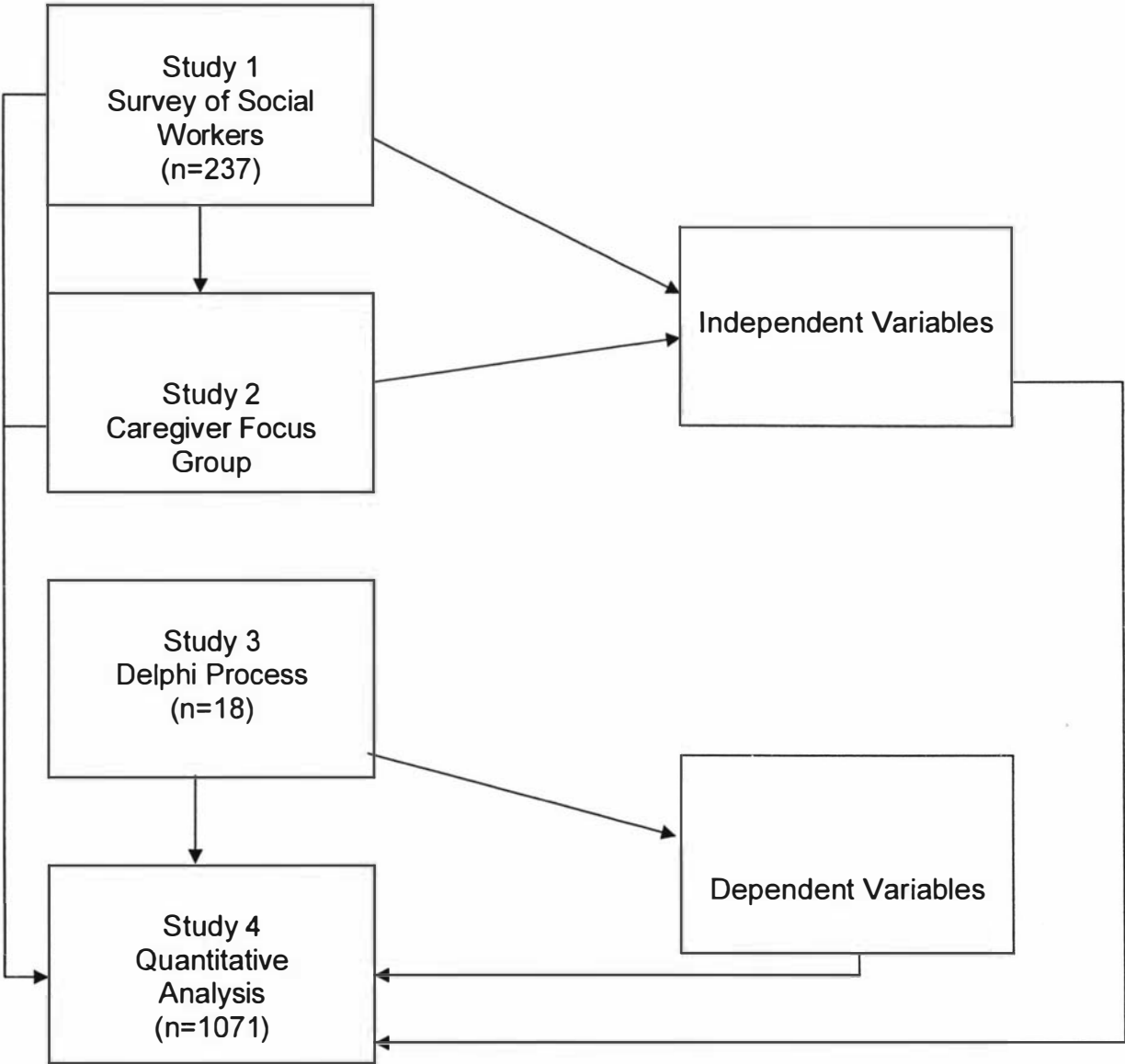
Overview of the research design

The research aimed to explore support to caregivers and the role of this support in strengthening care outcomes for children and young people with mental health problems in the care of Child, Youth and Family. This research design integrated four studies. The diagram below shows the methodological relationship between these studies.

Each study addressed one of the four central research questions described earlier in this chapter. In study one, a survey was used to derive social worker perspectives on the nature of effective support to caregivers in achieving positive care outcomes for children and young people with mental health problems. These findings were then contrasted and combined with

the views of caregivers looking after this group on behalf of Child, Youth and Family, which were obtained in a second study using a focus group methodology.

Table 4 Overview of the research design



Where data access allowed and data quality was sufficient, findings from studies one and two were constituted as independent variables to be used in the quantitative analysis. In the third study a group of operational experts constructed a measure for positive care outcomes for children and young people with mental health problems in the care of Child, Youth and Family. The results of the third study were imported into study four as the dependent variable for the quantitative analysis. In the fourth study a multivariate analysis was conducted of case history data, pertaining to this group of children and young people, using the variables generated in studies one, two and three. The qualitative material from the three studies was also used to assist in interpretation of the findings in study four.

In this way each study while conducted separately was integrated into an overall design. A detailed account of the methodology of each study is provided in the following chapters. The results of each study taken in isolation are incomplete and it is only when all findings are brought together that final conclusions are discussed within the final chapter of the thesis.

Conclusion

This chapter has discussed the gaps in the existing literature, the key research questions and outlined the mixed methods framework for this research. The intention to combine four studies in an iterative design, which weaves qualitative and quantitative results into a final set of conclusions, has been described. Each of these studies is outlined in the next four chapters with the final conclusions presented in chapter twelve.

Chapter Eight

Social Workers' Perspectives on Support

Purpose of the study

The aim of the first study was to identify how social workers view the provision of care to children and young people with mental health problems and the nature of effective support to their caregivers. Social workers were chosen as the beginning point of this research as they broker the provision of support on behalf of Child, Youth and Family and hold the statutory interest in child outcomes as delegated by the Chief Executive of Child, Youth and Family.

The survey aimed to discover social work views as to the effectiveness of formal support services to caregivers and other caregiving factors, in strengthening care for this group of children. Preliminary ideas about formal services were generated from the literature about support services to caregivers looking after children with mental health problems particularly those services available in parts of New Zealand. Due to the disparity in mental health services in different parts of the country, it was anticipated that not all social workers would be able to access a full range of these services. Other factors, which contribute to positive care, were identified from within the family strengths and resilience research reviewed in the first part of the thesis.

The review of research into statutory social work, described in chapters four and five, suggests that contextual and operational factors will be key determinants in social worker perspectives. The study aimed to provide opportunities for social workers to make reference to their operational context and its role in the negotiation of a support response to caregivers.

The study was designed to answer four questions:

- What is the nature of social work with children and young people with mental health problems?
- What do social workers regard as effective support services for caregivers looking after children with mental health problems on behalf of Child, Youth and Family?
- What informal support and /or other caregiving factors do social workers view as strengthening care outcomes for this group?

- How well is Child, Youth and Family managing to support caregivers who look after children with mental health problems?

The results of the survey were to be contrasted with the views of caregivers which were to be explored in the second study. This was an important objective because the relationship between a service provider representative and a caregiver is described as the nexus of identification of need and the negotiation of support services (Twigg & Atkin, 1995). The perceptions and expectations of social workers and caregivers, which are derived from their values and knowledge, underpin this negotiation.

Research design

Terminology

The study sought to involve social workers with experience in supporting caregivers looking after children with mental health problems on behalf of Child, Youth and Family. As this group was not readily identifiable in the organisation participation was restricted to social workers and supervising social workers who had placed a child or young person on the Child, Youth and Family mental health database in 1999. Supervisors and social workers were not delineated within this database, although these two groups are occupationally distinct in Child, Youth and Family with supervisors maintaining oversight of casework carried out by social workers. In operation however, these distinctions are less clear with supervisors having intense casework involvement with children and young people with high needs (Calvert, 2000; Child, Youth and Family, 1999b). Social worker was adopted as the generic descriptor for the group of participants in this study, although it was likely to include both social workers and supervisors.

The survey methodology

Work pressures in Child, Youth and Family affected this study. Research access to Child, Youth and Family staff was granted based on a short inquiry to staff, with no adverse impact on their work requirements. A research tool was sought that would elicit high quality information efficiently, while also providing an opportunity for open-ended responses. The challenge was to stimulate social worker recollection of general case circumstances but for this not to result in disclosure of case information. A survey was selected as the most appropriate method for eliciting social work perspectives within these constraints, allowing information to be collected from a large group of social workers in a short amount of time.

The motivation for people responding to surveys is the opportunity to state opinions and relate experiences to a sympathetic and non-judgmental listener (Sudman & Bradburn, 1982). It was thought that social workers practising within a difficult organisational context would welcome an opportunity to describe the constraints within which they operate. To enable social workers to respond openly about the organisational issues facing them, participation in the study was anonymous.

The names of potential social work participants were obtained from the mental health database. Child, Youth and Family provided work addresses for the 480 social workers who were invited to join the study. Alston & Bowles (2003) suggest that invitations to participate, covering letters and information sheets, need to be broad and designed to arouse curiosity and motivate involvement. A covering letter was prepared which drew social workers' attention to children with mental health problems, provided information about the research and described the anonymous nature of participation. The letter doubled as a participant consent form indicating that those people responding to the survey were consenting to be participants in the research. A copy of the letter is included in appendix 3.

The survey was conducted during July, August and September of 2000. Child, Youth and Family specified this timeframe, as it preceded the introduction of the new information system in November of that year. At that time, Child, Youth and Family acknowledged the problems they were having in managing care and looking to new ways to support caregivers (Child, Youth and Family, 2001c, 2002c). Consequently, there were likely to be sensitivities amongst social workers about inadequacies in their ability to support caregivers. These feelings had the potential to threaten the recruitment of participants and the integrity of their responses.

These sensitivities led to three decisions in respect of the design of the survey. Firstly, as stated above responses were anonymous allowing social workers to express their opinions openly and permitting safe self-criticism. Secondly, the title of the survey was chosen carefully to ensure that social workers understood that their individual performance was not the focus of the survey. The words *support services to caregivers* were used in the title in order that social workers would understand their individual practice was not being examined. Thirdly, the survey allowed social workers an opportunity to respond in an open field about the influence of organisational constraints on their provision of support.

Survey design

Good survey design attempts to limit the sources of error in participant responses. Sudman & Bradburn (1982) account for response error in surveys in respect of memory, motivation, communication and knowledge. This includes failure to recall material or events correctly, motivation to respond untruthfully because of fear of consequences, respondents being unclear what is being asked, and having insufficient knowledge to answer a question.

Attempts were made to address these concerns within the survey design.

The survey was intended to broaden social workers' consideration of the construct of support to caregivers, in particular to probe their views of formal support services and the value they place on informal support and caregiving factors. The method selected was a short self-administered survey, including closed question rated responses and open comments fields. Alston & Bowles (2003) recommend that survey questions be structured from the general to the specific, so that, as in good communication, a respondent is led from the simple to more complex or sensitive issues. There was a total of five questions. One question acted as a memory prompt, three questions asked social workers to rate pre-set items with the option to include self generated items and the final question was an open field, where respondents were invited to make their own comments. A copy of the survey is attached in Appendix 4.

Prompting memory – Question One

Human memory is known to be fallible and dependent on the length of the time period and saliency of the topic (Sudman & Bradburn, 1982). Social workers surveyed had recorded their experience with a client with mental health problems in 1999 but this may not have been current or immediate past experience for social workers in 2000. The first question acted as a memory prompt aiming to focus social workers and be undemanding in terms of response. This initial prompt question asked whether social workers experienced their work with clients with mental health problems as easier or as more difficult than working with children who did not have these problems. This question aimed to bring forward implicit memories about the client group from which answers to subsequent questions would be drawn, as well as providing a view of the nature of social work with this group.

Rated responses – Questions Two, Three and Four

Question 2 and 3 used inventories. In these questions, respondents considered and rated pre-selected items with the option of generating and rating further items in an open category. Inventories are useful when details may be difficult for respondents to retrieve. When using inventories the list needs to be as exhaustive as possible because under-reporting tends to occur in the open other categories, relative to items that have been pre-generated (Foddy, 1995).

Questions two and three explored the domains of formal services and informal factors within the construct of support. Inventory items were pre-selected based on research into supporting caregivers looking after children with mental health problems as described in the first part of the thesis. Information about effectiveness was the common thread through these two questions. However, a different stem was used in each question in order to prompt experience and memory. Effectiveness is conventionally thought of, as the extent to which desired goals are achieved and are attributed to a programme or intervention, distinguishable from change that would have occurred anyway (Malcolm Hill, 1999). As the word effective was thought to be potentially difficult, it was explored in the pre-test phase and confirmed as meaningful to social workers.

Rating scales

A rating scale was developed for social workers to express the strength of their response in questions two and three. A uni-polar scale was used whereby one category is labelled on the continuum of responses, rather than two, for example 'highly satisfied' through to 'not satisfied'. Rea & Parker (1992) advocate using a scaled response continuum from highly favourable to highly unfavourable with a neutral middle category and equal points on either side of this. A 5 point Likert scale was selected as the most efficient means of obtaining the information. Although 7 point scales are often recommended (Foddy, 1995), it can be difficult to construct points beyond five which add value. As Fowler (1995) suggests: *"it is hard to think of adjectives to add to the continuum between good and excellent that have meaning and do not sound redundant"* (Fowler, 1995 p.162).

Question two asked about the effectiveness of support services commonly offered to caregivers looking after children and young people with mental health problems. In the five point scale devised for this question effective services were rated with a 1, being the highest ranking able to be provided, and the lowest point on the scale was 5, for services rated as non-effective. Participants were reminded in each rating question that it was their own views,

which were being sought on the topic. Open fields were provided in each inventory for new services or factors to be added and ranked.

Question three explored informal support to caregivers and other caregiving factors. Social workers were again asked to consider a group of pre-selected items and rate these using a similar Likert scale to that constructed in question two. In the five point scale devised for this question, effective support factors were rated with a 1, being the highest ranking able to be provided, and the lowest point on the scale was 5, for support factors rated as non-effective. Question three used a common social work phrase 'preventing placement breakdown' as a proxy for the term 'strengthening care outcomes'. 'Placement breakdown' was used in this way because the term 'care outcome' was not in wide use by social workers in the organisation at this time. In the pre-test phase 'preventing placement breakdown' proved to be a meaningful phrase, which would successfully engage social workers considering positive care outcomes.

Question four provided a five point rating scale by which social workers assessed the adequacy of Child, Youth and Family support to caregivers. The wording of this question used the generic term 'organisation' as the entity under assessment rather than 'social work performance'. This was done to encourage truthful responses and in particular to provide a prompt to the next, open-ended, concluding question.

Open comments field – Question Five

A place was needed in this study for social workers to provide more complex responses. Open-ended questions are a good way to learn about the reasoning behind a conclusion or the preference of the respondent about a complicated situation (Fowler, 1995). This was appropriate in this survey as social workers were likely to have concerns about the role of the organisation on their ability to support caregivers effectively. Open ended questions do not presuppose which feelings or thoughts will be salient and allow the respondent to select fully from their repertoire of responses (Patton, 2002).

Alston & Bowles (2003) advocate the inclusion of open-ended questions at the end of a survey rather than the beginning, as they require more time and effort on the part of the respondent than closed questions. This final question asked social workers whether there were other important things that were needed to support caregivers for this group. The words 'important things' contained no assumptions about the response and provided opportunities for new information to be presented. This question allowed respondents scope to express strong feelings about matters already covered in the survey. The open question provided a

sense of closure to the inquiry and allowed complex feelings to be presented as participants' final contribution.

Survey administration

Pre-test

Information processing research suggests that survey responses involve a number of stages; interpreting the question, generating an opinion, fitting the response format and editing the response (Sudman, Bradburn, & Schwarz, 1995). The wording of the question and its construction may affect the responses chosen and so the survey format was pre-tested with a small number of social workers.

The survey was piloted using conventional pre-test techniques such as rephrasing and thinking aloud (Foddy, 1995). A small number of social workers were asked to read the questions and then re-phrase these in their own words as precisely as possible. This ensured the questions were not being misinterpreted and allowed improvement in terminology. Social workers were also asked to complete the survey and provide feedback on the ergonomics of the questionnaire design, the nature of the rating scales and the time taken to respond.

Wording in questionnaire design is difficult. Sudman et al. (1995) suggest staying with the general principle of using words which everyone understands and which have only the meaning intended. Alternatives for the terms 'effective' and 'positive care outcomes' were explored. Although some respondents expressed difficulty with the term 'effectiveness' it was preferred to alternatives such as 'working well' or 'making a positive contribution'. Participants in the pre-test phase believed that social workers would be sufficiently conversant with the term 'effectiveness' to reply appropriately. An alternative to 'positive care outcome', being 'preventing placement breakdown' was selected in the pre-test phase.

Survey distribution

With a straight-forward design the survey could be self administered. It was mailed, addressed directly to a social worker or supervisor by name, with a preaddressed, post paid, return envelope enclosed. The results, once compiled, were posted to all Child, Youth and Family social workers and supervisors in a special electronic bulletin using the Child, Youth and Family internal website.

Results

Four hundred and eighty social workers and supervisors were sent the survey and 237 of those people completed and returned these. This represented a response rate of 49.3%, which is acceptable for this form of research method. The survey gathered both qualitative and quantitative data. Quantitative data were analysed and statistics are presented in this section using frequencies, arithmetic means, standard deviation and confidence intervals. Tables summarising these results are provided in the text. Qualitative data from the open comments fields were categorised and interpreted. Illustrative quotations from the comments of respondents are included in the text.

Social work with children and young people with mental health problems

One hundred and eighty six social workers (78.5%) responded that working with children or young people with mental health problems was more difficult than working with other clients. A further 44 social workers (18.5%) stated that comparisons between clients could not be made. Only one social worker (0.4%) thought that children and young people with mental health problems were easier to work with while one other social worker (0.4%) thought that having a mental health disorder did not make a difference to the difficulty of the casework. Five social workers (2.1%) did not respond to this question.

Efficacy of support services

Table 5 below presents mean social worker ratings of the efficacy of support services. No new items were offered in the open comments field in this question. Social workers in this survey rated every support service as at least partially effective in supporting caregivers looking after children with mental health problems. Mean responses for all service categories appeared above the neutral category (3), however, no support service mean rating was above the partly effective score (2).

Table 5 Mean social worker ratings of the efficacy of support services

Support Services	Mean	Standard Deviation	Confidence Interval (95%)
Social work support	2.19	.995	Lower Bound 2.05 Upper Bound 2.34
Providing information about the disorder	2.31	1.30	Lower Bound 2.12 Upper Bound 2.50
Respite care	2.43	1.44	Lower Bound 2.21 Upper Bound 2.64
Minders and support workers	2.49	1.36	Lower Bound 2.29 Upper Bound 2.69
Service co-ordination	2.59	1.33	Lower Bound 2.40 Upper Bound 2.79
Support groups	2.70	1.27	Lower Bound 2.51 Upper Bound 2.89
Financial reimbursement	2.75	1.39	Lower Bound 2.55 Upper Bound 2.96
Home support	2.80	1.20	Lower Bound 2.62 Upper Bound 2.97
Training for caregivers to manage behaviours	2.80	1.55	Lower Bound 2.57 Upper Bound 3.02
Family therapy	2.87	1.16	Lower Bound 2.70 Upper Bound 3.04

Efficacy of other caregiving factors

Table 6 presents mean social worker ratings of the efficacy of informal support and other factors in preventing placement breakdown.

Table 6 Mean social worker ratings of the efficacy of informal support factors

Other Factors	Mean	Standard Deviation	Confidence Interval (95%)
Caregiver ability to manage behaviour	1.43	0.81	Lower Bound 1.31 Upper Bound 1.55
Caregiver understanding a disorder	1.44	0.77	Lower Bound 1.33 Upper Bound 1.56
Strong family relationships	1.48	0.72	Lower Bound 1.37 Upper Bound 1.58
Previous experience	1.57	0.81	Lower Bound 1.45 Upper Bound 1.69
Attending school or in work	1.62	0.83	Lower Bound 1.50 Upper Bound 1.74
Positive role models	1.67	0.81	Lower Bound 1.55 Upper Bound 1.79
After school and weekend activities	1.70	0.84	Lower Bound 1.58 Upper Bound 1.83
Support from friends and family	1.77	0.88	Lower Bound 1.64 Upper Bound 1.90
Identifying and incorporating culture	1.99	0.93	Lower Bound 1.85 Upper Bound 2.13
Spirituality and values teaching	2.46	1.03	Lower Bound 2.31 Upper Bound 2.62

No new items were offered in the open comments field in this question. The mean ratings for all items except spirituality as part of care were between the partially effective (2) and

effective points (1). The mean rating for spirituality, as part of care, lay between the neutral (3) and partially effective (2) point of the scale.

The difference between the overall ratings of formal support services and informal supports and other caregiving factors was further investigated, as Table 7 describes. A block mean was calculated for the mean ratings of support services in question two and for the mean ratings of other factors in question three, and a paired sample T test carried out. The difference between the two was significant ($t=11.9$ with a $p<.001$).

Table 7 Formal and informal block means and standard deviations

Block	Mean	Standard Deviation
Formal Services	25.77	9.88
Informal Supports /Factors	17.08	5.77

Adequacy of Child, Youth and Family social work support

In response to questions four, the majority of social workers viewed Child, Youth and Family as performing poorly in support of caregivers looking after children and young people with mental health problems. The mean score was 3.51, placing it between the neutral (3) and poorly (4) points on the rating scale with a standard deviation of .92, lower bound confidence interval of 3.38 and an upper bound confidence interval of 3.65.

Open comments field results

190 (80.1%) respondents provided comment in this open field. They recorded general points pertaining to organisational and contextual factors, along with providing further comment about support services, informal support and caregiving factors already covered in the earlier survey questions. For the purposes of interpreting this material some general categories are used below to discuss the comments of social workers.

Overall, the focus of these comments was on social work support and access to mental health services. The role of other caregiving factors was not well discussed within these comments, despite social workers rating these factors as more effective than formal supports in achieving positive care outcomes.

Inadequate mental health services

The predominant concern of social workers was the current inadequacy of mental health services. A range of opinion was offered about these deficits. Some social workers felt there were insufficient mental health services available in New Zealand for children and young people. Others noted particular gaps in respect of certain diagnoses, lack of practical assistance, and the low numbers of inpatient beds and residential care. In particular, the lack of mental health services outside the hours of 8.00 am to 5.00 pm was discussed, illustrating the unavailability of crisis back up for caregivers. Generally mental health services were seen as unresponsive. Social workers experienced unacceptable delays in negotiating assessments for children and support services for their caregivers.

Limitations of interagency co-ordination with mental health services

Social workers expressed frustration at working with a number of agencies, in particular health and education services and indicated that similar difficulties existed for caregivers. A picture emerged from social workers of a failure of agencies to work together despite co-ordination efforts. *"My experience is that mental health services are reluctant to diagnose and or treat young people, this makes supporting caregivers difficult as CYF social workers are not experts".*

Allocation of case leadership appeared to be contentious. Respondents suggested mental health services were not assuming case leadership when mental health problems were the presenting problem. What was needed, as one social worker commented, was: *"the mental health service to acknowledge and ACCEPT their responsibilities and be actively involved and supportive".* Openness and co-operation were highlighted as problematic particularly in case discussion: *"CYPS is happy to discuss and meet with all involved, health is too protective of their own and need to learn to be more open and to be available to attend meetings, (they're too busy to attend, not good enough)".*

Interagency protocols and agreements exist but were reported as functioning poorly. In some cases, the procedures were described as onerous, and in other cases, further protocols were needed because existing ones were not working. One social worker described what was needed: *"Clear protocols/working relationships with the Department and Child and Adolescent Mental Health Services or adult mental health. I believe this in turn will enable the social workers to support the caregivers better".*

Some social workers indicated in this context, that while existing protocols may achieve co-ordination, it is co-operation, which is needed. Respondents viewed co-operation as meaning: *"easy referrals, acceptance of each agencies obligations (no buck passing), simplified, easy access to funding"*. Another commented: *"All involved agencies need to have and maintain open communication and a trusting relationship with each other and the caregiver"*. Disparity in service philosophy accounted for some of the problems, for example, the difficulties engaging adult mental health services, who do not have a child focus, with child protection services.

Informal exclusion of Child, Youth and Family clients from mental health services

Many social workers attributed their difficulties with mental health services to an informal exclusion of children and young people who are involved with Child, Youth and Family. These were amongst the strongest comments made by social workers. *"It is my opinion that mental health offer little support especially when a young person is in the Chief Executive's custody"*. Social workers felt that if a child was with Child, Youth and Family, in effect this disenfranchised them, rather than promoting their access to support services. *"Too often Child, Youth and Family are expected to have the primary role with these clients when the mental health professionals are more appropriate"*.

Social workers commented on the implication of these access issues for caregivers:

"I think often CYF caregivers are disadvantaged when seeking health or education support for their child or young person as these agencies often see that CYF are involved and try to put the responsibility for staff and resourcing on to CYF. Caregivers often end up in the middle advocating for the child".

This appears to be the case for certain diagnoses:

"I don't believe that we work well with mental health services and I believe that this has a negative effect on placements and caregivers feeling supported e.g. young people who are experiencing suicidal thoughts and mental health services not accepting that their behaviour is suicidal but redefining it as a behavioural problem. This form of assessment means that totally unrealistic expectations and responsibilities are put on caregivers and CYF social workers".

Needing health expertise

Mental health expertise was highly sought by social workers surveyed. They identified that, on their own, they could not support caregivers looking after children with mental health problems and that support must also come from the mental health services that hold this expertise. Having a mental health worker assigned to support caregivers, because of their knowledge, was viewed as a priority for many social workers: *"It is crucial that the mental illness is correctly diagnosed and treated and that the mental health system is appropriately caring for the client and supporting the caregiver"*. One social worker suggested that caregivers needed to be recruited from within the mental health network: *"Mental health disordered children or young people need to be cared for by health department caregivers – CYFs caregivers are not trained for this"*.

Inadequate social work support to caregivers

Almost as crucial as the lack of mental health services was social workers' own inability to provide caregivers with adequate support. Social workers described themselves as having a central role in supporting caregivers although they were aware of the deficiencies in their support.

The nature of social work support

Caregivers were clearly valued by social workers who participated in this survey.

"Caregivers are the most important link for children and young persons with mental health disorders. We don't have enough of these caregivers. Most are taken for granted. Statutory agencies are not good at supporting caregivers".

The comments provided insight into how social workers constructed effective social work support to caregivers. Social workers described their support as constituting a range of matters including formal advice, passing on knowledge and expertise and providing access to resources such as respite care. For some respondents, social work support included listening, respecting caregiver opinions and relieving caregivers of self-blame.

Being available and accessible was understood as an important part of offering support, this was described as being involved, available and able to call on caregivers. *"Ongoing social work support regardless of the policy on frequency of visits, more frequent visits (higher*

input) tends to be needed". Providing practical support was emphasised by a number of other social workers: *"practical support re minders, respite, babysitting are most important because it doesn't matter how much a caregiver understands or cares if they are exhausted they will not cope."* Others mentioned: *"Appropriate resources, toys, books, computers in the house"*.

Some social workers included in their comments, a concept of teamwork whereby social workers and caregivers worked together to achieve casework goals. Teamwork, when discussed by respondents, included communication over planning, involving caregivers in treatment programmes, and joint decision making. Respondents emphasised the value of integrating caregiver experience and opinion in casework planning: *"Health and other service professionals listening carefully to caregivers and placing importance on what they say they are experiencing"*.

Problems in information sharing were viewed as confounding the provision of support to caregivers. Discontinuity exists at a number of points in the system, for example, between mental health and social work and between social workers and caregivers. Social workers highlighted how important it was for caregivers to have access to detailed information about mental health problems. Obtaining this information is perceived as difficult because social workers did not see themselves as possessing sufficient knowledge to assist caregivers in this way. Some social workers expressed frustration that access to information was blocked by mental health services, making it difficult for them to pass this on to caregivers.

Most importantly, social workers in this study linked their own capacity to support caregivers to the manner in which they were being supported themselves. *"Support must be more than lip service!-support needs to be seen to be happening both physically and emotionally –This of course is extremely draining on the social worker who also needs support"*. Social workers linked the failure of mental health to support them, to their acknowledged failure to support caregivers. Social workers particularly emphasised their lack of expertise. *"In my opinion social workers lack knowledge and are not adequately trained in mental health. This therefore hinders their ability to support, inform and advise caregivers"*.

The organisational constraints

Organisational constraints, in particular fiscal pressure, compromised social workers' ability to support caregivers. While special funding programmes existed, social workers described difficulty accessing these and needing skills to be successful in obtaining funding. Social

workers recognised that higher levels of remuneration to caregivers were justified in many cases due to: *"damage done by clients to caregivers' home, vehicles"* and the need for *"remuneration which reflects the difficulties in caregiving"*. In other circumstances, such as when a young person was too unwell to go to school, caregivers required extra financial support. However, social workers indicated that financial constraints impacted on their capacity to respond with higher remuneration packages. In addition, it was difficult to resource adequate support arrangements because of the problems in payment mechanisms.

Wider organisational problems also impacted on the ability of social workers to support caregivers: *"The office organisational structure needs to be taken into consideration i.e. offices that are under resourced, vacancies, new inexperienced workers, sick leave hinders any social workers availability to provide required support"*. Many respondents regarded social work caseloads as too high to allow adequate time to respond to caregivers. Others stressed the extra requirements in managing casework for children with mental health problems, such as interagency work. There appears to be little recognition within the system of these extra demands.

Social work support – someone else's job

A group of respondents indicated that it was no longer feasible for the main role of social work support to caregivers for this group of children and young people, to be carried out by the child's social worker because of the intensity of the task and the limitations on social workers time.

"We need more time to spend with them than with other caregivers as their role is often 24 hours and challenging without the let up of healing. Don't think a social worker can do that – need to have someone who has just that support, practical role, almost like a minder for caregiver!!"

Some social workers saw the new caregiver liaison social workers as able to fulfil this role. Others expressed doubts however, that the number of newly appointed caregiver liaison social workers would be sufficient to support caregivers in the way that was needed.

Lack of a range of support services

The majority of social workers making comments emphasised the lack of support services available. They noted that while the range of support services covered in the inventory in

question two was broad, in reality, few of these services were available to caregivers. Some social workers commented on the need for additional, different approaches for Maori mental health issues : *"Tohunga skilled and knowledgeable in the area of Maori mental health"*. Others commented on the need for all to have greater *"cultural awareness about the mind and spirituality"*.

Managing child behaviour was seen as key. *"Mental health professionals need to work much more directly with caregivers regarding behaviour management rather than just clients or social workers."* Mental health services were viewed as the place where information on behavioural management resided. However, problems accessing good clinical support for those in Child, Youth and Family care appeared to leave caregivers vulnerable and unsupported.

Social workers included shared care, weekend breaks and holidays as part of their concept of respite care but commented on the lack of respite options to build into plans. *"Well supported respite care. The strain on the family/whanau if they always have to organise respite care. The effect of sickness/ill health tiredness on caregivers ability to cope"*. Fiscal constraints within the service meant that respite care could not always be funded and mental health provision of respite care was: *"extremely scarce for young people"*. Additionally, the problems of organising respite care were attributed to the difficult nature of child behaviour and the lack of people willing to offer places.

Inadequate training

Many social workers saw the need for in-depth caregiver training to deal with issues presented by children and young people with mental health problems. *"If a caregiver can understand certain aspects of a client's behaviour they are more accepting of that behaviour"*. Other respondents emphasised training for both caregivers' and social workers but noted that this critical specialist training is not usually available to either group. One social worker suggested, their inadequate training meant that they were unable to support caregivers: *"Train the social workers first so that they can then support the caregivers."*

Is foster care a viable option?

A small group of social workers in the survey questioned whether foster care is an appropriate means of looking after children with mental health problems. They questioned whether any level of support could ever be enough:

“In many instances caregivers or foster placements are not in the best interests of the child and young person. They are often best placed in a less intense and more structured environment e.g. family home type placements; support in itself may not be enough”.

A range of other options was suggested by these respondents, including facilities for those with drug and alcohol disorders and medium and long stay therapeutic residences for adolescents with mental health problems.

Discussion

There is evidence in these results that Child, Youth and Family social workers who work with children with mental health problems understand the importance of informal support and the contribution of caregivers’ own strengths in the provision of successful care. Social workers and supervisors rated formal support services including social work support as less effective than informal supports and caregiving factors. The body of research on resilience, reviewed in chapters two and three, supports their judgement. These studies have established that care-giving and contextual factors are significant in the resilience of families and the life course outcomes of children and young people with mental health problems.

Social workers evidenced familiarity with the principles of strengths based practice, which emphasise the internal strength of caregivers and the importance of support such as that provided by friends and family members in caring for children with high support needs. Factors such as strong family networks, participation in school, recreational activities and building positive social networks were all rated highly by respondents as contributing to positive care outcomes. Caregiver experience and understanding of mental health problems were also highly regarded by social workers. Echoing research describing the importance of management of child behaviour to caregivers (A. Cox & Tregeagle, 1999; Richardson & Joughin, 2000), social workers in this study viewed the capacity of carers to manage difficult behaviours as important in achieving good care outcomes.

Formal support services (financial support, home support, training for caregivers and family therapy) were rated lower than informal factors but were nevertheless regarded as having value. All formal services were placed above the neutral point on the scale and many were highlighted in the open comments field. Reflecting the growing place of respite care in child welfare services (J. O'Brien, 2001), respondents to this survey also emphasised this form of support as having a positive role in care provision.

Unexpectedly, despite the high ratings social workers gave to informal factors, the open comments were dominated by concerns for better access to mental health services and improved social work support. Supporting informal carers' own networks and caregivers' internal strengths received comparatively little comment. This may suggest that while family resilience or family strengths is well understood and valued by social workers, there is less knowledge about how to adapt their own social work actions to promote these protective factors.

This study sought to understand the values and perspectives behind the construct of support used by social workers. The survey indicated that this group of social workers understood the difficult nature of care and identified many of the aspects of support which previous research suggests that caregivers value. As chapter five outlined caregivers construct effective social work support as including involvement in decision making, teamwork, practical support and assistance, emotional support, regular contact and provision of information (T. Fisher et al., 2000; Triseliotis et al., 1999). Respondents in this study also described all these matters as part of social work support.

As discussed in chapter three, Twigg (1989) describes three possible models by which social care agencies construct their relationship with caregivers, being caregivers as a resource, caregivers as co-workers and caregivers as clients. In this study social workers primarily regarded caregivers as a resource to the organisation. They held concerns in respect of the pressures on this resource. Some suggested that there is an insufficient supply of caregivers to maintain foster care as a viable option for some young people with serious mental health problems. Amongst participants there was also a desire for more teamwork, suggesting some social workers may view caregivers as co-workers or as having this potential.

In the negotiation of a support response, these results indicate that common ground may exist between caregivers and social workers surveyed. While participants understood many aspects of social work support, which are documented overseas as valued by caregivers, the results also suggest that social workers may be missing opportunities if their focus remains fixed on gaining access to formal support services. Social workers appeared to disregard their own role in inquiring about informal factors and seemed unfamiliar with ways to enhance and strengthen these networks. Child, Youth and Family may require further consideration of the role of social work support in respect of informal networks. Such thinking is likely to come within the strengths based practice developments planned by Child, Youth and Family (Child, Youth and Family, 2002e).

There was a high level of awareness of the failure of Child, Youth and Family social workers to support caregivers looking after this group of children and young people. The potential effectiveness of social work support in sustaining good outcomes accounts for the frustration experienced by social workers who are unable to provide this support. Compounding this disappointment was their inability to obtain mental health input and sufficient back up services and information to offer caregivers. While respite care was rated as the third highest formal support service, social workers noted difficulties experienced by families in finding adequate respite care in the presence of challenging child behaviours.

Social workers saw managing child behaviour as key to developing stable care. There were few suggestions however, about how to ensure caregivers were able to do this. Social workers reported themselves to be poorly informed about mental health problems and unable to answer detailed questions from caregivers.

A sense of powerlessness is perceptible in the comments of social workers. They felt that the provision of effective support to caregivers was largely out of their reach, given the organisational context and lack of engagement with mental health services. In the light of these deficits some social workers believed the support needed was unobtainable.

Alternatives suggested included sharing this role with mental health services, pursuit of non-foster care options and the development of specialist support roles within Child, Youth and Family, such as caregiver liaison social workers.

Interestingly, social workers did not comment on those aspects of their support role which were within their power to change or enhance. Social workers in this study demonstrated an understanding of the importance of regular telephone contact and emotional support but did not comment widely about their ability to improve these aspects of their support. Nor was there a sense that the involvement of caregivers in planning and casework was robustly in place in the organisation. These are matters which Child, Youth and Family social workers could attend to without additional resources or the input of others. Overseas research suggests that improving these aspects of support will increase the satisfaction of caregivers (Triseliotis et al., 1998).

The 'agency of last resort' as described in recent reviews (Brown, 2000; Ministry of Social Development et al., 2003) is reflected in social work commentary in this study. The child welfare service in New Zealand, as in other jurisdictions, appears to struggle to cope with the mental health problems of those in their care. Child, Youth and Family social workers reported difficulties with interagency relationships, which appear to persist (Ministry of Social Development et al., 2003). There was a striking similarity between these results and

the access problems and exclusions reported for this group of children and young people overseas (Nugent & Glisson, 1999; United States General Accounting Office, 2003). Interagency agreements and service co-ordination, while valued by social workers, were reported as failing or not in operation. Until a means is found for social workers to receive the support that they require from mental health services, it is unlikely that they will be confident or sufficient in their support to caregivers.

The resulting isolation reported by social workers who are involved with children with mental health problems is of concern. These findings concur with those reported by Child, Youth and Family(1999b) Calvert (2000), and Cockburn (2002). The majority of respondents viewed children with mental health problems as the more difficult of their cases. The open comments fields however, indicated that the frustrations relate to inter-and intra-organisational problems rather than to child symptomology. A picture forms of social workers struggling in isolation from mental health services, bearing what they believe to be an unfair level of case responsibility, constrained by fiscal and time pressures and aware of their inability to support caregivers sufficiently.

Independent variables

A final aim of the study was to derive variables from the results to explore further in the quantitative analysis contemplated in study four. All services and caregiving factors identified in the study were viewed by social workers as at least partially effective. No new factors or services were generated in the responses of participants. All factors were taken forward as potential variables to be used in the fourth study.

Limitations

While the discussion suggests some continuity in social work perspectives on support limitations around the choice of method, constitution of the sample and timing restrict the conclusions that can be drawn.

The construct of support is a complex one. The restrictions applying to access to social workers constrained the level and the manner in which this construct could be developed within the study. Ratings scales were used as an efficient means of constructing data and results were derived using arithmetic means. Rea & Parker (1992) point out that this process of treating ordinal data as if it were interval data has limitations. Firstly, it assumes that all respondents will share a common understanding of the response categories, which is not

necessarily the case when dimensions such as effectiveness are measured. Secondly, the interval manipulation of the rating scale assumes an equal distance between response categories, which again cannot be assumed. Despite these limitations it is acceptable that mean results can be presented in this way: *"because the power of the information obtained is considered to far outweigh the costs associated with relaxing these technicalities"* (Rea & Parker, 1992 p.154).

While rating scales are an efficient means of gauging strength of opinion, discovering the experience of social workers and the meaning they attribute to support could only be determined through an open comments field. The scale of response to this question suggests a richness of data, which could only be explored in a limited way in this study. The inclusion of this field made a significant contribution to the depth of information derived from the survey.

The study could not select social workers who were experts in the provision of support to caregivers looking after children with mental health problems, but was constituted from those who had experienced a social work role with children with these problems. There are limitations in deriving participants in this manner. Social workers with this experience, who had not completed returns for the database or who had this experience but did not have a child with a mental health problem in 1999 were excluded from participation. In some cases social workers included in the survey may have had involvement with only part of the care and protection process, for example an investigation into a notification for a child with mental health problems who was not in a care arrangement.

P. M. Wells & Smith (2000) note geographic disparity in the response of social workers to the original request in 1999 to include clients with mental health problems on the database. This has consequences for the sample of social workers available to this study. It is likely that the sample was not adequately representative of social workers from northern parts of the country. Sample error in respect of the 1999 mental health database is discussed further in chapters eleven and twelve.

Hill (1999) warns researchers of the problems of judging effectiveness of interventions when services exclude or are less accessible to certain groups. Gaps in mental health services for Child, Youth and Family clients, described in chapter four, meant that it is likely that social workers were called on to evaluate services in this survey, of which they may have had little experience. There is however, some evidence in the level of missing responses of participants that when they were unfamiliar with a service, they did not enter a response.

When the survey was completed in 2000, many of the new inter-sector initiatives such as the High and Complex Needs Strategy or the Intensive Clinical Support Services were yet to be introduced. Social workers surveyed in 2004 may have viewed inter-sector relationships as improving. In this way the comments of social workers about their difficulties working with mental health services and in particular the lack of case leadership may need to be regarded with caution. While there is an indication in Cockburn's (2002) study of some enhancement in inter-agency relationships, particularly between CAMHS and Child, Youth and Family, more recent analysis suggests these interface issues continue to be vexatious (Ministry of Social Development et al., 2003).

Conclusion

The aim of this first study was to explore social workers' views of effective support to caregivers looking after children with mental health problems. A survey methodology, incorporating rating scales and an open comments field was successful in building a comprehensive picture of social workers' perspectives on support. The study recruited a substantial group of participants. A response rate of 49.3% to the study was achieved during a period of extreme work pressures indicating the subject was of interest to social workers.

The results suggest that there is likely to be a shared basis for social workers to negotiate a support response with caregivers. Key aspects of support traditionally valued by caregivers looking after children with high needs were found to be part of this group of social workers' views of support. Social workers valued informal networks and caregiving factors more highly in achieving strengthened care than they did formal support services. However, social workers may require further practice guidance to promote practical support to the informal networks of caregivers.

Of particular concern is the isolation felt by social workers involved with this group of children and the problems they have with inter-agency relationships and access to mental health services. Until this isolation is effectively addressed it is difficult to see how social workers can approach the support of caregivers with confidence. The results of this study provided information from which to contrast the construct of support explored with caregivers in the next study. Findings from this study also formed independent variables for inclusion in the quantitative analysis in study four.

Chapter Nine

Caregivers' Perspectives on Support

Purpose of the study

The purpose of the second study was to explore caregivers' perspectives on caring for children with mental health problems on behalf of Child, Youth and Family, and identify those supports they view as effective. Family strengths theory suggests that caregivers will have intrinsic coping strategies and will be the best source of information about the support they need. Research, reviewed in chapter three, indicates that informal networks are likely to be important, along with formal support services (Friesen, 1989). Resilience research also confirms that a number of family-related factors, such as positive communication and spirituality can act to buffer children at risk against further negative life outcomes (Kalil, 2003). New models of foster care (Gilligan, 1997; Schofield, 2002) underscore the role of these protective factors.

Four questions formed the basis of this study:

- How do caregivers view their experience of providing care for children with mental health problems on behalf of Child, Youth and Family?
- What do they see as the nature of effective support?
- What kind of support is received from Child, Youth and Family?
- What other factors do they view as strengthening the care they provide for this group of children?

The study aimed to compare caregiver perspectives with the views of social workers surveyed in study one. In addition the study proposed to include those factors which caregivers identified as effective support, as independent variables in the quantitative analysis in study four.

Research design

Caregivers are likely to experience care provision as stressful and frustrating (K. Wilson et al., 2000). A research method was sought that could explore perspectives and enable expression of strong, sometimes painful feelings. A focus group was an appropriate

methodology for both developing viewpoints and providing a supportive process in which this expression could happen.

Focus groups

The focus group is described as an interview with a small group of people on a specific topic. High quality data are derived in this social context, as people can consider and develop their views in the light of those of others (Patton, 2002). While traditionally focus groups were thought of as a preliminary process leading to quantitative research (McQuarrie, 1996), the focus group also exists as a self-contained method. As Morgan (1997) remarks:

there is in fact a long tradition of treating focus groups solely as preliminary or exploratory research that must be backed up by other methods.....For many purposes, focus groups, like other qualitative methods can be a well chosen, self contained means for collecting research data (Morgan, 1997 p.18).

In this research the focus group was employed as an independent research method constituting study two, and the findings were also integrated, as variables for the subsequent quantitative study, and further interpretation of quantitative findings.

In a focus group participants can ask each other questions, comment and reflect on their own experience. An assumption of the focus group is that the group environment will encourage discussion, increase motivation to address critical issues and allow significant views to be expressed in a real, emotional and spontaneous manner (Sarantakos, 1998). Group interaction then, within the methodology, is a powerful tool to understand similarities, identify difference and refine meaning.

Focus groups are ideally suited to the investigation of perspectives, which includes the attitudes, opinions and meanings which participants attribute to their experiences. As Morgan (1997) explains: *"An emphasis on perspectives brings together attitudes, opinions and experiences in an effort to find out not only what participants think about an issue but also how they think about it and why they think the way that they do"* (Morgan, 1997 p.20).

The advantages of a focus group include cost effectiveness, data quality, ease of assessment of shared or divergent responses and participant enjoyment of the process (Krueger, 1994; Patton, 2002). In this research, these were considered significant benefits. As this was privately conducted research that consisted of a series of projects, the cost of each study had to be minimised. The study sought high quality data from participants and anticipated a need

to probe caregivers' responses. Given the difficulties reported by caregivers looking after this group of children and young people, and the problems they experienced with Child, Youth and Family, a supportive process was needed which participants could enjoy.

Focus group process

Rea & Parker (1992) describe the focus group as a limited discussion of a small number of fixed issues in a semi-structured format. Participants in focus groups are expected to hold shared interest in the subject of discussion and be interactive during the course of the group. The focus group is led in order to direct and expand discussion and obtain information from all participants. Facilitators commonly use a schedule of questions as a guide to the issues which are put to members during the course of the discussion. In this study an interview guide was used to shape the focus group process, which ensured that the main research questions were covered in the discussion.

Focus group size varies but usually involves up to 10 participants (Patton, 2002), although some writers discuss focus groups as constituting up to 20 members (Sarantakos, 1998). Participants need to be knowledgeable about the research topic and motivated to share opinions. The role of leader or facilitator during the session is to describe the issues, contrast viewpoints, present alternatives and establish where group opinion lies (Sarantakos, 1998). Conventionally focus group discussions take between one to two hours (Patton, 2002).

There are key phases in establishing a focus group. Rea & Parker (1992) describe these as: identifying the critical characteristics of potential participants, establishing the appropriate number, finding an appropriate facility, determining incentives for participants and establishing the optimum time. These are dealt with in turn below.

Determining the participants

Participants were sought with experience in providing care for children and young people with mental health problems on behalf of Child, Youth and Family. The viewpoints of a range of caregivers were needed, including those with little experience, long-term carers, kinship and foster caregivers.

There were two critical characteristics sought for participants. The first was that they had provided care as a formal arrangement on behalf of Child, Youth and Family rather than by private arrangement between families. To meet this requirement, participants could be

caregivers who were recruited by Child, Youth and Family or caregivers who were part of an independent Child and Family Support Service who were providing care on behalf of Child, Youth and Family. The second requirement was that caregivers needed some experience in looking after a child or young person who was identified as having a mental health problem.

Age and length of experience were not viewed as critical factors. It was anticipated that having participants with a diversity of experience and age would strengthen the group discussion. The inclusion of those who were less experienced in providing this form of care or who were younger would provide different insights, to those who had provided care over a period of time.

Determining the number

Care of this group of children and young people is typically constructed as an emotionally exhausting, sometimes frightening and difficult experience. Caregivers were expected to speak at length and need time to absorb and be sensitive to the feelings of others. The size of the focus group was anticipated as being in the middle range, between 12–15 participants. A group with greater than 15 participants risked there being insufficient talking time for group members.

Where focus group discussions are expected to be intense it is recommended that an assistant is used, to supplement recording and support facilitation of the discussion (Sarantakos, 1998). This approach was adopted in this study. A co-facilitator was used to assist in guiding the group debate, recording group comments and time keeping. Co-facilitation allowed the researcher to concentrate on focusing the discussion, ensuring all participants were given the opportunity to speak, and also recording group comments.

Sarantakos (1998) and Morgan (1997) discuss the relative merits of electronic and written recording of focus groups. The advantages of accuracy provided by electronic recording are often outweighed by intimidation some people feel when their statements are recorded, particularly when difficult matters are being discussed. The discussion topic was sensitive and expected to involve criticism of Child, Youth and Family. A tape recorder was viewed as likely to inhibit group comment and so the session was manually recorded. While having the advantage of reducing participant levels of anxiety, manual recording has the potential for researcher bias to influence what is recorded. To guard against this, the two facilitators made parallel transcripts of the discussion, which were then cross-referenced.

Determining the venue

There was no formal group representing caregivers looking after children with mental health problems at time that this research was conducted. While potential existed within the mental health database to identify possible participants, contacting caregivers directly would threaten the anonymity of clients on the database. For this reason caregiver participants were recruited from within the New Zealand Family and Foster Care Federation (NZFCFF) network. An opportunity existed to connect with these caregivers at the annual conference of the Federation. The prevalence of mental health problems amongst children in out-of-home care meant that it was likely there would be a sufficient number of caregivers attending this conference with experience of providing this form of care.

The New Zealand Family and Foster Care Federation is made up of foster carers and kinship carers who are connected with a broad range of organisations providing care throughout New Zealand (The New Zealand Family and Foster Care Federation Inc, 2004). It includes caregivers who provide care for Child, Youth and Family but it is not restricted to this membership. Annually, the Federation holds a conference for all local caregiver branch members to share information about matters of interest, provide support for members, lobby Government agencies for change and conduct annual elections. The annual conference offered this research a venue where caregivers would gather together in a self-organised setting with aims of self-education, support and policy development.

There were advantages in using an annual conference as a means to recruit participants and as a venue for the focus group. Firstly, it was a non-threatening forum run by caregivers with objectives of providing peer support and information. This allowed the study to be embedded in a context which belonged to caregivers and was not associated with the activities of government agencies. Secondly, participants would be primed to talk about the study topic, as support issues and the nature of caregiving were the primary focus of the conference. Recruiting participants from a live-in conference also overcomes problems of finding a suitable venue and time. The conference is a place where caregivers gain peer support and encouragement. It was anticipated that caregivers would have peer networks at the conference which might support participation in a focus group.

Incentives for participation

The conference agenda for the annual conference of April 2001 involved a number of activities concerned with looking after children with mental health problems, including a workshop on ADHD, and a briefing by Child, Youth and Family on the Youth Services

Strategy for children and young people with high needs. The conference agenda then was likely to stimulate interest in the focus group. As such special inducements were considered unnecessary. It was thought that caregivers would welcome the opportunity to discuss further, matters that were already in the conference domain.

All conference participants who pre-registered received an invitation to participate in the focus group and an information sheet in the month before the conference. Active recruitment was also carried out on the day of the conference to remind people who had already received invitations and to contact those who had not pre-registered. This recruitment was by way of posters, pamphlets and word of mouth. The invitation sought participants with experience of providing care for children with mental health problems on behalf of Child, Youth and Family. The information sheet is attached in appendix 5.

Determining the time

Permission was sought from conference organisers to run a focus group on the first evening of the conference after dinner. Should participant numbers be high, there was an option to run a second focus group later at the conference. The focus group was distinguished from the conference programme proper by its evening time slot, and advertised as a research-based session. The evening time, while usually problematic for caregivers, was conceivable in a live-in conference, as caregivers had already prearranged care for their children as part of their conference attendance.

Conducting the focus group

Twenty-two caregivers responded to the invitation to participate in the focus group. This is a larger number than is usually recommended for focus groups and a proposal was put to the group for it to split into two groups each led by a facilitator. Participants, however, were comfortable with the size and expressed a strong wish for the group to proceed with all members. The conference setting may have meant participants were already connected and supportive and in some cases did not want to contribute separately. Larger group discussions are typically more difficult to manage and require a higher level of moderator involvement (Morgan, 1997). However, having two facilitators meant the group preference, to remain together, could be met.

The session was anonymous and participants used only their first names in the group session. All members were invited to record their full names and addresses with the researcher if they

wished to be sent the results of the session. Approximately half of the participants chose to do this. Participants in the group appeared to be mostly middle-aged, female, and many stated in their introduction that they belonged to a church-based organisation that provided foster care. As discussed in chapter five these characteristics are typically found amongst foster caregivers in other child welfare jurisdictions (Berridge, 1997; M. E. Cox et al., 2002; Triseliotis et al., 1999). All were involved in the provision of foster care, there were no current kin caregivers present in the group. A final transcript was made utilising the notes of both facilitators, which was later sent to participants who wished to receive a copy.

The group process

The focus group session was entitled and advertised as Sharing Small Successes. This title was chosen in order to orientate the group to effective caregiving rather than the problems associated with this form of care. The funnel approach to moderating group discussion was adopted. Morgan describes this process as beginning: *“with a less structured approach that emphasises free discussion and then moves toward a more structured discussion of specific questions”* (Morgan, 1997 p.41).

Initially an opportunity was provided for members of the group to introduce themselves by first name. In order to orientate the group to thinking about success, participants were asked to recall a time when they felt something about their caregiving had turned out better than anticipated. Participants were asked to share this as a beginning point to the discussion and to make some guesses as to the factors or issues which may have been involved in these successes.

The group discussion then flowed naturally to the care of children with mental health problems for Child, Youth and Family. This was a comprehensive discussion drawing out caregiver perspectives on the nature of care and the meaning of effective support. As the session progressed, the facilitators worked with the group to explore informal support systems and the role of other intrinsic caregiving factors, for example, spirituality. In addition to scheduled questions, the facilitators made inquiries at certain points, in order to elaborate and contrast caregivers' views with those of others.

The emphasis was on exploring as many different perceptions as possible, rather than pursuing group consensus. Differences of opinion were identified and clarification sought where necessary. Morgan (1997) suggests that as a guide to what should receive most emphasis in the final results, is how much energy and enthusiasm the topic generates amongst the participants. The facilitators kept separate notes on the level of group consensus.

Strength of feeling was identified using verbal and non-verbal assent and dissent cues. The focus group process was lively and ran for approximately 90 minutes.

Results

Qualitative analysis consists of both description and interpretation. The separation of these phases of analysis is important (Patton, 2002). Description involves reporting the answers given by participants whereas interpretation involves explaining these results, attaching significance to certain responses and identifying patterns in these findings. In this results section a description of caregivers' responses is presented. Interpretation of these results is provided in the following discussion section, where the responses are also contrasted with the findings of study one.

The nature of care

The nature of care for this group of children drew high levels of emotion. On this topic there was a consensus of feeling amongst participants. Caregivers described the: *"in your face"* nature of this group of children and believed it is exhausting trying to meet their needs. The following description was greeted by nods and smiles: *"It's the intensity which is so demanding, you know she just wore down her caregiver, she was one of those kids who was just too close, too loud, too much"*.

The stresses identified were those which stemmed from managing difficult behaviours and personalities of these children and young people. *"There's different kinds of stresses, some kids they are loud and noisy, noise really matters to some people and they demolish things"*. The needs of other family members and the burden of care on siblings were also identified.

Providing care is a mission

For many participants, providing care for this group was described in spiritual terms as a 'calling' and or as a 'personal mission'. Most participants identified the church as their key informal support system. In New Zealand many of the non-government-organisations providing foster care, which are affiliated to the New Zealand Family and Foster Care Federation, are church-based. Some caregivers from this group were involved with these umbrella organisations however, others were not.

There was little reference in the group to spirituality being integrated into the teaching or rearing of a child or young person. Rather spirituality was the key sustaining force behind the provision of continuing care. For caregivers, their religious faith or spiritual identity provided a framework for interpreting difficult child behaviours and maintaining relationships with children whose behaviour is challenging.

For some foster carers, spiritual support was a key part of the social work support provided to them by the foster care organisations they were affiliated to. These foster parents emphasised how fortunate they were through their organisation to be able to access other foster carers who were also involved in such a spiritual mission. They spoke of the security of knowing you could talk to people who understood and endorsed what you were doing and who would help you endure and sustain care relationships. *"The support's there, there is a philosophy of supportive caring, your motivation is understood and people approve, they understand that what you are doing is a ministry, you won't get the condemnation"*. For other participants spiritual sustenance, prayer and group discussion was accessed through church membership rather than a foster care organisation.

Embedded in the nature of spiritually-based caregiving is the serious commitment which caregivers make to those children whom they look after. This group of caregivers stressed that once they became engaged in caring for a child, it was very difficult to withdraw from this, given their spiritual framework, even when it became clear that a care relationship with a child was no longer working. Some had experienced a destructive struggle to give up a caregiving relationship. There had been high personal cost in these situations and one caregiver restricted the care provided after this experience.

The nature of effective support

Respite care was emphasised as a key support to those trying to provide continuous care. *"Respite care was my saviour, sometimes for two times a week"*. Caregivers highlighted that in order to provide successful care, there needed to be ongoing respite or shared care, organised as part of the care arrangement. A caregiver who currently elected only to provide respite care commented:

"Respite is really good. You can really make them the sole focus, give everything to keep the peace, if you can keep a child happy then you avoid the grief but you can really only do this for short periods of time. Like one boy it was skateboard ramps so that's all I did we just went all around the skateboard ramps and that was all I focused on and it kept him happy. I turned my life around for this kid".

Many participants talked about the struggle to get their need for respite care recognised. *“But I feel that as caregivers you’ve got to beg for it (respite care) on your hands and knees”.*

There was agreement in the group that the need for respite care was not acknowledged by Child, Youth and Family social workers. Often other professionals were instrumental in obtaining this help, doctors and school principals being given as examples.

For some participants a first step was the recognition that their need for respite care was valid. One caregiver explained that it is hard when providing care to give prominence to your own needs and sometimes even to recognise these needs yourself. She talked of reaching a breakdown point before she would allow herself to acknowledge that she needed respite care and for her doctor to arrange this.

Although respite care was seen by so many as key, there was ambivalence because of the disruption it caused for this group of children. This created a dilemma for those wishing to access respite care. Overwhelmingly, caregivers saw placement stability as crucial and placement change to be avoided wherever possible. While there was awareness that placement change harmed children, participants acknowledged that respite care was necessary in order to sustain long-term care for children. Group members saw that, while respite care was required, it was disruptive and had consequences for family members when children returned home with new difficult behaviours. Access to the child's own family members was viewed as a particularly problematic form of respite care. Formal respite care was preferred with a carer trained to provide care and known to the child.

The informal network

Caregivers in the focus group described a lack of people in their own family networks who understood what they were going through. The group agreed that providing care to this group of children placed caregivers in a unique situation. Few people understood this apart from other caregivers. They saw their own peer network, that is, other caregivers who they knew, as vital in the process of supporting their provision of enduring care: *“the carers could also support each other because we both knew what we were going through. I just organised this myself, but have suggested this to others and it works for them, works for those in your face kids”.*

Caregivers emphasised that if you had to spend too much energy explaining why something was stressful in order to get support, you were worse off than if no approach had been made. This made it essential to be supported by people who understood the stress of this type of

care. Friends and families were not regarded as always helpful. Participants emphasised that wider family members could often make a situation worse because they did not recognise the commitment made by the caregiver. Family members were reported as believing that if caregivers were stressed this could be alleviated by terminating care. Family members who did not recognise the non-familial bond and serious commitment of fostering often generated this kind of advice. *"Your own family they don't understand, because they say like why do you do it, why don't you give it up. They don't understand"*.

The role of Child, Youth and Family support

There was consensus that the support provided to caregivers by Child, Youth and Family social workers was unsatisfactory. Social workers were seen to be inaccessible and not able to provide the kind of support needed by caregivers. Several participants talked about their inability to reach social workers. The voice mail technology for contacting social workers appeared to further frustrate and alienate caregivers seeking help. Social workers were reported to be not open with information about children and young people, using the Privacy Act as a rationale for providing caregivers with insufficient details.

Caregivers in this study did not regard social work support as the means through which they would seek changes in their care arrangements. Rather they sought support from social workers in order to share the reality of their situation and thus gain strength to endure the stress. The understanding and encouragement of a support person was the means by which caregivers reported they could continue to withstand the difficulties, sustain their vision and maintain caregiving relationships. They described an effective supporter as follows: *"they are walking with you through it. No one is solving problems for you, it's not like that, most of the time it is just listening, it's an opportunity to unload"*.

Participants felt that social workers did not understand the nature of this kind of support. There was a belief in the group that Child, Youth and Family social workers thought support involved problem solving, provision of extra resources or placement change. Caregivers in this focus group however, saw effective support as in-depth understanding and listening, taking a personal interest and being reliably in contact in order to share difficulties.

Child, Youth and Family as an organisation was viewed with some suspicion, in particular the move to encourage caregivers to establish legal relationships with children. This policy aimed to achieve increased rates of permanency for children and young people in care of Child, Youth and Family. Group members shared a fear that the initial packages put in place by Child, Youth and Family to support new guardians would later be withdrawn.

It is not unexpected then that the role of formal support services was not emphasised by caregivers in this study. This was, in part, to do with the lack of availability and the poor performance of support services. Caregivers expressed disappointment with the back up available from mental health services especially during crises. Crisis support was viewed as an essential part of providing enduring care, but caregivers thought that this was inadequately provided by both Child, Youth and Family and mental health services. While some professionals in both Health and Education were identified on an individual basis as helpful, this was because effective relationships had been established with these individuals.

Other factors which strengthen care

Learning your boundaries

Several in the group discussed the experience of providing care as a process of learning about themselves. In particular caregivers talked about determining clear limitations in the care they offered which they believed strengthened their caregiving. For many caregivers the process of learning personal boundaries and obtaining help was a very painful one. As one caregiver stated: *"it took me to burn out before I got the help that I needed, I needed to convince those around me. People around me didn't understand what I had to cope with"*. Another participant revealed: *"when I had the breakdown that's when I first got any respite care, two weeks away. I went away, but nobody helped my family cope in this time"*.

Caregivers attached different significance to establishing self-limits. Some emphasised that, unless you were able to set personal limits, you would not be able to establish boundaries with the children and young people in your care and teach them to set boundaries on their own behalf. In this way the setting of boundaries was critical to managing behaviour. Others explained that to provide ongoing care, caregivers needed to know their own limits in order to cope with the stresses involved. In this way boundary setting was about sustaining caregiving energy.

"We had a 16 year old who had tried to commit suicide, had lots of placement breakdowns, we shared the care of that person with another family, we had every weekend and one night off a week, shared with another family, it just took the pressure off and the intensity which is so demanding, you know she just wore down her caregivers".

Caregivers stressed the problems which providing care brought on other family members. Thus knowing the tolerance levels of the rest of the family was also integrated into caregivers' boundary setting.

Group members discussed the importance of preparation in providing enduring care. Participants identified that they usually lacked adequate preparation for placements. There was also insufficient matching of children with caregivers. A suggestion was made that there should be a clear trial period during which caregivers and children could see if they fitted well together. Caregivers viewed this as a natural justice process, given their intended serious commitment to a child.

There was agreement that caregivers needed information about specific mental health problems, along with training on how to manage behaviours relating to these problems and information about medication. The group shared hit-and-miss experiences with coping with medication and its effects on child behaviour. Diverse approaches to obtaining information were described, including the Internet and friends. Clinicians, although mentioned, were not the predominant source of information about medication for this group.

In respect to the role of other factors, caregivers emphasised the protective nature of employment for young people, once they were no longer able to be in school.

"I had a boy who did better than I thought; it was the job, really. We took him door knocking for a job, and he got work. He had been kicked out of two schools, his family was really bad, he associated with people who had murdered. He lives in Auckland, he is still a bit on the edge, he opts out of his family every so often and comes home for a few days but then he goes back and that is how he can cope really. That was really having a job".

Opinions varied about the significance of school attendance. While all in the group agreed it was important to try to maintain a child at school, there were mixed views about the support and assistance received from schools. Some participants had found those working in the educational setting to have been very helpful in establishing behavioural strategies, whereas for others in the group, this help was not forthcoming.

Discussion

The aim of the study was to identify the factors which a group of caregivers looking after children with mental health problems viewed as strengthening their care. A framework for interpretation of qualitative analysis is presented by Patton (2002), which includes approaches of process, issues, questions and sensitising concepts. As an objective of the study was to derive variables for further analysis, an issues-based approach was taken to the interpretation and discussion of findings. The following themes emerged.

The nature of care – a test of endurance

While caregivers echoed many of the issues identified by families of origin caring for children with mental health problems, there were important differences for this group of Child, Youth and Family caregivers. In keeping with other research (Friesen, 1989; Weiss, 1991) this study indicated that looking after children with mental health problems is stressful and demanding on all the family. The aspects of child behaviour that are difficult for all caregivers include the high levels of children's activity, their noise, the attention they seek and their potential for destructiveness.

Blame and stigma, which are significant issues for family caregivers (Friesen, 1989), were not discussed by this group, although they were referred to by social workers in study one. Participants in the study were foster caregivers who have no previous familial relationship with the child for whom they were caring. It is likely in this context, compared to family caregivers, they may experience less blame for child behaviours particularly from professionals.

Child, Youth and Family caregivers and social workers in this research had similar conceptions of the nature of care for this group of children. Between studies one and two there was agreement that children and young people with mental health problems were extremely challenging in terms of their behaviour, very demanding of caregiver time and energy and there was a need for extra support for their caregivers.

There were however, differences between the perspectives of social workers and caregivers. Social workers saw the difficulties of care as needing to be resolved. For some, the extent of the demands of care undermined the viability of foster care for this group. For caregivers however, the strain of providing care was something to be endured rather than resolved. The provision of foster care for many participants was part of a spiritual framework, an expression of helping others. On this basis, the difficult nature of care was cast positively,

interpreted within the framework of a spiritual mission, as an expression of love and the challenges to be endured. Such cognitive maps, which enable successful engagement with parenting stress, are discussed in the family resilience literature (Grant & Ramcharan, 2001). It is also congruent with the results of other research which describes caregiver expressions of personal growth and learning derived from the experience of raising a disabled child (B. Gibbs, 1993; Kosonen, 1996).

This study confirmed that caregivers, like other families, experience problematic relationships with service providers, uncertainty and lack of information (Friesen, 1989; Health Funding Authority, 2000a). For Child, Youth and Family caregivers in this study, the confidential status of information added to these problems. While lack of respect from professionals is a theme for family caregivers, this group did not emphasise this point, although they did discuss some deficiencies in their relationships with professionals, and their reliance on their own networks for information. In this study, as found by Friesen (1989), positive relationships with individual professionals are reported along with general difficulties experienced engaging with services. Like family caregivers, this group also reported an inability to access the level and types of services which they needed for the child or young person in their care.

A key distinction between foster caregivers and parents of children with mental health problems appears to be the elective burden of care. This group of foster caregivers referred to their personal decision to take on the care role and the difficulties they had balancing what they could ask of their own family. Experience helped them to clarify their boundaries and know the limits of their family members. Understanding these limits was crucial to their ability to provide enduring care. Being well informed about child problems and in particular being able to manage behaviour were matters discussed by these caregivers, which have been raised in research reviewed in chapter five (Richardson & Joughin, 2000). The emphasis from this study however, was less on the role of training in management of child behaviour as the place of caregiver self-knowledge, limit-setting and experience.

Caregivers had a clear sense of the need for permanence for children and the damage that was caused by placement change. This underpinned their reluctance to use respite care or terminate caregiving relationships even when these had become damaging. These experiences are similar to those of families considering the relinquishment of care, described in chapter three, and reiterate the pain, sadness and reluctance to terminate care described by other foster caregivers (Butler & Charles, 1999a, 1999b; Richardson & Joughin, 2000). While families may have to make these very distressing decisions generally only once in their life it is possible foster caregivers contemplate relinquishment of care more frequently.

These results provide evidence of both boundary setting and engulfment amongst this group of caregivers. These are response categories outlined by Twigg & Atkin (1995), discussed in chapter three. The findings suggest that on the way to boundary setting many caregivers do experience being overwhelmed. For some in the group this appeared to be their current state. These caregivers described their difficulty accepting respite care and the desire that respite care be automatically provided rather than having to be requested by caregivers. For some participants the struggle to obtain respite care ended in breakdown and exhaustion. Others, who emphasise self-knowledge and limit setting, demonstrated boundary setting behaviours.

The nature of support – "*walking with you*"

"Walking with you" summarises the kind of support valued by this group of caregivers. Foremost is a spiritual quality to the support required when care is an acknowledged and endorsed expression of religious faith. In this way effective support for these participants included a relationship with God, fellowship of others in the church or spiritual network and a spiritual framework for accepting the stresses of care. This phrase communicates the spiritual sense in which many caregivers believed that God was "*walking with you*" through the daily difficulties and demands of providing care.

These results also concur with research indicating the advantage of having a spiritual framework in respect of managing children with high support needs (Haworth et al., 1996; Skinner et al., 1999) and continuing to be willing to foster those with these challenges (Reilly & Platz, 2003). There is some discussion of the place of spirituality in voluntary social service work, the importance of understanding this source of motivation and being able to incorporate this into social work practice models (Canda & Furman, 1999; Woods, 2002). However, the spiritual framework of foster care has not received detailed attention, despite the importance of spirituality to foster carers (Pecora et al., 1999) and preliminary support for its protective effect in child rearing, as described in chapter two.

These results suggest that spirituality may not just be a significant motivator for becoming a foster carer but may also be important in providing continuing care, the construction of effective support and in the achievement of positive care outcomes. Caregivers spoke of those who were doing similar work as also being able to provide support to one another through mutual understanding of the spiritual nature of the care task. The place of such peer caregiver networks is well established in the family support literature (Gilligan, 2000a; Slater & Wikler, 1986) and has some received recent comment by foster care researchers concerned to build effective team approaches (Campbell, 1999; Wain, 1999).

The study confirmed findings of others about the importance of social work support to caregivers (Aldgate & Hawley, 1986; Triseliotis et al., 1998; K. Wilson et al., 2000) and the nature of this support (T. Fisher et al., 2000). Caregivers in this study, like those overseas, wanted social workers to be alongside them, involved and connected, staying in touch and showing an interest on a regular basis. The impression from caregivers in this study was that social work support was not sought in order to make a change in the caregiving situation, but to share the stress of care with some one else. For many it was the act of sharing these problems, which assisted in bearing the strain, and continuing the care.

In particular, caregivers sought contact from social workers because of their knowledge of the child, their empathy and understanding of a caregiver's position. This confirms research findings in respect of family caregivers with high needs who rate the interpersonal skills of social workers higher than their technical expertise (Marquis & Jackson, 2000). Participants were clear that having to explain why a situation is stressful in order to receive support was self-defeating and likely to add to, rather than reduce, stress.

As found in studies of resilience, a range of additional protective factors were identified by caregivers, as contributing to family coping, including the importance of having young people in school, work or engaged in activities. The results indicate there may be support amongst New Zealand foster caregivers for new approaches to foster care, which emphasise the role of caregivers in building these sources of resilience for young people (Gilligan, 1997, 2000a; Resnick, 2000a).

The role of informal support

This group of caregivers share some commonality with family members who, as reported in research reviewed in chapters two and four, rely on informal support more than formal support services; however, there are important differences. While family carers report they use their own family networks to provide emotional support, practical assistance and respite care (Friesen, 1989), this group of foster caregivers did not appear to do this. These participants saw their own families as less able to provide this support because of the absence of familial connection with the child. They felt their own family networks were inclined to see their care burden as self imposed. Allegiances with other family members meant they could, in some circumstances, become advocates for relinquishment of care rather than strengthening care provision. This dynamic has not received much attention in the foster care literature and perhaps explains why there is not extensive discussion of foster

caregiver family networks in the support literature, although some approaches are beginning to include these (Campbell, 1999).

These findings suggest that foster caregivers need other foster caregivers. Participants in this study drew support from other foster caregivers experienced in managing children with similar problems, particularly those spiritually motivated to provide care. The church was also a source of the emotional and spiritual support, enabling carers to link with others, gain information, advice and encouragement. Church members were reported as understanding the commitment made to children in care, in a way in which family members and professionals were unable to do.

The role of formal support services

The formal support service most sought by caregivers was respite care. This is similar to the preferences of other families looking after children with high needs (Bruns & Burchard, 2000; S. Cohen, 1982; Friesen, 1996; Sherman, 1995). Caregivers described disruption to child behaviour as a consequence of respite care and the conflict this creates, which is discussed elsewhere (Jenny Morris, 2003; Plenty, 2003). Perhaps, because of these conflicts, some caregivers appeared to require some sense of permission before they felt able to seek respite care. This has also received comment in overseas material (Aldgate et al., 1996). Caregivers in this study wanted respite care to be automatically included in the care package rather than as a response to caregiver request. The study indicates there may be merit in routinely packaging respite care into support arrangements for caregivers as is described overseas (Jenny Morris, 2003).

Deficits in Child, Youth and Family support

Not surprisingly, there were significant concerns expressed about the adequacy of formal support, in particular Child, Youth and Family social work support and mental health services. Common problems for all caregivers include: the inability to contact helping agencies, the lack of service options and the low level of experience and understanding of professionals. Again these findings reflect difficulties described within overseas care systems as outlined in chapter five and deficits in support reported by Child, Youth and Family at the time of this study, (Child, Youth and Family, 2001c, 2001e, 2002c) and which persist (Ministry of Social Development et al., 2003).

The expansion of caregiver liaison social workers in 2001 and 2002 may have resulted in improved support to caregivers, the impact of which could not be detected in this study. Determining whether a model such as caregiver liaison social work, where caregiver support is separated from child social work, is successful for these caregivers, will need specific analysis. The preference of caregivers not to have to explain the stress of their situation prior to receiving support and to obtain full child information will be important in this evaluation. Additionally, the impact of caregiver liaison social work on caregiver involvement in casework planning and developing a team approach needs further exploration.

The negotiation of support - contrasting social worker and caregiver perspectives

The view of support as a negotiated response (Twigg & Atkin, 1995) suggests that differences between social worker and caregiver perspectives about care and support are of interest. Study one identified that while social workers constructed aspects of support in a similar manner to caregivers, their emphasis was on strengthening formal support services. In the context of resource constraints, social workers viewed the provision of mental health services and social worker services as important, but largely unobtainable. This in turn created a sense of incapacity and lack of confidence about their ability to support caregivers adequately. Those aspects of support which are within a social worker's reach to improve, such as the provision of emotional support, maintaining regular contact and strengthening informal caregiver networks, were not emphasised in their comments.

Caregivers in this second study, however, placed little emphasis on the role of formal services in the provision of support, other than to comment on the failure of this form of service provision. They sought everyday contact with those social workers who knew their child well in order to gain information, emotional sustenance and practical strategies. Caregivers constructed this support as part of sustaining their coping rather than effecting a change in their caregiving circumstances.

These studies highlight a mismatch between caregiver perspectives and social workers' views that are likely to cause difficulties in the negotiation of support. Caregivers may be perceived by social workers, as seeking help in order to make a change in their circumstances through the addition of resources or services which social workers, in turn, believe they cannot access, due to lack of mental health provision or fiscal constraints. Reciprocally, caregivers tend to perceive social workers as potentially supportive but elusive. It is perhaps not surprising that social workers are not readily available when they believe that caregivers are seeking resources which cannot be accessed.

The findings suggest that the differences between caregiver and social worker perspectives will affect the negotiation of support. Respite care is a good example. Social workers value respite care but do not give it the same emphasis as caregivers. In addition, some of the recalcitrance and conflict which caregivers reported in taking up respite care may not be understood by social workers.

The differences in perspectives are to be expected and are not necessarily of concern, if mechanisms exist for dialogue between the parties. From a strengths perspective Saleebey (1997) reminds us that it is in the process of dialogue that *"we confirm the importance of others"*. What is concerning is that social workers and caregivers in these studies did not describe situations or contexts in which they are regularly talking to one another. The results indicate that dialogue and negotiation may not happen frequently and, as a result, the connection between caregivers and social workers is weak. While this continues, it is likely that the provision of support by social workers will be problematic and that caregivers will report poor responsiveness. Important opportunities will be missed for social workers to link caregivers together, inquire after and support caregiver informal networks and provide permission for caregivers to seek help in particular for respite care. In addition, social workers are likely not to appreciate the spiritual expression involved in care provision and will continue to be anxious about the burden on caregivers and their inability to alleviate this situation.

Family resilience

In summary, the results of this study are congruent with the findings of research into family strengths and resilience. They suggest that, in the face of considerable challenges, Child, Youth and Family caregivers develop coping mechanisms, which enable them to endure the stress of providing care for children and young people with mental health problems. These coping strategies include having a spiritual belief system and network, peer support, respite care and developing knowledge of self limits. By comparison, to these factors, the place of formal services and the role of social work support is less significant in strengthening caregiving. Significant problems were reported with maintaining contact with Child, Youth and Family social workers. The level of placement preparation, information and training were regarded as insufficient to support the serious commitment caregivers make to those placed with them.

Independent variables

Caregivers identified a number of factors involved in strengthening their care of children and young people with mental health problems. Factors mentioned by caregivers related to support services and caregiving factors. Ten potential independent variables were derived from these results.

Six variables constituted support factors and four concerned caregiving factors. The support variables included respite care, spiritual support, training for caregivers, information about the child's problems, Child, Youth and Family social worker support and support from mental health services. Caregiver factors identified in this study were caregiver experience (encompassing boundary setting), caregiver capacity to manage behaviour, matching children and caregivers and a child or young people's participation in school or work. Table 8 summarises these variables. The capacity to incorporate these in study four, given the information and research access constraints, is discussed in chapter eleven.

Table 8 Independent variables identified within caregivers' perspectives

Support Factors
Respite care
Spiritual support
Training for caregivers
Information about child disorders
CYF social work support
Mental health services
Caregiving and other factors
Caregiver experience/boundary setting
Ability to manage behaviour
Matching children and caregivers
School and work participation by child or young person

Limitations

There are a number of limitations to this study, which ultimately constrain any conclusions. These involve problems with the composition of the group of participants, the size of the focus group and error arising from difficulties encountered in the focus group methodology. These are discussed in turn below.

The advantages of using the New Zealand Family and Foster Care Federation conference, as a source of potential participants, and as a forum in which to conduct the focus group, were discussed earlier. This venue however, reduced the likelihood of kin carers being involved in this study, as the organisation has traditionally represented foster care groups. Caregivers in the focus group identified themselves as foster caregivers and the group did not involve any current kin carers as participants. This remains a serious limitation of the study and perpetuates deficits in existing research identified both overseas (Hunt, 2003) and in New Zealand (Connolly, 2003).

There were further problems arising from the decision to comprise the focus group from the conference membership. Participants recruited in this way were likely to be under-representative of stressed caregivers who may not have been attending the conference, those who had larger care commitments and those financially unable to attend. For caregivers looking after children and young people with severe mental health problems, who did not have access to respite care, conference attendance would have been difficult.

Participants who were at the conference were likely to be affiliated to some of the church based foster care organisations in New Zealand who are key members of this Federation. The results reflected this sample bias. Participants reported a high degree of religious affiliation and their perspectives were influenced by their spiritual paradigms. However, given the high degree of spirituality amongst foster caregivers (M. E. Cox et al., 2003), these findings remain relevant.

There are limitations inherent in focus group methodologies. Patton (2002) describes these as including restriction on the number of questions, potential problems of moderating the influence of dominant individual participants and under-representation of less responsive group members. Sarantakos (1998), reviewing focus group methodology, also draws attention to the constraints of group conditions, which may force people to hide their real opinions, particularly if these can have an effect on their personal lives. As participants were current caregivers it is likely that some opinions may not have been disclosed because of a perceived negative impact on future caregiving or standing with peers.

The choice to use two facilitators enabled some moderation of under-and over-participation. The large size of the group however, meant that findings may have been more representative of some members than others as it is harder to ensure full participation in a larger group. The discussion was lively and it was difficult to balance the need for participants to lay out their views fully, have a supportive hearing and ensure that all who wished to participate could do so. It is likely that any group discussion will reflect the views of those more experienced at

putting their viewpoints across and those more comfortable with speaking in a medium sized group. The mixed method design of the research with inclusion of a quantitative analysis assists in offsetting some of these weaknesses, including sample bias of this study.

Conclusion

The study successfully achieved its aim to explore, in an in-depth manner, caregivers' perspectives on looking after children with mental health problems on behalf of Child, Youth and Family. Establishing the nature of this care and the kind of support caregivers viewed as effective were objectives that were met in this study. A focus group methodology was chosen for its strength as a means of clarifying and identifying caregivers' values and beliefs and developing view points. Despite limitations it proved a successful choice of methodology, enabling a diversity of views to be articulated as well as identifying areas of consensus.

The study revealed problems in the level and nature of support provided by Child, Youth and Family and mental health services. Caregivers identified factors additional to these formal support services that they viewed as serving to strengthen their care. Caregivers were less reliant on family members than might have been expected and drew strength from their spiritual frameworks and networks and peers. The findings suggest some difference between the emotional support which caregivers seek, and a social work perspective of support. Social workers in study one believed that caregivers desire extra resources and information from them, which they cannot provide because social workers themselves do not have access to these. This study highlighted, however, that caregivers seek emotional support and everyday contact from social workers whom they view as largely unavailable to provide this form of support. The results suggested there were few opportunities for dialogue between caregivers and social workers in which they can share these perspectives and negotiate support. The findings of the study were successfully constituted as potential independent variables to be used in the multivariate analysis contemplated in study four.

Chapter Ten

Constructing Positive Care

Purpose of the study

The third study aimed to develop a construct for measuring positive care specific to children and young people with mental health problems in New Zealand child welfare care, in order to consider case history data pertaining to this group. No single criterion has yet been found to determine success for a child or young person in care and multiple criteria for measuring outcomes of care in child welfare are supported (Berlin, 1992; Kolko, 1998; McCroskey, 1997) particularly for those with mental health problems. In order to reflect the special characteristics of this group and the statutory requirements of the Children, Young Persons and their Families Act (New Zealand Government, 1989a), the study proposed to derive this measure using New Zealand expertise rather than relying on overseas child welfare outcome measures.

The study aimed to conduct a discussion amongst Child, Youth and Family experts about the nature of positive outcomes for children with mental health problems in the care of the organisation. This discussion would be used as the basis for developing a composite criterion, which could measure a range of care domains. An objective was to ensure that the construct was measurable within the research access constraints and data available within the Child, Youth and Family information system. This construct would be employed as the dependent variable in the quantitative analysis of case history data pertaining to this group, contemplated in the final study of the research.

The study had a further aim, to develop an additional outcome approach which could be used in conjunction with multiple criteria developed by Child, Youth and Family. As chapter six described, the use of a composite criterion has not been widely pursued in child welfare although Child, Youth and Family indicated an interest in developing a composite outcome index (Child, Youth and Family, 2002f). Parker, Ward, Jackson, Aldgate & Wedge (1991) consider as a possible future development within the Looking After Children framework, the option of combining outcomes with relative values into a single criterion, to give transparency in respect of social work decision making. In the British health care context, groups of experts have designed composite criteria, valued particularly because they make trade-offs clear (Rosser, 1983). It is likely that composite criteria will meet social workers'

desire for more holistic care outcome measures and assist decision making, requirements discussed in chapter six.

Background

The recent development of outcome measurement in Child, Youth and Family was discussed extensively in chapter six. An outcome system designed for the organisation in 1997 using standardised scales (J. G. Barber & Scott, 1996) was not implemented, although some criteria were taken forward into subsequent work on outcomes. By the end of 2000 the Government agreed that child and youth well-being, safety, permanency and stability, family functioning, cultural competence and client satisfaction be adopted as six outcome “domains” for Child, Youth and Family (Child, Youth and Family, 2000a). More recent change has been made to these outcomes, to focus on prevention of first occurrence of abuse and reoccurrence of abuse (Child, Youth and Family, 2004a).

There were a number of reasons why the outcomes already agreed could not be used for the purposes of this research. The six outcome domains approved in 2000 were high level criteria insufficiently defined for utilisation either by Child, Youth and Family (Child, Youth and Family, 2002a, 2003a) or the analysis proposed in this research. Secondly, the outcomes which had been developed, were designed for the general foster care population and were not objectives specific to those in care with mental health problems. Thirdly, the Child, Youth and Family set of outcomes were presented as multiple domains, and no mechanism existed to bring these together into a more holistic measure of care. A process was needed then which could establish an outcome criterion, incorporating multiple domains, based on the specific needs of children who had mental health problems in statutory care in New Zealand.

Measurement issues

Outcome measurement issues were extensively discussed in chapter six. A common set of problems exists, and conclusions about programme effectiveness will always be limited by these complexities. The difficulties include establishing causal links between interventions and child welfare outcomes, due to multiple intervening factors and interdependence between domains (Huxley, 1994; Parker et al., 1991). Although outcomes can be discussed at a range of levels, establishing the appropriate level of outcome measurement has been a concern in most jurisdictions (Parker et al., 1991).

Traditionally, the utility of child welfare information systems is limited by missing data, inaccuracy and poor measurement options, and these constrain outcome development (Gain

& Young, 1998). In this context, most jurisdictions have begun using event history data as proxy measures while information system improvements are made and measurement options increased (Gain & Young, 1998; Parker et al., 1991). Case history data were available to this research and represented an appropriate source of outcome data.

Construct validity

Given the measurement problems outlined in chapter six it is important to acknowledge the gaps between the ultimate criterion, being the ideal or theoretical condition for which measurement is desired and the actual criterion, which is adopted because those measures are the best fit possible, at the time. Blum & Naylor (1968) consider that the match between what can be measured and what should be measured (that is the degree to which actual and ultimate criteria overlap) is governed by degrees of construct deficiency, relevance and contamination (thought of in terms of bias and error).

The outcome criteria developed needed to be measurable within the constraints of this study. Consequently, it was not possible to measure many aspects of positive care and these deficits are referred to as construct deficiency. Those parts of the construct which are likely to measure aspects of positive care, represent construct relevance or construct validity. Finally, there will be measurement within the construct, which is not related to positive care at all, which is known as construct error. This study aimed to develop a construct for measuring positive care outcomes, which maximised validity within the data access constraints and minimised potential sources of error. The study sought to be explicit about the construct deficiencies in respect of the criterion developed. Construct error would be identified in the final study, where measures are assigned and bias and error are discussed.

Research design

Research access constraints

Research access constraints were discussed in chapter seven. Although multiple measurement sources are recommended in child welfare outcome designs, many data sources were not available to this research. This study was confined to developing a construct to measure outcomes using only case history data. For this reason, participants in this study were sought who were familiar with the scope and nature of Child, Youth and Family case history data. The lack of direct access to children and young people as a source of outcome measurement was significant. Social workers and caregivers, while able to participate in an

exploration of the construct of support, were not able to act as informants in respect of specific child outcomes.

Research methodology

Constituent and stakeholder discussions are recommended as the beginning point in a process of establishing outcome domains for child welfare services (S. J. Wells & Johnson, 2001). In the literature on construct development, procedures are described to combine measures into composite criteria, of which weighting by experts is a commonly accepted process (Blum & Naylor, 1968; Parker et al., 1991; Powell, 2003b). The judgment sought from experts is an evaluation of proposed criteria, establishing their individual degree of relevance or validity to the overall construct being developed.

Availability of Child, Youth and Family experts, many of who occupied senior positions within the organisation, was limited. In order to recruit and retain participants in this study, a discussion process was required which was time-efficient and also effective at achieving resolution. A methodology was required which could enable a composite criterion to emerge from a process of discussion amongst Child, Youth and Family experts.

While research suggests that group judgment is superior to judgment produced by individuals, groups commonly fail to reach their full potential because of interactional problems (Rohrbaugh, 1979; Steiner, 1972). As Rohrbaugh argues: *"groups perform at a level generally better than the competence of their average members but rarely as well as their most proficient members"* (Rohrbaugh, 1981 p.272). Techniques were sought which could enhance group discussion and be efficient at obtaining resolution. A combination of the Delphi method and the Nominal Group Technique were used in this study.

The Delphi method

The Delphi method is a process for structuring group discussion effectively, in allowing a group of individuals, as a whole, to deal with a complex problem (Linstone & Turoff, 1975). It allows the aggregation of group judgments and distillation of information on highly complex problems, which are characterised by uncertainty, lack of agreement or incomplete knowledge (Powell, 2003a).

The Delphi method is commonly used in forecasting or prediction, yet a diverse range of applications exist. Rothwell & Kazanas (1992) outline the Delphi methodology for the

purposes of collecting data for training needs analysis. Turoff (1975) describes its application to policy, where a Delphi method can be used to assess the assumptions of others, ensuring all policy options are considered and the impact and consequences are estimated. In the social services Bertin (1996) considered the Delphi method a successful decision making tool to provide information on priorities in a social health planning context where there was diversity of experience and conflict amongst professionals. In the area of child welfare Powell (2003b) used a Delphi method to derive early indicators of child abuse and neglect from a group of British child protection experts. In the context of this research, the Delphi method was used in a manner similar to Powell (2003b), but, in this case, for developing a suitable outcome measure for children with mental health problems who are in care.

A Delphi method or process normally consists of a number of iterations or phases, as described by Turoff (1975) and Adler & Ziglio (1996). Firstly, there is an exploration phase about the subject, where each individual participant contributes information which they feel is important. This is sometimes known as the first round, which poses the subject in broad terms and invites individual comment. In the second phase, the first questionnaire (Q1), which has been constructed from the results of the preliminary round, is considered by participants. Q1 has pooled the group contributions with the aim of developing the group view further. Participants in this second round evaluate the issue and make a judgement about their level of agreement or disagreement with the group view. These results are presented as Questionnaire 2 (Q2) in the third round. Subsequent phases continue the process as individuals in the group clarify and comment on the opinions of others. In this way agreement and disagreement are identified and priorities are developed. The final phase occurs when all information has been gathered and analysed by participants and the results are stable, in that extra consideration does not produce extra consensus (Adler & Ziglio, 1996; Turoff, 1975).

A key feature of the Delphi method is anonymity, which has a number of advantages (Turoff & Hiltz, 1996). Those with lower position authority in an organisation can openly challenge the ideas of people with higher status in an anonymous process. Unusual thoughts can be encompassed which participants may have been reluctant to express in face to face groups and radical changes of viewpoint can also be accommodated. As group members had worked together in Child, Youth and Family for some time an anonymous process enabled a range of participants' ideas to be considered without prejudice. For these reasons, an anonymous process was expected to facilitate broad discussion.

The Delphi method relies on written responses presented within a given time period. Questionnaires are distributed to participants and they may choose when to respond within a set period. This allows group members with heavy workloads, a flexibility of response. While the act of making a written response requires participants to think through ideas before sharing them, it can constrain the level of discussion of complex ideas (Ziglio, 1996). To promote in-depth discussion, participants in this study were actively encouraged within the questionnaire format to make comments and to add to the comments of others through progressive iterations. These conversation histories were presented within the questionnaires, enabling participants to overview the progression in group thinking.

The expression of group agreement

Determining the level of group agreement lies at the heart of the Delphi method. A number of techniques exist for this. Consensus can be developed based on qualitative analysis of the comments made by participants in each progressive round. However, group discussion, even in written form, can succumb at times to the influence of a few individuals. For these reasons Turoff (1975) recommends the use of rating scales to measure strength of response, using definitions such as 'very desirable' to 'very undesirable' or 'very important' to 'very unimportant'. Researchers such as Ziglio (1996), Niero & Robertson (1996), Bertin (1996) and Cline (2000) have effectively integrated other techniques with the Delphi method, in order to quantify the expression of group agreement.

Nominal group technique (NGT) (Delbecq, Van de Ven, & Gustafson, 1986) is a group discussion process that attempts to quantify group opinion. NGT uses structured face-to-face group meetings where individuals generate ideas, initially on their own, in a silent process. Structured sharing of ideas then occurs in the meeting, involving clarification and expression of assent and dissent, followed by individual ranking or rating. A mathematical outcome of the individual ratings constitutes the final group decision (Delbecq et al., 1986). The authors argue that a mathematical conclusion provides a greater sense of closure for participants than is experienced by other group techniques (Delbecq et al., 1986).

Combination of Delphi method and Nominal Group Technique (NGT)

As this study aimed to develop a composite outcome criterion, which could be used in the multivariate analysis, a quantifiable group solution was required. Nominal Group Technique was integrated into the Delphi methodology in order to provide this final resolution. The questionnaire rounds required participant commentary and weighting of criteria on the basis

of construct relevance to the overall 'positive care' criterion. These ratings were processed mathematically for each round, expressed as an inter-quartile range and median. Where participants wished to rate outside the inter-quartile range, they were asked to provide their rationale, in the form of a comment. In this way the inter-quartile range became an expression of the level of group agreement, and comments were the record of participants' hypotheses, clarification and dissent.

Those aspects of NGT incorporated into this study added further structure and conformity to the process. It was anticipated that participants might find weighting uncomfortable; however, the novelty of this method was thought to assist in maintaining group interest. The combination of the Delphi method and NGT, along with participant anonymity, allowed a diverse group to be constituted from different locations and rank within the organisation. It offered a structured discussion process, resulting in a quantifiable solution, which was able to be employed as the composite criterion within the multivariate study.

The research process

Recruitment of participants

Expertise on child welfare outcomes exists in a number of locations in New Zealand, for example in other parts of Government, in University Schools of Social Work, in non-government organisations (NGOs) and interest groups. However, in order to maximise construct relevance, reflect operational concerns and remain within the information constraints of the research, participation was restricted to experts located within Child, Youth and Family.

A Delphi group needs to be recruited from as diverse parts of the system under consideration as is possible (Linstone, 1975). Expertise in Child, Youth and Family was sought amongst staff developing and interpreting policy, those with management responsibility for operational delivery, supervisors and casework leaders at national and local levels. Those who had recently completed research into the subject area but who did not hold senior positions in the organisation were also invited to participate in this study.

Participants were required who would meet the following criteria. Firstly, they needed knowledge of statutory care provision for children and young people from either a practice or policy point of view and be currently engaged in their field. Although it would have been desirable to require participant knowledge of care for children with mental health problems there were too few staff who could meet this requirement. Secondly, participants were

sought who were interested in expressing their opinions and working with others to explore the development of a care outcome construct. Participants were also required to have time to devote to the exercise and a willingness to respond within the constraints of a Delphi and NGT process. Participant selection aimed to recruit those with a range of perspectives. Linstone (1975) describes selection of like-minded participants as a serious flaw in execution of a Delphi process. Having knowledge of the diversity of those in the organisation was an advantage for this researcher, in particular in actively recruiting Maori participants.

In September 2000 a group of 20 potential participants was identified and letters were sent to each person providing information about the research and inviting them to participate. These included staff from the Chief Social Worker's Unit, policy and operational advisory units, caseworkers, supervisors and researchers at the local office level.

Aspects of the Delphi process (anonymity and non-verbal communication) were expected to present some difficulties for some people, for example, those from cultures with a strong oral tradition. As the technique contemplated was not a common social work research methodology, the researcher spoke with all interested in participation, in order to explain the research method to be used and give participants the opportunity to ask questions or discuss any discomfort. Seventeen participants agreed to take part in this study, three of whom were Maori.

The procedure

All participants were oriented to the context of the research by receiving a copy of the research proposal, which provided information about the nature of the client group under consideration and an overview of the research. As a Delphi method has the potential to be lengthy, Turoff (1975) recommends, where time constraints are expected, pre-formulation of the obvious issues or ideas in an initial phase, as a means of reducing the number of rounds. This was also appropriate in order to confine consideration to criteria, which could be measured within the data access constraints of the research.

A definition of a positive care outcome and a list of proposed criteria was provided to participants. These were derived from reviews of the literature in the areas of child welfare outcomes (American Humane Association Children's Division et al., 1998; Gain & Young, 1998) as described in chapters six and from the objectives contained within the Children, Young Persons and their Families Act (New Zealand Government, 1989a). The term 'positive care' was adopted rather than 'strengthened care' as feedback from colleagues suggested that this was regarded as more direct terminology.

A positive care outcome was defined in this study as follows:

A care arrangement or set of care arrangements which provide safety and opportunity for a child or young person to grow and fulfil their developmental, spiritual, social and cultural potential, resulting in enhancement to their life chances, above the level that could have been reasonably expected had the placement not occurred. A care arrangement is thought of as a move of a child or young person from the jurisdiction of their original caregivers to a new set of caregivers while the subject of intervention by a departmental social worker.

Nine potential criteria, for which case history information was available, were proposed in the first round. This list excluded many outcome criteria regarded as significant, such as health status or educational achievement, because data on these outcomes were not available to the researcher. This list represented the best options within the research constraints, reflecting international care outcome criteria and New Zealand legislative imperatives. Table 9 summarises the 9 outcomes proposed in the first round.

Table 9 Proposed outcome measures

Time Taken to achieve an outcome that no longer requires the involvement of a Departmental Social Worker
Permanency in the caregiving relationship
Stability of placement planning
Restrictiveness of care placements
Maintenance of a family group, willing to participate in decisions about the child or young person
Protectiveness of caregiving arrangements
In school or work
Non-involvement in offending
Culturally appropriate provision of care

Criteria were worded as simply as possible in order to avoid jargon or generalisations. As the terminology of outcomes is often broad and overlapping, (for example stability and permanency), clarification was offered through the inclusion of typical measurement possibilities and examples. It was made explicit that determining the best measurement option for criteria was not a consideration of the study, although all criteria would need to be potentially measurable within the information system. This first questionnaire is attached in Appendix 7.

Results

In the first round, participants were asked to rate the importance or relevance of the proposed list of criteria to the overall construct of positive care. No comments were required in this round but a weighting out of 100 was sought for each item. In the next and subsequent rounds a questionnaire was prepared, summarising the medians and inter-quartile ranges of the weightings along with comments. Where participants wished to weight outside an inter-quartile range, comment was sought as to why they were weighting in this way. This process continued until there was no movement in scoring between the rounds, marking the point when agreement had been reached. At this point the Delphi process was concluded.

The total period of time to complete all rounds was 7 months. This was protracted because of delays in receiving written responses from participants.

Table 10 Questionnaire 1: Scores for proposed criteria (no comments sought)

Outcome Criteria	Median and Inter quartile range	Outcome Criteria	Median and Inter quartile range
Time Taken to achieve an outcome that no longer requires the involvement of a Departmental Social Worker	Median 5 Range 5-12	Protectiveness of caregiving arrangements	Median 15 Range 10-17
Permanency in the caregiving relationship	Median 15 Range 11-20	In school or work	Median 10 Range 5-11
Stability of placement planning	Median 15 Range 11-18	Non-involvement in offending	Median 5 Range 5-10
Restrictiveness of care placements	Median 5 Range 5-9	Culturally appropriate provision of care	Median 10 Range 7 –15
Maintenance of a family group	Median 12 Range 10-17		

Group attrition was also a problem. In the first round 17 subjects participated, in the second round 15 participants were involved and this dropped to 13 in round 3 and 11 in round 4. A small gift, acknowledging their help, was sent to participants at the mid point to assist with group retention.

Round 1

In the first round 17 participants were asked to consider the proposed outcome criteria and weight these with respect to construct relevance. Seventeen participants provided weighting, which resulted in the medians and inter quartile ranges, shown in Table 10.

Round 2

In the second round, 17 participants were provided with the previous results (Q1) and 15 provided new weightings. Comments were sought for any criteria participants wished, but were required where scoring was proposed that was outside the inter-quartile range. In two cases scores were outside the range but comments were not provided. Participant scores are provided with their comments, see Table 11.

Round 3

In the third round, 15 participants were provided with the new medians and inter-quartile ranges compiled as Q2. Again participants were asked to provide new scores in the light of previous group scoring, taking into account the comments of the group. Thirteen participants took part in this iteration, see Table 12.

Round 4

Thirteen participants were asked in this round to consider the new median and inter-quartile ranges, in the light of the comments made in the previous round Q3. Eleven participants took part in this round, see Table 13.

Table 11 Questionnaire 2: Scores and comments from questionnaire 1

Outcome Criteria	New Median and Inter quartile ranges	Comments made by participants Round 2
Time Taken to achieve an outcome that no longer requires the involvement of a Departmental Social Worker	Median 5 Range 5-8	<i>This is really important, minimum necessary intervention rather than care drift.</i>
Permanency in the caregiving relationship	Median 17 Range 15-20	No reason was provided for those who scored outside the previous inter-quartile range
Stability of placement planning	Median 15 Range 13-17	No reason was provided for those who scored outside the previous inter-quartile range
Restrictiveness of care placements	Median 5 Range 5-6	<i>As long as this is used appropriately.</i>
Maintenance of a family group	Median 14 Range 12-17	<i>One of the most important outcomes, for most c/yps we expect to be able to work towards reintegration with family. We cannot do this if they are not there. Even for those c/yps who may not return to or live with whanau, links need to be maintained.</i> <i>When we think of moving out of care these will be the connections that will endure if fostered, encouraged whanau keep in touch and involved.</i> <i>Focus cannot be on the individual alone despite principles of the CYP and F Act. Whanau are pivotal to making decisions about their child or young person – nothing less will work for that child otherwise.</i>
Protectiveness of caregiving arrangements	Median 14.6 Range 10-18	<i>Given that these children and young people have been placed because of care and protection concerns then placement needs to be safe, protective – bottom line conditions which "sanction" removal from the birth parents' care.</i> <i>The goal of care has to be safety, it is the key issue.</i>
In school or work	Median 9 Range 7-10	<i>This is important in terms of normalisation, source of stimulation /development for c/yps and respite for caregivers.</i>
Non-involvement in offending	Median 5 Range 5-10	No person scored outside the previous inter-quartile range
Culturally appropriate provision of care	Median 10 Range 10-15	<i>Identity is an important aspect for children to be matched up with caregivers who can provide the cultural aspects for that child, language, spirituality, whanaungatanga, customs, tikanga, values, kawa.</i>

Table 12 Questionnaire 3: Scores and comments from questionnaire 2

Outcome Criteria	New Median and Inter quartile Range	Comments made by participants Round 3
Time Taken to achieve an outcome that no longer requires the involvement of a Departmental Social Worker	Median 5 Range 5-7	No reason was provided for those who scored outside the previous inter quartile range
Permanency in the caregiving relationship	Median 17 Range 16-20	<i>Possibly dependent on child/caregiver. There is some thought that permanency has been superimposed on a child welfare system in which the structure is inherently dysfunctional from the point of view of prevention (Pelton 1991).</i>
Stability of placement planning	Median 15 Range 14.5 – 17	<i>Instability in care arrangements impacts adversely on all aspects of well-being in foster care.</i> <i>I could go on and on about how damaging changes in placements are.</i> <i>Definitional issue, what constitutes stability? Perhaps the real measure here is what constitutes belonging. I may have a sense of stability, be resilient but where do I belong, what is the relationship between permanency and this aspect of identity.</i> <i>I rate this extremely highly. I am currently dealing with a 12 year old who has had 88 placements - it is hoped that his current placement will provide him with some sort of placement stability.</i>
Restrictiveness of care placements	Median 5 Range 5-5	No scores recorded outside the previous inter-quartile range
Maintenance of a family group	Median 15 Range 13 – 17	<i>This is one of the most important aspects of a social worker's job, close 2nd after securing safety and well-being.</i> <i>Maintenance /improvement of family links is crucial, although at times not overly healthy where a family of birth have disagreed, and that a family group is involved in the decision making, oversight and support.</i> <i>Whether we like it or not c y/ps are highly likely to contact their families when we are no longer involved – it would seem logical and useful to link them into pro-social family members etc.</i>
Protectiveness of caregiving arrangements	Median 15 Range 15 – 17	<i>Protectiveness within a whanau placement is always a good thing.</i>
In school or work	Median 8 Range 8 – 10	<i>Important in order to make pro-social peers and get into good sports, hobbies, develop interests etc.</i>
Non-involvement in offending	Median 5 Range 5 – 7.5	<i>I still think that this is important coz the earlier you start offending the more likely you are to continue. Being in care is a great opportunity to offend, hardly anyone is taking any notice of you.</i>
Culturally appropriate provision of care	Median 10 Range 10-14.5	<i>Agree in principle however, difficulties arise where one parent is of one nationality and one of another which nationality is of greatest importance.</i>

Table 13 Questionnaire 4: Final scores and comments from questionnaire 3

Outcome Criteria	New Median and Inter quartile Range	Comments made by participants Round 4
Time Taken to achieve an outcome that no longer requires the involvement of a Departmental Social Worker	Median 5 Range 5-6	<i>Awareness of a child's timeframes is an outcome described in the CYPF Act.</i> <i>I still have to go outside the median here- minimum necessary intervention is really important in my opinion. It is not about the number of days (to me) but about a well investigated/assessed intervention that focuses on needs in a holistic manner-interventions provided within the child's sense of time etc. The time taken is the time needed to produce positive outcomes.</i>
Permanency in the caregiving relationship	Median 17 Range 16-19	<i>Don't really understand the point this comment is making.</i> <i>I agree with the above comment about being dependent on caregivers, re Pelton, perhaps it is the notion of care which is inherently dysfunctional.</i> <i>Permanency as an outcome assumes we'll get the care arrangement right – ie this is only realistic as a highly desirable outcome if we can deliver highly competent care management.</i> <i>I can't really get a solid train of thought on this one- resilience is thought to be more important than permanency. I'd tend to agree with this and support stable placements as being more important (e.g. stable placements that build resilience) rather than maybe working towards permanency. Particularly if it is out of family!!!</i>
Stability of placement planning	Median 15 Range 15-17	<i>I reiterate my comment on identity and belonging (see appropriate (culturally) provision of care).</i>
Restrictiveness of care placements	Median 5 Range 5-5	No scores recorded outside the previous inter-quartile range
Maintenance of a family group	Median 15 Range 13-16	<i>Personally I find it unbelievable that I'm outside the median on this one. I worked with family members (admittedly mainly parents) who didn't want to participate and gave them info (when I could find them) whether they liked it or not. The legislation talks about y.ps' family/whanau, hapu, iwi, family groups....in fact I'm astounded this is being ranked as important as out of family care, although maybe I'm seeing things differently. On the basis that stability is within family placements I'll change my score to 15, although the more I think about it the more I would tend to score it at 20, can't decide I will leave it at 15.</i>
Protectiveness of caregiving arrangements	Median 15 Range 15-17	<i>I have reduced weighting to item 2 and item 5 to apply greater weighting here. I did not want this to be at the expense of culturally appropriate care below.....</i>
In school or work	Median 8 Range 8-10	<i>This one and the next one build healthy relationships, positive social skills and habits. I personally wish we'd place more emphasis on the role of schools /vocational activities (positive) and the negative impact that anti social peers and involvement in offending has particularly on those CYPS who are already vulnerable.</i>
Non-involvement in offending	Median 5 Range 5-6	No scores recorded outside the previous inter-quartile range
Culturally appropriate provision of care	Median 10 Range 10-13	<i>Believe this identity with caregivers greater than other assessors have recorded as a contribution to good care outcomes.</i> <i>Culturally appropriate provision of care is about ensuring that children have access to all of their cultures as well as matching ethnicity. Appropriateness is determined by careful assessment of identity and belonging. Many of us have multiple ethnicities, one of our developmental needs is how we manage this and achieve integration of our selves.</i> <i>Both are important, the child is made from both or many ethnicities – focus on the child (rather than the parent) but within the context of the family.</i>

Conclusion of the process

The process was concluded with the completion of Round 4. Criteria showed no movement in the medians from results of (Q3) and (Q4), although movement was still taking place in the inter-quartile ranges of some criteria. The nature of the debate in the fourth round however, suggested that the optimum level of consensus had been reached and participants were unlikely to adjust scores further. It is important to identify when comments become reiterative. Discussion beyond this point is liable to entrench rather than modify opinion and frustrate participants. Time constraints and group attrition meant another round would only have been justified if significant movement was likely. As this was not the case the Delphi exercise was concluded at this point and the final results were sent to all participants.

Redistribution of final median scores to 100

The final result was calculated and the median scores totalled 95. Although individuals had ensured their own medians totalled 100, group results do not necessarily equal 100. The remaining 5 points were distributed across all medians on a proportional basis. In this way the outcome criteria could be constructed as percentages of a composite of 100, see Table 14.

Table 14 Final redistribution of Delphi scores to percentages

Criterion	Q4 Median	Median
Time in care	5	5.26
Permanency	17	17.89
Stability in planning	15	15.79
Restrictiveness	5	5.26
Maintenance of family	15	15.79
Protection	15	15.79
School or work	8	8.42
Non-involvement in offending	5	5.26
Cultural care	10	10.54
Total	95	100.00

Discussion

Development of group consensus

The Delphi process, incorporating NGT, successfully generated a high level of debate amongst participants and developed group consensus within four iterations. Table 15 gives initial and final medians and inter-quartile ranges. The level of group difference is expressed in the inter-quartile range. This decreased over the four iterations of the process for each criterion as illustrated in Table 16.

The debate traversed current issues in Child, Youth and Family concerning the provision of out-of-home care, as discussed in chapters four and five. These included the damaging effect of unplanned placement change, the problems associated with high numbers of caregivers and efforts in achieving permanency resulting in less investment in prevention work with families. Criterion ratings most influenced by the discussion process are those where both the median and the inter-quartile range had the greatest movements between initial and final rounds. These items were permanency, followed by family involvement and school/work.

Table 15 Comparison of first and final round inter quartile ranges

Outcome	First Round median	First round Inter – quartile range	Final round Median	Final Round Inter-quartile Range
Time	5	5-12	5	5 –6
Permanency	15	11-20	17	16-19
Stability	15	11-18	15	15-17
Restrictiveness	5	5-9	5	No range
Family involvement	12	10-17	15	13-16
Protection	15	10-18	15	15-17
School or work	10	5-11	8	8-10
Non-offending	5	5-10	5	5-6
Cultural safety	10	7-15	10	10-13

Table 16 First and final round inter quartile range and median values

Outcome	First Round Value of Inter-Quartile Range	Final Round Value of Inter – Quartile Range	Decrease Between First and Final Inter-Quartile Range	Difference Between First and Final Median
Time	7	1	6	0
Permanency	9	3	6	2
Stability	7	2	5	0
Restrictiveness	4	0	4	0
Family Involvement	7	3	4	3
Protection	8	2	6	0
School or work	6	2	4	-2
Non-offending	5	1	4	0
Cultural safety	8	3	5	0

The domains of restrictiveness and non-offending had the least movement, generating little or no comment, stable medians and low levels of movement in the inter-quartile range.

Restrictiveness generated one comment, the initial inter-quartile range of 5-9 narrowed to 5-6 in the second round and there was complete consensus in the third and fourth rounds. The median score for restrictiveness remained constant. Non-offending similarly generated only one comment, the median was stable and the final inter-quartile range was narrow at 1.

Construct validity

The criteria proposed were differentially weighted by participants in respect of construct relevance to a positive care outcome. The criteria, which received the greatest weighting, were permanency, stability in placement planning, protection and family involvement. These represent the core concerns that a child with a mental health problem who is subject to a care intervention will be safe, that is, protected from further maltreatment. They will have stable care arrangements, which are enduring and predictable and will remain connected with their family. These criteria have prominence in overseas child welfare outcome measurement (American Humane Association Children's Division et al., 1998; Gain & Young, 1998) and in the Child, Youth and Family's own outcomes specification (Child, Youth and Family, 2002a). The inclusion of family involvement in this cluster reflects the unique emphasis in New Zealand child welfare legislation, which preserves the role of family in decision making.

Culturally appropriate care achieved a mid range scoring, as did participation in school and work. These outcomes were viewed as having less relevance than the four core concepts above but greater relevance than some other criteria. While there was a high level of debate, culturally appropriate criterion scoring did not reflect the primacy of this criterion in the current set of Child, Youth and Family outcomes or in the legislation. This may reflect the group view of the relative importance of other criteria when dealing with specialist needs of children with mental health problems. The result may also be influenced by the composition of the expert group, which is discussed further in the limitations of the study.

There were three criteria, which were viewed as having less relevance than the others to positive care outcomes for this group of children and young people. These were length of time in care, restrictiveness of placement and non-involvement in offending.

Although length of time in care or time to achieve reunification has traditionally had a significant place in measurement of permanency outcomes, there was dissatisfaction with this criterion in the group. The comments described problems with length of time as an outcome, noting the need to match children's timeframes and to take the time needed to be able to carry out holistic and needs-based interventions. This discussion reflects recent dissatisfaction with length of time in care as a measure as is described by Gilligan (1997), who is concerned that too much focus on ending the period in care may lead to an untimely discharge.

Restrictiveness and non-offending criteria were viewed as having less construct relevance than other criteria. Restrictiveness and non-offending are two domains associated with youth justice provisions under the Children, Young Persons and their Families Act (New Zealand Government, 1989a). The lower level of scoring may reflect the dichotomy in New Zealand legislation and child welfare administration, between youth justice and child welfare issues. Matters pertaining to the restrictiveness of care environments and offending may have less prominence in care outcome discussions in New Zealand, because of the operational split between youth justice and care and protection work in Child, Youth and Family.

Despite the constraints on data sources, the results of this study produced criteria that could readily integrate into Child, Youth and Family existing outcomes framework. The findings suggest that experts view permanence and stability in casework planning, family involvement, protection, cultural appropriateness and participation in school or work, as key outcomes for children with mental health problems in care.

Key themes in the participants' commentary

The debate amongst participants illustrated key themes in the provision of care in statutory child welfare services as described in chapters four and five.

Family strengths

The discussion reflected the importance of family strengths, as represented by the domain of family involvement, which generated some of the strongest comments. The median movement from 12 to 15 during the discussion was the greatest median adjustment in the study. The discussion focused on the limited tenure of child welfare intervention and the need to retain family participation. The legal imperatives in the Children, Young Persons and the Families Act (New Zealand Government, 1989a) to involve family in decision making were also reflected in participants' comments. The results suggest that a base exists amongst some Child, Youth and Family experts for the proposed introduction of a strengths based practice framework orientated to families.

The tension between ensuring child safety and finding family solutions not reliant on out of family care was reflected in the group comments. Balancing the tensions in the Children, Young Persons and their Families Act (New Zealand Government, 1989a) between child safety, expressed as the paramountcy of the child, and family based decision making, was also traversed. Within the criterion of permanency there was commentary about the need for prevention, and concern that the goal of permanency to some degree works against preventive action. In the end the criteria of protection and family involvement were given equal weight in the final scores, mirroring the need for this balance.

Resilience

The composite criterion developed in this study reflected the participants understanding of resilience. Group members commented on the need for outcomes specific to the timeframes of the child. They discussed the importance of stability in care placements and in planning in order to maintain and rebuild child identity. Echoing some of the wider views of care (Schofield, 2002), including reorganising infant attachment (Dozier et al., 2001), restoring individual function (Gilligan, 1997) and building resilience (Resnick, 2000a), participants in this study thought of care outcomes as encompassing building strengths, networks and belonging. Within the constructs of stability in placement planning, school and work, non-offending and permanency, participants discussed the role of pro-social peers and developing

ongoing relationships with family. While the goal of building resilience had not been formalised in the outcome discussions of Child, Youth and Family, at the time of the study, there was evidence that this body of theory was informing expert opinion on care outcomes.

The concept of belonging underpinned the construct developed by the group. Again this relates to building resilience and family strengths. Comments made about family involvement, permanency, stability in placement planning, school and cultural safety were informed by a concept of belonging. Using words which have inherent meaning for participants is an advantage in social research processes, as participant discussion is more likely to be stimulated in this way. This is particularly so for construct development, where common meaning needs to be established amongst group members. As such, a future exercise could usefully explore 'building belonging' as an alternative title for the construct of positive care outcomes.

The organisational context

A lack of confidence in the capacity of the organisation, and the impact of this on achieving positive care outcomes, was indicated in the participants' discussion. Participants identified concerns about current organisational health, the climate of constraint in Child, Youth and Family and the impact of these matters on care management. One participant suggested that there was insufficient attention to individuals once they entered care, with the implication that young people became involved in offending because of the low interest taken in them by social workers. These comments are underscored by the findings of others, who identified poor capacity of Child, Youth and Family at the time to manage care (T. Ward, 2000; Yates, 2001). It is concerning that such a lack of confidence is expressed in this study by a group of experienced and in many cases senior staff.

Multiple versus composite criteria

Researchers, considering outcome development within the Looking After Children framework, suggest that composite criteria have both utility and validity for social workers. This was endorsed by the results of this study. These findings clarify how experts view relativities between the outcome domains for this client group and suggest that composition of a holistic criterion has meaning in Child, Youth and Family. There was no problem indicated in the commentary or scores of participants in developing a composite criterion. Participants readily agreed that a range of criteria was relevant to the composite and that the relativities could be satisfactorily expressed within a composite construct. The integration of

Nominal Group Technique into this Delphi process provided a way of expressing these relativities and making trade-offs clear.

It was anticipated that the multi-dimensional nature of the various criteria could cause problems. Both negative and positive values were expressed within the outcome criterion. For example, the absence of offending is viewed as positive, whereas the presence of another item such as culturally appropriate care is regarded positively. The group was not required to deal with directionality at this point but to focus on the criterion domains and assign relative proportions to these. Participants demonstrated clarity about the inclusion of each criterion as a proportion of a measurement framework irrespective of directionality.

Limitations

There are a number of limitations to this study, which constrain the interpretation of these results.

Construct deficiency

Availability of data from the Child, Youth and Family database dictated the initial criteria proposed. Non-identifiable case history data were the only data sources accessible to this research for outcome measurement. Inference, therefore was the key measurement approach available based on events and facts recorded in the information system. As such, the criterion developed is not as robust as it would be were it to incorporate other sources of outcome measurement.

Absence of individual observation, client self-report or key informant data restricted the criteria which could be included. In particular, child well-being measures such as child behaviour and functioning could not be incorporated into this composite criterion. Outcome measures for children and young people with mental health problems commonly include child functioning measures and so these areas of construct deficiency are particularly significant to the population of concern in this thesis. Despite this, inference is an acceptable and readily operational means of outcome measurement and has been pursued by many jurisdictions (Gain & Young, 1998). Sources of error are, however, likely (J. G. Barber & Scott, 1996), and these are discussed further in respect of the quantitative analysis in the next chapter.

Participation was restricted to experts who were knowledgeable about Child, Youth and Family data. While their expertise is sufficient in respect of children in care it is likely that the group lacked experience in child mental health problems. A group of experts more experienced with children in care who had mental health issues may have constructed the criterion differently. Consequent construct deficiency could be offset by a similar Delphi exercise conducted with fewer data and participant constraints. This would allow criteria such as individual development or psychological well-being to be included in an alternative composite criterion.

Construct error

Inter-dependence of criteria is anticipated in child welfare outcome measurement in which criteria are not necessarily always separate or independent of one another (Parker et al., 1991). The Delphi discussion foreshadowed some co-linearity. There was a degree of confusion amongst some participants about the criteria of tenure of care, permanence in relationships between caregivers and children and the stability of placement planning. Based on some comments, the criteria of time, permanence and stability were not viewed as independent. For example, in the minds of participants, the criterion 'stability of planning' appeared to include both the negative impact of multiple placement change and the disadvantages of unpredictable casework decision making. A degree of inter-dependence within the criteria of the composite is anticipated but remains unknown in this study. Further criterion definition, estimation of inter-dependence and ultimately simplification would need to be based on data analysis, such as a factor analysis. This exercise would enhance the composite derived in this study.

Methodology

The Delphi method has limitations that are acknowledged by a number of experts in this technique (Linstone & Turoff, 1975; Rotandi & Gustafson, 1996; Ziglio, 1996). A Delphi process operates using the individuality of each participant as a strength and does not aim for objectivity. Results will be restricted by the subjectivity and inherent judgement bias of group members. Discussion and critique of each other's viewpoints is the means within the process to offset this bias. However, as Linstone (1975) points out, a natural tendency of people is to simplify and suppress conflict. In this way the Delphi method, which leans on subjective judgements, is likely to be biased towards simplification of ideas and minimisation of conflict.

This has implications for the selection of membership in order that all aspects of the construct can receive due consideration. An adequate level of Maori membership of the group was difficult to achieve in this study because of high demands on senior Maori staff members. The composition of the group and lack of strong representation of Maori may have affected the nature of the debate and the resulting criterion. It will be important to extend this exercise using a different cultural composition to determine the influence of this on criterion weighting.

In-depth discussion is difficult to achieve within the Delphi method. The length of time between rounds and the protracted nature of the process can limit the chance for critically exploring ideas (Ziglio, 1996). The process took longer to complete than anticipated. Delays can mean that rationale for pursuing some arguments is lost during the process of waiting to receive the subsequent group summary and comments. The long time delays and the limited number of exchanges in this study may have restricted in-depth discussion. Group attrition from 17 to 11 group members may also have been a consequence of these delays. Group attrition is likely to weaken results, as it may be that those with divergent views elect to withdraw from the process.

The social work profession rests on valuing expression of feelings, autonomy and viewing difference as strength. The process of scoring within an increasingly narrow range can be uncomfortable for those who do not adhere to group opinion and interpret this as unacceptable pressure for group conformity. Concern that participants would be uncomfortable with quantifying concepts or opinions proved unfounded. There were no errors in the responses elicited, which confirmed that all participants understood the technique. Comments were focused on the debate not the process. Feedback suggested that attrition was more likely to be the result of time delays and workload pressures rather than discomfort with the Delphi procedure.

At the time of the study, there was no way to generate anonymous replies within the departmental e-mail system. In future an anonymous computer-based application of the Delphi method may be possible. This would be more time-efficient and could profitably extend the methodology in ways that current paper-based systems prohibit.

Conclusion

The objectives of the study, to conduct a discussion amongst Child, Youth and Family experts and derive an outcome criterion for measuring positive care, were achieved. A composite criterion was obtained which permits holistic measurement of a range of care

domains judged relevant to positive care for children with mental health problems. While Maori participation was lower than desirable, there was consideration of cultural and legislative imperatives within the process of deriving the construct. As with studies one and two, participants demonstrated an understanding of the concepts of resilience and family strengths, which were reflected in the results. There was sufficient movement in scores to suggest that the debate had been well considered by participants.

The construct that was finally developed was measurable within the research access constraints and could be incorporated into the final study. While the criterion was sufficient to be used in the final phase of the research, further debate and analysis would be beneficial. Constituting a new expert group, with better Maori representation, and greater expertise in child mental health problems, working within fewer data constraints, would strengthen the development of a future composite criterion. Such an exercise could explore 'building belonging' as an alternative title to the construct 'a positive care outcome'.

Chapter Eleven

A Multivariate Analysis of Case History Data

Introduction

This research aimed to explore the role of support to caregivers in strengthening care outcomes for children and young people with mental health problems in Child, Youth and Family care using four linked studies within a mixed method design. As outlined in the research design, in the first two studies the perspectives of social workers and caregivers were investigated in order to understand the nature of care for this group and the role of formal and informal supports in strengthening this care. These perceptions were explored and contrasted and reported in chapters eight and nine. Independent variables were derived from the factors which caregivers and social workers viewed as important, in supporting and strengthening care. As described in the previous chapter a group of experts in a third study, compiled a composite criterion, which could be used to measure positive care outcomes for this group.

Purpose of the study

The purpose of this fourth and final study was to utilise case history data to explore further the relationship between supports to caregivers and positive care outcomes for a group of children and young people with mental health problems who were in the care of Child, Youth and Family. Case history data were to be explored by means of stepwise linear regression using the independent and dependent variables constructed in the previous three studies. The analysis also included additional individual factors which research, reviewed in chapter two and five, suggests may also influence variability in care outcomes. These variables included type of mental health problem, age at first placement, parental mental health, severity of problem and age at first notification.

There is no existing description of the group of children and young people with mental health problems in a care relationship with Child, Youth and Family, except from a small review of arrangements for 36 young people (Calvert, 2000). Previous research (P. M. Wells & Smith, 2000) provided an analysis of the group of children and young people who were more generally involved with Child, Youth and Family but this research did not separately

describe those who had established a care relationship with the Department. It was appropriate therefore for this study to include, as an objective, a description of this group.

Background

Growing awareness of mental health problems amongst children and young people involved with Child, Youth and Family during 1998 and 1999 led to the development of a mental health database, as described in chapter four. Child, Youth and Family social workers and supervisors identified children and young people involved with Child, Youth and Family who were diagnosed with a mental health problem, who were in assessment or where it was expected that a diagnosis could be made. Being involved with Child, Youth and Family required that each child or young person had a Child, Youth and Family social worker allocated at the time of the inquiry. As described in chapter four diverse levels of awareness about mental health problems and workload pressures meant that the social worker response to this identification of clients was variable (P. M. Wells & Smith, 2000).

For the purposes of this research Child, Youth and Family allowed access to a non-identifying version of the mental health database. Each child or young person was allocated a number, which replaced any identifying information. Data provided included demographic variables, mental health diagnoses and clinician details. Additional comments were also provided for many children and young people, for example, non-identifying details about the presence of parental mental health problems, school arrangements, mental health services and medication.

Research design

Research access constraints

Research access criteria were described in chapter seven. While direct access to children and young people with mental health problems in the care of Child, Youth and Family was restricted, it was possible to derive a data set using the Department's non-identifying mental health database, combined with data from the Child, Youth and Family casework information system, known as SWIS. Individual case-notes from this information system were not available to this research. However, non-identifying reports generated within SWIS provided key case status data about such events as placements, notifications and family group conferences. Child, Youth and Family do not require informed consent in respect of research into case history records of this nature, as this information forms part of the standard annual reporting provided by the organisation. SWIS was to be replaced by a new

information system, CYRAS, during the period of this research. This transition dictated the data extraction point for this study, which was set at November 2000 before the new information system was introduced.

Client inclusion criteria

The mental health database contained a group of 1730 children and young people whose case histories potentially could be included in this study. While the mental health database included all those who were involved with Child, Youth and Family, this research focused on those who had entered a care relationship with the organisation, under the provisions of the Children, Young Persons and their Families Act (New Zealand Government, 1989a). This included care provided by extended family, Child, Youth and Family foster caregivers, caregivers supplied through non-government organisations and care within Family homes and Residences run by Child, Youth and Family. Children and young people appearing on the mental health database who had a least one care placement were included in the study.

Only those on the mental health database who had a mental health problem identified were able to be included. Those who were recorded as in assessment or with no diagnosis specified were excluded. Diagnoses were case-note based. Data access constraints meant that no validation of identified mental health problems was possible in this research. Case-note diagnosis is commonly viewed as a valid means of identifying mental health problems amongst child welfare populations, as for example in a recent study of Swedish young people (Sallnäs et al., 2004).

All children and young people on the mental health database who had an identified mental health problem were included even where this identification had been made by a social worker rather than a clinician. This inclusion decision was made on the basis of documented access problems for Child, Youth and Family in obtaining mental health assessments (Child, Youth and Family, 1999b; Cockburn, 2002) particularly for some types of disorders and on the reported reliability of social work judgments about mental health problems (S. A. Kirk et al., 1999).

Clients with different case histories

The mental health database included children and young people with varying levels of involvement with the organisation and with diverse lengths of time in care. This is a common problem encountered in cross-sectional studies of children in foster care. While the methodology of choice is cohort studies (Fluke, Edwards, Kutzler, Kuna, & Tooman, 2000)

others recognise that longitudinal designs are often not feasible and cross-sectional studies have a place in outcome research (Minty, 1999). Attempts were made to deal with the methodological problems arising from the cross-sectional nature of the data. In order to make outcome comparisons between children and young people with different care histories mean and proportional measures were sought whereby variability would not be influenced by the length of time in care. For example, the total number of placements could not be used when the period of time in which children were involved with Child, Youth and Family were variable and so mean placement length was calculated.

Given the gaps in mental health services and the lack of respite care in New Zealand it was anticipated that there might be a group of children and young people whose time in care placements was of a short respite nature. While studies of children in care often exclude those with very short periods of care, for example fewer than five care days, the exploratory nature of this study meant it was appropriate to retain those with lesser periods in care in order to understand the nature of care to this group.

A study that is concerned with outcomes, however, does require that children and young people are exposed to a minimum period of intervention, although not necessarily a minimum placement length. To be included all subjects were required to have had the first day of their first placement at least six months prior to when the data was extracted, that is Nov 20th 2000. The six-month timeframe is regarded in New Zealand law (see section 140 of New Zealand Government, 1989a) as an appropriate point at which outcomes of interventions can be evaluated.

Constructing the variables

Decisions were made in the study about the optimum way within the data constraints, to measure the dependent and independent variables generated in the previous three studies. These matters are reviewed again within the discussion section of this chapter. The criteria developed for each variable are discussed in detail in the appendix along with likely sources of error. Below is a summary of the dependent and independent variables used in the analysis.

The composite criterion – the dependent variable

The Delphi process described in chapter ten derived 9 variables, which experts viewed as constituting a composite criterion, to measure positive care outcomes for children and young people with mental health problems in the care of Child, Youth and Family. Median weighting in the 9 criteria were proportionally adjusted in this final analysis in order to ensure a sum of 100, enabling the calculation of variables on a percentage basis within the composite criterion.

Case status measures were adopted as proxy outcome criteria in this study. As discussed extensively in chapter six this is a commonly accepted approach when data constraints exist. The table below summarises the measures utilised in the construction of the composite variable.

Table 17 Measures used in the construction of the composite dependent variable

Domain Name	Measure
Time in care	The proportion of time involved with Child, Youth and Family, which was spent in active care placements.
Permanence	The mean placement length.
Stability	The proportion of all placement changes which were unplanned
Protection	The presence of a new and substantiated care and protection notification, received after a child had commenced a care relationship with Child, Youth and Family.
Restrictiveness	The proportion of total care days spent in restrictive care settings. This was calculated by weighting care placement days according to their level of restrictiveness.
Family involvement	The average attendance of family members at care and protection family group conferences.
School inclusion	The level of inclusion of the last recorded school type. This was calculated utilising a school inclusion scale.
Youth non-offending	The presence of a youth justice Family Group Conference which was held after a young person had commenced a care relationship with Child, Youth and Family.
Cultural care	The proportion of total care days where the ethnicity of the caregiver matched that of the child or young person.

The directionality of three variables (permanence, family involvement and cultural care) was reversed in order to achieve uniformity in the composite dependent variable. Each variable was weighted and combined to provide a single continuous dependent variable score for each case. The scores for each of these variables were then standardised in order to combine different measures within a final composite score.

The Independent Variables

Social workers in study one viewed all the support services and caregiving factors, they were asked to consider, as at least partially effective in achieving positive care outcomes for this group. As all variables were rated above the neutral mark on the scale they were all included as potential variables in this study. Caregivers emphasised respite care and spiritual support as crucial factors for them. They also identified the importance of information, knowledge and experience in managing child behaviours, setting personal boundaries and the value of training. Other important factors identified by caregivers were participation of those in care in school or in work, matching children and caregivers and formal support from social workers and mental health services.

Despite the range of support services and factors identified in studies one and two, only a limited number of these could be constructed as independent variables in this study due to the data constraints. Table 18 below summarises the potential independent variables and indicates where these variables or proxies for them could be incorporated into the research. Unfortunately the level of formal mental health services could not be measured nor could social work support. The mental health database indicated a large amount of purchasing of mental health services for this group by Child, Youth and Family (P. M. Wells & Smith, 2000) however, there was no capacity within the information system to quantify this. Nor was there capacity within the data available to estimate the level of caregiver training or of information provided about child mental health problems in order to explore the relationship between these factors and variability in care outcomes.

There were six variables identified in studies one and two for which some proxy measures could be derived. These were respite care, religiously based care, caregiver experience, financial remuneration, school involvement and identifying with culture. The term spirituality and religion are commonly distinguished within the literature. Religion is defined as:

organised, structured set of beliefs and practices shared by a community, related to spirituality and spirituality as involving a search for meaning, purpose and morally fulfilling relations with self, other people, the encompassing universe and ultimately reality (Canda & Furman, 1999 p.316).

In this research caregivers referred to their religious beliefs and participation in religious networks, while social workers considered the role of spirituality. In this analysis religious affiliation was the only proxy variable available to measure spirituality of caregivers within the data constraints.

As described in chapter six, it is common in child welfare measurement that the same variable can be of interest both as an independent variable and also as an outcome criterion. Two independent variables (identification with culture and school inclusion) featured in the composite dependent variable and so were excluded as independent variables. Four independent variables were therefore included in the analysis. These are described below in Table 19, along with the proxy measures constructed for these variables. A full description of the definition of these independent variables can be found in Appendix 8.

Table 18 Variables identified by caregivers and social workers

Social Worker Variable Name	Measurable within Data Constraints	Caregiver Variable Name	Measurable within Data Constraints
Caregiver ability to manage behaviour	No	Ability to manage behaviour	No
Caregiver understanding about the disorder	No	Respite care	Yes
Strong family relationships	No	Religiously based care	Yes
Previous experience	Yes	Caregiver experience	Yes
Attending school or in work	Yes	Training for caregivers	No
Positive role models	No	Information about disorders	No
After school and weekend activities	No	Social work support	No
Support from family and friends	No	Mental health support	No
Identifying and incorporating culture	Yes	Matching children and caregivers	No
Spirituality and values teaching	Yes	Attending school and work	Yes
Social work support	No		
Providing information about the disorder	No		
Respite care	Yes		
Minders/ support workers	No		
Service coordination	No		
Support groups	No		
Financial reimbursement	Yes		
Home support	No		
Training for caregivers to manage behaviour	No		
Family therapy	No		

Table 19 The four independent variables able to be included in the analysis

Respite care	Proportion of total placements that were respite care placements
Religiously based care	The proportion of total care days that were spent with religiously affiliated caregivers
Caregiver experience	Mean age of caregivers
Remuneration	The proportion of total care days where a non-standard board rate was paid

Additional independent variables

A number of additional independent variables were included in the analysis in order to capture individual factors which are identified in the resilience research as associated with improved care outcomes for this group. These variables could readily be derived from both the information system and from data recorded within the mental health database. The variables were included to explore the extent to which variance in care outcomes might be shared between the support variables identified by caregivers and social workers and the individual characteristics of children and young people in the study.

Table 20 Additional independent variables used in the study

Age at first notification	From CYF information system
Age at first placement	From CYF information system
Length of time between first and last care or protection notification	From CYF information system
Parental mental health	From CYF mental health database comments
Ethnicity	From CYF information system
Gender	From CYF information system
Type of mental health problem	From CYF mental health database field
Severity	From the CYF mental health database

A fuller description of the definition of these independent variables can be found in Appendix 8.

Results

Exploring the nature of this group - descriptive statistics

An objective of this study was to provide a description of the group of children and young people identified with mental health problems who had a care involvement with Child, Youth and Family. Descriptive statistics were derived for the group. The means and standard deviations are presented in Table 21.

Demographic data

One thousand and seventy one of the 1730 children and young people who were recorded on the Child, Youth and Family mental health database had entered some period of care at least six months before the data was extracted for the study in November 2000. Fifty nine point two percent of this group were recorded as having a severe or urgent mental health problem. Mental health professionals (defined in the mental health database as psychiatrist, psychologist, CAMHS, and Specialist Services) provided a mental health diagnosis in 71% of cases, social workers identified mental health problems in 19% of cases and paediatricians in 7% of cases.

Alcohol and drug disorders formed the largest proportion of primary mental health problems of this group with 23.9% having this recorded as their primary diagnosis, with ADHD the next biggest group at 15.8%, conduct disorder at 13.7% and behavioural problems in 11.9% of cases. Nine point four percent had depression, suicidal or self-harming behaviours. Sixty nine point four children and young people were recorded as male and 30.6 % were female. Thirty eight point nine percent of children and young people were recorded as of Maori or Maori /European decent, 52.8% were European and 5% Pacific Island, with 3.3% in other ethnic categories.

Care data

The placement patterns pertaining to this group are interesting. Twenty two point three percent were under five years old when they were the subject of a first care or protection notification and over half the group (58.3 %) were notified before the age of 10 years. In this study the mean age of first notification is 8.7 years with a standard deviation of 4.2 years. These are notifications, which were recorded as requiring further investigation.

Although the pattern of notification establishes an early level of contact with Child, Youth and Family, first placement happens considerably later for this group. Placement includes any movement into care, even of a short term or respite nature. The majority of these children and young people were first placed at an older age, that is, over the age of ten years. The mean age of first placement was 11.8 years with a standard deviation 3.6 years. In only 6.3% of cases did children and young people establish their first care relationship with Child, Youth and Family before the age of five years. By the age of ten years a further 20.5 % of children and young people in the study group had experienced a first placement. A further

38% of the group was first placed between 10 and thirteen years and 35.1 % of the group were first placed at fourteen years or older. The mean proportion of time which Child, Youth and Family had a care involvement that was spent in active care placement was 65 % with a standard deviation of 31.5.

The research indicates that a significant proportion of placement change for this group was not anticipated. For this group the mean proportion of placement change that was unplanned was 49.2% with a standard deviation of 27. This represents a substantial degree of planning instability in the life of a child or young person with mental health problems in the care of Child, Youth and Family.

There is evidence that while in a care relationship with Child, Youth and Family the group had some protection from further abuse or neglect. In just over 70% of cases, children and young people in this group received no further substantiated notification of maltreatment after the first day of their first care placement. Similarly for offending, from the point of entering care only 34.7% of the group went on to be the subject of a youth justice family group conference. As the study was cross-sectional for some children and young people there may have been only six months elapsing since their first day of first placement, for others in the study this time period would be much greater. The mean family attendance at the care and protection family group conferences amongst this group was 5.4 family members with a standard deviation of 4.5. Table 21 summarises these results.

Table 21 Descriptive statistics for the group

Name	Mean	Standard deviation
Mean age at first notification	8.7	4.2
Mean age at first placement	11.8	3.6
Mean percentage of time that Child, Youth and Family was involved that was spent in active care placements	65	31.5
Mean rate of unplanned placement change	49.2	27
Mean family attendance at care and protection family group conferences	5.4	4.5

Multivariate analysis

This study aimed to explore the relationship between support to caregivers and strengthened care outcomes using case history data. Multiple linear regression was conducted to

investigate this relationship. Variables were entered into the analysis using a stepwise procedure.

The composition of the dependent variable required all cases to have a value entered for each of the 9 domains in the composite. Given the extent of missing data this meant that in the final analysis only 179 children and young people were included in the multiple regression. This is a considerable reduction in the sample and indicates the problem in obtaining complete Child, Youth and Family data for children and young people in care, which is discussed by others (Adair, Dixon, & Widdowson, 2000; Ministry of Social Development et al., 2003). This problem is intensified when multiple outcome measurement is contemplated.

The independent variables (see tables 19 and 20) were entered in a stepwise multiple regression using the composite outcome variable constructed in study three. Linear multiple regression was conducted using the full set of independent variables as predictors. The final model contained respite care, and religiously based care which had a multiple R of .375 and together accounted for 14% of the variance in the dependent variable ($r^2 = .14119$, $p = .0033$).

Table 22 shows the independent variables which predicted some variance within the composite outcome measure. Note that the directionality of the dependent variable meant that negative scores in the independent variables indicate improvement in care outcomes.

Table 22 Multiple linear regression between chosen independent and dependent variables using stepwise insertion

Multiple R	.37575				
R Square	.14119				
Adjusted R Square	.11829				
Standard Error	32.26549				
Analysis of Variance					
	DF	Sum of Squares	Mean Square		
Regression	2	12836.54470	6418.27235		
Residual	75	78079.64229	1041.06190		
F =	6.16512	Significance of F = .0033			
----- Variables in the Equation -----					
Variable	B	SE B	Beta	T	Sig T
RELIGDY2 (Spiritual support)	-.262332	.115750	-.242584	-2.266	.0263
RESPIT3 (Respite care)	-2.471289	.904330	-.292500	-2.733	.0078
(Constant)	19.478009	3.259613		5.976	.0000

In order to explore whether there was shared variance between these caregiving factors and other variables included in the analysis, the regression was repeated with those caregiving factors excluded. As table 23 shows in this analysis age at first placement produced a multiple R of .242 and accounted for 5.9% of the variance ($R^2 = .059$, $p = .0177$). Therefore

entering care for the first time at a younger age is marginally associated with an improvement in care outcomes. This result indicates a degree of shared variance between respite care, religious care and age at first placement; however, age at placement only has predictive power when the respite care and religious care variables are excluded, so it is not adding unique variance. When age at first placement was excluded from the equation no other individual factors were found to account for variation in the composite dependent variable.

Table 23 Multiple linear regression using only variables related to the characteristics of children and developmental history variables using stepwise insertion

Multiple R	.24291				
R Square	.05900				
Adjusted R Square	.04889				
Standard Error	33.51133				
Analysis of Variance					
	DF	Sum of Squares	Mean Square		
Regression	1	6548.70562	6548.70562		
Residual	93	104439.88630	1123.00953		
F =	5.83139	Significance of F = .0177			
----- Variables in the Equation -----					
Variable		B	SE B	Beta	T Sig T
AGEPLMT2 (Age at first placement)		2.369855	.981377	.242906	2.415 .0177
(Constant)		-18.738892	11.535826		-1.624 .1077

Discussion

The descriptive statistics show this is a group of children and young people with severe or urgent problems with a long history of concerns indicated by welfare contact from an early age. Although first notification happens early in a child's life, the first placement, even of a respite care nature, appears to take place much later for this group. From the point of first placement over half the ensuing period that children and young people in this group were involved with Child, Youth and Family was spent in active care placements. A feature of this care was considerable instability, with nearly half of all placement changes being unplanned. Approximately one third of the group continue to experience abuse or neglect after first entering care and a similar proportion went on to experience a family group conference for offending matters after they had first entered care.

The purpose of this study was to utilise case history data to explore the relationship between supports to caregivers and positive outcomes for children and young people in the care of Child, Youth and Family. The results provide preliminary evidence of the protective effect, for children in care, of support to their caregivers, which are similar to the findings of other research in the family support area, described in chapter three. While the study is

exploratory, it does provide some confirmation of caregivers' views of effective support described in study two.

Caregivers emphasised the importance of their spirituality in strengthening their provision of care. They accounted for this effect through their access to religious networks and the personal strength they obtained through their faith, which enabled them, to endure the challenges of caregiving. Some of the comments of caregivers in study two also suggested that their beliefs enabled them to interpret child behaviour more positively. In the review of the literature in chapters two and three previous researchers have found evidence of these kinds of protective effects amongst families with religious beliefs (Mahoney et al., 2001).

Although the role of religious beliefs of foster caregivers has not received separate attention in the literature, this study provides tentative support for its inclusion in future exploration. It would be interesting to determine whether effects can be more strongly established in an analysis where the variable of religious affiliation is more carefully developed, as for example in research by Fetzer Institute (1999) or Pearce, Jones, Schwab-Stone, & Ruchkin (2003).

There is agreement between the findings of this study and the research into caring for disabled children, that the provision of respite care so valued by caregivers (Friesen, 1996; Sherman, 1995) has a positive influence on child outcomes (Bruns & Burchard, 2000; Rimmerman, 1989). In study two respite care was emphasised by caregivers as a crucial part of managing the demands of providing care and ensuring that other family members' needs are also met. In study one social workers also rated respite care as effective in supporting caregivers although their comments suggested that low levels of resources constrain the extent to which this could be provided. Despite these constraints this study found evidence of short-term planned placements that were likely to constitute respite care for this group. In the analysis a higher proportion of these placements was associated with positive variance in care outcomes which warrants further exploration.

The results then provide tentative support for an association between religiously based care, respite care arrangements and improved care outcomes for this group of children and young people. The nature of the shared variance between religious caregivers and respite care may also be worth exploring further in order to understand whether there is an interaction between these factors. These findings may indicate that the provision of respite care and having a spiritual framework within which to interpret the demands of foster care has a positive impact on care outcomes for children with mental health problems. The implications

of this for Child, Youth and Family policy, practice and further research are discussed in the next chapter.

A model of the possible buffering effect of religiously based care and respite care found in this study is illustrated in Figure 2. In this model religiously based care and respite care in effect buffer caregivers from the stress of providing care through the action of additional underlying protective factors such as support networks, regular rest and positive interpretation of the stress of parenting. The action of these underlying factors may result in improved care outcomes in domains such as placement stability, child behaviour and school inclusion.

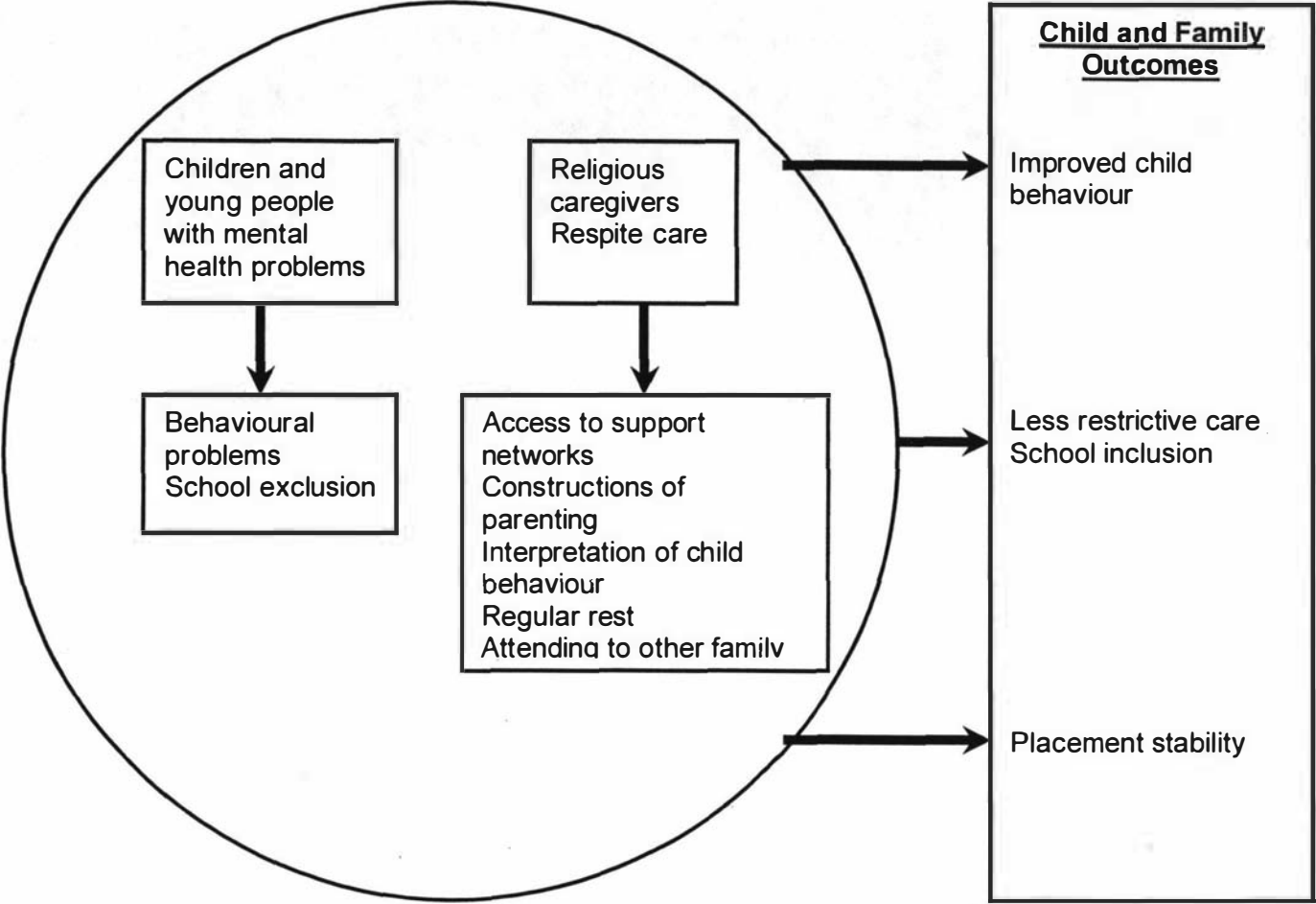
The entry of age at placement into the equation once religious and respite care variables were excluded suggests some degree of shared variance between these three variables which could be further explored. For example, shared variance may be explained if it is found that children who enter care earlier are more likely to be placed with religious caregivers and have respite care arrangements put in place.

Although care data can be difficult to interpret, these results suggest that while this group is the subject of a care and protection notification to Child, Youth and Family early in life first placement is delayed and as a group they are being placed at what is considered to be a late age. Age at first placement is an established predictor of care outcomes for children in foster care and in particular for children and young people with mental health problems in foster care (Brand & Brinich, 1999). Placement stability for children in care interacts with being younger when first placed and being more successfully cared for. Some question whether later placement in foster care is an effective option for those with high levels of need such as mental health problems given its association with poor outcomes (J. G. Barber et al., 2001; Richardson & Joughin, 2000). Based on what is known about the consequences of late placement, Child, Youth and Family may wish to consider placement practices more fully for this group. In particular, consideration is needed as to whether early provision of respite care at the point of first notification is more effective than delaying first placement. This is discussed further in the final chapter of the thesis.

Individual factors such as type of mental health diagnosis, severity, age at first notification, and days between first and last notification were proxy variables for factors that were indicated in the literature as having some role in variability of outcomes. These were not established as significant predictors of care outcomes in this analysis. Furthermore, other variables of interest to social workers such as mental health services could not be measured within the constraints of this research. Variables unable to be included and those deemed

non-significant would need to be explored further in a larger study before they could be viewed as unimportant.

Figure 2 A model of the possible buffering effects of religious care and respite care



While the findings of this study are modest and cautious they do have utility for Child, Youth and Family. Although individual factors, for example heritability of child mental health problems, are receiving new attention (Arseneault et al., 2003), these factors are rarely within the control of a child welfare organisation. The multiplicity of relevant factors can often overwhelm and paralyse rather than enlighten. As one practitioner found: *“in practice, framing children’s troubles as evidence of a complex interaction of multiple variables led both to a sense of urgency and to the contradictory perception that the probability of fixing anything is unlikely”* (Nybell, 2001 p.223). The results of this research however, indicate an area worth further investigation, which is of practical use and has greater utility than other individual factors generating stronger effect sizes. The application of these findings for Child, Youth and Family are included in the discussion in the final chapter.

The composite outcome criterion derived by Child, Youth and Family experts was employed successfully in the regression. While Child, Youth and Family have traditionally focused on multiple outcome measures development of a composite index has raised interest in the

organisation (Child, Youth and Family, 2001j) and overseas (Parker et al., 1991). This study makes a contribution to this future work. It supports continuing the development of holistic outcome measures alongside the more traditional multiple domains. Further development of the criterion is warranted, which is described in more detail in the next chapter.

Limitations

In this study there are limitations, which restrict the interpretation of the results. Caution needs to be sounded about the nature of multiple regression analyses when conducted with small samples. As the data set is drawn from those included on the mental health database limitations also relate to the constitution of this database. Case history data drawn from the Child, Youth and Family information system also may contain error. These limitations are discussed briefly below along with problems of construct deficiency.

The nature of statistical regression

Stepwise multiple regression as a methodology is based entirely on statistical criteria, where decisions about which variables will be included or omitted from the equation are derived from computations. Small differences can have large effects on the apparent importance of independent variables (Tabachnick & Fidell, 2000). The limitation of this methodology is particularly significant given the small size of the final data set. Although the original sample consisted of 1071 children and young people, only 179 of these could be included in the regression because of the nature of the composite dependent variable and the high amount of missing data. It is recommended that cross-validation of results with a second sample occurs (Tabachnick & Fidell, 2000). Unfortunately, this was not possible within the constraints of this study and the level of data available from Child, Youth and Family. It will be important for future interpretation of these results to attempt to replicate these findings with a larger sample.

Given the vulnerable nature of children and young people in care it is of concern that the statutory agency has so much missing data for this group, especially in respect to key outcome domains identified by the organisation. The need for Child, Youth and Family to consider its capacity for data analysis of the nature carried out in this study is discussed further in the next chapter.

Sample error

The mental health database was intended to record all clients of Child, Youth and Family in 1999 who were identified as having a mental health disorder. P.M. Wells & Smith (2000) describe some of the error likely to have occurred in the constitution of this group. Sample bias is anticipated due to the inconsistent response by social workers to the original mental health database request. Both under- and over-inclusion can be anticipated.

The large urban centres, in particular, Auckland, had proportionally fewer social work respondents and therefore fewer subjects on the mental health database. The reason given for traditionally low response rates in Auckland is the workload demands in this metropolitan area which make it difficult for social workers to respond to information requests (Cockburn, 2002). As over 70% of those in this study group had their mental health problems identified by a mental health clinician it suggests that the sample may be biased towards those mental health problems, which are recognised by New Zealand mental health services. The study then is also likely to include fewer children or young people with mental health problems which are excluded from CAMHS, particularly those with conduct disorders or mental health problems directly attributable to abuse.

The possibility that social workers under recognise mental health disorders, is discussed in the Brown Review of Child, Youth and Family (Brown, 2000). Such under-recognition is likely to have affected this study. Evidence that Child, Youth and Family social workers may not identify mental health problems was indicated by the prevalence calculations derived from the database, which were low by international comparisons (P. M. Wells & Smith, 2000). In particular externalising disorders are viewed by some social workers as behavioural, justice or delinquency issues rather than indicative of mental health problems, although some researchers argue there is evidence that social workers are accurate in these judgments (Wakefield, Kirk, Pottick, & Hsieh, 1999). Without specific analysis of Child, Youth and Family social worker recognition rates it is difficult to estimate the likelihood that valid cases were excluded from the database.

The sample in this study had mental health problems identified on the basis of case-note records. The presence of a disorder could not be validated during the course of this research due to research access constraints. Sample error is anticipated in circumstances where problems identified may have been initially inaccurate or of brief duration. Given the reported long term nature of severe child and adolescent mental health problems described in chapter two it is unlikely there will be significant inappropriate inclusion of those who may no longer experience problems.

It is anticipated that the sample under-represented Maori and Pacific Island children and young people for a number of reasons. CAMHS excludes those with sole presentation of conduct disorder, which is more prevalent among Maori young people (Horwood & Fergusson, 1998). Therefore Maori young people may be less likely to be accessing CAMHS and less likely even when they do, to have a diagnosis confirmed. As discussed in chapter two, ethnicity may also influence whether social workers are willing to make referrals to mental health services in New Zealand. There is evidence in one recent report that Child, Youth and Family social workers will not refer Maori clients to mental health services which they view as inappropriate for Maori (Child, Youth and Family, 2004b). Geographic under-reporting of New Zealand northern urban Child, Youth and Family sites on the mental health database is also likely to mean the sample is under representative of Maori and Pacific Island children and young people as they are over represented in these regions of New Zealand. While these areas of bias remain untested it potentially limits the generalisations that can be made about these findings in respect of outcomes for Maori and Pacific Island children and young people.

Recording error

Research problems associated with using case event history data are significant and consensus is that the interpretation of these data is always difficult. J.G. Barber & Scott (1996) note that outcome measurement systems reliant on inference from case history data are likely to encounter error, and that over- or under-estimation of effect can be anticipated because of recording error and missing data. Missing data from case records within information systems is a common problem amongst studies within statutory child protection services overseas (Miller, Fox, & Garcia-Beckwith, 1999) and in New Zealand (Adair et al., 2000). Evidence of recording error in case records of Child, Youth and Family was found when cleaning the data for this analysis, for example, mismatched number of placement days and start and end-of-care periods. In all cases where recording error was detectable these cases were excluded from the analysis.

As chapter four outlines, the period in which this study was conducted was a time of workload pressure and unallocated cases were accumulating. For these reasons it is possible that data were not recorded accurately as evidenced by the failure of social workers to record closure of cases on the information system. As administrative data in child welfare organisations are known to be problematic it is preferable to cross-validate results as for example Fluke et al. (2000) recommend. In this way the errors in complex data systems such

as CYRAS can be detected and rectified. Regrettably, research access constraints meant that it was not possible to estimate the level of contamination through recording error as it was not possible to cross-validate data against individual case records. These limitations could be overcome in a future analysis which has fewer data access constraints enabling triangulation of data sources and cross-validation of case history records.

Construct deficiency

While research participants in the previous three studies articulated the variables they viewed as significant, deriving adequate measurement of these within the data constraints of this study was more difficult. There were significant limitations to data available with which to develop the constructs of interest for both independent and dependent variables. Deficiency in the dependent variable particularly in relation to the measurement of child and family well-being was noted in chapter ten.

There were also significant deficits in the independent variables able to be measured. In particular it was not possible to determine the extent to which mental health service provision was associated with strengthened care. While there have been mixed findings about the relationship between community mental health service usage and positive child outcomes (Stanger et al., 1996; Visser et al., 1999) uptake of mental health services is nevertheless a variable of significant interest to social workers as was established in study one. Child, Youth and Family have also made access to mental health services a primary focus for this client group. The inability to measure these services in order to investigate their relationship to outcomes is a serious information gap. Other important variables identified by social workers and caregivers such as social work support, caregiver training and experience could also not be easily measured within the information system.

It is common in child welfare outcome frameworks to find variables, which are regarded as outcomes as well as predictors, family functioning or placement stability, are good examples of this. The exclusion of school inclusion and cultural safety as independent variables because they were also included in the dependent variable suggests there should be further exploration of their interactive effects with other independent variables and their influence on the other care outcomes.

Conclusion

The study aimed to describe a cross-sectional group of children and young people with mental health problems in care of Child, Youth and Family. In addition, case history data were utilised to explore the relationship between support to caregivers of this group and strengthened care outcomes. These objectives were achieved in this study. A quantitative methodology was employed utilising independent variables derived from caregivers and social workers which were supplemented by additional individual factors associated with variance in care outcomes from previous research. The analysis included, as the dependent variable, a composite criterion for positive care outcomes established by social work experts in study three. Case history data were only included where children and young people had an identified mental health problem and where they had a care involvement with Child, Youth and Family which was of at least six months duration.

While the limitations of this study are significant the findings do provide support for further investigation of the protective role of religiously based care and respite care in respect of this group of children and young people. The coping strategies identified by Child, Youth and Family caregivers in the second study and findings of other researchers into family resilience, are given tentative support in the findings of this study.

Due to the small numbers included in the final analysis, there is risk of over-fitting data and the study should be replicated with a larger group. Such research could address sample bias and deal with recording error through cross-validation of data. Further work would assist in untangling the interactive effects of religiously based care, respite care provision and age at first placement, as some shared variance is indicated in these results. In particular a Factor Analysis process would assist in establishing the degree of co-linearity in both the independent and dependent variables. This would be particularly useful in further refining and simplifying the composite outcome criterion. A discussion of the conclusions of the research as a whole follows in the next chapter along with the policy implications and specific suggestions for further research.

Chapter Twelve

Strengthening Care: Policy and Practice

Introduction

Children and young people with mental health problems in statutory care have been the subject of recent research attention in Britain (Mental Health Foundation, 2002a), the United States (Landsverk, 2001; United States General Accounting Office, 2003) and in Australia (Morton et al., 1999). In 1999 Child, Youth and Family researched and identified for the first time that approximately one quarter of young people who were involved with the service had moderate or serious mental health problems (P. M. Wells & Smith, 2000). As these data focused on prevalence of problems, they left a substantial gap in the knowledge about the care arrangements and outcomes for this group.

For children and young people who are involved in statutory child welfare systems, pathways to wellness involve establishment or re-establishment of wholesome attachments in appropriate care settings. However, as previous research reviewed in chapter five indicates problems amongst this group are continuous and the demands on caregivers are high. In this context enduring care relationships can be difficult to develop particularly for children who exhibit challenging behaviours. Although children and young people with mental health problems are identified by Child, Youth and Family as a key risk group (Child, Youth and Family, 2002a) specific strategies targeted to support their caregivers are not well developed in New Zealand.

This research explored the relationship between support to caregivers and positive care outcomes for children and young people with mental health problems in the care of Child, Youth and Family. The research asked four questions:

- What do Child, Youth and Family social workers consider are effective supports for caregivers looking after a child or young person with mental health problems?
- What do Child, Youth and Family caregivers perceive as the kind of assistance which will help them to better manage the care of these children?
- What do Child, Youth and Family social work experts consider to be the range of positive care outcomes of interest for children and young people with mental health problems who are in care?

- What do the case history data, relating to a group of children and young people identified with mental health problems in the care of Child, Youth and Family suggest about the relationships between caregiver supports and positive care outcomes?

Four linked studies were conducted using a mixed method design. In the first study 237 Child, Youth and Family social workers and supervisors provided their perspectives on support to caregivers of children and young people with mental health problems. In study two, caregiver perspectives on support were developed within a focus group methodology and these views were contrasted with those of the surveyed group of social workers. Child, Youth and Family experts were canvassed in study three in order to determine what is understood by positive care outcomes for this group of children and young people in care. Finally, a multivariate analysis conducted in the fourth study using case history data, explored the relationship between support variables identified in studies one and two and the positive care outcome criterion developed in study three.

While the findings of each of the four studies have been described in chapters eight through to eleven this final chapter brings together a discussion of these results to arrive at the conclusion of the research as a whole. The key findings are discussed in the first part of the chapter, followed by a set of policy and practice implications suggested by the research. The limitations of the research are briefly reviewed in the final section of the chapter, along with suggestions for further work.

Key findings

As a whole, the results of the four studies converge to provide preliminary support for the protective roles of spirituality and respite care, in the care of children and young people with mental health problems in a child welfare context. The central themes which emerged from this research are discussed below.

The nature of care

The difficulties encountered by Child, Youth and Family in looking after this group of children and the challenges their caregivers face, are established in this research, much as they are described overseas (Butler & Charles, 1999b; Delfabbro, Barber, & Cooper, 2002; Mental Health Foundation, 2002a). Participating caregivers and social workers agreed about the difficult nature of providing care for this group. Social workers who were surveyed

talked about the complexity of relationships with other agencies and the time-consuming nature of the social work involved. Caregivers spoke about the difficulties of managing child behaviours and the impact of this on other family members. The nature of these problems adversely affected the ability of caregivers to access support both from respite carers and from other family members.

The role of wider family

Support from family is established as critical amongst those caring for their own children with mental health problems (Friesen, 1989). This research, however, identified an important difference between foster caregivers of this group and the overseas reports of family members who provide care for children with mental health problems. This difference can be thought of in terms of the elective nature of foster care in a child welfare context. Caregivers in this research emphasised their choice in providing care for Child, Youth and Family. This element of choice however, had implications for their access to support from their own family members.

Some participants reported that their family members believed caregivers had brought problems on themselves by offering to provide care. Consequently caregivers felt that they had a reduced right to call on the family network. Some suggested that rather than providing support, family network members at times actively sought to end placements, particularly where there was disruption to siblings who were kin. They emphasised the inability of family members to empathise with the role of providing substitute care, to either understand the difficulties faced, or the level of commitment made. Fearing that family members would advocate relinquishment of care, this group of caregivers viewed kin as less significant to them than other support systems.

The tension between caregivers and their wider family is of interest and has not received full attention in other research. Nor was it reflected in the discussion of Child, Youth and Family social work participants in this research. Social workers who were surveyed rated informal support from family members as more effective than formal support services in stabilising care. Unfortunately study four did not have the potential to examine the role of informal family support in achieving positive care outcomes, nor whether informal family support differed between kin and foster caregivers. It is possible that kin caregivers who were not represented in the second study may have fewer problems accessing family support than foster caregivers because the children who they care for are related. This result has implications for the evolution of strengths based approaches to support for this group of

foster caregivers, as the model would generally anticipate significant support from within the family network.

The meaning of caregiver experience – learning your limits

Caregivers and social workers participating in this research were in agreement about the importance of caregiver experience in achieving successful care outcomes but there were differences in the interpretation of 'experience'. The social workers surveyed believed that experience, understanding and training were significant and that caregivers with greater experience would understand more about the needs of those in their care. Caregivers described experience as the gaining of self-knowledge rather than child knowledge, and as the means through which they came to define their own limits. Included in self-limits were not only the personal energies of caregivers but also the tolerance levels of other family members.

Twigg & Atkin (1995) describe this boundary setting as one of their principal caregiver response types. They see strength in the ability of boundary setting caregivers to detach from the caregiving situation and make a separation between their needs and those of the person cared for. Some caregivers in this research suggested that this boundary setting has been a key to their provision of strong care. By articulating these boundaries to themselves, they could ensure that care undertaken was within these limits and therefore more likely to be sustained. Social workers looking to select caregivers only on the basis of experience, rather than boundary setting may miss the opportunity to assess caregivers' capacity to articulate limits and ensure that care is within these tolerances.

The nature of support - someone to walk with you

Social workers in this study emphasised the importance of mental health services, social work support, knowledge and training, and financial support. While social workers rated informal support more highly than formal support services, their comments focused principally on deficiencies in formal supports (mental health and social work support) and the need to increase caregiver access to these. This response inconsistency may suggest that social workers, while understanding the importance of informal support, lack knowledge about how to engage with informal support structures and are uncertain of their role with these support systems. It also may reflect the dominant emphasis of Child, Youth and Family in developing better access to formal mental health services over the past nine years.

Social workers' comments and ratings indicated an awareness of their inability to provide effective support to caregivers. This included the inability to provide adequate information about mental health problems, secure respite care, arrange fair remuneration for care costs and access training. In the face of these failures social workers in this research were preoccupied with their own lack of response, some doubting that foster care could ever be sufficiently supported. However, those aspects of social work support which social workers could readily improve, such as regular telephone contact, received little comment although caregivers' indicated these are principal means by which they obtain the emotional support they value.

Caregivers' view of social work support may provide some comfort to social workers. Caregivers in this research emphasised that they sought social work support not in order to effect change in their situation but to give them sustenance and a sense that someone cares. Caregivers' construction of support, as "*someone to walk with you*" implies that being supported is not contingent on changes being made in a caregiving situation. The phrase provides insight into what caregivers value, that is contact and a sense that they are not on their own. This is well established in overseas findings in respect of foster caregivers (T. Fisher et al., 2000) and kinship caregivers (L. Gibbons & Mason, 2003). Thus it is possible that the inadequacies felt by social workers because of the resource constraints they operate within, are misplaced. Unfortunately, while social workers continue to think caregivers seek unobtainable resources from them they are likely to remain less available to caregivers than is desirable.

Informal support - the role of spirituality and respite care

As discussed in chapter eleven the term spirituality and religion are commonly distinguished within the literature. In this research caregivers referred to their religious beliefs and participation in religious networks, while social workers considered the role of spirituality. In the multivariate analysis a proxy variable was established, which measured religious affiliation of caregivers.

Caregivers participating in this research were an experienced group many of whom provided foster care for church-based organisations. The focus group findings reflected their spiritual motivations for providing care, and the significance of their church networks as a source of informal support, which family members could not offer.

By contrast social workers in this research identified that spirituality was a matter of importance, but did not give it the same prominence as caregivers. Social workers considered the presence of spirituality as a positive input into child rearing but did not discuss its effect in buffering caregivers against the stress of care. The extent to which spirituality or religious networks are a factor in the support systems of kin caregiving is not explored in this research but is of further interest.

For children with mental health problems who are in care effective management of difficult behaviours is crucial in order to retain the place of children in new families (J. G. Barber & Delfabbro, 2002; Triseliotis et al., 1998). The role of spirituality in enhancing parenting effectiveness, marital commitment and child well-being was discussed in chapter two; however, this research is under-developed. Although spirituality has had some discussion in New Zealand in respect of social work curricula (Nash & Stewart, 2002) and social service volunteers (Woods, 2002) there has been little exploration of the role of spirituality in foster care in New Zealand or overseas, despite consistent evidence of the importance of spirituality as a characteristic of foster caregivers. Improvement in child well-being is associated with the enhanced marital relationships and co-parenting behaviours that are established amongst religious caregivers (Brody et al., 1994). In addition spirituality is associated with a willingness to foster children with difficult behaviours (M. E. Cox et al., 2003). These positive effects make spiritually-based care an area of future research interest particularly for children and young people with mental health problems who are difficult to place and vulnerable to placement breakdown.

The role of respite care is well established, as a positive contributor to families looking after children with a range of high support needs as described in chapter three and in supporting families involved in child welfare services (Aldgate et al., 1996; J. O'Brien, 2001). Preliminary support for the effectiveness of respite care was found in this research. Caregivers explained that respite care was a key means of maintaining their personal energy, meeting the needs of others in their family thus fostering family resilience. While participant social workers viewed respite care positively, they were less certain about their ability to resource this. Results of the fourth, quantitative study provided further support for the role of respite care in achieving positive care outcomes for this vulnerable group of children and young people.

Dialogue and the negotiation of effective support

There is value in considering how social workers and caregivers dialogue in order to negotiate an effective support response (Twigg & Atkin, 1995). Strengths based models of social work practice also reinforce the importance of dialogue particularly in the opportunities it provides to share social work and client perspectives (Saleebey, 1997). Exploration of the perspective of caregivers and social workers in this research suggest both commonality and difference in their views of support. However, the opportunities for these parties to dialogue and remain connected are few. In this context it is likely that misunderstanding will occur and opportunities will be missed to reshape support more effectively. For example, while caregivers and social workers view respite care with equal importance, without comprehensive dialogue social workers may fail to appreciate the reluctance with which caregivers approach respite care for this group of children and young people. Nor will caregiver preference that respite be offered automatically, as part of a care support package, be understood by social workers.

Regular fora to discuss different views of support did not appear to exist in Child, Youth and Family at the time of this research. Social workers surveyed spoke of their inability to provide enough back up and support to caregivers and caregivers spoke of their repeated failure to access Child, Youth and Family social workers to discuss their needs. While this situation exists it is likely that effective support to caregivers will not always feature in social workers' planning and ultimately in Child, Youth and Family's care strategies.

Relationship with child mental health services

Access to mental health services was the key issue raised in the comments of social workers in this exploration along with the lack of an appropriate care continuum including wrap-around packages, residential and intensive foster care options. Social workers identified mental health services as failing to take case leadership where mental health problems were prominent, leaving both themselves and caregivers with insufficient training and knowledge about disorders to manage cases well.

These findings confirm the same kinds of problems between Child, Youth and Family and child mental health services as are experienced by other child welfare jurisdictions. Poor access to mental health services and the inadequate response of these services have been described in New Zealand (Child, Youth and Family, 1999b; Cockburn, 2002; Ministry of Social Development et al., 2003) and overseas (Lau & Weisz, 2003; Richardson & Joughin,

2000; United States General Accounting Office, 2003). Efforts to improve relationships with mental health services have been consistently applied yet Child, Youth and Family social workers report similar problems in establishing interagency collaboration as their colleagues overseas (A. Cooper et al., 2003; Jenny Morris, 2003). Resulting system reactivity and its negative consequences for this group of children, young people and their caregivers are well described overseas (Nugent & Glisson, 1999; United States General Accounting Office, 2003).

What this research indicates is that the problems obtaining adequate mental health services contribute to social workers' own sense of isolation and reinforce their beliefs about their failure to support caregivers. Comments in studies one and two indicate a cycle of disappointment, whereby social workers feel let down by mental health services because they are provided with inadequate back up services and information. In turn they feel ill informed and unable to provide adequate support to caregivers, who then feel unprepared and unable to fully manage children in their care. Improving access to mental health services can be expected to bring benefits not only to those children who obtain access to these services. It is likely to reduce the isolation felt by social workers and increase their confidence to provide better support to caregivers. Information about problems, treatment, advice and support about behavioural strategies, are particularly important.

Policy and practice implications

Emerging from these findings are a number of policy and practice development options for Child, Youth and Family to consider which could enhance support to caregivers and improve care outcomes for children and young people with mental health problems.

Improving care outcomes through caregiver support

Child, Youth and Family efforts to improve the outcomes for this group, to date, have centred on increasing access to mental health services and on interagency co-ordination of services. These findings indicate that gains could be made in child outcomes by aiming to improve the effectiveness of support to caregivers for this group. This can be approached through enhancing social work support, strengthening informal support systems including spiritual networks and considering the role of kin caregivers. These are discussed in turn below.

Enhancing social work support to caregivers

Given the documented struggle of Child, Youth and Family to provide effective social work support, this research suggests there are grounds for optimism in continuing the effort to improve support to caregivers by social workers. Understanding that caregivers principally seek emotional support through contact, encouragement and practice advice rather than extra resources, may assist social workers to be more available. Much of what caregivers seek in support from social workers is immediately possible, if Child, Youth and Family were to support mandatory, regular telephone and face-to-face contact between social workers and caregivers.

The perspective that support is a negotiation based on the expectations and perceptions of caregivers and social workers suggests time and opportunities need to be made for these parties to hold in-depth discussions about their respective views of care and support. As management of child behaviour is a key concern for those looking after children with mental health problems, caregivers are likely to need regular dialogue with the social worker responsible for and knowledgeable about the child, their problem behaviours and current treatment strategies. Caregiver liaison positions were established by Child, Youth and Family as part of an initiative to raise the level of support to caregivers. The wisdom of having intermediaries within the caregiver and social worker relationship has been questioned in some care circumstances (Doolan & Nixon, 2003b). It may be useful for Child, Youth and Family to specifically consider the effect of these positions in the process of establishing effective dialogue about support between social workers and the caregivers of children with these high needs.

Working with the informal networks of caregivers

The research showed that while social workers understood the importance of the informal network in contributing to positive care outcomes, their orientation is towards assisting caregivers to access more formal support. Providing guidance for social workers as to how to inquire about, respect, reinforce and supplement informal caregiving networks should be part of a strategy aimed at maintaining the capacity of the foster family to care for children with mental health problems. Such practice models are becoming available in New Zealand (Jack, 2003; R. Munford & Sanders, 2003b), and are well established overseas (O'Neill, 1993; Saleebey, 2002). There are models available which are specific to caregivers of children with mental health problems (Friesen & Huff, 1996) and disabilities (Dunst et al., 1994; Herman

et al., 1996), which could be used as a basis for Child, Youth and Family practice development.

The strengths based practice initiative currently evolving in Child, Youth and Family may assist social workers in providing support to caregivers' informal networks. The development of this approach gives an opportunity to consider the particular needs of foster caregivers looking after children with mental health problems. This model should take account of the elective nature of foster care and anticipate that support from the family network may not always be forthcoming. Additional sources of informal support may need to be developed for those in this group without these networks, such as that derived through spiritual networks and peer caregiver groups, cultural and recreational connections.

Acknowledging the place of spirituality

This research provides preliminary evidence for the positive role of spirituality in the provision of foster care for children with mental health problems. However, like other statutory social work organisations Child, Youth and Family has paid little attention to how to involve spiritual faith as a resource for families caring for children. An understanding of the reasons for the exclusion of spiritual beliefs from international social service frameworks can be found in Dosser, Smith, Markowski & Cain, (2001), which include particularly the effort to be value-free and training approaches which emphasise social worker neutrality. These authors recognise a tendency for the spiritual beliefs and the faith community to be overlooked when resources are identified.

The use of spiritual resources can supplement and complement the traditional resources that are typically included in treatment plans, thereby strengthening plans. With families that possess a strong spiritual orientation, faith communities and spiritual leaders can become key allies in the service delivery process (Dosser et al., 2001 p.70).

Individualised service models such as systems of care overseas and in New Zealand, the High and Complex Needs Strategy, offer the opportunity to pay more attention to spiritual sources of family strength. This is not likely to happen, however, until social work practitioners are certain about their own beliefs and confident about discussing spirituality with caregivers. Canda & Furman (1999) stress the need to cultivate the spiritual component of the helping experience, including the need for social workers to have values clarity, to develop respectful helping relationships which inclusively honour client beliefs and nurture creativity in clients. Nash & Stewart (2002) also discuss the importance of practitioners

being able to examine their own values and motivations, and this is included in some social work curricula in New Zealand.

Child, Youth and Family, in the development of the strengths based practice framework, also have an opportunity to enhance the ability of social workers to reinforce family belief systems and spiritual resources. This includes establishing collaborative relationships with spiritual networks in communities. The development of this practice, which acknowledges the strength of faith-based interventions, needs to be underpinned by personal reflection, training and supervision.

This research indicates that social workers skilled in this way will be useful to caregivers contemplating relinquishment of care. When care relationships have become destructive, social workers will understand the particular difficulty this creates for spiritually motivated caregivers. Matching caregivers and children with mental health problems is also identified as an area needing improvement by both social workers and caregivers. Woods (2002) describes how understanding spiritual motivation can assist in the selection and support of volunteers along with matching the caregiver with the person being helped.

Kinship care

This research could not separately investigate kinship care in respect of children and young people with mental health problems. However, overseas research indicates that there may be potential benefits offered by kin caregivers for this group. Early results suggest lower levels of behavioural problems amongst children in kinship care (Rowe et al., 1984; Solomon & Marx, 1995), a high level of commitment by kin carers to managing grief reactions (Pecora et al., 1999) and improved placement stability in the face of disruptive behaviour in kinship compared to foster care (Berrick et al., 1994; Sallnäs et al., 2004).

In New Zealand a large proportion of Maori children in statutory care are placed in kin care (Child, Youth and Family, 2003b). For Maori, spirituality is a key part of their indigenous frameworks for health and well-being, discussed in more detail in chapter two. This research has noted possible protective effects of religious affiliation of caregivers for children in statutory care. In New Zealand then, kin based care that is spiritually based, holds promise for many children and young people with mental health problems who are involved with Child, Youth and Family and may be particularly appropriate for those who are Maori.

There is a natural alliance between kinship care provision for Maori supported through Iwi Social Services and Maori mental health models which also aim to build whanau strengths, including their spiritual well-being. Iwi Social Services as legal entities under the child welfare law of New Zealand provide supervision and support of whanau care. They enable kin care for Maori to be appropriately supported and strengthened. In addition, many iwi who provide this form of support may be likely to be part of Kaupapa Maori mental health services. Early indications from Child, Youth and Family are that Iwi Social Services have had some success in providing care for children with serious mental health problems (Calvert, 2000) but more exploration of this is warranted before conclusions can be reached.

Development of kin based care models for this group would need to ensure that existing disparities between support for kin caregivers and foster caregivers are addressed in a creative and appropriate manner. Established access to appropriate clinical services is part of this support. Child, Youth and Family have expressed an interest in developing new policy designs for strengthening the support provided to kin based caregivers (Matheson, 2003). General models for appropriate forms of kin caregiver support are provided by Scannapieco & Hegar (2002). An ideal opportunity exists for Child, Youth and Family in the planned development of a kin based care policy framework to ensure the particular needs of those caring for children and young people with mental health problems are met.

Development of a policy framework for caregiving

Attempts to re-orientate support to caregivers in Child, Youth and Family are unlikely to be successful unless underpinned by a clear policy framework, which prioritises support to caregivers. The invisibility of caregivers in child welfare services and the lack of policy frameworks to address their needs have been described overseas: *"They exist as if they were off centre to service provision, rarely themselves the direct focus of an intervention, yet often significant in the determination of provision"* (Twigg & Atkin, 1995 p.7).

Twigg (1989) presents three conceptual approaches to caregivers adopted by social care agencies. These are caregivers as resources, caregivers as co-workers and caregivers as co-clients. Much of the social work research on caregivers in child welfare systems described in chapter five, tends to view caregivers as a resource, describing the "industry" need for caregivers in terms of supply and demand. Child, Youth and Family's own strategic analysis of care approaches caregivers from this standpoint (Child, Youth and Family, 2002c). There was evidence in the comments of social workers in this research that they too regard caregivers as a valuable resource. Attempts to command and direct caregivers as resources

however, have proved to be difficult in child welfare (J. G. Barber, 2001; Triseliotis et al., 1999). Child, Youth and Family have reported similar problems (Child, Youth and Family, 2001e).

Debate about the place of caregivers in child welfare services has included the need for caregivers to be more closely perceived as members of a team or as co-workers (Campbell, 1999; Wain, 1999). There was evidence in these findings, that some social workers thought Child, Youth and Family should be building more of a team-work approach to caregivers who look after children with mental health problems. Twigg (1989) points out, however, that the concept of caregivers as co-workers still only goes some way towards meeting caregivers' own needs. Although caregiver morale and involvement is attended to in a team approach, it is still an intermediate outcome, on the way to increased welfare of the cared-for person (Twigg, 1989).

There may be value in Child, Youth and Family considering the development of a policy approach which regards caregivers as co-clients (Twigg, 1989). In the context of this research, this means social workers viewing the whole caregiving unit as the client rather than just the child with mental health problems. In this way caregivers and their networks become recipients of support in their own right along with the child or young person. Twigg (1989) argues that it is only in this model that the conflicts of interest between the caregiver and the person cared for can be fully recognised.

For Child, Youth and Family the strengths based approach may provide the policy framework which can enable caregivers of children with mental health problems to be regarded both as members of a team and, like those they care for, legitimate recipients of support. In such a framework, the views and strengths of caregivers and their networks are valuable contributors towards positive outcomes for those in their care. Recognising and incorporating these views into the plans of those they care for is part of a strengths based approach. Support then encompasses meeting the needs of caregivers and those of their informal network members through respite care, remuneration and access to appropriate clinical support services and crisis back up.

Assessment of caregivers

There is a range of strengths based assessment tools used overseas which Child, Youth and Family could explore, as a means of gathering information about the internal resources of families, see for example the Social Support Scale (Dunst et al., 1988) and the Family

Support Scale (Dunst et al., 1994). Caregiver self-assessment tools provide another useful approach (Early, 2001). These tools offer enhancement to Child, Youth and Family's current assessment of caregivers for this group of children and young people.

Caregivers and social workers commented in this research about the shortcomings of current caregiver preparation and matching of caregivers to the specific needs of a child. Improving the description of the caregiving task assists in determining whether there is a fit between the skills, knowledge and abilities of the caregiver and the care requirements. This is an approach which has been established overseas (Simms, 1991).

The results of this research place an emphasis on the ability of caregivers to set boundaries around their care. A clear description of the task would aid social worker assessment of and dialogue about caregivers' boundary setting skills. It provides the necessary information to caregivers making a serious, often spiritual commitment to provide care for a high-needs child.

Sanft's (2002) job analysis developed for the care of a child with mental health problems provides a starting point for Child, Youth and Family. This framework could be developed further in the light of these findings about the importance of caregiver boundary setting abilities. Foster caregivers can provide valuable input into such assessment initiatives and mechanisms to achieve this input are discussed further below.

Care of children and young people with serious mental health problems

There was doubt expressed by some social workers in this study about the ability of caregivers to meet the needs of young people with more serious mental health problems. Caregivers also described experience of having to relinquish care when it was no longer possible to provide this because of the demands of the child. Calvert & Lightfoot (2002) have described practice models that follow therapeutic foster care approaches for a small group with more serious problems, currently funded through the High and Complex Needs Strategy. Further investigation of those therapeutic foster care arrangements, which are emerging from current practice, is suggested by these findings, in which social workers and caregivers both describe a small group of young people as unable to be managed in foster care. Therapeutic foster care is a well established and well evidenced care option for this group overseas (Kutash & Rivera, 1996; US Surgeon General on Mental Health, 2000). Child, Youth and Family may wish to consider whether the formal introduction of therapeutic foster care as a practice model for this group would be of benefit.

Continuing to improve access to mental health services

Despite considerable effort by Child, Youth and Family to address service access issues, beginning in 1996, the Baseline Review of Child, Youth and Family in 2003 maintained concerns that:

- *Unmet needs in the health and education arenas may lead to children and young people inappropriately becoming CYF clients*
- *CYF's care and protection clients may not have had timely access to appropriate health and education services*
- *Health, education and related services were not available to facilitate the exit of children and young people from the care of CYF* (Ministry of Social Development et al., 2003 p.63).

Despite an extensive history of unsuccessful efforts to resolve these access issues as described in chapter four the Baseline Review concludes with recommendations which focus on: *"various actions to improve service access through better collaboration, joint protocols and possible short term changes to organisational policies"* (Ministry of Social Development et al., 2003 p.64).

This research indicates that social workers are unlikely to view recommendations that focus on protocols and service collaboration with much confidence. Interagency agreements and service co-ordination while having some value in social workers' ratings were reported in their comments as failing or not working in practice. As described in chapter four, some jurisdictions are cautious about the capacity of collaborative efforts alone to deal with the problems of linking clients to appropriate services, particularly where there are service gaps, poor quality services, lack of evidenced-based interventions and professional and conceptual differences (A. Cooper et al., 2003; Koroloff et al., 2002). Even where access is achieved, community mental health services have been shown overseas to have problems meeting the particular mental health needs of maltreated children, within their usual service delivery designs (Lau & Weisz, 2003).

A necessary next step is to consider the nature and type of mental health services, which families who are involved with Child, Youth and Family require. In New Zealand access is still viewed as the means by which families who are involved with Child, Youth and Family, take up existing mental health services. There has been little recognition that the mainstream

mental health services may need to change their nature and type if the substantive and long standing access issues are to be addressed. An audit of New Zealand mental health services in respect of their suitability for those families at greatest risk of welfare involvement has been suggested as a means of examining the degree of fit between current services and those needed by Child, Youth and Family caregivers (P. M. Wells, 2003).

As a preliminary attempt to address service appropriateness, four intensive clinical support services (with wrap-around funding) were established as pilot mental health services in 2001 for Child, Youth and Family clients. These were discussed in chapter four. These services hold special interest. They look beyond improving transactions between existing services, and acknowledge the need for change in the nature of mental health services for this group. In particular these services are designed to increase the flexibility and intensity of child mental health services for those involved with child welfare services (Child, Youth and Family, 2004b). Similar strategies exist in the United Kingdom where special mental health initiatives for this group are nested in child welfare and child welfare services are reciprocally located in mental health (Z Kurtz & James, 2002). In this way there is an anticipated flow-on effect from specialist programmes to the mainstream services which constitute their operational context.

A preliminary review of the implementation of the four intensive clinical support services has shown, that while difficult to establish, these services, once operational, are valued by Child, Youth and Family staff (Child, Youth and Family, 2004b). This form of inter-agency initiative could be extended to supplement other models of collaboration currently in place such as the High and Complex Needs Strategy and service liaison. Evaluation of these services should inform analysis of the suitability of mainstream CAMHS services for families who are likely to be involved with Child, Youth and Family.

Sustaining family – a new policy approach to mental health services

Child mental health problems are increasingly viewed as chronic conditions (Arseneault et al., 2003; Pfeifer et al., 2002), in which serious problems have been shown to persist (Greenbaum et al., 1998), suggesting a need for early intervention and a focus on the provision of long-lasting family care. While care data are notoriously difficult to interpret this present research indicates that families with children with mental health problems become involved with Child, Youth and Family early, but that care relief, in the form of first placement, is delayed.

Recognition that many child mental health problems are likely to be ongoing should provide a basis for developing a more timely response to these families in Child, Youth and Family and a reconfiguration of priorities in New Zealand mental health services. The debate needs to focus on the persistence of many child mental health problems and the supports needed to sustain families so that they can continue to provide both care and a sense of belonging to their children.

Currently there is little acknowledgement in the shape of mainstream mental health services of the ongoing high stress experienced by families managing care of children with mental health problems in New Zealand. This is reflected in the absence of home-based support, behavioural support services in the home and out-of-home care. As described in chapter three, in New Zealand, respite care for families is defined as a temporary measure designed to avoid inpatient care. It is not viewed as a key early intervention aimed at providing long term support in order to sustain family care. Currently respite care provision is at 33% of the benchmark established by the Mental Health Commission (Mental Health Commission, 2003). The provision of long term respite care for families at an early point should be considered a crucial part of Child, Youth and Family's agenda with the Ministry of Health.

The mental health services described by participants in this research focus predominantly on assessment and treatment for children and young people who meet diagnostic and severity thresholds, as described in chapter three. The High and Complex Needs Strategy in New Zealand although providing flexible funding for some individuals has entry criteria defined in terms of the idiosyncrasies and extreme nature of individual need. It does not aim to fill long standing gaps in mental health services in New Zealand in order to sustain families who provide care to those with serious problems.

This present research provides support for Child, Youth and Family to continue to raise issues about deficits in mainstream mental health services which miss opportunities to sustain family resilience. The range of family support services described within the systems of care approach requires consideration in New Zealand. The importance of establishing mental health services early in a placement is explained by Nugent & Glisson (1999). Home support, behavioural support and respite care to assist caregivers are important supplements to assessment and treatment traditionally offered within mental health service designs.

A number of possibilities already exist in other parts of the New Zealand health services, for this reorientation of mental health services. The disability support services in this country offer a broad range of family-orientated services, which include coverage for those with a psychiatric disability of more than six months duration (Ministry of Health, 2002a). Given

the persistence of child mental health problems many families should qualify for access to these services on the same basis as families who care for disabled children. Specifically this would provide early access to needs assessment, service co-ordination, home support, respite care, shared care, behavioural support in the home, short and longer term out of family care (Ministry of Health, 2002a). A discussion with the Ministry of Health may identify the extent to which some families caring for children with mental health problems are already accessing some of these services and the extent to which this option could be extended to all qualifying families.

Maori mental health service designs and delivery as described in the early chapters of this thesis represent another working model which acknowledge the centrality of whanau well-being and are orientated towards building whanau strengths. As described in chapter two Maori models of health place whanau well-being at the centre of individual wellness. As these programmes are already provided within mental health services in this country, they offer a platform for Child, Youth and Family to advocate for extending family-orientated services to mainstream mental health services.

A channel for family participation in service delivery and design

This research provides evidence of the contribution which caregiver perspectives can make to the design of both mental health and child welfare services. The involvement of families caring for children with mental health problems in mental health services overseas has been a key step in ensuring that the support services provided are those which are valued by families (Friesen, 2001b; Friesen & Huff, 1996) and are able to be accessed by them. In the United States both mental health services and the Child Protection Service (CPS) are developing community-based, family participatory approaches within the systems of care model (Friesen & Stephens, 1998). Structures which are showing promise in securing family participation in service design and delivery continue to be researched and the findings of these studies can be of use to Child, Youth and Family taking early steps in this area. Families can articulate the barriers which prevent them from accessing or continuing with the mental health services which are offered (Kruzich, Jivanjee, Robinson, & Friesen, 2003). The Family Barriers Checklist (Elliott, Koroloff, Koren, & Friesen, 1998) is another caregiver self-assessment tool which may assist New Zealand caregivers to articulate the means through which they can engage more effectively with mental health services.

Standards for mental health services in this country require that consultation be established with consumer representatives, which includes families caring for children with mental

health problems (Ministry of Health, 1997c). In New Zealand a standing mechanism for ensuring ongoing input into service design by families has yet to be developed by Child, Youth and Family or mental health services. Child, Youth and Family could consider developing a reference group of caregivers to assist in any ongoing work to improve services for families caring for children with mental health problems. Such a group would also be well positioned to advise the Ministry of Health about the access and design issues pertaining to New Zealand mental health services. Ensuring this process adequately represents the views of kin caregivers along with foster caregivers is essential.

Developing outcomes measurement for this group

This research sought to develop outcome measurement in an organisational context where this was regarded as a medium term goal. The key deficits in information have been discussed in the previous chapter and more recently in the Baseline Review. A plan to invest further in data design and analysis within Child, Youth and Family has been recently developed (Ministry of Social Development et al., 2003). Using this improved information, ongoing research into outcomes for children with mental health problems can become a priority for Child, Youth and Family. This is necessary as this group is currently subject to a number of interventions which are expected to bring benefits however, the research base for this is not established (Child, Youth and Family, 2002a).

This group while being notified early to Child, Youth and Family are delayed in their entry to care. The link between early entry to care and improved care outcomes should be furthered explored in New Zealand, as it has been overseas. Preliminary results here suggest that there is a substantial amount of placement instability, which needs further investigation, given the vulnerability of this group. Cross-validation of data against case records to estimate error variance in respect of key accepted proxy measures such as placement stability is important work for Child, Youth and Family in the short term. Error associated with the use of proxy measures could then be off set by triangulated data sources, while further data improvements are made.

Use of a composite outcome criterion

The findings of international research did not support the use of any of the existing Child, Youth and Family outcome domains as sufficient single measure of positive care for children and young people with mental health problems. In the practice of statutory social work decision making, multiple criteria such as permanence, safety or well-being, are not

considered individually but are regularly weighed against one another by social workers and caregivers. The decision to intervene, the need to evaluate placement success or terminate orders under the Children, Young Persons and Their Families Act (New Zealand Government, 1989a) all require social workers and caregivers to consider relativities between key outcomes. A composite criterion enables comprehensive measurement of care across a range of domains and this may have utility at crucial decision making points such as discharge or change in care status.

While it is widely acknowledged that individual child welfare outcome criteria are unlikely to be valid measures of care outcomes and that disaggregated multiple measures are unsatisfactory for social workers, constructs which integrate a number of criteria have not been developed, although they are of interest (Parker et al., 1991). In other disciplines, such as organisational psychology (Landy, 1989), extensive use of composite criteria support such procedures as job selection and performance assessment.

As Child, Youth and Family (Child, Youth and Family, 2001j) and overseas outcome researchers (Parker et al., 1991) have expressed interest in future composite indices, the criterion developed in this research for the dependent variable, may be useful. This criterion offers an alternative approach which can be used alongside multiple criteria, which are still being developed by Child, Youth and Family.

This research would argue for increased efforts to stabilise Child, Youth and Family outcome definitions and develop measurement options particularly for child and family well-being. Child, Youth and Family could widen potential data sources by revisiting the measures incorporated within the previous outcome design by J.G. Barber & Scott (1996). Integrating some of these well-evidenced scales into current Child, Youth and Family outcome design will widen the possibilities for evaluating interventions for children and young people with mental health problems. In addition, as new evidence comes to light, about the nature of child welfare outcomes, criteria in use should be reconsidered and redeveloped.

Improving social worker use of outcome data

The need for Child, Youth and Family to improve front line practice in both the short and medium term, has been recently identified (Ministry of Social Development et al., 2003). Social workers' investment in data collection is low and the resulting missing data frustrates research endeavours. Currently an information field does exist in the Child, Youth and

Family database to record mental health problems; however, a recent report indicated that recording is at such a poor level as to render this unusable (Child, Youth and Family, 2003h). Child, Youth and Family needs to strategise to curb the problem of staff non-compliance with information requirements about the outcomes of their activities, in order to improve the data offered back to social workers.

This research draws attention to the substantive gaps in key information about interventions for children in care, as have been described by others (Adair et al., 2000; Ministry of Social Development et al., 2003). Key to the development of social work practice is the inclusion, in outcome-based models of research, of interventions commonly used with this group such as mental health services (both public and private), caregiver support services and programmes provided by non-government-organisations.

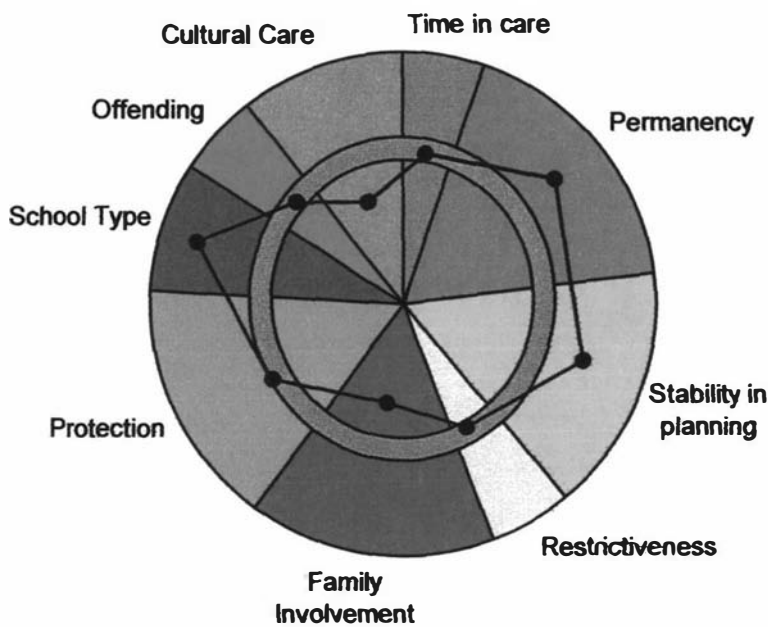
Finding ways in which information is collated and reviewed by front-line social workers becomes critical to this process. Information has to be accessible and meaningful to social workers, supervisors and caregivers, along with families and ultimately the children and young people who receive these services. Preston-Shoot (2002) emphasises that social workers are less likely to change practice by regulation than through the supervisory-led dialogue. Use of outcome research at the supervisory and management level ensures that questions about the effectiveness of interventions can be regularly asked and answered based on evidence.

Child, Youth and Family, like other child welfare organisations, has difficulty persuading social workers and supervisors to value research (Barratt, 2003). The preference of social workers for practice-based experience over other forms of learning (Sheldon & Chivers, 1995) means there is often a gap between endorsement of evidence based approaches and implementation (Barratt, 2003). Researchers concerned with the introduction of outcome measurement into child welfare organisations have commented on the lack of trust social workers hold in outcome data (Lyle, 1997). In particular social workers are frustrated that comparative data about individual cases on their caseload are unavailable (Sladen, 1997).

To offset these implementation issues Child, Youth and Family needs to present social workers with individual and summary data which can provide them with measures of client progress and facilitate decision making. Presentation of outcome measures can be developed in a number of ways. An example is illustrated below, whereby both individual and summary data are accessible visually in a form that can be shared readily with caregivers and families. Using the composite construct developed for positive care in this research, domain relationships can be presented graphically with the group means and individual case

performance recorded. This would present visually for social workers the performance of an individual case, compared to that of the group, in each of the key outcome domains. Further work by Child, Youth and Family could test the ergonomics of such data presentation with social workers and caregivers.

Figure 3 Possible practical depiction of composite care outcome



Limitations of the research

Limitations to this research have been discussed more fully in each of the study chapters. Research access conditions constrained the sources of data available. While case event histories were obtainable, it was not possible to balance this proxy data with direct perceptions of those in care, nor could child well-being measurement be included within the care construct. Other key variables of interest identified by social workers and caregivers, such as the provision of mental health services, had no measurement possibilities at all within the existing case history data.

Variation in care outcomes is likely to involve individual response to risk which could not be well investigated in this analysis. All children and young people included in the analysis had been exposed to child abuse or neglect and had attribution of mental health problems; however, the wide variation to be expected in the nature of the problems, the age of onset and duration may also influence care outcomes. Exploration of the importance of these individual characteristics was limited and remains a matter for further investigation.

The cross-sectional nature of the case history data, sampling error associated with the mental health database, poor data quality and the small size of the final sample reduce the power of the multivariate study. By using a mixed-methods design the limitations around the case history data analysis are to some degree offset by the data sources explored in studies one and two. Ideally, longitudinal designs overcome many of the well known methodological limitations of cross-sectional research and are recommended.

Integrating the perspectives of children and young people with those of caregivers and social workers was not possible in this research design. This absence of voice of children and young people is a common limitation of statutory social work research. Children and young people have views on care outcomes, which need to be integrated into research designs (Connolly & Rathgen, 2002) along with those of social work practice experts. The challenges of effectively engaging young people in research endeavours is usefully explored by Gilbertson & Barber (2002) suggesting social workers need to assist researchers in this regard.

Directions for future research

While these findings are tentative, they do contribute to an area of research that has been little explored in New Zealand. Connolly (2002) argued the need for New Zealand to strengthen research into the impact of world-leading child welfare legislation. She suggests Child, Youth and Family develop *"a comprehensive programme of research and evaluation that focuses on the experiences and outcomes relating to children and young people in the state care system"* (Child, Youth and Family, 2003e p.1).

Research into resilience is also undeveloped. In New Zealand the research base for family resilience has been noted as particularly weak (Kalil, 2003) and this has led to calls for greater research effort in this country (Mackay, 2003). However, even overseas research into resilience is still in a preliminary form. There are warnings about the complexity of the

construct of resilience and the limitations of current explanatory and research models (W. J. Curtis & Cicchetti, 2003),

These present findings make a contribution to New Zealand resilience research in respect of a group of children and young people in Child, Youth and Family care who are regarded as at particular risk. It indicates some areas of further interest. Replicating these findings with complete case history data using a larger group of children and young people, in which geographic disparities in sampling are addressed, is an important next step. Developing a comprehensive longitudinal analysis would be a particularly useful investment for Child, Youth and Family. Children and young people with mental health problems should be supported to be able to participate in any future research of this nature.

Increasing capacity in the information system of Child, Youth and Family, makes possible a larger study into the support needs of caregivers of this group of children. This would allow the effects noted in respect of spirituality of caregivers and respite care to be further explored. While the protective effect of respite care is described already for families of disabled children the role of religiously based care is of new interest. MacKay (2003) and Nash & Stewart (2002) note that spirituality is an important part of Maori and Pacific peoples' world views. Child, Youth and Family with a high representation of these ethnic groups amongst the client base needs to develop practice frameworks for understanding, engaging and supporting client spirituality. The confluence between Maori models of mental health, Iwi Social Services, kinship care and strengths based models of practice offer a choice of practice frameworks within which to develop future research.

In future work the construct used in the quantitative study, being religious affiliation could be advanced. Mahoney et al. (1999), and Mahoney, Pargament, Tarakeshwar & Swank (2001) encourage greater development of the variable of religiousness given the relationship with improved family functioning and child well-being which can be established using global constructs. Pearce, Jones, Schwab-Stone, & Ruchkin (2003) do this in their study of religiousness amongst young people where four indicators of religiousness are used; organisational religiousness, religious practice, beliefs about spiritual experience and self-ranked degrees of religiousness. Such construct refinement is an important part of future research into the role of spirituality in family resilience and positive care outcomes.

In New Zealand there are legislative requirements to seriously consider the placement of children with kin. A key area of further research interest is to investigate the possible superiority of kin care in respect of the care of children who have mental health problems. Kinship carers appear to demonstrate strengths in maintaining family contact and dealing

with children's issues of loss. Furthermore, in at least one study of kinship care, the negative effect of behavioural problems on placement stability, so well established for foster care, appears not to disrupt kin care to the same degree.

The non-government sector in New Zealand has a key role within legislation in the provision and support of kin care and foster care. For Maori children and young people Iwi Social Services are approved under the legislation to provide culturally appropriate support of whanau providing such care. For non Maori Child and Family Support Services are key providers of foster care for Child, Youth and Family clients and for families not formally involved with statutory services. Involving both Iwi Social Services and Child and Family Support Services in the design of kin specific support strategies could be considered a positive next step.

The outcome criterion constructed for the purposes of this research could be revisited in future work. Using qualitative methods a similar exploration of the phrase 'building belonging' rather than 'positive care outcome' was indicated as likely to have intrinsic meaning for social workers. Ensuring adequate cultural representation in further development of this construct is necessary. Using quantitative tools, a factor analysis would also assist in simplifying the construct; in particular by establishing, with a greater level of confidence, the level of shared variance accounted for across the nine outcome domains.

Future refinement of the independent variables is also recommended. As access to mental health services improves for this group over time, the integration of mental health treatment variables into analysis of outcomes for this group becomes possible. In turn, this could feed into the establishment of common evidence based approaches across both mental health and child welfare services and make a contribution to the body of international research in this area.

Families' interests need to be assured in future design and delivery of services.

"What really matters in the support of carers is how far and in what ways their interests are incorporated, who controls access to mainstream services and whose decisions collectively can be said to make up the response of the service system as a whole" (Twigg & Atkin, 1995 p.6).

Development of structures for family participation in service design and research is an internationally recognised means of achieving appropriate programme design and delivery but is new territory for Child, Youth and Family.

Precedent exists in the United States for family caregivers to be involved in the direction and design of research which concerns their interest (Friesen & Stephens, 1998). The advantages of this includes improvement in the relevance and rigours of research and increased use of findings by families (Turnbull, Friesen, & Ramirez, 1998). Those already embarked on joining families as research partners suggest this form of research will take longer, will need increased funding and its process and results may challenge institutional rules (Turnbull et al., 1998).

New Zealand has the opportunity to learn from this overseas development and use these findings to evolve a strong platform on which to base family involvement in research. Any further research by Child, Youth and Family would benefit from the input of both kin and foster caregivers. A reference group or forum of caregivers constituted to provide policy advice to both mental health and child welfare services, as described earlier, could also consider the design and direction of research into their support needs.

Conclusion

Finding pathways to wellness for children with mental health problems in care is a significant challenge for child welfare jurisdictions all over the world including Child, Youth and Family. In this research some preliminary evidence has been gathered for the role of respite care and spirituality in sustaining caregivers and for an association between these factors and positive care outcomes for this group. However, the exploratory nature of the design and the research limitations discussed, mean these findings require further investigation and confirmation.

The research has established that Child, Youth and Family social workers and caregivers share an understanding of the difficulties of this care, the importance of support, the contribution of informal support systems and the usefulness of respite care. These findings could become the basis for incorporating a family resilience approach to the wider policy work which Child, Youth and Family is undertaking with the Ministry of Health. Maori mental health models and disability support services which already exist in the Health sector, are also helpful. These hold promise as appropriate designs for future child mental health services because they are orientated towards building resilience in families.

In the last eight years Child, Youth and Family's attention in respect of children and young people with mental health problems has been caught up with issues of individual cases, service access and interagency collaboration. By contrast this thesis has concentrated on the

place of caregivers in achieving positive outcomes for children and young people with mental health problems. Its conclusions point to a different focus, that of sustaining caregivers, so that they can offer continuing care and belonging to their children. The research findings support the development of a policy and practice framework in Child, Youth and Family, which places caregivers both as team members and as clients worthy of support in their own right. It suggests a need for greater connection between the caregiver and the social worker responsible for the child placed, with space created for regular re-negotiation of support. This negotiation includes an acknowledgement of caregiver strengths and caregiver definitions of effective supports and recognition of the place of caregivers' networks. Such a framework, along with the research agenda, which underpins it, needs to be built with the involvement and direction of caregivers.

Some argue that all social work research is political in nature, as it has a principal aim to raise the voice of the powerless (R. Fisher & Karger, 1997). This research has gone some way to address the invisibility of the needs of caregivers who look after children with mental health problems on behalf of Child, Youth and Family by drawing attention to role of caregiver support in achieving positive care outcomes. In these conclusions we are reminded of George Eliot's words:

For the growing good of the world is partly dependent on unhistorical acts; and that things are not so ill with you and me as they might have been, is half owing to the number who lived faithfully a hidden life, and rest in unvisited tombs. (Eliot, 1871 p.896)

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Appendices

**Appendix 1 Blueprint for Mental Health Services
(Mental Health Commission 1998 p. 100)**

Services for children, youth and their families	Current resources: Total NZ	Benchmark: Total NZ	Benchmark /100,000 total population	Benchmark 0 - 14s years	Benchmark 15 - 19 years	Benchmark 20 - 64 years	Benchmark 65+ years
Acute inpatient - child and youth - beds or care packages	24.0	75.5	2	1.1	0.9		
Secure inpatient - child and youth - beds or care packages	0.0	15.1	0.4	0.2	0.2		
Community mental health teams - child and youth - FTEs	300.2	1,080.2	28.6	15.6	13.0		
Respite services - child and youth - care packages	0.0	30.2	0.8	0.4	0.4		
Day programmes - child and youth - care packages	0.0	151.1	4	2.2	1.8		
Community residential services - child and youth - beds or care packages	0.0	75.5	2	1.1	0.9		
TOTAL BEDS/CARE PACKAGES	24.0	196.3	5.2	2.8	2.4		
TOTAL FTEs	300.2	1,080.2	28.6	15.6	13.0		
TOTAL - DAY PROGRAMME	0.0	151.1	4.0	2.2	1.8		

Appendix 2 Gain and Young (Gain & Young, 1998). Listing of Child Welfare Measures or Indicators Described in the Literature as Outcome Measures or Indicators

LISTING OF CHILD WELFARE MEASURES OR INDICATORS DESCRIBED IN THE LITERATURE AS OUTCOME MEASURES OR INDICATORS

CHILD PROTECTION OBJECTIVES:

- Protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- To assist families to protect children and young people

BROAD GOAL: SAFETY

Desired Outcome	Measure or Indicator (*as expressed by the literature source)	Literature Source
The child will be safe from immediate physical, sexual, emotional abuse or neglect	• Ratio of children investigated for abuse to number reported at risk • Abuse or neglect while active case • Decrease in number of subsequent confirmed cases of open cases • % of children re-abused (baseline performance 5% on open cases, Performance goal 2% on open cases) • Numbers of substantiated maltreatment incidents on active family preservation cases • What % of cases reported and assessed as founded for an abuse or neglect report and which were provided protective services after the assessment, represent cases which were previously assessed for abuse and neglect while services were still being provided?	Alexander Poertner et al Orthner et al Malone & Matusiewicz Markley NCWRCMA
The child will become/ Remain safe from any/further physical, sexual, emotional abuse or neglect/Children will be safe from maltreatment	• Abuse or neglect recidivism after case is closed • Abuse or neglect after return home • Confirmed abuse cases • Decrease the number of subsequent confirmed reports of unsubstantiated cases of abuse or neglect • Deaths • What percentage of cases reported and assessed as founded for an abuse or neglect report within a given time period represent cases which were previously assessed for abuse and neglect? • What percentage of cases reported and assessed as founded for an abuse or neglect	Poertner et al McCroskey 1992 NCWRCMA

	report within a given time period, and which were closed at the end of the assessment, represent cases which were previously assessed for abuse and neglect? • Which of the cases were reported and assessed as founded after services had been terminated? • What percentage of cases reported and assessed for abuse or neglect are subsequently reported and assessed as founded within 12 months of the earlier report? • Decrease in number of subsequent confirmed case within a specified time • % of children needing protection who get services beyond investigation • % of children for whom no incident of determined abuse occurred during reporting period • 80% of families successfully completing the program (no child removed from home) will have no confirmed reports of abuse or neglect within six months of case closure • Percentage of child welfare cases with a subsequent substantiated report of CA/N for any child in the home: (a) within a given time frame following the initial substantiated report, (b) while open for child welfare services, (c) for families involved in prior unsubstantiated cases, (d) within a specified period of time following case closure. • Child's sense of safety and security	Oerthner et al Alexander Lyle 1993 Markowitz McDaniel & Thielman 1997
Reduce frequency of abuse and neglect	• % of cases in which caretakers are rated at 4 or 5 on dimensions III & IV of Parenting Scale • Increase by 20% the number of families closed in the Department with no subsequent abuse and neglect after initiation of services • Increase by 50% the number of families with no subsequent substantiated abuse and neglect within 12 months after case closure • Decrease by 20% the duration of open cases • Decrease the number of preventable injuries/deaths resulting from abuse or neglect	Lyle 1993 Malone & Matusiewicz AHA 1995
Reduce propensity for/ risk of, future abuse and neglect	• Potential for future abuse (measured by worker rating of risk variables (• Reduction in following risk factors: medically diagnosed injuries, lack of physical necessities (clothing, food); punishment (excessive; bizarre); lack of supervision; parental behaviour toward child (parent ignoring child, antagonistic) • Percentage of children whose cases were opened due at least in part to living conditions, e.g., housing quality and	Berkely in M&M 1986a Incadex in Magura & Moses 1986a NCWRCMA

	cleanliness, stability of income, etc., live in improved conditions when services are terminated?)	
Safety of children and communities will improve	- Improved child safety through improved child and family functioning measured by a standardised instrument such as: (a) Child Wellbeing Scales, which quantify 43 different dimensions of the physical, psychological and social needs of children including items for physical health care, nutrition, clothing, household furnishings, overcrowding, sanitation, parental supervision of young children, consistency of discipline, abusive discipline, deprivation of food/water, and measures of child behavior such as academic performance, school attendance, and misconduct. (b) The Family Risk Scales. 26 items including habitability of the family residence, suitability of living conditions, financial problems, social support, parental health, parental mental health, parental substance abuse, child's health, delinquency, child's home related behaviour. - Increase by 30% the community services families utilise while their cases are open - Increase in families' knowledge of available resources - Decrease by 25% the average length of time a case is in court under a Dependency and Neglect Petition - Decrease by 30% the number of police contacts a family's children experience while their case is open - Increase in use of appropriate discipline - Improved level of parental knowledge re physical and developmental needs of children - Increased reports from community - Increased availability and adequacy of an array of services - Decrease in rate of juvenile delinquency - Decrease in rate of criminal arrests or charges for child welfare cases - Decrease the factors that put adolescents at risk of perpetrating violence or becoming a victim of violence - Higher rates of service provision for newly opened services (especially in parenting skills training, family counselling and mental health services)	Fraser Malone & Matusiewicz Kimmich 1996 Malone & Matusiewicz Oerthner et al AHA 1995 Bard et al

BROAD GOAL: PERMANENCY AND STABILITY		
Desired Outcome	Measure or Indicator	Literature Source
The child will have a permanent home/Children are in a permanent home	• Number or percent of confirmed child protection cases where children remain in own home without further support • Number or percent of confirmed child protection cases where children remain in own home with support services • Reunification with birth families or original caretakers • No. or % returned home after entry to foster or residential care	Lyle 1998 Poertner et al
The child will have continuity of care.	• Number of different people who have acted as the child's main carer since s/he was a baby • Number of returns to parents after first separation • Number or % of child protection cases where children re-enter substitute care after reunification	Dept. Health UK 1995 Berlin Poertner et al
The child will have a safe and permanent home	• Children will live in safe, permanent homes reflective and respectful of the child's cultural, ethnic, racial, and kinship identity	McDaniel & Thielman

BROAD GOAL: CHILD WELLBEING/CHILDREN ARE ON THE RIGHT TRACK		
Desirable Outcome	Measure or Indicator	Literature Source
The child's wellbeing will improve/be maintained on a number of dimensions/The child is receiving the care expected by the community that would be provided by a "reasonable parent". This will result in maintained/improved wellbeing on a number of dimensions/Children will be assisted to become caring and productive adults	Health/Mental Health Dimension • The child is normally well, i.e., unwell for 1 week or less in the last 6 months • The child is thriving (satisfactory growth and development) • All preventive health measures, including appropriate immunisations, are being taken • Percent of children with current immunisations. • Inadequate immunisations • Percent of children who received a yearly medical examination • Percent of children who received a yearly dental examination • All ongoing health conditions and disabilities, including developmental delays, are being addressed as soon as recognised • The child is reasonably protected against	Health Dept. UK 1995 Poertner et al M Croskey 92 Poertner et al Dept. Health UK 1995

	common accidents, environment is safe (carer(s) are aware of common hazards and take adequate precautions) • receipt of pre-natal care • normal births • adequate birthweight • insured children • alcohol & drug use • Percentage of children whose cases were opened due at least in part to diagnosed mental conditions who have an improved diagnosis at the termination of services • Percent of children who received a yearly medical examination • Percent of children who received a yearly dental examination • Eliminate the use of alcohol and smoking during pregnancy	McCroskey 92 NCWRCMA Poertner et al Schmid
	Education Dimension • Percent attending school x% of the time scheduled) • Percent graduating from school • Graduation rates • Percent who complete high school • Youth prepared for university admission (• Improved school attendance and/or performance for children within a specified time following service • School performance and educational progress • Reduction in truancy/increase in the number of days a child attends school) • Child at age appropriate school grade level at entry	Lyle 1998 McCroskey 92 Poertner 1998 McCroskey 92 Oerthner et al Poertner et al Schmid Berlin
	Identity Dimension • The carer(s) are responsive to and encourage the baby's emerging individuality • The young person has a positive view of him/herself and his/her abilities (generally confident in new situations, takes on challenges & expects to succeed, enjoys meeting new people, expects to be liked) • The young person can relate to his/her racial or ethnic background	Dept. Health UK 1995
	Social & Family Relationships Dimension • The child/young person's contacts with his or her birth family strengthen his/her relationship with them • The baby is definitely attached to at least one caregiver • The young person is able to make friendships with others of the same age	Dept. Health UK 1995

	• The young person has a relationship with a person who is prepared to help him/her in times of need • Child's connection to family and community	McDaniel & Thielman
	Social Presentation Dimension • The young person can communicate easily with others • The young person's appearance is acceptable to young people and adults • The baby gives every appearance of being well cared for	Dept. Health UK 1995
	Emotional & Behavioural Development Dimension • The baby/child/young person is free of serious emotional and behavioural problems • The baby/child/young person is receiving effective treatment for all persistent serious emotional and behavioural problems • Percentage of children whose cases were opened at least in part due to their own behavior who have become more able to control their behavior in appropriate ways by the time of termination of services? • Improved behavior within a specified time following service) • Increased availability and affordability of child care options • Bedwetting	Dept. Health UK 1995
		NCWRMCA
		Oerthner et al
		Berlin
		Dept. Health UK 1995
	Self Care Dimension: • The young person can function independently at a level appropriate to his/her age and ability • The child is learning simple self-care skills for coping with early independence	Oerthner et al
	Employment and Training Dimension • Increase in number of adolescents successfully involved in education or vocational activities	McCroskey 1992
	Economic wellbeing Dimension • Children in poverty • % of child support orders on which some payment is made • Financial conditions	Nelson & Sladen
	Law & Order Dimension • Adjudicated delinquency rates for youth receiving child welfare services • % not in juvenile corrections system • % of youth returning to community from youth	Lyle 98 McDaniel & Thielman

	centers who re-offend within 6 and 12 months of release	
Improve or maintain functioning of child	• % of children for whom 1 or more problems on the checklist are resolved (expectation 60%) • % of children with no problems checked • Decrease in child's fear toward parent • Improvement in quality of child parent interactions • Improved effective communication and non abusive techniques to resolve family conflict • Improved sense of cohesion • Improved parental care-giving capacity (care, nutrition, hygiene, supervision) • Increased community recreation services and community support	Lyle 1993 Oerthner et al
Young person will be prepared for independent living/will be successful in independent living	• Education and employment • Public Aid Use cost to the community • Pregnancy/Parenting - whether the person has a child • Family Relative contact - contact with biological mother, father, siblings, extended family, foster care family or group home family • % not in juvenile corrections system • % not having children out of wedlock • % not active in social service caseload • % of youth returning to community from youth centers who re-offend within 6 and 12 months of release	Poertner et al 1997 Lyle 1998 McDaniel & Thielman

BROAD GOAL: FAMILY WELLBEING/STRENGTHENED CAPACITY FOR CHILD REARING		
Desired Outcome	Measure or Indicator	Literataure Source
Improve or maintain functioning of caretaker	• % of cases in which male and female caretaker is rated at 4 or 5 on dimensions III & IV of Parenting Scale • %of cases in which male and female caretaker maintains rating of 4 or higher on all dimensions of Parenting Scale	Lyle 1993
Families will function better	• North Carolina Family Assessment Scale • Improve parenting capacities (CWLA Family risk Scales) • Improved application of parenting skills appropriate to child's level of development • Improved parental ability to access and use formal and informal community resources • Improved parent and family members awareness of how their behavior impact the	Markley Pecora AHA 1995

SUPPORTED PLACEMENTS OBJECTIVE: The objective of supported placement services is to care for children and young people aged 18 years who cannot live with their parents for reasons of safety or family crisis

BROAD GOAL: SAFETY

Desired Outcome	Measure or Indicator	Literature Source
The child will be free of physical, sexual, emotional abuse or neglect whilst in out-of-home placement	Decrease in number of subsequent confirmed cases in out-of home placements	Certhner et al

BROAD GOAL: PERMANENCY/STABILITY

Desired Outcome	Measure or Indicator	Literature Source
Length of time in a non permanent placement will be minimised	- Length of time in a non permanent placement will be minimised % of children for whom permanency plan was achieved within 24 months - Length of time for child in out of home care to achieve permanent plan - Length of time to finalise an adoption once parental rights terminated	Markowitz Alexander Arnold
Permanency plan will be achieved	- The child will be re-united with birth family, original caretakers - The child will be placed in kinship care with transferred guardianship - The child will be adopted - Number of children not moving to permanency plan	Markowitz
Increase the success rate of reunification (Schmid)/Children who return home after a supported placement will remain at home (Poertner et al)/More children who return home from foster care will remain at home (Markowitz)	- Number of children who re-enter substitute care following reunification with birth family) - expressed as percentage of children in care - Frequency of parental visits when in foster care as a predictor of reuniting	Poertner et al Berlin
Improve the stability of children's living arrangements	- Children in placement will experience fewer moves (- Maintain sibling groups wherever possible	Markowitz AHA 1995

	- and appropriate • Increase the number of local community placements for out of home care • Increased % of children with planned discharges from residential treatment	Drews
Movement to less restrictive environment when a child's placement with the provider facility is terminated	• Moving from group home to foster care (measure of success) • Child running away or going to another equally or more restrictive measure (measure of lack of success)	Bassett & Bjorklund; Chamberlain et al
BROAD GOAL: CHILD WELLBEING		
Desired Outcome	Measure or Indicator	Literature Source
The wellbeing of children in supported placements improve/be maintained on a number of dimensions/ children in supported placements will receive a similar standard of care to that which would have been provided by a "reasonable parent"	Health Dimension • What percentage of children in substitute care who have physical health problems experience improvements in their physical functioning while in substitute care? Education Dimension • What percentage of children in substitute care who are performing below grade level when they enter substitute care experience improvement in their performance during their stay? • School performance assessed through grades, citizenship and attendance Emotional & Behavioural Dimension • Percent of children in substitute care who always feel loved by their caretakers • Percent of children in substitute care who feel safe General • % of children who received purchased supportive/rehab services in substitute care	NCWRCMA NCWRCMA Bassett & Bjorklund Poertner et al Alexander
BROAD GOAL: CONSUMER SATISFACTION		
Desired Outcome	Measure or Indicator	Literature Source
Users of supported placement services will be satisfied with services received	Satisfaction levels	Various

**Appendix 3 Information Sheet for Social
Workers**

INFORMATION SHEET FOR SOCIAL WORKERS

Supporting Caregivers Looking After Clients with Mental Health Disorders

Research by Philippa Wells

There is growing concern about the number of clients of the Department of Child, Youth and Family who have mental health disorders. Acting as a researcher I have designed a project to look at the placements of these clients and what services work best to support their caregivers. Massey University's School Social Work and Social Policy and the Department's Research Access Committee have approved this research.

The research looks at the placements of a large group of clients with mental health disorders (including drug and alcohol disorders) who were involved with the Department in 1999. It is hoped that this research will provide some information that will be useful to those planning new support services both in Welfare and in Health.

What do you have to do, if you agree to participate?

You are recorded as a social worker who may have been involved with a client with a mental health or drug or alcohol disorder. I am seeking your input into this project. I would like to ask what you, as a social worker, think is the best kind of support services to offer caregivers for clients with these problems. I am also interested in how well you think that the Department is managing to provide this support. I am not seeking any details about any of your clients.

As social workers are very busy people I have only got five questions to ask in the following questionnaire. It should take 5 to 10 minutes for you to complete this set of questions. Your answers are completely anonymous.

Please fill in the questionnaire and return this in the stamped addressed envelope enclosed. If you would prefer to be contacted verbally rather than by mail please request this and I will contact you by telephone.

I would also welcome any additional views or comments that you may wish to make during the course of the project

Who else is involved?

It is also planned to ask a group of caregivers to comment on the kind of supports which they need to provide stable care for a child who has a mental health disorder.

Anonymity and Confidentiality

- ❖ The questionnaire responses will be anonymous, your reply will not be able to be identified in any way by me or by any one else.
- ❖ All responses will be treated with strict confidentiality.

- ❖ No social worker names will be used in the research report or in any presentation of the findings.

What will the research project offer you?

Please request be e mail if you wish to be kept informed about the progress of the research. I will be available to discuss any aspect of the research with you during the project.

At the conclusion of the project the findings can be made available to you as a participating social worker once the Research Access Committee has approved the release of the findings.

Consent

- ❖ It is assumed that filling in the questionnaire implies consent to be part of the project.
- ❖ You have the right to decline to answer any particular question.
- ❖ If you do not wish to participate in the research project I would appreciate it if you could reply by telephone, fax or e mail saying that you are unwilling to participate in the research.

Thank you very much for your time.

Philippa Wells

Contact Details

Philippa Wells
Researcher
Address and telephone number withheld from thesis

Supervisors

Professor Robyn Munford
Dr Jocelyn Y Quinnell
Address and telephone number withheld from thesis

Appendix 4 Social Worker Survey

SUPPORT SERVICES TO CAREGIVERS OF CLIENTS WITH MENTAL HEALTH DISORDERS (this includes clients with drug and alcohol disorders)

This questionnaire is specifically about the provision of support to caregivers who are caring for children and young people with mental health disorders.

Question 1 – Social Work

❖ Is doing social work with a client who has a mental health disorder generally different to working with a client who does not have a mental health disorder?
(Please tick ✓ the answer that fits best)

You cannot compare clients, they are all different _____	☐
No, these clients are no different than other clients _____	☐
Yes, these clients are usually more <i>difficult</i> than other clients _____	☐
Yes, these clients are usually <i>easier</i> than most other clients _____	☐
Not sure _____	☐

Question 2 - Support Services to Caregivers

❖ The following services are used to support caregivers providing care for clients with mental health disorders. In your view what is the effectiveness of these services? For each service please enter a number from the scale below.

(1) Effective	(2) Partly Effective	(3) Undecided	(4) Not very Effective	(5) Not at all Effective	
Service co-ordination _____					☐
Information about the client's disorder _____					☐
Training for caregivers to manage the behaviour of the client _____					☐
Financial reimbursement to caregivers _____					☐
Social work support and advice _____					☐
Respite care so that caregivers can have a break _____					☐
Minders or support workers to assist caregivers managing the behaviour _____					☐
Home support for example, cleaning, cooking _____					☐
Family therapy for caregivers and the client _____					☐

Support groups with other caregivers _____ ☐

Please enter any other services that you think are important and rate them

Other: _____ ☐

Question 3 – Other Factors

❖ The following factors may help to stop the placements for clients with mental health disorders from breaking down. In your view what is the effectiveness of these factors. For each factor please enter a number from the scale below.

(1) Effective	(2) Partly Effective	(3) Undecided	(4) Not very Effective	(5) Not at all Effective
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Strength of relationships within the care giving family _____ ☐

Previous experience in providing care for clients with these kinds of needs _____ ☐

Ability to manage challenging behaviour _____ ☐

Understanding the client's disorder and needs _____ ☐

Caregiver having lots of informal supports like friends and family to help _____ ☐

Caregivers identifying with the culture of the client and this culture being part of the care that they provide _____ ☐

Caregivers teaching values or spirituality as part of the care they provide to the client _____ ☐

Having something for the client to do in the weekends and after school _____ ☐

Keeping clients attending school or in work _____ ☐

Please enter any other factors which you think are important and rate them

Other _____ ☐

Question 4 – How well is Child, Youth and Family supporting caregivers?

- ❖ How well do you think that social workers in Child, Youth and Family manage to support the caregivers of clients with mental health disorders? (Please tick ✓ the answer that fits best)

(1)
Very
Poorly

(2)
Well

(3)
Satisfactorily

(4)
Poorly

(5)
Very
Well

Question 5 - Is there anything left to add?

Are there any other important things that are needed to support a caregiver of a child or young person with a mental health disorder?

Thank you very much for your time.

Philippa Wells
Researcher

By filling out this questionnaire it implies you have consented to be part of this research.

Address and telephone number withheld from thesis

Appendix 5 Information Sheet for Caregivers

Supporting Caregivers looking after clients with mental health disorders

Research by Philippa Wells

Are you a Caregiver who has looked after a child or young person with a mental health disorder for the Department of Child, Youth and Family?

You are cordially invited to be part of a Focus Group discussion on what works best to support caregivers looking after children and young people with mental health disorders. This is part of a research project with Massey University, which is outlined on the attached information sheet.

Where: At the foster care conference

Date : Thursday 19 April

Time: 7.000 pm

Room: Room to be advised

If you wish to participate in the group discussion please contact Philippa below. If you cannot make this group but would like to arrange to have an individual discussion on Friday please contact Philippa below.

Contact Details

Philippa Wells

Researcher

Address and telephone number withheld from thesis

**Appendix 6 Information Sheet for Caregiver
Participants**

INFORMATION SHEET FOR PARTICIPANTS

Supporting Caregivers Looking After Clients with Mental Health Disorders

Research by Philippa Wells

There is growing concern about the number of clients of the Department of Child, Youth and Family who have mental health disorders. My research looks at the placements and supports for a large group of clients with mental health disorders (including drug and alcohol disorders) who were involved with the Department in 1999. It is hoped that this research will provide some information that will be useful to those planning new support services both in the area of child welfare and in health.

Who am I?

I am a mother, caring for my 7 year old daughter, who is diagnosed with Aspergers syndrome and so I know many of the issues which caregivers face who are looking after children with mental health disorders. I work part time for the Department of Child, Youth and Family in the policy section of National Office in Wellington.

Acting as a researcher I have designed this project to look at the placements of Child, Youth and Family clients and what services work best to support their caregivers. Massey University's School of Social Work and Social Policy, Massey University's Ethics Committee and the Department's Research Access Committee have approved this research.

What do you have to do, if you agree to participate?

I am seeking the input of caregivers who have looked after a child(ren) or young person(s) with mental health disorders on behalf of the Department of Child, Youth and Family. I would like to hold a focus group where a number of caregivers are willing to share their experiences of providing care with other caregivers. In particular I will be asking you about the best kind of support services to offer caregivers who are looking after children and young people with mental health problems. I am also interested in how well you think that the Department is managing to provide this support. I am not seeking any details about any of the children or young people who you have looked after.

As caregivers are very busy people and are hard to bring together I have requested that I use an hour or so at the New Zealand Federation of Foster Carers Conference to conduct this focus group. The session is set down for Thursday evening, time and room to be advised. If you are unable to be there I will also be available for an individual interview on the Friday. You can arrange to share some ideas with me at a specific time by phoning me on (numbers withheld for thesis)

I would also welcome any additional views or comments that you may wish to make during the course of the project.

Who else is involved?

I will survey a group of approximately 400 Departmental social workers to seek their views about the kinds of supports which are important for caregivers looking after children and young people with mental health disorders.

Anonymity and Confidentiality

- ❖ Participants will have the right to decline to participate and to withdraw from the focus group at any time. Participants may ask questions about the study at any time during participation.
- ❖ All information from the focus group or interviews will be treated with strict confidentiality.
- ❖ No caregiver names or client names will be used in the research report or in any presentation of the findings.

What will the research project offer you?

At the conclusion of the project the findings can be made available to you as a participant once the Research Access Committee has approved the release of the findings.

Consent

- ❖ It is assumed that by participating in the focus group or interview you are consenting to be part of the project.
- ❖ You have the right to decline to answer any particular question.

Thank you very much for your time.

Philippa Wells

Contact Details

Philippa Wells

Researcher

Address and telephone numbers withheld from thesis

Telephone : (Withheld from thesis)

Supervisors

Professor Robyn Munford, Dr Jocelyn Y Quinnell

Address and telephone numbers withheld from thesis

**Appendix 7 Delphi Questionnaires- A Positive
Care Outcome**

A POSITIVE CARE OUTCOME

Introduction

Thank you for agreeing to assist in the definition of a composite care outcome for a large group of Department of Child, Youth and Family clients with mental health disorders (n 1400) who are the subject of my research. A copy of the research proposal is attached for further information. Defining a composite care outcome is of current interest to many of us and the product of this work may have utility in the Department's own outcome design.

Delphi technique

The Delphi technique is a procedure for attaining group consensus as to the definition and prioritising of key criteria. It uses an identified group of experts who in an anonymous process develop and refine their judgements about criteria in order to reach agreement about a current problem.

The Process

The process is as follows:

As an individual, anonymous member of the expert group you are asked to consider the attached set of proposed components of a composite care outcome measure. These criteria have been generated within the constraints of the research that is they are retrievable from the current set of IAP tables for an anonymous data set.

Please consider the 9 outcome criteria and assign a relative weight out of 100 that you believe each criteria to be worth relative to one another in a composite outcome. For example you may weight stability of caregivers to be worth 30 points out of one hundred and the length of time in care as worth 20 points, 50 points would be able to be allocated between the remaining 7 criteria.

All the results of the expert group are calculated to obtain a median value for each criterion. These results are presented back to each member along with an inter quartile range for each criterion and you will be asked to once again provide a weighting for each criterion in the

light of the group weights. You are asked to provide a reason where ever you wish to weight an item outside the range that has been provided.

The individual reassessments are then re- calculated to determine a new median with the reasons provided where there has been a score included outside the given range. These new weightings are then returned to the experts to determine whether there is enough consensus among the group to agree the weighting. If not a further round of recalculation may be necessary. Although it is not expected that that everyone in the group will be persuaded to weight the same way, further discussion will not be needed once opinions remain fixed.

Your participation in the expert group is anonymous. Your response is identified only to the researcher. The final results will only be available to the researcher and to all individuals within the group. With the permission of all individuals within the group it is hoped to make the final results available to the Department in order to support their internal work on outcome measurement.

Thank you very much for your contribution to this project.

Philippa Wells
Researcher

Definition: A Positive Care Outcome

A care arrangement or set of care arrangements which provide safety and opportunity for a child or young person to grow to fulfil their developmental, spiritual, social and cultural potential, resulting in enhancement to their life chances, above the level that could have been reasonably expected had the placement not occurred.

A care arrangement is thought of as a move of a child or young person from the jurisdiction of their original caregivers to a new set of caregivers while the subject of intervention by a Departmental social worker.

Please consider the following set of criteria. Present a weighting for each category so that the total weights equal 100. **(The measures are still being refined ,they are included only as a means of clarifying the criteria).**

CRITERIA

- ❖ Time taken to achieve an outcome which,
no longer requires the involvement of a
Departmental Social Worker ☐
(number of days between entry to care and case closure)
- ❖ Permanency in the care giving relationship/s
(average number of care givers providing care) ☐
- ❖ Stability of placement planning
(average number of times placements changes are unplanned) ☐
- ❖ Restrictiveness of care placements
(proportion of days in restrictive settings, eg residential placements,
trackers or minders) ☐
- ❖ Maintenance of a family group,
willing to participate in decisions
about the child or young person ☐
(numbers of non official invitees and attendees at first and last FGC)
- ❖ Protectiveness of care giving arrangements
(number of substantiated investigations of abuse or neglect
while in care, reported incidents of self harm, suicide) ☐

❖ *In school or in work*
(proportion of days where child was in school or work) _____ ☐

❖ *Non involvement in offending*
(number of reports of offending while in care) _____ ☐

❖ *Culturally appropriate provision of care*
(number of placements where ethnicity of caregivers matches that of _____ ☐
the child)

Total of all above must =100 100

Appendix 8 Definitions of Dependent and Independent Variables

Criteria Developed for the Composite Dependent Variables

In study three a composite outcome criterion was derived from a structured discussion process. In the final multivariate analysis, measures for each of the variables within the composite criterion were established within the limitations of research access and data quality constraints. The individual criteria developed are discussed below.

Time in Care

Time in care = proportion of the time Child, Youth and Family were involved that was spent in care placements

This criterion was described in study three as the length of time taken for those who had a established a care relationship with Child, Youth and Family to have a permanent care arrangement made which no longer required the involvement of this statutory organisation. As the study was exploratory, using cross-sectional data, subjects had heterogeneous periods of involvement with Child, Youth and Family. A construct was established which measured the proportion of time during which Child, Youth and Family had a care involvement which was spent in active care placements. A lower proportion of placement days out of total days during which Child, Youth and Family had a care involvement, indicates greater time spent reunited with family.

Total placement days were readily measurable within the information system. The time period in which Child, Youth and Family had a care involvement with a child or young person was more difficult to establish. The first date of the first placement was utilised as a beginning point for this criterion. The last day of the last recorded placement was used as an end point for the period of Child, Youth and Family involvement. For many clients the last day of the last placement was sufficiently long ago that it was clear that the case has been closed and Child, Youth and Family were no longer involved. For others the last day of the last placement may have represented a further supervised period of return home. For those clients who were still in a care placement at the time of the study, the date of data extraction, being Nov 20 2000, was substituted as an artificial last day of the last placement.

Permanency

Permanency = mean length of placement

In circumstances where the period of care is uniform a straightforward count of caregivers or the number of placements can be used as a measure of variability in continuity of care. A unique caregiver identifier in the information system made it possible to determine how many new caregivers were associated with a child during the periods in which they were receiving care. As the caregiver count was derived from unique caregiver identifying codes, regular respite arrangements by the same caregiver could be excluded. In this cross-sectional study a measure of permanency was calculated using total number of unique caregivers, and the total days in care to give a mean placement duration for each child or young person. This enabled comparison of placement duration between children with different lengths of time in care.

Stability

Stability = the proportion of placement changes which were unplanned

When a placement is created in the Child, Youth and Family information system, a social worker must define the period for which the placement is planned for, by specifying a beginning and end date. Unplanned placement changes in this study were defined as those placements, which were terminated before the end date specified when the placement was created. This represented the best indicator of unforeseen placement breakdown possible within the data constraints. Placements which ended after the end date proposed when the placement was created, were not classified as a placement breakdown, as they represented extended time with a caregiver and did not indicate the same degree of instability as premature placement end. The number of these unplanned placement changes was established as a proportion of the total placement changes in order to establish a rate of placement planning stability, enabling comparisons across clients with different lengths of periods in care.

Restrictiveness

Restrictiveness = proportion of care days spent in restrictive care settings

Care arrangements within any statutory child welfare service vary greatly in the degree to which they restrict a child or young person or offer opportunities for social inclusion. Child,

Youth and Family describes care within five care types being extended family (or kinship care), Child, Youth and Family foster caregivers (foster care), caregivers with a Child and Family Support Service (agency care), care in a small group home (family home care) and residential care (residential care). To reflect this variability in care a weighting was provided for each placement day according to the type of care. This provided a basis for detecting variability in the level of restrictiveness of care days.

Whanau (kinship care) and foster care were viewed as equally unrestrictive and so were not weighted. These are socially inclusive arrangements in family-based care without any capacity for detention. Children placed in this form of care mix with children of caregivers and usually retain their local school arrangements. Residential care was weighted at 100 being the most restrictive form of care. Residences are highly regulated both legally and administratively and have the capacity for restraint and detention of individuals. School is provided within the residence so there are fewer opportunities for mixing with non-problem peers.

It was not possible to delineate whether the care provided by agencies was foster care, kinship care or group home care. Agency-based care was therefore weighted at 5, slightly above Child, Youth and Family foster care and kinship care in recognition that many Child and Family Support Services provide a mixture of group home and foster care. This is a likely source of error as some children placed continuously in foster care arrangements will attract a weighting higher than the circumstances require, whereas those in ongoing group care will attract a lower score than this care justifies.

Family homes do not integrate children into an existing family structure and tend to congregate children and young people with similar problems in a group living situation. For these reasons a weighting of 20 was applied to days spent in this form of care.

Family Involvement

Family Involvement = mean family group conference attendance by family members

Family group conference family attendance data was used in this research as a proxy for family involvement. It was used as a means to measure the maintenance of family connection during the period of Child, Youth and Family care involvement. The study calculated mean family attendance at Family Group Conferences whose dates fell within the period of care involvement, that is, between the dates of the first day of the first placement and the last day of the last placement (or the substitution date of 20 November 2000). While mean attendance

could not provide the actual pattern of family attendance over time, it did provide an overall measure of attendance during the whole period rather than at any single point. It also allowed comparison of cases with very different care histories, experiencing variable numbers of Family Group Conferences.

Protection

Protection= any incident of a substantiated care and protection notification that occurs after the first day of the first placement

The protection variable sought to measure the safety of children and young people once they had commenced a care involvement with Child, Youth and Family. Protection was defined categorically as the absence of any substantiated notification to Child, Youth and Family after the first date of the first care placement and prior to the last day of the last placement or the 20 November 2000. Substantiation refers to the confirmation through an investigation by a social worker that an alleged incident of abuse or neglect has taken place. A categorical approach was taken to this variable whereby one instance of substantiated abuse or neglect taking place during the care period was given the same weight as multiple events. This reflected the strength of weighting and comments about the protection variable in Study Three.

There were two significant sources of error within this variable. Due to previously discussed error associated with the failure to close cases, the variable was likely to include cases where Child, Youth and Family had actually ceased involvement and therefore subsequent abuse or neglect was taking place in a return home context, with no oversight or aftercare by Child, Youth and Family. Error is also anticipated whereby clients in care placements who were the subject of a report of abuse did not have this recorded as a formal notification, as the matter was being dealt with informally by the social worker already allocated. It is also anticipated that there is under-reporting of abuse and neglect of children and young people in care placements.

School Inclusiveness

School inclusiveness = the level of inclusion of the last recorded school type

Restricted access to individual casework records in this research meant that it was not possible to include conventional measures of school attainment such as attendance or

achievement. The mental health database however, contained some information on the recent school arrangements, recorded in the open comments field. From the descriptors of these school arrangements, the rating scale shown below was devised to compare the relative levels of social inclusion within these recent school arrangements.

There is error anticipated with this variable. The data provided a snapshot of variability in school inclusion in the group of children and young people for whom these records were made. In the absence of any continuous data this snapshot can only be an approximate indication of the path of educational inclusion rather than a substantive measure.

Table 24 Rating scale descriptors for school inclusiveness

Scale	Descriptor
1	School attendance without special support or problems noted
2	Mainstream schooling with additional support of teacher aid or RTLB noted
3	Mainstream schooling where there was a record of truancy or suspension
4	Alternative school arrangements being Correspondence school, School in CYF residences, activity centres, home schooling or residential schools

All clients on the mental health database who had no comments recorded about their schooling were coded as missing. This missing data is likely to include those whose educational arrangements were highly unsatisfactory but whose social workers were reluctant to record these matters, along with those where school attendance was unremarkable, thus attracting no case-notes.

Non-Offending

Non-offending = any recorded youth justice family group conference that occurs after the first day of the first placement

In this study a simple approach was taken to measuring non-offending. A record of a youth justice family group conference was used as the indicator of a youth offending event of significance. Any youth justice Family Group Conference which was held between the first day of the first placement and the last day of the last placement or the November 20 2000 indicated youth offending while in a care involvement with Child, Youth and Family.

As with protection, a categorical approach was taken to measuring this variable, which assigned the same significance to a single offending event as to multiple events. In this way the variable measured the commission of a single offending event rather than severity or chronicity of offending. There is the same anticipated error in this variable as there was in that of protection, as it was not possible to exclude offending which occurred when Child, Youth and Family had actually ceased involvement but failed to close a case.

Culturally Matched Care

Cultural matched care = proportion of all care days that were ethnically matched

Data pertaining to variability in the cultural appropriateness of placements were limited. The information system enabled caregiver ethnicities to be recorded for two care types, whanau or kinship care and foster care. For these forms of care it was possible to measure on a day-by-day basis where the ethnicity of the child or young person matched that of the caregiver. A variable was constructed which calculated the proportion of the total care days which had the potential to be ethnically matched which were recorded as actually being ethnically matched. This provided a proxy for culturally appropriate care provided by Child, Youth and Family. Those days spent in a form of care which could not be measured on the basis of ethnicity were excluded from the calculations. The variable reflected a dimension of culturally appropriate placement practice which was able to be captured within the data and acted as a proxy measure for some aspects of cultural safety.

The Independent Variables

The following section outlines the measures used to construct those independent variables included in the analysis. As with the dependent variables compromises were needed to establish measurement within the data constraints. Where possible the error associated with these proxy measures is discussed.

Respite Care

Respite care = proportion of placements which were planned and less than five days duration

No measure for respite care existed in Child, Youth and Family. Placement data in Child, Youth and Family however, does discriminate between those placements which relate to sustained periods of care and those which are regular short term care arrangements by another caregiver. Respite care was defined as the number of planned placements with a

length of less than five days. The number of these placements was calculated as a proportion of the total number of placements and constituted a continuous variable.

It is anticipated that there will be some error in this measure. Planned placements of greater than five days were considered in this study to be permanent rather than respite care placements, however, it is likely that in some cases regular respite of greater than five days may be arranged. Similarly the analysis may have included some cases where there were single planned placements of short duration that were included as respite care.

Religiously Based Care

Religious Care = proportion of total care days that were provided by a religiously affiliated caregiver

Information about variability in spirituality of caregivers was extremely limited, however, some proxy measurement was possible using religious affiliation of caregivers which is collected by Child, Youth and Family.

For caregivers providing kinship and foster care and care in family homes, religious affiliation of caregivers is able to be recorded. For these forms of care it was possible to determine religious affiliated caregiving on a daily basis. A variable was constructed which calculated the proportion of the total care days (for which religious affiliation could be ascribed), which were recorded as being with a religiously affiliated caregiver. This represented the proportion of religiously affiliated care being provided in Child, Youth and Family. The days of care provided in a care context where caregivers could not be ascribed in terms of their religious affiliation were excluded from the calculation of total care days. In this way children and young people with care histories that consisted entirely of residential or agency care would be described as having a missing value.

As many agencies providing care are church based social services it is anticipated that many children receiving care from a religious caregiver affiliated with an agency may have been excluded from the analysis. The identification of religiousness is made when a caregivers is registered. The low level of contact between caregivers and social workers at this time of this research suggested that this information is not likely to be updated regularly. Undetected change in the religious affiliation of caregivers is also likely to be a source of error in this variable.

Remuneration

Remuneration = proportion of care days where a non-standard board rate was paid

In Child, Youth and Family non-standard board payments are available for caregivers to recognise the special requirements of a child. They can be used to deal with extra demands on caregivers who care for children with mental health problems. Remuneration to caregivers is recorded in the information system as either a standard or non-standard board rate on a placement day basis. This enabled calculation of the proportion of total days in care where a non-standard board rate is paid. There is possible error in this measure as it would also include circumstances where caregivers had agreed to a lesser rate of remuneration.

Caregiver Experience

Caregiver experience = mean age of caregivers providing care

There were no data available as to the length of time which caregivers had been providing care to children and young people. Caregiver mean age was substituted as a proxy variable for caregivers experience although error is anticipated in cases where older but less experienced caregivers are providing care.

Supplementary independent variables

The mental health database constructed in 1999, required social workers to enter a range of data. Definitions were provided to social workers so that data could be consistently recorded. It is anticipated that given the low level of social worker knowledge at this point there is likely to be variability in response to some of these field and the reliability of this information may be compromised. The following brief explanatory notes are made about variables taken from the mental health database; a full discussion of these variables can be found in Wells and Smith (2000).

Severity

The categorisation of severity was dependent on a social worker judgement of severity according to the descriptors provided. The mental health database provided the following descriptors for those rating severity.

Urgent - receiving or requiring psychiatric hospitalisation or in-patient assessment
Severe – Requires treatment to prevent further deterioration
Moderate – Requires treatment to achieve current life goals
Mild – Could derive benefit from treatment

Primary diagnosis

Co-morbidity is common amongst children and young people with mental health problems. While the mental health database allowed for a primary and a secondary problem category to be recorded, only the primary category was used in this analysis.

Parental mental health

The mental health database contained additional comments made by social workers pertaining to the mental health status of parents or caregivers, which was used to construct a categorical variable. Where a record was made by a social worker of a parent or caregiver with a mental health problem this was used as a positive value. In cases where a social worker had recorded that there was no mental health problem amongst parents or caregivers this was coded as a negative value. The greatest number of clients however, had no record or comment in this field and were therefore recorded as a missing value.

There is considerable error anticipated in this data as it is expected that social worker knowledge about mental health problems will be low even though a full investigation may have taken place. Further there was no way to determine whether those caregivers with mental health problems who were in recovery and no longer experienced problems, were recorded as still having mental health problems.

Age at first notification / Age at first placement / Days between notifications

These variables were measured based on the data that was available through SWIS. Case history data were used to establish the age at first placement and age at first notification variables.

Ethnicity and Gender

These demographic variables use standard reporting categories devised by Child, Youth and Family as described in the annual reports of the organisation.