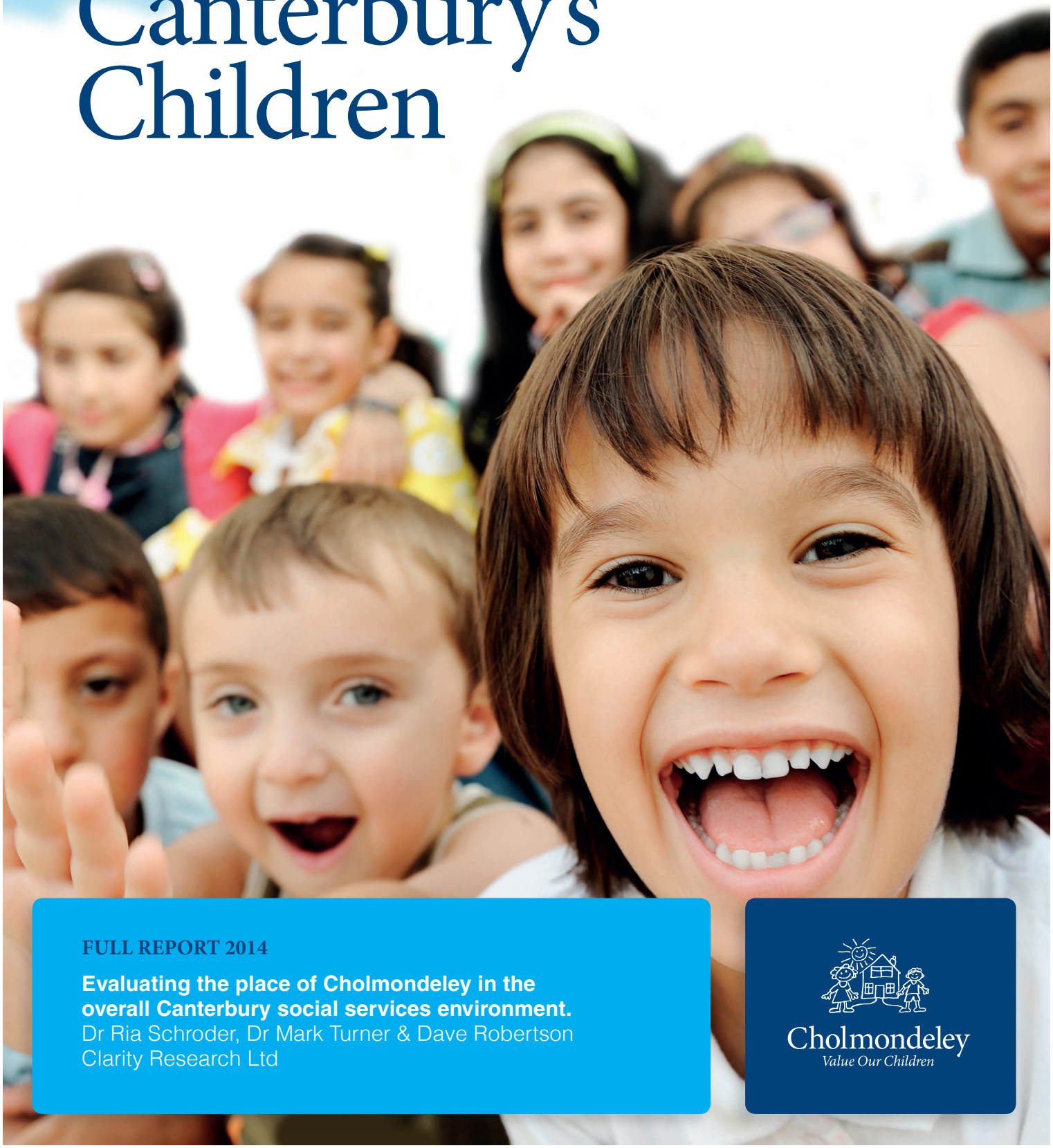
Hearing the voices of Canterbury's Children



FULL REPORT 2014

Evaluating the place of Cholmondeley in the overall Canterbury social services environment.

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Clarity Research Ltd

Cholmondeley
Value Our Children

Ko koe ki tēnā,
ko ahau ki tēnei
kīwai o te kete

You hold that handle,
and I'll hold this handle
and together we will carry the basket

Foreword

E ngā iwi, e ngā reo, e ngā karangatanga maha o ngā hau e wha, tēnei te mihi atu ki a koutou katoa,

Almost 89 years ago on 7th March 1925, Cholmondeley Memorial Children's Home opened its doors for the first time. The original admission book records the first child arriving on 25th April, 1925; an eight and a half year old boy who stayed until 17th May that year, leaving in "much improved health". So begins the legacy begun by Hugh Heber Cholmondeley's bequest of the original home and Governors Bay property in memory of his late wife, Margaret.

That legacy now includes many thousands of stories over the ensuing years. They are not only the stories from over 25,000 children who have stayed, but include their immediate and extended families. They also include the countless people who are working or have worked at Cholmondeley, who serve or have served in its governance and who support or have supported the organisation, either financially or in another way.

These stories have accumulated over time and are gathered as part of people's ongoing contact and experience with Cholmondeley. To this point, anecdotal information, along with published research, has guided and informed the organization in how it delivers its services to children and families.

This evaluation marks the first significant step in an ongoing process to develop a more rigorous, evidence based approach to determine the outcomes this organization is achieving for children and families, the benefits to the community, and to inform the development of our services into the foreseeable future.

The study is purposefully qualitative in nature. Our goal has been to establish a baseline of outcome related themes that will be further defined, measured, quantified and reported. It is the first of many steps to be taken in ensuring that Cholmondeley stays relevant to the needs of children, families and the community. It comes at a point in time where the last several years have been the most challenging in the organizations nearly 90 year history, which has placed it at somewhat of a crossroads.

An increasingly precarious financial position resulted in a major restructure of Cholmondeley in 2010, consolidating the organization back to its original purpose of providing highly accessible, community based, short term care. A refreshed vision, a strong commitment towards the principles of best practice and a philosophy of care entrenched in the rights of children has placed it on an exciting journey ahead.

Subsequent to this the Canterbury earthquakes in 2011 resulted in Hugh Heber Cholmondeley's original home being demolished. Our services have continued in alternate premises while the process of rebuilding a new; purpose built Cholmondeley Children's Centre has been undertaken.

This evaluation comes at a time where the process of rebuilding is now well advanced with all our services scheduled to return to our original site in February 2015.

Good practice is anchored in the values and principles of the organization, upheld by those responsible for governing, managing and delivering that practice. While much has needed to evolve since Cholmondeley's inception in terms of practice, and how it delivers its services to children and families in an ever evolving society, its reason for being remains the same as in 1925.

The demand for Cholmondeley's services is higher than it has ever been. This evaluation forms the foundation for its ongoing development, ensuring our services continue to be of benefit for those children and families we serve long into the future.

Our sincere thanks go to all those who have participated in this study. Your stories have been a precious gift to this legacy begun so many years ago.

Kāore e kume roatia te kōrero.

Nō reira, noho ora mai ra

Kerry Dellaca

President

Cholmondeley Children's Centre

Shane Murdoch

General Manager

Cholmondeley Children's Centre

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All the aforementioned persons and organisations are not responsible for the views outlined in this publication, which are those of the authors.

Executive Summary

This report comprises two parts. The first, a literature review, provides an overview of the extant literature on child and family resiliency and respite care for children and families at risk. This review serves a formative function to inform the second part of this report, presentation of the findings of a wider service evaluation for Cholmondeley Children's Centre.

Respite care endeavours to benefit all family members, especially the child, including preserving families, reducing risk and preventing admission into residential care. There is a lack of research regarding the utilisation of respite care to develop child and family resiliency. Research on child and family resilience recommends that interventions, such as respite, should be a means to apply strength-based practice models that promote systemic resilience through enhancing assets and adaptive systems of the child and family. Moreover, such interventions need to be cognizant of key child development periods, the importance of early intervention, interagency collaboration and have an intimate understanding of the culture, family functioning and social context of the child. Literature focussing on child and family risk suggests respite is of most benefit to the most vulnerable children under the age of six and/or for families with multiple risk factors.

Cholmondeley Children's Centre, established in Governor's Bay in Canterbury in 1925, provides emergency and planned short term respite care and education for children aged 3-12 years old, whose families are experiencing significant stress or difficulties. Cholmondeley is closely guided by a family preservation philosophy and works at an early intervention stage on the continuum of services for children and their families.

An independent evaluation of Cholmondeley Children's Centre was designed to answer the following questions:

1. What is Cholmondeley's role in the Canterbury community and the Canterbury social services sector?
2. What impact does Cholmondeley have on the ability of families to keep their children safe, and prevent issues escalating to the point where care and protection concerns arise for the child?

Qualitative, semi-structured interviews were undertaken with four groups of people essential to the day-to-day functioning of Cholmondeley. These included children who had attended Cholmondeley in the period between 2009 and 2013, the carers of these children, Cholmondeley's referrers and brokering partners and staff members of Cholmondeley. All participants were interviewed between July 2012 and July 2013 by trained interviewers.

Findings of this evaluation indicate a high level of support for Cholmondeley among interviewees with clear identification of a range of shorter and longer term outcomes for children, their families and the community at large. The reports from key stakeholders and professionals involved with Cholmondeley are testimony to the efficacy of the service in keeping children safe and providing them with an environment where they can just be children and learn skills that will benefit them for life. Reports from the children suggest that they love Cholmondeley; reports from carers suggest that they wouldn't function effectively as a family without the benefit of Cholmondeley; and staff and referrers/broker partners imply

that the wider community would be poorer if it weren't for the existence of Cholmondeley in the region.

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Introduction

Overview of Cholmondeley

Cholmondeley Children's Centre (previously Cholmondeley Children's Home) was opened in March 1925 and bequeathed to the province by a private benefactor with the aim of ensuring safe short term care for children recuperating from illness. In the ensuing years Cholmondeley gradually evolved to providing care for more psycho/social and behavioural reasons. Over the last 85 years Cholmondeley estimates it has looked after about 25,000 children. The original home in Governors Bay was destroyed in the February 2011 earthquake. Since then Cholmondeley has been operating its child care services from Bellbird Heights at Living Springs.

Cholmondeley operates as an Incorporated Society which depends on financial support from private donations, fund-raising, grants and sponsorship. Operational oversight is delivered by a General Manager (reporting to a Board of Governance), alongside an Integrated Services Manager, Care Supervisors, a Programme Supervisor, an Intake Social Worker/ Coordinator, Teachers, Adventure Based Learning Coordinator, Child Care Workers, administration and domestic staff and a fundraising team.

Cholmondeley's core service is the provision of emergency and planned short term respite care and education for children aged 3-12 years old, whose families are experiencing significant stress or difficulties. This service operates outside of the statutory sector and only some of the families have involvement with Child, Youth and Family. Referrals come from social service, health, educational providers and directly from parents and carers.

Respite involves a short stay of several days to several weeks. Many children attend regularly throughout the year. An average of 15-18 children per day stay at Cholmondeley for an average of five days. Usually around 80% of referrals are from Christchurch, the rest come from wider Canterbury and other South Island provinces.

School-age children attend an on-site education programme. Education staff liaise with the child's "home" school and the child and learning goals are set for the child's stay. The education programme focuses on the development of the key competencies. This is achieved through the provision of a wide range of experiential and adventure based learning activities using the local environment. These learning opportunities include activities such as rock climbing, swimming, kayaking, baking and cooking, growing an edible garden, beach walks and coast steering. At the end of the child's stay information is fed back to the child's "home" school and their parent or carers in the form of a Learning Story. The practice at Cholmondeley is informed by strength based approaches and the teachings and concepts of Social Pedagogy (Petrie et al, 2006). Cholmondeley is the only community based short term and emergency respite care providers for at-risk children in New Zealand and one of a few international facilities of its kind.

Cholmondeley is closely guided by a family preservation philosophy and works at an early intervention stage on the continuum of services for children and their families. Cholmondeley aims to release the tension within families so care and protection issues for the children are avoided or don't escalate to the point where the statutory services such as Child, Youth and Family are required to intervene.

Cholmondeley's key goals are having services that are immediately accessible to children and families in need, and to increase the level of partnerships with other social service providers in the sector, working collaboratively with them as part of a wraparound approach for families in need.

Cholmondeley recognises that children do not live in isolation from others and through its engagement with children it also develops relationships with their families and whānau and helps connect them to their communities, with the goal of providing opportunities to increase protective factors with the child, the family and the community. Whilst the child is involved with the service the parents or carers and the family and whānau are supported to gain access to other agencies and services in their communities that can offer services and supports to address concerns and to further strengthen their resilience.

A core philosophy of care underpinning Cholmondeley practice is children's rights, ensuring that every action and intervention is in the best interest of the child. This is founded on the United Nations Convention on the Rights of the Child (UNCROC), which is a human rights treaty based on the rights of children, to which New Zealand has been a signatory since 1993. UNCROC recognises parents and the family environment as having the most important role in raising children for "full and harmonious development" of children "in an atmosphere of happiness, love and understanding". Moreover, families should be given protection and assistance to meet these responsibilities.

The child-rights philosophy states that children have a right to be valued, consulted and enabled to build resiliency. This approach values what children have to offer as children, ensuring that they are listened to and respected, whilst the adults take responsibility for providing a safe, stimulating environment with clear boundaries and expectations and where relationship building is paramount.

The Cholmondeley Philosophy of Care stipulates:

- Children have the right to be unconditionally respected by adults
- Children have the right to feel safe and be free of violence
- Children have the right to have their physical, emotional, social, intellectual, cultural and spiritual needs met
- Children have the right to experience positive and secure attachments
- Children have the right to have fun
- Children have the right to experience opportunities for success
- Children have the right to expect adults to notice their strengths and to support them to further develop these
- Children thrive in relationships where they are valued
- Children thrive in warm, stimulating, nurturing and developmentally appropriate environments, and are capable of making choices and decisions about things that affect them
- The child knows what works for them and has the right to expect the adults to acknowledge and build on this
- Children have the right to make mistakes without fear
- Children have the right to have their voices listened to
- Children have the right to ask for help and for advocacy

- Children have a right to expect their whole community and society to take responsibility for their safety and wellbeing

Review Methodology

The literature review was completed using a systematic search strategy[1]. Electronic databases were searched including Medline, PsycINFO, Psychology & Behavioral Sciences Collection, Web of Science and Google Scholar. Hand searching followed, based on the references from the articles retrieved through the electronic searches. Government and agency reports, conference proceedings and textbooks were included. Finally, local and international experts and current researchers in the field known to the author (DR) were contacted. Where available, cultural perspectives were examined with a focus on New Zealand sources and perspectives.

Child and Family Risks and Stressors

Child Risks and Vulnerability

Risk factors have been defined as stressors that have proved or putative effects on increasing the likelihood of maladjustment in children (Gutman, 2008). Such risk factors threaten child wellbeing through depriving children's basic needs for physical sustenance, protection, emotional security, attachment and social interaction.

Longitudinal research illustrates that clusters of risk factors pose the most threat to child development, as opposed to single risk factors which only minimally increase the likelihood of poor outcomes (Fergusson, Horwood, & Lynskey, 1994; Centre for Social Research and Evaluation, 2011; Gutman, 2008). Vulnerability to poor outcomes is dependent upon the interactive effects of a range of factors, the developmental stage of the child and the cumulative presence of risks over time (Centre for Social Research and Evaluation, 2011).

Exposure to risks and their effects varies according to the age of the child (Gutman, 2008). For instance, infants are unlikely to suffer as much as older children from the Christchurch earthquakes due to their lack of understanding of what is happening. Older children and adolescents may have wider social supports (a protective factor), yet they may be more influenced by the loss and devastation (Gutman, 2008). Conversely, other risks disproportionately affect younger children. For instance, the risk of death due to maltreatment is higher the younger the child (UNICEF Innocenti Research Centre, 2003).

Risk factors supported by the literature (Centre for Social Research and Evaluation, 2011; Gutman, 2008; Fergusson, Horwood, & Lynskey, 1994) to adversely affect child outcomes are summarised in Table 1.

[1] The literature review was conducted by Dave Robertson. Dave was trained at Canterbury University and worked as a Clinical Psychologist for the last 20 years in a variety of settings, including 10 years in clinical director positions in organisations running respite care, therapeutic foster care, group residential care, and evidence-based family therapy and parenting programmes for children and youth at risk and/or evidencing behaviour problems. In 2009 Dave co-authored (with Mel Bleach) Foster Care and Youth Offending: A Review of the Evidence, published by the Henwood Trust.

Table 1: Child Risk Factors

Sphere	Risk Factor
Prenatal	Parental stress or mental ill health during pregnancy Exposure to fetal toxins (alcohol, cigarettes, psychoactive drugs) Poor maternal nutrition and health care
Parent Characteristics	Poor mental health Substance abuse Low education Teen mothers
Family Structure	Single parenthood Numerous stressful life events Crowded households Poverty
Family Processes	Family dissolution Harsh parenting Maltreatment Bereavement Exposure to family violence Poor infant attachment Parental criminality
Peers	Peer rejection Delinquent peers
School	Lower qualified teachers Lack of school resources
Community	Violence Poverty Crime Victimisation
Societal	Discrimination Racism Prejudice
Environmental	War Natural disasters

***Source**:* (Centre for Social Research and Evaluation, 2011), (Gutman, 2008), (Fergusson, Horwood, & Lynskey, 1994)

Children at the severe end of the risk continuum have worse outcomes in later life. Such outcomes include poor education, health and employment and higher rates of criminal behaviour (Fergusson, Horwood, & Lynskey, 1994). Children in care and protection or welfare care are known to have high rates of a wide range of mental disorders, social, emotional, behavioural and educational problems and be at greater risk of a wide range of negative life outcomes, including later criminal offending, homelessness, teenage pregnancy, unemployment, and adult mental health disorders (Rutter, 2000; Bleach & Robertson, 2009).

The greater the propensity of risk factors, the greater the disadvantage and poorer outcomes for the child. For instance, The Christchurch Longitudinal Study (Fergusson, Horwood, & Lynskey, 1994) found that the most disadvantaged 5% of the cohort had over 100 times the risk of severe maladjustment than the more advantaged 50% of the cohort.

The Centre for Social Research and Evaluation (2011) estimated the number of children in the most at-risk 3%, 5% and 15% of the population (Table 2).

Table 2: Numbers of Disadvantaged Children (Top 3%, 5% or 15% Most at-risk)

Age of children (Years)	Total number	15%	5%	3%
0-5	373,000	56,000	19,000	11,000
6-9	228,000	34,000	11,000	7,000
10-12	176,000	26,000	9,000	5,000
13-17	307,000	46,000	15,000	9,000
Total (0-17)	1,084,000	163,000	54,000	33,000

Source: Statistics New Zealand estimated resident population for the December 2010 year.

About one third of New Zealand's most vulnerable children fall in the under six age bracket. Infometrics Ltd (2008) estimated that child abuse and neglect generates annually a long term bill of $NZ 2 billion. As such, it is not surprising that the greatest financial societal opportunities come from investment in the lives of vulnerable children in the pre-school years, with depreciating benefits throughout middle and late childhood (Knudsen, Heckman, Caeron, & Snonkoff, 2006).

The Centre for Social Research and Evaluation (2011) collated New Zealand research summarising the range of child risk factors (Table 3)

Table 3: Summary of New Zealand Research into Child Risk Factors

Risk Factor/ Outcome	New Zealand Incidence/Prevalence Estimates	Study	Publisher/ Author & Date
Teen mothers	• 29.6 births per 1,000 women under the age of 20 years • Māori teen birth rate is four times higher than the non- Māori rate	Administrative data	MSD 2010 MSD 2008
Mothers smoking in pregnancy	• 10% of mothers continue to smoke in pregnancy • More likely in higher deprivation areas and amongst Māori mothers and mothers who had left school without any formal qualifications	Growing Up in New Zealand	University of Auckland 2010
Maternal alcohol consumption in unplanned pregnancy	• 13% of mothers with unplanned pregnancies consumed 4 or more drinks per week in the first trimester	Growing Up in New Zealand	University of Auckland 2010
Family violence	• 74,785 children were recorded by Police as present in family violence incidents and offences • 27% of New Zealand children aged 9– 13 years reported witnessing violence against adults	NZ Police Statistics Children's perceptions of violence survey	Family Violence Clearing House 2008 MSD, Carroll-Lind et al., 2011
Living in hardship	• 18% of children (190,000) were found to be in families experiencing hardship using the EU index.	New Zealand Living Standards Survey	MSD, Perry 2009
Conduct problems	• 5% of children and young people 3–17 have significant levels of conduct problems (40,000)	Derived from New Zealand longitudinal studies	Office of the Prime Minister's Science Advisory Committee 2011, Fergusson et al., 2011
Parental factors associated with child abuse	• 71% of mothers whose children came into care under the age of 2 years had concerns noted about alcohol or drug use; 43% had concerns noted about mental illness; 25% of mothers had criminal convictions	Child, Youth and Family administrative data	Connolly et al., 2007

Source: Ministry of Social Development. Vulnerable Children: Numbers and Risk Factors, July 2011.

Family Stress

Families of children at risk have traditionally needed support to manage stress, parenting, prevent family breakdown and out-of-home placements (O'Brien, 2001). Children today are more likely than in the past to grow up in single parent households where the custodial parent is more likely to be single, female, unemployed, with low educational attainment and income, and pairing with multiple partners (Fergusson, Horwood, & Lynskey, 1994; Poland, Cameron, Wong, & Fletcher, 2007). Not surprisingly, the types and severity of stress experienced by families varies according to the interaction of individual, familial and environmental factors (Abidin, 1992).

Individual Stressors Affecting Family Functioning

Stress in the parent-child relationship is bi-directional and influenced by both the child and caregiver (Armstrong, Birnie-Lefcovitch & Ungar, 2005). Parental ill health may lead to a reduction in a parent's ability to cope with stress and manage child behaviour problems, which in turn may worsen. Mothers who are depressed are more likely to use less effective parent management strategies, such as physical punishment and/or adopt a low-nurturant or critical approach with their children (Carr, 2006). Parents who are physically and/or emotionally abusive are more likely to perceive their children as difficult to manage when independent assessments of children's behaviour do not support such a conclusion (Whipple & Webster-Stratton, 1991). In addition to correlates of child maltreatment such as substance abuse, parental mental ill health and parenting skills (Whipple & Webster-Stratton, 1991), the perception of stress may further exacerbate risks when other pre-disposing factors are in place (Howze & Kotch, 1984).

Individual child or parent risk factors include:

- Low parenting competence (such as in negative, harsh, abusive or permissive parenting) that increases children's vulnerability to attachment, mental health and behaviour problems (Carr, 2006).

- Parental psychopathology affecting both the adjustment of the adult and child - particularly maternal depression and parental substance abuse which is a risk factor for negative, ineffectual and emotionally unavailable care-giving, family conflict, attachment difficulties in children, and externalising behaviour problems, especially in boys (Whipple & Webster-Stratton, 1991; Carr, 2006). Anxiety and adjustment disorders may be particularly pertinent for families who engage with Cholmondeley given the recent Canterbury earthquakes.

- Difficult temperament (in particular where the parenting style is mismatched to the child's temperament), mental health problems or behaviour difficulties in children (Carr, 2006).

- Child chronic illness or disability, such as chronic medical conditions, learning or developmental disabilities (Cohen, 1982; Bruns & Burchard, 2000).

Economic Stressors Affecting Family Functioning

Cross cultural research illustrates a clear association between poverty or financial hardship and the physical abuse of children (Young, Baker, & Mannone, 1989; Vinson, Berreen, & McArthur, 1989).

In the Vinson et al., (1989) study they found that the bottom four percent of economically deprived areas had 2.5 times higher rates of child physical abuse than the next 6 percent of the next higher SES area.

It is generally asserted that financial hardship can exacerbate stress and disrupt the parenting process. Tregeagle (1990) summarised some of these mechanisms:

1. Parents who are poor gain less relief from constant child rearing. They are less likely to afford childcare, entertainment, baby-sitting, social and recreational activities, including holidays that assist in stress relief.

2. Families who are poor tend to experience high levels of conflict and family disruption (O'Brien, 2001). They are more likely to live in crowded housing situations, making it difficult to gain adequate separation from other family members.

3. Such parents are less likely to afford books or to have been exposed to education about parenting or self-management skills that may assist with stress and/or the management of child behaviour problems.

4. Parental monitoring and positive supervision of children tends to reduce in families with greater financial hardship for a range of reasons, including the necessity to work at times when children are not in school (Sampson & Laub, 1994)

The above effects, when compounded, provide a pertinent argument for how and why economic stress disrupts parenting and facilitates child neglect and abuse.

Systemic Psychosocial Stressors Affecting Family Functioning

Psychosocial stressors such as single parent status, large family size and lack of intra- and extra-familial supports, significantly increases the risk of child maltreatment (O'Brien, 2001). Mothers who are physically abusive tend to have smaller social networks than mothers who are non-abusive (Gaudin, Polansky, Kilpatrick, & Shilton, 1996; Coohey, 1996). Such studies have highlighted that mothers who maltreat have fewer social contacts, including with wider family (Coohey, 1996), neighbours (Garbarino & Sherman, 1980; Corse, Scmid, & Trickett, 1990), and also use less available organised support services (Garbarino & Sherman, 1980).

Another study (Corse, Scmid, & Trickett, 1990) found less non-familial peer support and more disturbed extended family relationships. In addition, Coohey (1996) found that mothers who abuse children feel less supported, rate their partners as being less supportive and generally have less satisfying relationships (Coohey, 1996), (Whipple & Webster-Stratton, 1991). Polansky, Ammons & Gaudin (1985) identified significant levels of loneliness and resultant apathy and reduced interest in, and attention towards, children in mothers who

lacked close and caring partners. As such, it appears that the presence of emotionally supportive partners also has an impact on the quality of maternal parenting (O'Brien, 2001).

Alongside emotional support is instrumental support, which includes assistance with care-giving and household tasks (O'Brien, 2001). The Polansky, Ammons & Gaudin (1985) study found that mothers with a neglectful parenting style had less instrumental support than matched controls. Salzinger et al., (1983) and Vinson et al., (1996) highlighted the effect of social isolation and impoverished contacts between immediate family and more distant familial and extra-familial social networks in families that supported abuse (Salzinger, Kaplan, & Artesnyeff, 1983; Vinson, Baldry, & Hargreaves, 1996). They found that social contact tended to be limited to immediate family members, where abuse-supporting beliefs and values were less likely challenged and with less modeling of alternative ways of parenting.

Summary

Risk factors adversely affecting child outcomes span pre-natal, parental, familial, peer, school, community, societal and environmental domains. Risk factors often interact and may change depending on the social and economic context of the family and the developmental stage of the child. Multiple, rather than single, risk factors are more likely to adversely impact child outcomes, with one third of the most vulnerable children in New Zealand under the age of six. The incidence of child maltreatment and poor parenting practices is more likely in families that suffer chronic stress, are under-supported, have single care givers with low educational attainment and who suffer from economic hardship.

Child & Family Resiliency

Resiliency has been defined as the intrapersonal, interpersonal and systemic characteristics of a person and their environment characterised by good outcomes in spite of serious threats to adaptation or development (Masten, 2001). Walsh defines resilience as:

> *"the ability to withstand and rebound from disruptive life challenges."* (Walsh, 2003; page 1)

Resiliency research began several decades ago with examination of child protective factors. Protective factors relate to individual features of resilience in children. Much of the earlier research into resiliency focused on the attributes of people and their environments that contribute to positive adaptation or resiliency for children under conditions of adversity (Gutman, 2008). Such protective factors tend to fall into three spheres: child characteristics, family characteristics and external support systems (see Table 4).

Table 4: Protective factors for Children

Sphere	Factor
Child	Gender Intelligence Temperament Sociability Perceived control Self-esteem Coping style
Family	Attachment style Parent-child interactions Parenting style Family cohesion Family routines Family support Family resources
External	Friendships Teacher support School resources Organised activities Neighbourhood cohesion

Source: Gutman, (2008)

Given risks are multi-faceted, accumulate, cluster and interact in complex ways, contemporary research into resilience has moved away from a focus on individual factors or characteristics of resilient children to how children's social environments adapt to meet the needs of children facing adversity (Gutman, 2008). Moreover, research supports the view that resilience is a common and normative function of human adaptation and not an extra-ordinary characteristic of a few (Masten, 2001). Masten (2001) argues that the greatest threat to child development are those risks that interfere with the systems underlying these adaptive processes, such as brain development and cognition, caregiver-child relationships, and self-regulation of emotion, motivation and behaviour. Despite the large list of risk factors that can jeopardise child development (see Tables 1 & 3), Masten (2001) cites a relatively small set of global factors associated with resilience, i.e. connections to competent and caring adults in the family and community, positive peer relationships and cognitive and self-regulation skills, including positive views of self.

These factors tend to be supported by New Zealand research. Family and peer connections were protective against depression in a New Zealand study of 268 alternative education secondary students (Denny, Clark, Fleming, & Wall, 2004). Among a Māori sample of 1702 young people age 12-18 years, Clark et al., (2011) found that family connection was a compensatory mechanism reducing the risk of suicide attempts for Māori students with depressive symptoms (Clark, et al., 2011).

In Fergusson's Christchurch longitudinal study, resilient teenagers (exposed to high levels of family adversity during childhood but not exhibiting externalising behaviour problems in adolescence: substance abuse, offending or school problems) were characterised as having

higher IQ, lower novelty seeking and lower affiliations with delinquent peers (Fergusson & Lynskey, 1996).

A North American study examining the differences between stress-affected and stress-resilient 10-12 year olds found that positive parent-child relationship qualities (positive parental attitudes, involvement and guidance) played an important protective role favouring resilient outcomes in children who experienced major life stress (Gribble et al., 1993).

Child Resiliency and Attachment

A leading New Zealand researcher into childhood attachment for children in care (Atwool, 2006) argues that attachment theory has explanatory power in bridging the relationship between individual and external/social characteristics of resilience and how in combination they provide protective effects. The primary caregiver is the main provider of the environmental stimulation necessary for sensitive periods of neurodevelopment as well as mediating the processes of whole brain integration and acquiring adaptive and flexible means for emotional self-regulation (Siegel, 2001). Moreover, via the attachment relationship, functional connections that develop allow the developing brain to infer emotional states of others and link emotional states to actions, which are essential to effective functioning in close relationships (Pears & Fisher, 2005; Fonagy, 2003). Healthy attachment styles allow the individual to emotionally self-regulate, develop theory of mind, develop a positive self-concept and engender social support when faced with adversity (Pears & Fisher, 2005; Atwool, 2006). Conversely, disordered attachment styles interfere with these processes.

Research over the last few decades has confirmed the universality of attachment theory, including Ainsworth's classification system (Ainsworth, 1989), although cross-cultural research suggests that children can experience secure attachment to wider family involved in care giving (rather than just to a mother alone) when these variations are securely and positively located within culture (Atwool, 2006). This has implications for traditional Māori care-giving practices (such as whangai and grandparents raising children for periods of time).[2] Moreover, Atwool (2006) makes a strong case for Māori children in care to be placed with access to Māori caregivers in order to contribute to the development of a secure cultural base which is intimately related to self concept and self-worth, maintaining and/or developing resiliency-enhancing links with the wider Māori community, as well as facilitating the development of a meaningful caregiver-child relationship.

Similarly, in special conditions, a consistent, trusting and nurturing relationship with a non-familial caregiver (such as ongoing respite) could also conceivably assist the development of a secure attachment. More likely, however, is the opportunity for extra-familial care environments (such as respite) to assist the reworking of internal working models (the attachment mediated self-concepts of worthiness or unworthiness of care, support and

[2] Whangai is a traditional Maori practice in which a child is raised by a relative or someone else other than their birth parents. Common types of whangai include a grandchild being raised by grandparents and taught tribal traditions and knowledge, or an orphan or child whose parents were young or who was born out of wedlock being taken in by a family. Other reasons for whangai may include taking in a child from a large family that was struggling to support all the children or allowing children to inherit land (Keane, 2011).

intimacy in a child with history of maltreatment (Atwool, 2006); (Gilligan, 2008), (Pears & Fisher, 2005). Deficits in theory of mind capabilities are found in children in foster care, compared with community samples (Pears & Fisher, 2005).

Ungar (2001) presents a case for the positive, constructive role of residential placement in re-ordering disordered attachment. Residential placements can create a discontinuity in old (negative) identity stories and allow the opportunity for new, more positive identities to develop (Ungar, 2001). Stokholm (2009) argues that the peer culture and social dynamics in residential care can play an important part in assisting children's identity development (Stokholm, 2009) as well as building resiliency through therapeutic teaching (Hawkins-Rodgers, 2007). For this to occur, the residential placement needs to be perceived by the child as emotionally secure, but there also needs to be opportunities to engage in relationships with significant adults to re-organise attachment behaviours (Hawkins-Rodgers, 2007; Atwool, 2006). Such adults need to understand attachment and the importance of their relationship with respect to attachment processes and the development of resiliency.

Family Resiliency

Research on family resilience is less established than research in child resiliency. (Kalil, 2003). This may reflect the more recent move away from understanding child resiliency as a set of static characteristics to understanding it more as a normative dynamic and interactive process across a range of systems, including the family system (Masten, 2001). Thus, family resiliency discourse is often subsumed within child resiliency models.

Nonetheless, some researchers have attempted to parse out child and family resiliency constructs, such as Walsh (2002):

> *"Family resilience is a flexible construct that encompasses different family strengths in different contexts and at different points in the family life cycle"* (Walsh, 2002; page 131)

Researchers into family resilience have struggled with a number of challenges. There is little consensus on how family resilience is understood. It has variously been described as a trait, a process and an outcome, and consequently there is little agreement on how the construct should be measured (Kalil, 2003). While the literature on family stress is well defined, it is unclear whether the concept of resilience is a meaningful and discrete family level construct and/or whether separate research into family resiliency contributes above and beyond the literature on child resiliency that includes family-level processes (Hawley & DeHaan, 1996).

Armstrong et al., (2005) argue for an integration of literatures on coping and stress that recognises the interaction effect of family stress on personality, coping resources and other attributes of the actors (Armstrong, Birnie-Lefcovitch, & Ungar, 2005). Moreover, social support is conceived as a stress buffer i.e. has a positive mediating effect through protecting the individual from the harmful effects of stressful events (Armstrong, Birnie-Lefcovitch, & Ungar, 2005).

Research indicates that the delivery of extra social support mitigates the damaging influence of social and economic stressors providing an argument for why it may reduce the rates of child maltreatment. As such, providing respite for families may directly reduce the risk factors associated with child maltreatment (O'Brien, 2001).

Research on family resilience has focused on two areas (Kalil, 2003):

- Properties of and processes within the family unit, such as family cohesion, family beliefs, and pattern of communication and problem solving (Walsh, 2003).

- The family as a protective setting that fosters the development of the child, with particular focus on parenting practices.

Adaptive family-level processes that are associated with the development of good child outcomes (in the face of family risks) include:

- Positive parenting practices, especially nurturance, consistent discipline, appropriate provision of child autonomy, parental involvement and acceptance (Kalil, 2003; Zakeri, Jowkar, & Razmjoee, 2010).

- Family belief systems such as positive outlook, transcendent world view, religion and humour promoting positive family interactions (Mahoney, Pargament, Tarakeshwar, & Swank, 2001; Walsh, 2003).

- Moderate levels of family cohesion (Kalil, 2003)

- Family coping, particularly communication, conflict management and problem-resolution (Walsh, 2003; Kalil, 2003).

- Active involvement by non-residential fathers (Kalil, 2003).

- Multi-generational co-residency (Kalil, 2003).

- Supportive relationships with the wider community and culture (Kalil, 2003; Ungar, 2010).

Child & Family Resiliency-Enhancing Interventions

Resiliency research is less supportive of a deficit-focused model (focusing on reducing risk factors per se) and more encouraging of strength-based interventions that promote systemic resilience through addressing processes and mechanisms (Gutman, 2008; Schofield & Beek, 2005).

In the delivery of resiliency-promoting interventions there are three broad approaches (Gutman, 2008):

- Risk focus: interventions designed to reduce the level of risk exposure in a child's development. An example would be children placed in care to prevent exposure to an abusive or neglectful environment.

- Asset focus: interventions designed to provide higher quality or greater quantity of assets in children's lives, including involvement of asset-building relationships. An example would be teaching parenting skills or increasing the availability of accessible support services (such as respite) for a family.

- Process focus: interventions designed to improve the adaptive systems of children such as key relationships, self-regulation, cognitive functioning or coping skills. A process approach can focus on different levels within a child's system, such as

family, school and neighbourhood, as well as interactions between these sub-systems. See Table 5 for a summary of these adaptive sub-systems.

Table 5: Child Adaptive Systems and Resiliency

Adaptive Systems	Processes
Learning systems of the human brain	Problem solving, information processing
Attachment system	Close relationships with caregivers
Mastery motivation system	Self-efficacy processes, reward systems related to successful behaviour
Stress response system	Alarm and recovery systems
Self-regulatory system	Emotional regulation, executive functioning, activation and inhibition of attention or behaviour
Family system	Parenting, interpersonal dynamics, expectations, cohesion, rituals, norms
School system	Teaching, values, standards, expectations
Peer system	Friendships, peers, values, norms
Cultural and societal systems	Religion, traditions, rituals, values, standards, laws

***Source**:* Masten & Obradovic,(2006)

Just as risks are multi-faceted, accumulate, cluster and exist in complex interactions, so too resilience-promoting interventions need to be perceived as a cumulative promotion of competence and adaptation to stress (Masten, 2001). Such adaptive systems are associated with resiliency across diverse situations and when damaged are associated with abnormal development.

> "*Many of the systems relate to self regulatory systems of the human brain as it learns and develops and the self-regulatory capacity embedded in human relationships and ties to cultural traditions"* (Masten & Obradovic, 2006 pages 21-22)

Regarding intervention to promote resilience in children, Masten and Obradovic (2006) caution the following:

- Resilience is not a single trait nor process – multiple processes are involved.
- There are multiple pathways to resilience.
- Resilience is embedded in specific cultural, developmental and historical contexts.
- Evidence strongly implicates the roles of transactional processes and adaptive capacity in the external world of the child.
- There are no magic bullets for producing resilience.
- There are no invulnerable children.

- There are levels of risk and adversity so overwhelming that resilience does not occur and where recovery is rare or impossible.

- Many sources of child threat are preventable and far less costly to prevent than address once they begin to erode developmental and adaptive tools for life.

Masten (2011) recommends the following with respect to resilience-enhancing interventions:

- A positive competency-based approach and initiation of positive developmental cascades, where competence begets competence.

- A mix of risk reduction and asset development. Adding positive experiences without neutralising the negative ones does not exert much of a protective effect (Rutter, 1999).

- Tailoring interventions to optimise developmental timing when leverage for change is greatest. An example would be developmental transitions and neural development which is dependent upon nurturing relationships and stimulation throughout childhood and adolescence, but especially during early childhood critical periods (Waldegrave & Waldegrave, 2009). A significant amount of post-natal brain development is mediated by interactions between the individual and the environment (Curtis & Cicchetti, 2003).

- Given the diverse and complex array of factors influencing resilience, a multi-disciplinary perspective, a multi-systems focus and collaboration among a range of agencies will be informative.

- Gilligan (2008) argues that for children in care, building resources of informal support (outside of agency-driven services) in the child and family's social ecology is critical for the development of resilience. This seems particularly important for boys, who tend to evidence more impoverished support networks than girls (Woolley & Bowen, 2007).

The family resilience literature recommends the following features of effective family resilience-enhancing interventions (Kalil, 2003):

- Focus on early intervention in pre-school years. This is particularly pertinent in the New Zealand context as children under the age of six make up over one third of care and protection placements and most vulnerable children in New Zealand (Bleach & Robertson, 2009; Centre for Social Research and Evaluation, July 2011).

- Sensitivity to differing family cultural beliefs and values (Clark, et al., 2011; Atwool, 2006; Horsburgh, Trenholme, & Huckle, 2002; Pere, 1988; Penny, 1997).

- A range of programmes that are suited to different types of family environments.

- Focus on reducing family risks as well as building protective factors.

More specifically, a family resilience orientation should endeavor to (Kalil, 2003):

- Identify adaptive modes of family behaviour when faced with stress.

- Help families develop social networks and linkages to larger systems, including wider kin.

- Teach problem solving and communication skills to strengthen family interactions (Walsh, 2003).

- Understand that both family and child resilience is a systemic process (Walsh, 2003; Ungar, 2010). Who gets respite should in part be dictated by the availability and accessibility of resources for families to navigate stress and manage resiliently (Ungar, 2010)

Summary

Resilience refers to the intrapersonal, interpersonal and systemic characteristics of a person and their environment that influences a person's ability to adapt to life disruption. Contemporary research into resilience has moved away from a focus on characteristics of the individual to how children's social environments adapt to meet the needs of children facing adversity. Resilience is a normative function of human adaptation that is linked to a number of underlying developmental processes such as attachment, relationship, self-regulatory and identity formation.

Key factors associated with resilience include connections to competent and caring adults (both in the family and community), family cohesion and coping, positive peer relationships, adaptive cognition, self-perception and self-regulation skills. It is argued that respite care can facilitate the development of healthy self-identity, attachment and social support in children and families. As such, resilience-enhancing interventions need to reflect this multi-system approach that aims to not only reduce risk but also improve the assets and adaptive functions of the child and their wider system. Moreover, such interventions need to be cognizant of key child development periods, the importance of early intervention, interagency collaboration and have an intimate understanding of the culture, family functioning and social context of the child.

Introduction to Respite Care

Respite Care as a Form of Family Support

Parenting commands multiple stressors and requires social support. Significant stress, the presence of risk factors and/or the absence of adequate social supports for families can ultimately impact on the outcomes for children. Respite care arose to meet the family support needs impacted on by various individual, social and environmental stressors. The literature has consistently reported respite to be the most often-cited service type requested by parents of children with special needs (Cohen, 1982; Bruns & Burchard, 2000).

Prior to the 1970's, respite was offered mainly in institutional settings such as hospital and specialised welfare or care centres (O'Brien, 2001). The deinstitutionalisation movement beginning in the 1970's in health and welfare was underpinned by the expectation that children receive more appropriate and cost-effective care in the community or least restrictive setting (Bruns & Burchard, 2000). Parent groups lobbied for more flexible respite services delivered in environments similar to the child's home (O'Brien, 2001).

Knowledge of respite care has largely come from research into families of children with learning disabilities, chronic medical illnesses or from families caring for a relative with dementia (Jivanjee & Simpson, 2001). Respite for families of children with serious emotional or behavioural disorders has been slower to develop (Jivanjee & Simpson, 2001; O'Brien, 2001). As such, there is a dearth of research on the effect of respite on families of children emotionally or behaviourally at risk. The small amount of research that has been undertaken typically suffers from serious methodological limitations, such as ill-defined models and lack of control or comparison groups (Bruns & Burchard, 2000).

Respite is often cited to achieve two outcomes: to provide support to caregivers and/or to prevent or delay admission to residential care (Armstrong & Shevellar, 2006; O'Brien, 2001).

Respite care typically exists to provide benefit for all family members: parents receive a break from care-giving, siblings of the cared-for-child may receive more beneficial interactions with their parents and the cared-for-child receives positive social and recreational experiences (Jivanjee & Simpson, 2001).

All, including society, benefit from the prevention of family breakdown and/or a child's placement in longer term out-of-home care (Jivanjee & Simpson, 2001).

O'Brien 2001 suggests the reasons for respite are to:

- Provide relief from the normal stresses of being a parent.
- Provide children with relief from stressful daily living.
- Help manage children's behaviour.
- Help with the stress of living in continual poverty.
- Offer an alternative to admission to full time accommodation.
- Provide relief to sick parents.

- Provide early diversion from potential physical abuse.
- Build parents' self-esteem and confidence.
- Offer children a different and relaxing experience.
- Allow parents to address their own problems.
- Give children someone else to go to if they need adult help.
- Give birth parents support and ideas about positive child management.

Armstrong and Shevellar (2006) discuss the more subtle meanings of respite. It can refer to use of time or to geographical location. Its various aims are to give family members time to temporarily relieve stress, and in turn prevent abuse and neglect and promote family unity (Armstrong & Shevellar, 2006). Others (Boothroyd et al., 1998) argue that respite care promotes wellness in parents, empowers parents to better care for their dependents, and provides opportunity for respite carers to model behaviours and teach new skills to children (MacDonald & Callery, 2004).

The literature is clear that multiple types of respite care services are required to flexibly meet the diversity of needs in children and families (Bruns & Burchard, 2000; Jivanjee & Simpson, 2001). In-home options include informal carers (friends, family), day care (professionals coming into the home), or day programmes (children attend during day only).

In-home respite is usually provided by one worker on a planned, need-driven basis coming into the family home for several hours during the day or overnight. Often the worker may take a child into his or her own home or into the community to engage in activities for a specified time (Bruns & Burchard, 2000).

Out-of-home (overnight) respite care options tend to fall into two broad categories:

1. One-on-one foster family respite (professional or volunteer foster parents or extended family providing care in private homes).
2. Congregate care respite (group homes, institutions, hospitals, welfare residences, health camps or wilderness programmes).

Pollock et al., (2001) drew the distinction between primary and secondary respite. Primary respite is where the specific intent of the service is to provide the family with relief from care giving. Secondary respite is where the purpose is to meet the needs of the child in the first instance and respite occurs as a by-product (Pollock, et al., 2001).

Who Uses Respite?

Currently, many different child sub-populations within the emotionally or behaviourally at-risk may be delivered respite. Such groups may include children of parents with a mental illness (Owen, 2010), parentified children in care-giving roles (Byng-Hall, 2002), children suffering a bereavement (Hung & Rabin, 2009), children whose parents are undergoing divorce (Hetherington & Stanley-Hagan, 1999), children and families under stress due to natural

disaster or refugees from war-torn countries (Masten & Osofsky, 2010), children with mental illness (Tarren-Sweeny & Hazell, 2006), children with externalising behaviour problems (Bleach & Robertson, 2009), maltreated children (Hulette, Freyd, & Fisher, 2011), and children at risk of care and protection involvement and/or residential placement (Jivanjee & Simpson, 2001).

Children are most commonly placed in respite when the caregiver is under stress and in need of a break from care-giving. In addition to natural family parents, respite care may also be delivered to alleviate foster parent strain (Farmer, Lipscombe, & Moyers, 2005) and to assist grandparents raising grandchildren (Gladstone, Brown, & Fitzgerald, 2009).

However, only a small proportion of children and families under stress use respite care. In an attempt to understand what leads to parents relinquishing care, Boothroyd, et al., (1998) found that families who used respite care had fewer relatives or other informal supports to provide respite, compared with families who did not use respite. A more recent study in the intellectual disability field (Nankervis, Rosewarne, & Vassos, 2011) reviewed the reasons why families relinquished care into out-of-home respite care. They studied their own population of carers of young adults with moderate to severe learning disabilities, often coexisting with autism and challenging behaviours (mean age=21 years; n=32) and found the reasons for relinquishing care fell into three categories:

1. Characteristics of the individual with the intellectual disability.
2. Characteristics of the family/caregiver.
3. Characteristics associated with the support context of the family.

See Table 6 for exemplars of these categories.

While the families studied reported positive effects from respite (improved sleep and family functioning), they also experienced guilt, mourning and a sense of failure following the placement into out-of-home care (Nankervis, Rosewarne, & Vassos, 2011). They concluded that their study results supported the literature on the psychological impacts of caring for a child with a learning disability, namely higher than normal levels of stress, depression, anxiety, financial burden, fewer social activities and low levels of informal supports compared with families of children who do not have a child with a learning disability.

Challenging behaviour and unmet service needs are common predictors of poor psychological outcomes for carers (Nankervis, Rosewarne, & Vassos, 2011). They also concluded that services that would prevent relinquishment into out-of-home care were parenting interventions, psychological interventions and social interventions (such as linkage with informal supports) when early warning signs for relinquishment were apparent (Nankervis, Rosewarne, & Vassos, 2011).

Power (2008) highlighted gaps in service availability, provision and coordination as well as financial burden as being key predictors of relinquishment of care of children with mental illness.

Table 6: Factors Associated with Relinquishment of Care

Individual Characteristics	Family Characteristics	Support Context
Challenging behaviours Low communication ability Limitations of function High levels of dependence	Emotional strain/distress Psychological characteristics of parents (coping style and self efficacy) Sole parenting Poor health of carers Family size Subjective burden of care Physical exhaustion Financial costs	Low levels of social/informal supports Availability of respite Availability of supports Social isolation Lack of informal supports Acceptance of need for relinquishment

Source: Nankervis, Rosewarne, & Vassos, (2011)

Summary

Respite aims to benefit all family members: parents, siblings and the child in care. Respite also aims to achieve the added benefit of preserving families, reducing risk and preventing admission into residential care. Respite care arose to meet the family support needs, initially for families of children with special needs. Literature on respite for children with emotional or behavioural problems has been slow to emerge. The few studies of respite for children with emotional or behavioural problems suffer significant methodological limitations.

Following the deinstitutionalisation movement in the 1970's the most common form of respite has been community, home-like environments. Only a small minority of families use respite. The reasons for relinquishment of children into care include individual characteristics (e.g. behaviours and functional limitations), family characteristics (e.g. parental support, burden, competency, stress), and the support context (e.g. service availability, social supports).The literature recommends that multiple types of respite care are required to flexibly meet the diverse needs of children and families.

Consumer Perspectives

Parent Perspectives

Based on parent report, in-home respite has been cited in some research as the most valued form of planned respite (Pollock, Law, King, & Rosenbaum, 2001), and the most popular for families caring for individuals with physical and developmental disabilities (Cohen, 1982). While reviews conclude that in-home care is more popular than out-of-home care, a substantial minority (up to 40%) report a need for out-of-home respite services (Cotterill, Hayes, Flynn, & Sloper, 1997).

Pollock et al., (2001) reviewed the qualitative literature on parent's evaluations of respite services. From a parental perspective, the strongest themes that emerge from the literature are (Pollock, Law, King, & Rosenbaum, 2001):

- Respite is a well-thought-of and necessary service.
- Families want access to a wide variety or network of coordinated respite care options that meet the needs of their child and family.

- Families want access to information about available services to allow them to make a choice.
- Families want their children placed in a positive, enriching and supportive environment.
- Parents need to develop a relationship of trust with the service.
- Regarding planned respite, families prefer in-home services as they are seen as less disruptive and families are able to monitor the quality of service provision.
- Regarding emergency and long term respite, out-of-home respite was preferred, but in a home-like setting with small numbers of children (e.g. group home or other family home, rather than an institution).

In another study families with children with serious emotional disorders expressed a preference for in-home respite care (Evans, Armstrong, Dollard, Kuppinger, Huz, & Wood, 1993). These findings, including the themes from the Pollock et al., (2001) review, are supported by more recent research (McConkey, Truesdale, & Confliffe, 2004).

Conversely, another study interviewed 26 parent recipients, nurses and social workers involved in respite for children with complex needs (MacDonald & Callery, 2004). The parents found in-home respite less useful than overnight respite in another environment because it did not meet their recuperative needs. This was seen as more valuable because it enabled a period of sustained rest to alleviate exhaustion, as well as being able to visit places unsuitable to bring their child.

Professionals interviewed (nurses and social workers) also found in-home respite to be problematic as such care impinged upon privacy of the family and did not allow parents to have a real break. Nor did it provide the child with a change from their environment and routine. Interestingly, social workers believed the best form of planned respite was that which allowed the child to remain in the home, which was seen, as preferable to out-of-home planned respite. They believed that out-of-home respite should be reserved for crisis situations, although the reasons for such crises were not defined. (MacDonald & Callery, 2004).

Children's Perspectives

Interestingly, there is little qualitative research into the perspectives of child recipients of respite care. This reflects the preponderance of respite care research being in the disabilities field, as well as the focus on respite care being to alleviate parental stress rather than directly contribute value to the child. Notwithstanding the strong theoretical support within the child resiliency literature, there is an implicit and untested assumption in the respite literature that what is good for the parent is good for the child. Interestingly, there is an absence of the reverse assumption: what is good for the child is good for the parent and wider family.

Several New Zealand qualitative studies have examined the lived experience of children in care. Marjoram and Fouche (2006) examined the experiences of a small number of New Zealand children (n=7, aged 11-13 years) in a care and protection unit. Most important issues to these children were:

- Family/whānau attachment (most wished for contact with family).

- Desire for normality (spending time with peers, being part of a sports team or club).
- Sense of security (trust, belonging, safety).
- Autonomy (freedom, choice and space).
- Relationship with caregivers (secure relationship with one staff member).
- Sense of identity (most children indicated low sense of self worth and esteem).

Atwool (2010) interviewed 47 New Zealand children and young people (aged between 7 and 18) in care across a range of placements: foster care (kin and non-kin), care and protection residence, youth justice residence, boarding school and family homes. Of this group, 17 had experienced respite placements, although the type of respite placement was not specified. The most important aspect was whether or not they knew the person/people they were going to stay with. One theme was the long time it took to trust people because of multiple past rejections (Atwool, 2010).

With regards to their experiences in longer term care, the children rated a number of key issues (Atwool, 2010):

- Stability of placement and reduction in number of moves.
- The importance of contact with family whilst in care.
- The importance of caregivers understanding what it is like for children in care.
- Reduced staff (social worker turnover) and involving children in saying good bye.
- Greater involvement of children in their care plan.
- Difficult peer dynamics in group care.
- More considered placement planning, including matching care givers to children.
- Changes and more choice in the education received.
- More activities in residential care.

A South Australian study identified that children in foster care were more satisfied than a comparison group in residential care who felt less secure, satisfied and understood with carers less interested in them (Delfabbro, Barber, & Bentham, 2002). The samples, however, were not directly comparable as the children in foster care were younger and with less severe behaviour problems than the residential sample (Delfabbro, Barber, & Bentham, 2002).

Summary

Parents of families who utilise respite report a preference for a wide variety of coordinated respite care options. Families want choice and a positive, enriching environment for their

child. There is mixed feedback among permanent carers regarding the preference for in-home vs. out-of-home respite which reflects the relative strengths and limitations of each model. However, more consistently permanent carers report a clear preference for home-like environments. Professionals differ in their preference for in-home vs. out-of-home respite models. However, there is agreement that out-of-home respite is more suited to crisis situations.

There is a limited qualitative evidence base for children's perspectives. Of those few studies, children preferred contact with their family whilst in care, a normalised activity-based environment, a sense of security and autonomy, placement stability, and trusting, familiar relationships with caregivers

Effectiveness of Respite

Limitations of Outcome Research

There is a clear lack of rigor in respite care research methodology, including a lack of clarity within programmes about the stated purposes of respite care and lack of standards regarding what constitutes quality (O'Brien, 2001; McConkey, Truesdale, & Confliffe, 2004). As such, the benefit of respite care has yet to be categorically ascertained (O'Brien, 2001). Moreover, while there are some evaluations that provide indications of the likely benefit of planned respite, such evidence is more strongly located in the child disabilities population than at-risk children. Moreover, outcome research has tended to singularly measure the effectiveness of foster family (non-congregate) respite. As such, little is known about the effectiveness of group home or group residential forms of respite.

Respite care has traditionally been focused on the immediate needs of the carers (such as increasing carer wellbeing, reducing carer stress, alleviating the psychological and physical consequences of caring) or the needs of the service system to delay or prevent more intensive, often institutional, care (McNally, Ben-Shlomo, & Newman, 1999; Boothroyd, Kuppinger, Evans, Armstrong, & Marleen, 1998). Such research has largely failed to study the effects of respite care on the child users of the service. The assumption is often made that what is good for the carer translates positively to the person being cared for. If a caregiver becomes less stressed and is afforded time to themselves then the assumption is made that the quality or at least longevity of their caregiving will at least be maintained, if not increased. However, this is largely an untested assumption.

It is possible that the respite model could exacerbate the very problems it seeks to remedy (Armstrong & Shevellar, 2006). For instance, little research has sought to answer whether gifting carers with more time to themselves makes them more attentive and committed carers, rather than less so.

Furthermore, where research has examined positive effects, little is known about what are the active ingredients (e.g. fatigue management, re-focusing of attention, attending to unfinished tasks, relationship invigoration etc.) and for whom and in what circumstances respite works (e.g. optimal time-frames, how carers self-manage stress, accept vs. feel guilty about placing person in respite etc.).

There is a distinct lack of attention to mediating variables in studies of the effectiveness of respite. An example of the effects of caregiver psychological mediating variables (in this

case natural parents) was the Wisconsin Outcome Evaluation Study (Respite Care Association of Wisconsin, Inc, 2002). This study analysed data from 47 care parents across services in Wisconsin. They found an increased risk of separation or divorce for parents prior to respite care and for the same parents anticipating the negative effects of the respite service ceasing. The same effect was apparent for parental experience of personal stress, levels of strain on family relationships, parental health and opportunity to participate in social/recreational activities and build up networks of friends and support. This decreased with respite care and, again, increased at the anticipation of the care ceasing (Respite Care Association of Wisconsin, Inc, 2002). Given the lack of attention to the psychological states of the carer (such as controllability, predictability, mindfulness, sense of mastery and hope), it is not surprising that improvements in carers' psychological wellbeing typically last for only 1-2 weeks after the end of respite (McNally, Ben-Shlomo, & Newman, 1999). An example of interventions based on targeting caregiver psychological functioning comes from the area of respite for caregivers with a relative suffering dementia (Oken, et al., 2010). They found that mindfulness training and education interventions decreased self-rated caregiver stress compared with respite-only controls.

Another important mediating variable may be the timing of respite provision in relation to longevity of parental stress. In the elderly care-giving literature, Lawton, Brody, & Saperstein (1989) posited that the poor treatment effect of respite for carers of Alzheimer's patients was in part due to the service being accessed too late, in response to a crisis and where the carers were unable to benefit from the respite due to having reached 'breaking point'. This may be a relevant factor in respite for families of children with psychiatric or externalising behaviour problems.

There is an underlying assumption in much of the quantitative research that respite interventions should have lasting measurable effects in order to be a worthwhile exercise. There is little value apportioned to the role of temporary alleviation of suffering for children and families.

Moreover, respite care research has tended to only examine formal respite services, as opposed to informal family/whānau, friend or neighbourhood arrangements. Little is known about the effectiveness and implementation issues associated with this purportedly common form of respite care.

Respite care evaluations are often methodologically poor due to small sample sizes, lack of control groups and control over potentially confounding variables, such as relationship of the cared-for person to the caregiver (McNally, Ben-Shlomo, & Newman, 1999). Outcome studies that have used comparison groups have tended to compare respite (foster) care with institutional (e.g. hospital) treatment or group residential environments (Chamberlain & Reid, 1991). Some studies utilising comparison groups have compared respite with other caregiver interventions such as education or mindfulness training (Oken, et al., 2010). Quasi-experimental pre- post designs or longitudinal designs are less common. No randomised controlled trials were identified in the literature.

Given this weakness in the outcome evaluation literature, research into respite care for other child populations will be reviewed, as will research into longer term group home care for children at-risk.

Congregate vs. One-on-One Out-of-Home Respite Care

The respite literature is overwhelmingly based on the one-on-one foster family model. There is a dearth of research into congregate care respite (such as group homes and residential care). This is based on the fact that the vast majority of respite programmes utilise the foster family model (O'Brien, 2001). Moreover, the assumption is made that the foster family model is far preferable to congregate care models. This is based on research from family consumers that largely support this approach over group home or institutional care, although it is important to note the absence of children's voices in such consumer research (see section on consumer perspectives). The historical legacy of abuse associated with children's homes also slants public and professional opinion towards preferring non-congregate and non-institutional care. This is despite an equally serious documented legacy of abuse occurring in foster care environments (Hobbs & Hobbs, 1999).

One exception in the literature is the study by Chamberlain and Reid (1991) in the field of respite for children leaving psychiatric institutions. At three month follow-up the respite care group (using treatment foster care) evidenced significantly fewer problem behaviours than controls. However, at seven month follow-up the respite foster care group was only slightly more successful at maintaining wellness in the community than children discharged from group residential homes or family placements (Mikkelsen, Bereika, & McKenzie, 1993).

To encourage an impartial appraisal of the relative strengths and benefits of both models, the author has collated relevant issues in Table 7. In addition, given the limited amount of research into group home respite care, and given the clear relevance of the congregate model of care to Cholmondeley, the author has summarised research into group home care for at-risk children placed in longer residential stays.

Table 7: Advantages and Limitations of Congregate vs One-on-One Respite Care

	Advantages	Limitations
Group Congregate Respite	✓ Greater opportunity for peer socialisation ✓ Peers may assist in identity development ✓ Peers may help normalise child experiences ✓ Accommodation of sibling groups ✓ Respite from foster care placement in less emotionally demanding environment ✓ Easier to train staff ✓ Routine ✓ Offer programme of activities ✓ Easier to implement quality assurance systems and manage a model of care ✓ Greater ability to monitor and manage staff behaviour ✓ Resources available for children's programming ✓ Service profile through existence of a bricks and mortar service	× Child may receive less input if surrounded by children with greater needs × Staff levels may fluctuate or be inconsistent, meaning relationships more chaotic × Behaviour may be function of group peer situation and not reflect behaviour in home-like setting × More difficult to teach skills in ecologically valid/normalised, home-like setting × Stigmatising × More difficult to match to attachment style of child × Child may be exposed to contagion effects from other disturbed children × Difficult to tailor interventions to a group with diverse developmental levels × Cost – more expensive investing in bricks and mortar and employment of staff.
Individual Family/Foster Respite	✓ Assessment of child in more ecologically-valid environment ✓ A child can receive more intensive interventions than congregate care ✓ A family oriented model is more normalising and able to teach ecologically valid skills ✓ Match child with appropriate adults (culture, interests, personality etc.) ✓ Less stigmatising ✓ More capacity for nurturance ✓ Less likely to expose child to contagion effects from peers ✓ It can be tailored to meet the child's needs and developmental level ✓ Superior child to staff ratio ✓ More capacity for monitoring and assessing child's behaviour in a normalised setting ✓ Flexible geographical location for easier access to care and able to locate care close to, or far away from, from family as required	× Can be confusing for kids or trigger divided loyalties × Harder to train foster parents due to availability (many have day jobs) × Less supervision around children of foster parents × Burnout in full time respite caregivers × Child has to fit around needs of families, may not match needs of child × More difficult to supervise foster parents in practice × Less able to manage and police safety issues

***Source**:* Meadowcroft, (1989), Goldstein & Gray, (1981), Bleach & Robertson, (2009), Barker, Buffe, & Zaretsky, (1978)

Longer Stay Residential Group Home Care

Research is mixed regarding the relative efficacy of foster care vs. group residential care (Farmer, Murray, Kelsy, Ballentine, & Morris, 2009; Lee & Thompson, 2008; Eddy & Chamberlain, 2000). There are effective and ineffective models within both service delivery modalities (Farmer, Murray, Kelsy, Ballentine, & Morris, 2009). Effective models of either modality, such as Teaching Family Homes (TFH) in congregate care and Multi-dimensional Treatment Foster Care (MTFC) in one-on-one care, depend upon a clear model of practice with strong quality systems ensuring fidelity to the model (Eddy & Chamberlain, 2000; Fixen & Blase, 1993).

Farmer et al., (2009) measured a comprehensive range of quality measures in group homes applying either a Teaching Family Home model or no specific group home model and found near-unilateral superior outcomes for TFH on measures such as skill teaching, youth's understanding of programme, peer leadership, and presence of a positively-focused behavior motivation system (Farmer, Murray, Kelsy, Ballentine, & Morris, 2009).

The Teaching Family Homes model is widely considered to represent best practice in group home residential treatment and has been recognised as a significant evidence-based model by Mark Lipsey (Lipsey, 1999), the American Psychological Association, Californian Clearing House, and the New Zealand Independent Advisory Group on Conduct Problems (Interagency Working Group, 2007).

The research base behind TFH includes 200 single case studies and two randomised treatment control trials (Kirigin et al., 1982; Jones et al., 1981). Initial analysis of these trials led to significant doubts about the effectiveness of TFH compared with other group homes and the generalisability of TFH gains post placement (Jones, Weinrott, & Howard, 1981; Kirigan, Braukmann, Arwater, & Wolf, 1982). However, re-analysis of both studies found TFH to have superior effects to non-TFH residential programmes and also found sustainable effects one year post-discharge (Kingsley, 2006).

The TFH model evidences quality fidelity systems which focus on five principal components of model-specific aspects of delivery:

- Application of problems solving model to daily events.
- Perceived opportunities to teach (preventative teaching, pre-teaching, de-briefing).
- Family style living.
- Relationship development.
- Motivation or positive reinforcement behaviour management system.
- Organisational-wide systems such as: staff selection, training, consultation, evaluation, quality assurance, and facilitative administration (organisational-wide systems necessary to ensure model success; Fixen & Blase, 1993).

A review of non-specific residential mental health placements for children and youth (Frensch and Cameron, 2002) concluded that community factors such as family support, family structure, parental involvement in treatment and community follow-up were the factors significantly related to child outcomes. Hair (2005) similarly found support for residential

interventions that were multi-modal, holistic and ecological, despite the limited number of methodologically robust studies.

The Knorth et al., (2008) meta-analysis similarly concluded that residential programmes that use behavioural and family interventions have the best outcomes (mean effect sizes of .45 for internalising problems and .60 for externalising problems), although they also concluded that there is little evidence for long term outcomes from residential care (Knorth, Harder, Zandberg, & Kendrick, 2008).

Two additional studies of children with emotional problems in group home care found that early intervention was associated with better outcomes (Fields, Farmer, Apperson, Mustillo, & Simmers, 2006; Hukkanen, Sourander, Bergroth, & Piha, 1999). Additionally, the Fields et al., (2006) study found that a longer length of stay was also associated with better outcomes.

Effectiveness of Respite for Families of Children with a Disability

Research into respite for children with developmental disabilities suggests that it can be effective to reduce stress, enhance parental coping skills and emotional well being, improve family functioning and decrease the placement of children in out-of-home care (Henggeler, Schoenwald, Rowland, & Cunningham, 2002), (O'Brien, 2001). An example of an individual study showing positive intervention results is Rimmerman (1989) who used a matched, control group design to evaluate the effectiveness of respite in mothers of children with developmental disabilities. The matched controls were mothers who needed respite but had no access to such a service in their community. Significant differences were found between the groups on measures of maternal stress levels and positive views of their children at 6, 12 and 18 months post the respite service beginning (Rimmerman, 1989).

Strunk (2010) reviewed qualitative and quantitative outcome studies on respite for families of special needs children and concluded that respite is associated with significant reductions in parental stress and psychological distress. Respite care was more effective than no support or standard services only. Moreover, it was considered an effective intervention for child abuse for those children with challenging behaviours (Strunk, 2010). The child abuse prevention role was supported by the research of Cowen and Reed (2002) who found that social support and service level were negatively correlated with the occurrence of child maltreatment in families of children with developmental disabilities who were enrolled in respite care programmes.

Robertson et al., (2011) reviewed 60 evaluation articles and reports and concluded that short respite breaks positively impact on the wellbeing of carers (although these effects did not tend to be maintained over time) but also benefitted the children receiving the breaks as well as the family as a whole. Family relationships and stress levels improve. In the child, increased independence, social skills, social awareness, interests and confidence were noted in some studies (Robertson, et al., 2011). A smaller number of studies (albeit more methodologically rigorous) that attempted to objectively measure change identified no significant differences in social outings, friends, or child behaviour problems (Robertson, et al., 2011). They identified key gaps in the literature, namely little is known about the effects of respite care on fathers, siblings, the synergistic effect of other interventions, and long term effects (Robertson, et al., 2011).

McLennan et al., (2009) also found a lack of sustained effects post the cessation of respite as well as a discrepancy between parent perception and standardised measures of parental stress and child mental health functioning (McLennan, Urichuk, Farrelly, & Hutcheon, 2009). They also found that more targeted services, in addition to respite, were required if the aim was to reduce either chronic parental stress or influence child functioning.

Effectiveness of Respite for Families of Children at Risk

Studies looking specifically at respite for children with serious behavioural and emotional problems are equivocal regarding its effectiveness (Boothroyd, Kuppinger, Evans, Armstrong, & Marleen, 1998). The literature tends to support the finding that improvements in carers' psychological wellbeing typically last for a limited period of time following the end of respite (McNally, Ben-Shlomo, & Newman, 1999).

One of the few controlled studies measuring the effectiveness of respite for parents (n=33) of children (mainly Caucasian boys) with serious emotional and behavioural problems reported greater carer optimism, reduced carer stress, lower incidence of negative behaviours expressed in the community and fewer out-of-home placements compared with similar wait-list families. The intervention group received a minimum of 50 hours of pre-planned respite care over a six month period (Bruns & Burchard, 2000). Interestingly, families were able to decide whether they received in-home or out-of-home respite. Moreover, the amount of respite received positively correlated with lower reported hassles and negatively correlated with the reported need for future placement (Bruns & Burchard, 2000).

An Australian Barnardos evaluation study highlighted high rates of family preservation (91-95%) in a planned and crisis respite programme for children at risk of out-of-home placement. Some 3.4 % were adopted and 5% required long term out-of-home care placement (Voigt & Tregeagle, 1996). Unfortunately, no controls or comparison groups were used, severely limiting the conclusions able to be made regarding programme success and active ingredients of this success.

A four-year study by Aldgate et al., (1996) of short-term respite care in the UK showed that participating parents felt more in control of their lives, experienced increased self-esteem, felt more confident about their parenting, were less preoccupied with their own chronic health concerns and over 50% of the parents had mobilised to reduce their social isolation. About one third felt more integrated with their community through creating links with carers. The study cited no significant evidence that respite led parents to abandon their children to long-term care (only two out of 60 placements became long-term care arrangements).

Effectiveness of Respite Care for Children with Mental Health Problems

The proliferation of respite foster care for children with serious emotional problems began in the late 1970's as a response to the deinstitutionalisation movement in psychiatric treatment settings (Meadowcraft, 1989).

In this model of treatment care, parents are viewed as a professional member (like a mental health technician) of the wider multi-disciplinary team. As such, respite foster care is more closely aligned with treatment foster care, medical foster care and psychiatric residential care (Barker, Buffe, & Zaretsky, 1978; Davis, Foster, & Whitworth, 1984).

Cross-study comparisons or even cross-placement comparisons within services are difficult given the natural variance in service delivery. Models of respite treatment for children suffering mental illness can be difficult to define. Some services deliver 24/7 monitoring, others do not. Some have daily monitoring by psychiatric staff while others don't (Meadowcroft, 1989; Barker, Buffe, & Zaretsky, 1978). Outcome studies that have used controls or comparison groups have tended to compare respite foster care with hospital treatment or group residential environments. Despite that, the severity and complexity of the populations in both respite care and comparison hospital environments appear similar across studies (Mikkelsen, Bereika, & McKenzie, 1993).

There is no evidence of an increase rate of suicide, homicide or serious self-harm for children in respite care diverted from psychiatric hospitalisation or received from a psychiatric institution (Barker, Buffe, & Zaretsky, 1978). Barker et al., (1978) reported no absconds, despite the less secure setting. The Barker et al., (1978) study found a 69% rate of post-treatment (three month follow-up) placement with family or relatives. This appeared to be congruent to studies following up children following psychiatric hospital treatment (Barker, Buffe, & Zaretsky, 1978). This finding is replicated in other outcome studies (Meadowcraft, 1989).

Chamberlain and Reid (1991) suggested that their treatment foster group at follow-up was placed outside of the hospital setting more frequently and quickly than controls (residential group homes and family placements). At three month follow-up the respite care group evidenced significantly fewer problem behaviours than controls (Mikkelsen, Bereika, & McKenzie, 1993). This significant short term effect is important for treatment of psychiatric problems (such as first episode psychosis) where treatment within a critical time window is indicated.

Chamberlain and Reid (1991) found at seven month follow-up the respite foster care group was slightly more successful at maintaining wellness in the community than children discharged from group residential homes or family placements (Mikkelsen, Bereika, & McKenzie, 1993).

The Wisconsin Outcome Evaluation Study (2002) noted the decrease in use of out-of-home care (19% pre-service dropping to 4% during service). There was also a higher risk of parents placing their children in an out-of-home placement (pre-respite service) compared with during respite care delivery (Respite Care Association of Wisconsin, Inc, 2002). Interestingly, this risk increased in anticipation of the respite care ending, albeit not returning to pre-service levels.

Hutcheon et al., (2011) found no change in strengths and difficulties questionnaire ratings (ratings by both primary caregivers and respite carers) pre and post respite care (and compared with a comparison group) for a population of 3-8 year old children with mental health issues (n=62). The treatment group received 10 months of six-hours-per-week day (non-overnight) planned respite. The comparison group received short term emergency respite only. Interestingly, the primary caregivers rated higher levels of mental health difficulties in their children than did respite carers (Hutcheon, McLennon, & Urichuk, 2011).

The Vermont Family Services Study measured the effects of respite usage against a range of child, parent, family and service utilisation variables (Bruns and Sturdivant, (1996) cited in

Boothroyd, Kuppinger, Evans, Armstrong, & Marleen, (1998). They found no differences in the use of crisis intervention services, family functioning, parental stress, child behavior or child-reported life satisfaction in families who used respite compared with wait list controls. Positive effects were found on two variables: respite service users used fewer out-of-home placement days and also experienced reduced personal strain.

Summary

There is a clear lack of rigor in respite care research methodology. Respite care evaluations are often methodologically poor due to small sample sizes, lack of control groups and lack of control over potentially confounding variables. No randomised controlled trials were identified in the literature. Respite care (and its evaluation) has traditionally focused on the needs of carers or the service system wishing to prevent institutional care. Such research has largely failed to study the effects of respite care on child consumers. Furthermore, little is known about what are the active ingredients or mediating variables and for whom and in what circumstances respite works. Conversely, little is known about whether or not respite care causes harm. Little is known about the effectiveness of group home or group residential forms of respite.

Home-like environments are preferred models of service delivery. However, there is a lack of research supporting this preference, despite some of the advantages of residential care and wider literature supporting evidence-based, longer term residential treatment. Finally, respite care research has tended to only examine formal respite services, as opposed to informal family/whānau, friend or neighbourhood arrangements.

As such, the benefit of respite care has yet to be categorically ascertained. While some evaluations provide indications of the likely effectiveness of planned respite, this evidence pertains to children with disabilities, rather than children at-risk. The research into respite for children with developmental disabilities suggests that it can be effective to reduce stress, enhance parental coping skills and emotional well being, improve family functioning and decrease the placement of children in out-of-home care.

Studies looking specifically at respite for children with serious behavioural and emotional problems are equivocal regarding its effectiveness, indicating that any improvements last for only a brief period of time following the end of respite. There is an underlying assumption in much of the quantitative research that respite interventions should have lasting effects in order to be a worthwhile exercise. There is little value apportioned to the role of temporary alleviation of suffering in children and families.

Integrated Strength-Based Approaches

Expanding Services Beyond Respite Care

In addition to improving child resiliency, another of Cholmondeley's core aims is to work at an early intervention stage of the continuum of services for children and their families and to increase the level of partnerships with other social service providers in the sector, working collaboratively with them as part of a wraparound approach for families in need (see Section 1). As such, Cholmondeley does not aim to compete with other providers in delivering a comprehensive suite of child and family intervention services. Nonetheless, it is important to be aware of other non-respite models of intervention for three reasons.

- Firstly, Cholmondeley is dependent upon the choice of models chosen by other providers, which will in turn influence the outcomes Cholmondeley is able to achieve.
- Secondly, it is important to know the strengths and limitations of other models, given there are always children and families who need more or alternative intervention than the non-respite model can provide on its own (such as the need for emergency respite care).
- Thirdly, should Cholmondeley integrate other strength-based interventions to complement respite care, it needs to be familiar with the literature on the effectiveness of such approaches.

Armstrong & Shevellar (2006) argue that rrespite should become a means and not an end. Indeed, some respite models such as secondary respite services see the purpose of respite purely as a means to provide other interventions (Pollock, Law, King, & Rosenbaum, 2001). Respite care services vary in the degree of treatment brief that the respite care team holds for a child and their family. Some services are configured to provide treatment to the natural family (such as parenting skills training) or to follow up the child after they are discharged home (Meadowcroft, 1989).

The role of additional strength-based, family preservation interventions should be carefully considered in each case to decide upon the most appropriate intervention to enhance competencies and natural supports for a family (Armstrong & Shevellar, 2006). Armstrong & Shevellar (2006) list examples of complementary respite-alternative interventions, such as:

- Behavioural interventions in the home to improve parent-child relations
- Assisting competency-building in parents and/or improve their self-efficacy in seeking their needs in the community
- Accessing and developing wider family/whānau supports
- Promoting involvement in local community-based organisations, such as church groups, cubs or girl guides.

A strength-based approach asserts that respite should be a means to provide other resource-building interventions. Traditional respite care aimed at alleviating family stress or mitigating risk is a deficit-focused model. There is limited literature on the application of strength-based practice models. As aforementioned (see section 3.3) the child and family resiliency literature is more encouraging of the addition of strength-based interventions that promote systemic resilience through addressing processes and mechanisms through asset enhancement (e.g. building relationships, cultural connections, teaching parenting skills or increasing the availability of services) and/or improving the adaptive systems of children (e.g. self-regulation, cognitive functioning, cultural competencies, coping skills, social skills etc).

Therefore, the intervention that is required needs to be based on an evaluation of need, including thorough assessment of the child and family (MacMillan, Wathan, Barlow, Fergusson, Leventhal, & Taussig, 2009) and having a range of options available to meet that need (Jivanjee & Simpson, 2001), (Armstrong & Shevellar, 2006). Rather than asking: 'is respite required?' Armstrong and Shevellar (2006) encourage questioning along the lines of 'What would it take so that both the family and the child achieve a better life?'

Evidence-Based Programmes

There are a wide range of strength-based, family preservation, evidence-based programmes that serve different populations and needs. A detailed examination of such programmes is

outside of the scope of this literature review (see the Review of MacMillan et al., 2009 for a detailed review of models).

The evidence-base for, and real-world utility of, interventions vary depending upon a range of dimensions, such as the:

- Populations studied e.g. focus on parents vs. children; pre-school vs. school-age children vs. adolescents (MacMillan, Wathan, Barlow, Fergusson, Leventhal, & Taussig, 2009).

- Aims of the programme e.g. prevention vs. treatment; different types of abuse/neglect or reducing effects of abuse (MacMillan, Wathan, Barlow, Fergusson, Leventhal, & Taussig, 2009).

- Programme modality e.g. in-home vs. clinic vs. out-of-home (MacMillan, Wathan, Barlow, Fergusson, Leventhal, & Taussig, 2009).

- Quality of research design, limiting meaningful comparisons between programmes whose treatment populations may differ in severity or range of problems or who use variable types of controls or comparison groups (Littell, 2005).

- Discrepancies in the efficacy of the primary model implementation vs. real-world effectiveness (Fixen, Naoom, Blase, Friedman, & Wallace, 2005; Littell, 2005).

- Strength and limitations of the amount or quality of evidence supporting the programme (MacMillan, Wathan, Barlow, Fergusson, Leventhal, & Taussig, 2009).

- Costs, other resources and organisational capacity required to deliver the programme (Fixen, Naoom, Blase, Friedman, & Wallace, 2005).

- Availability and acceptability of programmes within the New Zealand context, including effectiveness and cultural safety for Māori and other ethnic communities (Connolly, 2007).

MacMillan et al., (2009) summarise the state of research evidence for family preservation programmes:

- Nurse-Family Partnership and to a lesser extent Early Start (on which the New Zealand Family Start is adapted from) show the most benefits for reducing child physical abuse and neglect (Fergusson et al., 2005).

- The Triple-P programme (also in New Zealand), whilst needing more research, has evidenced positive effects on child maltreatment.

- Regarding the prevention of maltreatment recidivism, Parent-Child Interaction Therapy has shown positive outcomes for child physical abuse.

- No interventions have been found to be effective in reducing child neglect recidivism.

- For maltreated children, treatment foster care evidenced improved mental health outcomes and standard foster care can benefit the child who has been maltreated compared with those who remain at home.

Respite Care and Evidence-based Programmes

Proponents of strength-based, evidence-based, family preservation models, such as Multisystemic Therapy (MST) argue that the great majority of the time, family interventions are best delivered in the community by empowering families to access or build up their naturally occurring relationships and supports in the community (Henggeler, Schoenwald, Rowland, & Cunningham, 2002). They argue that good respite should be focused, brief and designed to facilitate the child's participation in his or her usual daily activities. This contrasts with some respite programmes that introduce children to experiences that families cannot normally afford or programmes that provide formal respite without investigating the presence of possible informal respite providers (wider family, neighbours or friends). MST believes that it is the family's role to expose children to activities that promote positive development (Henggeler, Schoenwald, Rowland, & Cunningham, 2002).

Armstrong and Shevellar (2006) further argue that by retaining people in valued community roles they are more likely to experience far richer rewards, the wider social network and community is likely to be enhanced and the family itself will benefit from a better life.

Evidence-based family preservation programmes, while producing moderate-to-strong effect sizes, do not succeed in all cases. However, the literature is silent on what approaches are needed for such 'treatment failures' or the value of services such as emergency respite to provide ongoing support and risk management for children and families who failed to respond to a community-based family preservation programme. Advocates of respite care might argue that out-of-home respite care should be reserved for (and are certainly needed by) those cases that do not respond to in-home interventions. Indeed, some community family preservation models are integrating out-of-home respite care into their enhanced service models (Evans, Boothroyd, & Armstrong, 1997).

Summary

A strength-based approach asserts that respite should be a means to provide other resource-building interventions. Traditional respite care aimed at alleviating family stress or mitigating risk is a deficit-focused model. There is a dearth of literature on the application of strength-based practice models. The child and family resiliency literature is more encouraging of the addition of strength-based interventions that promote systemic resilience through addressing processes and mechanisms through asset enhancement and/or improving the adaptive systems of children and families.

The role of strength-based, family preservation interventions should be carefully considered in each case to decide upon the most appropriate intervention to enhance competencies and natural supports for a family. In the delivery of such, children and families need a thorough needs assessment and a range of options available to meet those needs. There are a wide range of strength-based, family preservation, evidence-based programmes that serve different populations and needs. Real world effectiveness, implementation utility and cultural fit of such programmes need to be carefully considered before programmes are invested in.

Risks of Respite Care

Negative Treatment Effects

Armstrong and Shevellar (2006) argue that in some instances respite may actually exacerbate rather than resolve difficulties. Children with anxiety or sensory sensitivities (e.g.

those on the autistic spectrum) and/or who require familiar controllable routines may become more distressed or exhibit problem behaviours upon their return home. Robertson et al., (2011) cite several studies where respite was associated with homesickness and worsening behaviour problems in children with developmental disabilities.

Longer respite stays may alienate children from valuable relationships and decrease rather than increase competencies (Armstrong & Shevellar, 2006). Middleton (1998) suggests that the term 'respite' reinforces the notion that the child is the problem for a family rather than being an individual with his or her own needs.

While some studies have asserted that respite reduces the likelihood of permanent out-of-home care (Voigt & Tregeagle, 1996; O'Brien, 2001), these studies tended to be without control groups and often of small sample size (Robertson, et al., 2011). Robertson et al., (2011) cite several studies that highlight an opposite effect: badly provided short breaks may disturb the child or highlight to carers how much caring has altered their life and, as such, encourage them to seek an out-of-home placement.

The Robertson et al., (2011) review also cites studies that identified increased emotional conflict between carers as a result of respite, as well as guilt and increased anxiety about the standard of care being provided.

Stalker & Robinson (1994) raise the issue of differential effects, particularly parents reporting positive benefits from respite but the child remaining unhappy with the placement. Some parents may be at risk of over-riding their children, particularly when there is no external advocate acting on behalf of the child who is also independent of the programme.

Adjustment and Attachment Problems

Homesickness is a common experience among children in out-of-home care, whether that be group residential or foster/family-based care (Ward, Skuse, & Munro, 2005; Minkes, Robinson, & Weston, 1994). In one study, up to two-thirds of children experienced significant adjustment difficulties, suggesting that children are often ill-prepared for the adjustment to residential care (Stalker & Robinson, 1994). Manso et al., (2011) assessed the adjustment of children and adolescents (age 6-18) to residential care and found a high level of failure to adapt at a personal or social level, with symptoms such as dissociation and negative thoughts (Manso, Garcia-Baamonde, Alonso, & Barona, 2011). Minkes et al., (1994) assert that children who are consulted about going into care have better adjustment once in care (Minkes, Robinson, & Weston, 1994).

Attachment research would predict that separation anxiety would likely be worse for children under the age of four years. For children who have yet to develop theory of mind and ability to perspective-take (which begins at age two and continues to develop through to middle childhood), their level of cognitive development would struggle to understand or correctly attribute the reasons for the respite, for example they may blame themselves as being the reasons for going into care (Pears & Fisher, 2005; Stalker & Robinson, 1994; Atwool, 2006). The effects of parental separation may be most acutely felt by children with an insecure attachment style, who have multiple experiences of separation from parents or who are temperamentally anxious (Howe & Fearnley, 1999; Atwool, 2006). Presence of siblings in care may mediate this anxiety, while some siblings reported anxiety following separation from the child placed in respite care (Robertson, et al., 2011).

The quality of the relationship with (attachment to) the caregiver predicts the chances of the placement proceeding vs. breaking down. Children who develop a secure attachment have a better chance of the placement proceeding (Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007). In-home respite may reduce the likelihood of such attachment disruption (Stevens, Ruiz, Bracamonte-Wiggs, & Shea, 2006). Conversely, inconsistent care-giving is associated with more severe attachment disorders (such as indiscriminant friendliness) in children who have been maltreated in out-of-home care (Pears, Bruce, Fisher, & Kim, 2010).

Such adjustment and attachment concerns need to be balanced against other studies of children's experiences of being in care where children identified with, and appreciated relating to, caring adults (Minkes, Robinson, & Weston, 1994). Moreover, Rutter (1995) acknowledged the importance of children being given the opportunity for forming selective attachments with staff who are able to make emotional investments in children. Rutter (1995) believed this to be more beneficial to children than avoiding the stress of parental separation.

Natural parental involvement may include preparing natural families for the loss of the respite arrangements, as evidence suggests that parents may experience an increase in stress and adult relational problems at the prospect of the respite placement ending (Respite Care Association of Wisconsin, Inc, 2002). Involvement of natural parents also aims to normalise and demystify the role of out-of-home carers, reduce anxiety for both the natural parents and the child through acknowledging attachment and separation effects and facilitating transitions.

Negative Peer Interactions

Congregate care can provide children with valuable sources of social interaction and an opportunity to develop social skills. However, interviews of children in residential care cite the negative, aggressive and/or antisocial behaviour of other children as being stressful and problematic (Ward, Skuse, & Munro, 2005).

The research on peer contagion in congregating antisocial children and youth together (particularly exposing children with mild-moderate externalising behaviour problems with children and young people who have severe externalising behaviour problems) is well described in the literature (Dishion, McCord, & Poulin, 1999).

Bullying is cited as a common phenomenon in group care, with young people most often victims and older males most often the perpetrators. This is more common in institutions where there is an established residential group hierarchy, during transitions of children in and out of care, and where staff minimise or hide episodes of violence (Barter, 2008)

Cultural Safety

There is a paucity of information about specific cultural models and how cultural issues are addressed in mainstream services. Cotterill et al., (2009) argue that it is essential to critically examine cultural-based assumptions about caring, to expose harmful myths and stereotypes. For instance, in more extended family-focused cultures (such as Asian, Black and Afro-Caribbean communities in Britain) they are assumed to have lower levels of need for respite, whereas upon direct enquiry they have been found to more likely express a need for respite, albeit using a family-based model (Cotterill, Hayes, Flynn, & Sloper, 1997).

Costs of caring also tend to be worse for ethnic minorities due to financial hardship, poor housing and institutional racism. Ethnic minorities may have greater levels of fear about putting their children into a potentially discriminatory service and/or feel shame about doing so (Cotterill, Hayes, Flynn, & Sloper, 1997).

Internationally, there is an ethnic imbalance between minority children needing care and the availability of culturally-matched carers (Cotterill, Hayes, Flynn, & Sloper, 1997; Brown, George, Sintzel, & Arnault, 2009). In a longitudinal three-year UK study examining respite care for families of children with disabilities, families from low SES areas and from minority ethnic communities had less choice of services (Robinson & Stalker, 1993).

Foster parents prefer cultural matching, noting smoother transitions, less stress, having more in common with the child and the children themselves feeling more secure (Brown, George, Sintzel, & Arnault, 2009). Cotterill et al., (1997) recommend flexible approaches to staff recruitment (such as use of active cultural networking), selection and training to facilitate a culturally matched workforce.

A New Zealand report from the northern health region concluded that Māori and single mothers have the most difficulty accessing palliative respite services for terminally ill children (Penny, 1997). In New Zealand, there was no located published data on the use of respite services for Māori or Pacific Peoples. As such, little is known about the context within which respite care provision is utilised by different cultural groups (Horsburgh, Trenholme, & Huckle, 2002).

It is argued that in-home/foster respite care has the ability to be more culturally specific and sensitive than congregate care (Meadowcroft, 1989) and in the case of Māori culture more family centered, particularly if a kinship caregiver is utilised. In care of children, the whole person is being looked after. As such, cultural and spiritual issues need due attention (in addition to individual and family).

While models of Māori wellbeing may be useful to guide practice, such as Te Whare Tapa Wha (Durie, 1994) or Te Wheke (Pere, 1988), it is important to remember that within modern pluralistic society the needs of each family may constantly change and be in need of frequent reassessment (Horsburgh, Trenholme, & Huckle, 2002).

Abuse

Children placed in care are vulnerable. They have a high rate of mental health problems, histories of abuse and trauma and are at greater risk of poor life outcomes (Hobbs & Hobbs, 1999; Bleach & Robertson, 2009). This places such children at greater risk of further victimisation. Hobs and Hobbs (1999) noted that children in foster care were 7-8 times, and children in group residential care 6 times, more likely to be assessed by a pediatrician for abuse than children in the general population. Historically, residential institutions, group homes and foster care environments have been exposed as places perpetuating physical and sexual abuse (Hobbs & Hobbs, 1999). Often verbal abuse is cited as the most common form of abuse, followed by physical abuse with sexual abuse the least common. A number of authors assert that the majority of abuse is kept hidden from staff (Hobbs & Hobbs, 1999; Barter, 2008).

The Hobbs and Hobbs (1999) study identified that it was not only staff and other children who were perpetrators (41% and 20% of incidents respectively), but also natural family

parents on contact were perpetrators in 23% of cases. Rosenthal et al., (1991) identified that 27% of reports of abuse of children in out-of-home care implicated perpetrators with prior allegations. Allegations of abuse reported by adult foster care alumni (Foster Care Alumni Studies, 2005) tend to be associated with an historical era of residential and foster care delivery when quality standards of care and oversight were lacking. However, it is important to note that evidence of abuse in contemporary out-of-home care continues, such as unearthed in the Hobbs and Hobbs (1999) study, which retrospectively collated the rates and types of abuse that occurred to children in care during the mid-late 1990's.

Service Dependency

Armstrong and Shevellar (2006) present socio-political drivers for respite, such as respite services not really advancing people's circumstances, political imperatives that encourage particular solutions to community issues, and economic imperatives that encourage congregate models of care. In particular they argue that families become embraced in a human service culture and progressively grow more isolated from the wider culture, and in turn need more of what the human services have to offer, leading to a proliferation of more respite services. "Respite is both an expression of things not being quite right while also being a panacea for it" (Armstrong & Shevellar, 2006; page 3). They argue that this escalating need can only be reduced if parents are enabled to better deal with the issues requiring support. Respite becomes the need, rather than the needs requiring the service in the first place, such as need to rest, re-energise, reconnect, recover, remaining engaged in roles and in the community (Armstrong & Shevellar, 2006).

Respite can be a solution that does not address the fundamental problems nor develop competencies to better cope with them (Armstrong & Shevellar, 2006). This may be a particular trap for parents who make direct referrals to Cholmondeley and where they aren't engaged to seek alternative solutions, and/or where they may have embellished perceptions of problems in their child due to their own psychopathology, and/or who may be reflexively replicating their own experiences of being placed in Cholmondeley themselves as a child.

There is some evidence that the development of informal support networks is unaffected by respite (Robertson, et al., 2011). Often the time afforded by short term respite was used by carers for basic activities such as sleep. In one study carer tiredness wasn't alleviated in 27% of carers receiving respite (Bruns & Burchard, 2000) and with family stress levels and child behaviour problems persisting (Bruns & Burchard, 2000; Robertson, et al., 2011).

Armstrong and Shevellar (2006) go on to argue that the respite model can create a problematic triangulation of causes and effects. The parent needs to enter the "victim" or helpless role to receive respite, automatically identifying the child as the cause of the difficulty and thus cast into the devalued role of 'the burden' (Armstrong & Shevellar, 2006). Furthermore, the 'victim' role can increase rescuing or disempowering responses in others (particularly via emergency respite), reducing personal responsibility for, and/or mastery over, circumstances (Armstrong & Shevellar, 2006). Traditional respite-only service paradigms can promote unhelpful systemic processes and limit creative thinking (Armstrong & Shevellar, 2006). The corollary is that because respite can be a medium-long term repeated event then the opportunity for developing competencies is large.

Summary

A number of potential risks and pitfalls are associated with respite care. Such problems include: exacerbating rather than resolving the target difficulties, service dependency, failing to address fundamental issues, lack of strengths-based practice, lack of cultural attunement, adjustment difficulties, decreasing parental commitment, abuse, negative peer influences and bullying (in congregate respite). Children placed in care are vulnerable and are at greater risk for abuse than age-related peers. Unfortunately, evidence supports the belief that abuse of children in care is a contemporary problem.

The literature highlights the importance of children having a voice, independent advocacy and avoiding giving children the message that they are the problem because they are the ones taken out of the family.

Congregate care respite needs to manage negative peer influences and bullying. Cultural-based assumptions about caring, models of respite care and service access need to be examined with the aim of appropriately matching to the needs of the family's culture. Little is described in the literature about the context within which respite care provision is utilised by different cultural groups, including Māori and Pacific Peoples.

Concluding Comments

The literature suggests that respite can benefit all family members: parents, siblings and the child in care. Respite also aims to achieve the added benefit of preserving families, reducing risk and preventing admission into residential care. Respite should be a means to apply strength-based practice models that promote systemic resilience through enhancing assets and adaptive systems of the child.

While only a small minority of families use respite, the most common and preferred form of respite for permanent caregivers are community, home-like environments. Children prefer contact with their family whilst in care, a normalised activity-based environment, a sense of security and autonomy, placement stability, and trusting, familiar relationships with caregivers. Professionals differ in their preference for in-home vs. out-of-home respite models. However, there is agreement that out-of-home respite is more suited to crisis situations. Given the diverse reasons for respite, the literature recommends that multiple types of respite care are required to flexibly meet the diverse needs of children and families.

Rigorous outcome research on respite for children with emotional or behavioural problems is lacking. Respite care has traditionally focused on the needs of carers and/or the service system and failed to study the effects of respite care on child consumers. The benefit of respite care has yet to be categorically ascertained. Some evaluations provide indications of the likely short term benefit of planned respite, however, little is known about what are the active ingredients or mediating variables and for whom and in what circumstances respite works. Conversely, little is described in the literature about the use and experiences of respite by Māori and Pacific Peoples, whether or not respite care causes harm, and the effectiveness of informal or congregate forms of respite.

The potential risks and pitfalls associated with respite care described above highlights the importance of children having a voice, independent advocacy and avoiding promulgating the message that the child is the problem due to being taken out of the family home and into care.

The literature review aims to ascertain what the scientific and best practice literature states about the effectiveness of respite care and the promotion of resiliency in children and families. This literature review represents the first step in a wider comprehensive programme evaluation, which will formatively examine the strengths and pertinent issues of the Cholmondeley programme, which will influence its course into the future. As such, this literature review served as an information source to guide the development and focus of the evaluation presented below.

Evaluation Method

This independent qualitative evaluation was conducted by Clarity Research and was designed to answer the following questions about Cholmondeley:

1. What is Cholmondeley's role in the Canterbury community and the Canterbury social services sector?
2. What impact does Cholmondeley have on the ability of families to keep their children safe, and prevent issues escalating to the point where care and protection concerns arise for the child?

Qualitative, semi-structured interviews were undertaken with four groups of people essential to the day-to-day functioning of Cholmondeley. These included children who had attended Cholmondeley in the period between 2009 and 2013, the carers of these children, Cholmondeley's referrers and brokering partners and staff members of Cholmondeley. All participants were interviewed between July 2012 and July 2013 by trained interviewers. All interviews were digitally audio recorded and took place in a location of the participant's choosing.

Participant selection

In order to ensure that a representative sample of participants was selected, a random selection process was applied to each group of participants. Cholmondeley staff were asked to generate a full list of:

1. All the children who had attended Cholmondeley in the 12 months between 1/2/11 and 31/1/12
2. All the staff employed at Cholmondeley as of 1/12/12
3. All referrers and brokering partners as of 1/1/13

Child and carer selection and recruitment

In order to maintain the privacy of families involved with Cholmondeley, Cholmondeley staff were the first point of contact about the evaluation. For this reason the list of children and their carers was de-identified and sent to the researchers for randomisation using a computer generated random order. This randomised list was then returned to Cholmondeley staff who had been trained to make initial contact with each family, to explain the evaluation to them and to get their consent to have their contact details passed on to the evaluation team. Each family was contacted by Cholmondeley staff in the order they appeared on the randomised list. Of the 32 families where contact attempts were made five were not contactable and three chose not to participate. This resulted in 24 families agreeing to be contacted by the researchers to hear more about this evaluation. These 24 families represented 54% of the families that had been involved with Cholmondeley over the stipulated time period.

After each family had given consent to be contacted by the researchers, a referral form was sent to the researchers who then made contact with the nominated adult family member to further explain the study, gain verbal consent to participate and to arrange an interview time with the carer(s) and/or children. Of the 24 families that were referred for interview, 22 agreed to participate. One of the families that did not participate was not able to be contacted by the researchers and the other had a change of family circumstances and,

although willing to participate, was not able to at the time the interviews were being conducted. Participants were all interviewed in their own homes and each family received a $20 grocery voucher for their participation.

Staff and referrer/brokering partner selection

The lists of Cholmondeley staff members and brokering partners were sent to the researchers. As the information contained on this list was publically available these lists also included the work contact details of each member.

Staff

A list of 21 staff members was constructed by Cholmondeley. This contained names, contact details and role of each staff member. To ensure that a variety of staff roles were covered, researchers purposively selected participants based on their role. Where there was more than one staff member per role a random selection was made of the person to be invited to interview. Of the initial seven staff members selected, one was not able to participate due to ill health and so a second person from that role was invited to participate.

Referrers and Brokering Partners

A list of referrers and brokering partners was constructed by Cholmondeley. This contained the name of the referrer/brokering partner, the name of the organisation they worked for, their role within that organisation and their contact details. Overall this list contained the details of 25 people representing 11 organisations. Purposive sampling was used to select 15 participants that represented the range of organisations and the various roles within them that referred to and/or were brokering partners to Cholmondeley. Of these 15 people, 12 people from nine organisations were interviewed. Three people were not able to be interviewed, two of these because they had left their organisation and one because they were too busy. As data saturation had been achieved with the 12 participants interviewed there was no need to recruit other participants to replace these three.

Analysis

All interviews were transcribed verbatim and were analysed using thematic analysis (Boyatzis, 1998). Thematic analysis is a qualitative method of analysis, which requires in-depth examination of the data to allow common themes to emerge. Initial structural coding (Saldana, 2012) based on the semi-structured interview questions revealed a number of minor categories that were summarised into preliminary themes. Further analysis based on descriptive coding (Saldana, 2012) resulted in these preliminary themes being condensed into the major themes discussed in this report.

Ethics

This project was deemed to be ethical by Professor Michael Belgrave, Massey University, Albany.

Clarity Research is committed to ethical research and evaluation practice and subscribes to the Australasian Evaluation Society 'Guidelines for Ethical Research'. In line with its ethical guidelines, the researchers undertook to ensure at all times that:

- all participation was voluntary
- informed consent was sought and gained from each participant
- The right to privacy and confidentiality was respected for each participant
- The dignity and worth of every individual and the integrity of families/ whānau and the diversity of cultures was respected

In particular, potential participants were given a written explanation of the project that explicitly advised that participation was strictly voluntary and that there was no expectation that they had to participate and that any participant was free to withdraw from the study at any stage without having to explain why. Signed consent forms were obtained before the start of each interview; these forms included a commitment from the researchers that identities would be kept strictly confidential by the research team. Consequently, no names or identifying details of participants have been used in this report.

This project was peer reviewed after completion in order to ensure methodological rigour.

A note on the 2010-11 Canterbury Earthquakes

This research was scheduled to begin in 2010, around the time of the Canterbury earthquakes. After the February 2011 earthquake, the main Cholmondeley building in Governors Bay was destroyed and Cholmondeley moved temporarily to Living Springs. There, new activity-based options were introduced and there was a change to the service provided by Cholmondeley.

The earthquakes also brought a variety of challenges and extraordinary stressors to the lives of children, families and staff of Cholmondeley. The project was delayed to allow some form of normality to return to not only the lives of participants, but also the service provided by Cholmondeley.

Future readers of this report should take into account the events of 2010-11 and the additional stressors facing all participants in this report.

Results

The results of this study are presented in relation to each of the key research questions asked in this study.

1. What is Cholmondeley's role in the Canterbury community and the Canterbury social services sector?
2. What impact does Cholmondeley have on the ability of families to keep their children safe, and prevent issues escalating to the point where care and protection concerns arise for the child?

In addition the final section of these results provides some additional information that participants provided about their experiences of Cholmondeley. This section in particular provides an overview of children's and carers overall impressions of this experience.

Description of Participants

Carers

The carers of 22 families who had attended Cholmondeley within the last three years were interviewed. From these families 25 adults were interviewed. The majority of these adults (n=17) were the mothers of the children that attended Cholmondeley. The remaining six were grandparents (four grandmothers and two grandfathers), one stepmother and her male partner. It was not clarified whether this male partner was the father of the children who had attended Cholmondeley.

Many of the carers interviewed had previous personal experience of Cholmondeley. Seven of the mother's reported having attended Cholmondeley themselves as children, one reported her children's father had attended and one set of grandparents reported that their own children had attended Cholmondeley.

Families were referred to Cholmondeley from a variety of sources with the main referral source being through schools (n=9), followed by CYFS/Barnardos New Zealand (n=5), health (including specialist hospital teams), counsellors and support workers (n=4), three families self-referred; one having heard about Cholmondeley in the media, and the other from a friend, and the other stating they had just always known about Cholmondeley. One family did not state how they were referred to Cholmondeley.

Children

Twenty seven children were interviewed. These children were aged between 6 and 14 years with a mean age of 9.8 years. Sixteen (59%) were female, and 11 (40%) had their ethnicity recorded as Māori on Cholmondeley files. According to data from these files, the children had attended Cholmondeley an average of 10 times (range = 1-74). All had attended Cholmondeley in the three years prior to interview, with the earliest starting at Cholmondeley in 2009.

Staff

Seven staff from Cholmondeley were interviewed for this evaluation. These seven represented the range of employee responsibilities at Cholmondeley, including child care worker, co-coordinator, teaching, administrative and supervisor roles. These staff also

represented a range of newer and older staff members (range 2 years to 16 years). Four of the staff members interviewed were female and three were male

Referrers/Brokering Partners

Twelve people representing nine different agencies that either refer to Cholmondeley or work with Cholmondeley to provide additional services to the children and families they support (referred to by Cholmondeley as brokering partners) were interviewed. These organisations represented the majority of Cholmondeley's main referral or brokering partner agencies (9 of 11), and came from a variety of sectors including health, justice, education and welfare. The roles of participants included social workers, fieldworkers, nurses, managers, co-ordinators, liaison, and school principals.

Cholmondeley's role in the Canterbury community and the Canterbury social services sector

Carers

Carers, while mainly asked to comment about their families personal experiences with Cholmondeley also indicated that Cholmondeley played a very important role in the Canterbury community. This role was seen as providing an essential service to help and support families function (sometimes at a very basic level) and to assist children to grow and develop important social and emotional skills. While acknowledging the importance and uniqueness of Cholmondeley to the community, it is also important to note that many families actually knew very little about Cholmondeley and the services it provides prior to their becoming involved in Cholmondeley.

Those carers who had previously heard about Cholmondeley often had quite outdated impressions based on rumours, or their own or other adults' childhood experiences, resulting in some initial reservations about sending their own children there. Following their own children's experiences at Cholmondeley however, carers recognised their outmoded impressions and saw Cholmondeley very differently and in a much more positive light.

Given their initial experiences of lack of information, or inaccurate information, a key suggestion by parents (and referrers/brokering partners) was for Cholmondeley to actively market itself more in the community. Carers expressed a desire to have more information made easily available about Cholmondeley and what it does, how it works, how to access, who the staff are, what the schooling is like, disciplinary practices and the different ways Cholmondeley can be used to support children and families. It was thought that this would assist with providing information to help families to access Cholmondeley and also to increase fundraising for Cholmondeley.

Referrers/Brokering Partners

When asked about the core business of Cholmondeley, what they thought it was, and how well they did it, all of the referrer/brokering partners perceived the core business of Cholmondeley as respite care. The majority perceived that Cholmondeley undertook this business extremely well and provided children and their families with a high quality, user-friendly service. When asked to comment about what would happen to children and families if Cholmondeley was not available in the community the large majority of respondents commented that this would result in increased stress to children and their families, the referral agencies and the community at large.

As well as respite care being seen by referrers and brokering partners as Cholmondeley's core business it was also seen as their point of difference from other organisations. It was also identified as a much needed service. Other points of difference included:

- the location,
- the kind, caring, positive, child-centred and parent-centred atmosphere,
- that multiple children from one family could attend together, and
- that it provided overnight care.

Things Cholmondeley does well

As well as thinking about the core business of Cholmondeley, referrers and brokering partners were also asked to comment on the things they thought Cholmondeley did well. These included:

- role-modelling
- provides fun activities
- reassurance of parents
- easy referral process
- there when you need them
- provide a really, really happy supportive place
- they are caring, and they listen.
- communicate well
- they are very helpful
- they work with children
- they work with families
- non-judgemental to families
- caring for children
- they have provided a safe, caring and nurturing environment for children who need a fun place to be, outside of their home environment.

Things Cholmondeley could do better

When asked about the things that Cholmondeley could do better referrers and brokering partners made only a very few suggestions about changes they would like Cholmondeley to make. These included:

- better communication with schools
- do more parenting stuff
- take more children
- better communicate/advertise what they do
- more of what they already do

Staff

Cholmondeley staff that were interviewed reported the core business of Cholmondeley as providing respite care to children and families, providing a safe environment for children, and working with children and their families. The majority of staff perceived that Cholmondeley did this well with responses ranging from 'exceptionally well' to 'we do quite well'.

This perception of Cholmondeley's core business was also reflected in staff perception of the role that Cholmondeley plays in the community and the role that staff think they should play.

When asked what they thought Cholmondeley should be doing for the community, all staff agreed that Cholmondeley should keep on doing what it is currently doing.

Things Cholmondeley does well

When asked to consider the things Cholmondeley does well staff reported the following:

- staff are child-focussed
- provides an activity-based learning programme
- staff work well together
- easily accessed by the community
- make sure children are presented well
- is warm and inviting for the children
- good communication with referrers

Things Cholmondeley could do better

In terms of things Cholmondeley could do better, the staff were the most critical of all participants and identified the following as areas of improvement or change:

- communicate more
- do more community-based work
- have multi-disciplinary teams
- work more with families
- create better community awareness of Cholmondeley
- be better at sharing information
- teach children more skills
- have on-site family involvement

Future directions for Cholmondeley

Many of these suggestions were also reflected in staff perceptions of future directions for Cholmondeley where the following suggestions were made:

- more support with the families
- take older children
- use a multi-disciplinary approach
- more professional development
- teach children life skills
- open more Cholmondeley's nationally

Summary

While professionals considered the core business of Cholmondeley as respite care they also maintained that it provided a unique and essential service to the families of Canterbury. Carers saw its role as of vital importance to the functioning of families in the community by assisting children to develop essential social and emotional skills. Prior perceptions of Cholmondeley by families often tended to be different to the reality, with misconceptions perpetuated by a lack of information.

Staff and referrers/brokering partners identified areas where improvements could be considered, but also aspects in which Cholmondeley is highly successful.

Referrers/brokering partners suggested that if the service did not exist then the added stress to families, referral agencies and the wider community would be significant.

The impact of Cholmondeley on keeping children and families safe and together

Carers expectations of what Cholmondeley could provide

In contemplating carers' perceptions of the impact of Cholmondeley on their family, there was a clear demarcation between what carers expected to happen for their families and the overall impact of their children attending Cholmondeley.

When discussing their expectations of what Cholmondeley could provide for their family, carers' described expectations that focussed on immediate relief from their current situation rather than any longer term outcomes about keeping their children and families safe and together. Overwhelmingly, carers reported the expectation that Cholmondeley would give them a break from their children. Only a few carers mentioned expecting assistance with children's behaviour problems, parenting advice, or support for the whole family.

Carers' expectations about what Cholmondeley would provide for their children included giving the children a break from carers and/or other siblings, an opportunity to have fun and experience new activities, be in a safe environment, provide opportunities for social interaction and working on changing behaviour.

To ascertain whether these expectations were met, carers were asked about what actually happened for them and their children while they were at Cholmondeley. All carers who expected to have a break from their children reported that this actually happened, although most of those who had expected assistance with strategies to manage children's behaviours and/or to learn parenting skills reported that this had not happened.

These carers also reported that Cholmondeley met their expectations in terms of providing their children with a break from the home environment and exceeded their expectations in terms of the amount of fun that the children had, the range of activities they had to do, skills they were taught, relationships they developed, and the support and care they received from staff. Only one family reported that their expectations had not been met and that they were disappointed by the service provided for their child. This was largely due to some name calling by other children experienced by the child while they were at Cholmondeley.

Carers perceptions of outcomes

Although caregiver's described having few expectations about the longer term impact of Cholmondeley on their families, the beneficial longer term impacts became very evident as the carers described the outcomes for themselves, their children and their families associated with their children attending Cholmondeley.

Discussion on outcomes emerged as carers were asked questions about the benefits and the downsides of their children going to Cholmondeley and the changes they noticed in their children after attending Cholmondeley. The responses to these questions produced an overwhelmingly positive evaluation of the outcomes for both the children and their families

and represented both immediate and longer term impacts. These positive outcomes have been categorised as:

Improved interactions

- New opportunities to socialise and develop friendships
- Improved social interactions with other children/learned how to treat other people/respect for others
- Improved interactions/relationships between siblings
- Improved interactions/relationships between carers and children
- Improved interactions/relationships between parents

Providing a much needed break

- Carers had time out and subsequently felt more refreshed and relaxed and able to cope with day-to-day life
- Children had time out from stresses of family life

Change of environment

- Children got to be in a relaxed environment
- Children got to experience lots of activities/events that carers could never provide
- Children got a chance to be children
- Children had positive experiences of schooling
- Carers felt supported because children experienced rules and consequences from other adults
- Children had other adults to talk and share with

Positive input

- Received help and support with children
- Affirmed carers parenting role and gained confidence in being able to parent
- Children got to experience positive male role models
- Carers benefited from hearing positive comments about their children from others
- Children had lots of positive experiences
    - gave them something to talk about, feel proud of
    - gave carers something to talk with them about
- Children and carers felt proud of child's achievements

Skill development/behavioural change

- Children develop confidence
- Children's mood improved
- Children's behaviour improved
- Children learnt to understand themselves better
- Children learning how to help and support others

Impact at home

- Carers regained custody of children

- Provided opportunities to build on positive behaviours and experiences when children return home
- Home environment became more calm and relaxed
- Become closer as a family
- Children became more appreciative of carers

Carers perceptions about the overall impact of Cholmondeley on the family

In answering the question about what would have happened if their children had not attended Cholmondeley, carers expressed their views about the overall impact that Cholmondeley had on their families. The majority of carers perceived Cholmondeley as an essential service in their lives and one that had significantly contributed to the wellbeing, safety and stability of their family. These sentiments are reflected in the comments below.

Prevention of negative health and behavioural outcomes for carers and children

For some, the implications to home life, if the children had not attended Cholmondeley, were centred on behavioural outcomes for their children and mental health outcomes for themselves, with time at Cholmondeley assisting in both these areas.

> *To be quite honest, two extremely out of control kids… and… I would have been… pretty… pretty down and out. I don't think I would have been in a very good place. … Yeah, it was getting to a stage where I was just literally at my wit's end and it wasn't doing my health any good. And um, yeah… it wasn't doing any of us any good whatsoever.* (A1)

> *I think behaviourally it would have got worse. Because there was nowhere else. Well that I knew of. And there wouldn't have been that break, I think they needed from me as much as I needed it from them. They needed it as well.* (A18)

Others were clear that not having access to Cholmondeley would have made life a lot harder for their families because of their child(ren)'s behavioural difficulties.

> *I probably would have had to access something else I guess, but life would have been a lot harder I think, if I had nothing! Because he is pretty full on* (A4)

Or because of the family's social and economic circumstances.

> *I think things can get pretty tense for us sometimes, because [name of child] gets bored and I don't have a lot of money and stuff like that to take him places. I can't always be there all the time, things can get pretty tense, we both need a break every now and then. And if there wasn't Cholmondeley then I don't honestly think we would really get that.* (A24)

In other cases carers perceived that attending Cholmondeley protected the children from experiencing some difficult home circumstances that would otherwise have made life miserable.

> *I think it would have been a very dark time of his life.* (A6)

> *Ohh. Would have made things a lot harder. [name of child] has already got low self-esteem, and I think that that would have dropped it down even more.* (A16)

Other's talked about the direct impact that access to Cholmondeley had on their own recovery.

> *I don't think I would be coping to the extent that I am now, I think my road back to health, losing the plot and having a mental breakdown would be a lot longer than what it has been.* (A8)

Regardless of the reasons that they accessed Cholmondeley, many carers expressed the sentiment that Cholmondeley had provided them and their families with a lifeline.

> *Well what would we have done? Put it that way! What would we have done?... it is a lifesaver for us, definitely is a life saver for us. In that fact of having that time out from [name of child] too, but what would he have done, yeah?* (A14).

Many also saw that Cholmondeley had provided this lifeline by doing the simple things such as listening, respecting, and being there when needed. Cholmondeley was seen for many as providing the role of an extended family that they could turn to in both good and bad times.

Disintegrated family

In addition to these health and behavioural outcomes there was a real sense among many of the carers that maintaining life as an integrated family would have been a lot harder without the input they received from Cholmondeley.

Depictions of possible family disintegration ranged from a carers having to leave the family to access their own respite or mental health care;

> *I would have been quite depressed and I probably would have been in respite care for myself. (A2)*

> *Oh, I might have ended up in a nutbar hospital, oh nah, I don't know if it would have come to that, but I was struggling at that time, you know, so… Yeah so it was real nice to have them bugger off for the weekend so I could get my deal back together and jiggle the brain back in place, and just de-stress… Oh and for their safety too really, you know, I didn't want to lose it all weekend at them. (A3)*

to having children placed in the care of someone else;

> *So the only other choice would have sort of been into foster care.* (A9)

> *I hate to think, I would have had a break down. [Name of child] could have gone into a depression, or been on medication. Cholmondeley was the only alternative or I would have to give him away. (A12)*

or not regaining access to children who had been removed from their care

> *But I believe that if Cholmondeley hadn't been available there is no way that they would have let me get my kids home. So I think if it wasn't for them, I wouldn't have. (A13)*

Others perspectives on the outcomes of Cholmondeley for children and their families

The impact that Cholmondeley had on family wellbeing, safety and stability were further reinforced in the interviews with staff and referrer/brokering partners as they discussed a range of positive outcomes for children and their families.

Referrer/Brokering partners

The outcomes described by referrers/brokering partners closely reflected those described by carers.

Outcomes for children

Reported outcomes for children included experiencing good structures and routines, being physically active, developing essential life skills, being safe, having opportunities to socialise and learn and enhance social interaction skills, having fun and a break from the normal day–to-day routine, increased self-esteem and self-confidence, good schooling, and being exposed to positive adult role models.

Physical environment/structure/routines

Stakeholders/brokering partners discussed these outcomes in a way that not only illustrated the multiplicity of outcomes but also some of the things they believed contributed to them. The physical environment and the structure and routines provided by Cholmondeley were seen as important components by many.

> *I think it is the experiences, it's where it is, going away on holiday. So leaving the city, and children that haven't ever left the city boundaries, it is big for them, to see the water, and the hills and yeah it is awesome. And that they do have boundaries and they have routines and that they can build relationships with other people and that they actually get to meet a lot of other children that are there at the same time, so build relationships with them, with other people outside school or Mum and Dad's friends.* R6

Routines and the role of Cholmondeley staff as role models were also seen as important.

> *They can get into some good routines, they have some physical activity, the socialisation, self-esteem, self-confidence, the routines, and I feel like sometimes that being, you know, with those sort of*

young role models they can kind of make it cool to do the right thing, to follow instructions and that they can manage the behaviour. Well then that is sometimes why it sometimes quite good if they can then pass those skills on to the parents, of course as well, but hopefully other agencies cover that. But that is where you could get a good tie in. Yeah, and like I said, good routine, physical activity... Learning a lot about themselves, yeah new skills. Yeah. Values, life skills. R3

I just think the benefits for kids is the structure and the routine and the role modelling and the healthy eating and the exercising and just all of those things. And the benefit is definitely that it is for a period of time, as opposed to us which is an hour. Or a few hours. So they get it consistently for that period of time. R7

In addition to the structure and routine provided by Cholmondeley, an additional benefit was the opportunity for children to continue their schooling while at Cholmondeley.

I think... one of the key differences is that even if they spend a week away from their parents they are still having that schooling. They are not missing out on any of that sort of education stuff. And the beauty of that is, it is not like a camp and it is fun, and you just go away. You are still keeping routines, whereas a camp [routine] all kind of goes out the window and there might be lot of like, well not late nights probably, but you know what I mean. Whereas there is lot of structure, and I think some of my families in particular, those kids really need structure. R12

Repeat visits

The value of repeat visits and establishing strong family-type relationships with the Cholmondeley community were also seen to facilitate outcomes. The positive experiences children had while at Cholmondeley were considered important in facilitating children's wishes to return to Cholmondeley and the desire for their carers to allow them to go there.

Well you know, because you do get those short-term benefits, Mum is under stress and so it gives Mum a breathing space, the child is in a safe secure environment and their routines and structures at Cholmondeley are so set that the child goes in there, some children have, go there three or four times, and so it is almost like going back to another family. Because of that routine and that ritual that goes with the place. It has got a really high opinion, and I have used this before when, with children. "You have been to Cholmondeley, tell little Johnny about it because he is going to be going", and they alleviate children's fears. Children come back having had a good experience, which is really, really important. R4

It was recognised however, that these repeat visits were only beneficial if both carers and children had positive experiences of Cholmondeley.

If a child comes back into their family's care after some time at Cholmondeley and they have had a really good time, and they want to go back again, and the parent is really happy with the break that they have actually had from their children and they feel that they have had only positive experiences themselves and conversations or working alongside Cholmondeley professionals then that can only be a good thing. R13

Positive interactions and opportunities for learning

While many referrers/brokering partners acknowledged the importance of the child having a break from their normal family environment, most perceived that this break alone was not sufficient. It was the positive interactions with adults and the opportunities for learning during each stay that was perceived to really provide the greatest benefits to children.

Well obviously because they have got that 24/7 experience, they are going to be learning a lot about social skills, and social interactions and getting that great role modelling of positive adults around them 24/7. So it is not just about breaks and respite care it is about actually kids learning lots of really neat social skills. And seeing that life can be a really positive experience, you know, because I imagine, from what I have seen and heard of how it works there, that it would be very much like when we take our kids on school camp. You know, it is just such an amazing opportunity to get the kids away from home, and have just totally functional, reasonably unstressed adult interacting with them, in a really positive way, yeah I see those as probably the biggest benefits really. R5

Providing children with the opportunity to experience a sense of achievement, to know they have the ability to do good things and having those achievements recognised by caring, supportive adults highlighted the longer term impact of visits to Cholmondeley for children.

I mean they might not do things that are so great, but they have always got something about them that there is something good about them. So I think that whatever Cholmondeley do, like self-esteem, like this adventure-based programme, for children's self-esteem, to see that they can actually do something, and know that "I can climb up that rope", or "I can" and someone is there watching me and praising me and saying you have done well, you know what I mean? R9

These longer term impacts were not only discussed in terms of tangible skills and feelings of wellbeing but also the positive memories and values that children can take with them and build on for the rest of their lives.

I think it is providing for children, well it is providing them with good memories, ... and like someone said to me years ago, whatever you do for children that you care for, you will make a difference, and you might not think you are making a difference now, but you will know in the future, and I think that is the same sort of thing, I think for

> *what they do for children, and families will make a difference in their lives and it might not be huge, or it might be! Or it might just be something really, really small, like even something as simple as table manners, or something like that, you know what I mean? Like just something, not saying that is an important part of your life, but in life it is important isn't it? As you get older and things, and so I think, and their values and respecting other children, respecting their property.* R9

Cholmondeley as a reward not punishment

While the physical environment was seen as important, others also discussed the importance of what happened within that environment, to create a sense that being at Cholmondeley was a reward or positive experience rather than punishment, as a key contributor to outcomes.

> *Well, I suppose what I think about is the children. And for the children to have some where to go that is consistent and is stable, nurturing and they have fun and, it provides also for families to have that extra support. And that children have somewhere to look forward to going to. They are not being sent away, so it is like a holiday that is how I see it*. R9

This sense of what happened within the environment of Cholmondeley and the atmosphere of care that was created for the children was also seen to contribute to children seeing Cholmondeley as a place where they belong. Known to be vital to optimal growth and development for any child (Ungar 2010) this sense of belonging is deemed especially important among children in respite care who may often perceive they are unloved, unwanted or a problem as a result of their need to be in respite care.

> *When you have got a kid having the ability to read and acknowledge someone else as well, then there is growth in there and there is a sense of belonging, and so if kids are feeling belonging when they are going to a respite setting, that is perfect. Because the inverse could very easily happen when you are going to "respite care" in that sense is that you are not wanted by the situation you are currently in so you are going here, unwanted. From my experience the kids don't feel that. They feel wanted in that way…from my observations there was a genuine aroha and love and the staff were upping the kids in the sense of…respect. It starts on a ground of respect and then yeah the interactions stem from there.* R11

Outcomes for families

Outcomes for families were largely centred around the theme of being easily able to access support in times of need. This support was ultimately seen to assist the maintenance of a functioning family structure through a variety of mechanisms.

Providing a break

One of the most commonly reported mechanisms of assisting families was through giving parents a break.

> *The benefits for the families are that a lot of these parents aren't coping, and so it gives them a break, which is only good for everybody, away from their children, or with their other children just to, yeah, to help that. R7*

This break was seen to be beneficial for many reasons including keeping parents going.

> *I have had many parents say to me that it helps them keep going as well. "If it wasn't for Cholmondeley, if it wasn't for the fact that [name of child] is going back up to Cholmondeley I think I would, I don't think I could do it anymore". So there is that parent seeing it as a bit of a life saver. R5*

Giving them time to work on themselves and their relationships.

> *I think in a lot of my cases it is giving that, the families have hit crisis point, definitely, and that then it is almost like you need to, they need that time to you know, re-establish themselves and quite often that relationship with the children.* R8

Providing opportunities for learning about new experiences to share with their children.

> *There is the respite but then they can hopefully learn from their kids as well, in some situations, kids come back with all these exciting things they have done so they can maybe tap into some of that. R3*

Knowledge about the reliability of Cholmondeley, the structure provided, and the forward planning of visits were seen to further enhance the benefits of having a break. Families were able to endure difficult situations safe in the knowledge that they had the support of Cholmondeley to call on or that a planned break was on the horizon.

> *I guess families manage at different levels and different things come into their lives and at different points it is different, things become more difficult. And sometimes things become pretty close to unmanageable, and for a family to know that there is a reprieve or an ease of stress coming up, I know I have heard of families talking about oh yeah and they are going to Cholmondeley in two weeks' time, and that kind of provides a release or a light at the end of the tunnel, for the journey that the family is on. In the sense that they may be experiencing a difficult time with their child or just in the family dynamic. So it is, yeah, it is a reassurance that someone is there for them, and it is going to happen, and it probably gives them a little bit of strength as well, to know that they have some support. R11*

Having somewhere to turn

While having a break is a seemingly simple concept for many families, there was clear recognition from referrers/brokering partners that for many Cholmondeley families the logistics of this were not so simple.

For some this was due to lack of extended family support. The concept that the Cholmondeley community enabled breaks to happen through its ability to serve as a substitute extended family was seen as particularly important for these families.

> *And I know families use, well all families use different supports, whether they use grandparents, aunties, uncles for that, and for some families that is not an option. They don't have those supports, so it is almost like a family support. And the way they use, the way they talk about Cholmondeley, it is kind of what it is, and the kids instead of going to grandparents for the weekend, they will be going to Cholmondeley for the weekend, and from the feedback I sort of hear emphatically would be that it sits in par, the experiences that they are going to have, they are going to be good experiences, they know that. R11*

For other families this was due to a general lack of support, so Cholmondeley provided a much needed place to turn to.

> *They would be thankful, I think that would be the key word, just that thankfulness that there is an entity that can support them in that time of need. Because by the time that they get through to there, many of them have exhausted their resources and they are running on empty. R4*

Cholmondeley was perceived to be easily accessible, flexible to individual needs and without long waiting lists.

> *I guess it is providing, there is this weird sort of hope, well hope to families? That when there is not a lot of support out there and there is lots of hoops to run through and there is lots of complications, Cholmondeley is there and it is easy to access. R12*

> *It wouldn't work, it would not work [having to wait six weeks to access a service]. You would get children who would end up being hurt or harmed or put in less than safe circumstances. That has been our life saver here, that for those needs. R4*

Relationships

Another fundamental mechanism by which Cholmondeley was seen to assist families was through the formation of strong, caring relationships. This was seen as particularly important because many families had negative experiences of working with outside agencies.

> *And although I don't have a lot of direct knowledge of how closely they work with the families, I only hear good things about that relationship. Parents often talk about the teachers and that, being so good, and being really, them getting on well, and talking, and like I*

> *said I don't have direct knowledge of how it all works, but I have only heard good things about how that relationship goes. And a lot of our parents are really dubious about, I mean they have bad experiences with schools when they were young so, it is all just working, another organisation working to make positive connections with at-risk families really.* R5

The ability of Cholmondeley to develop trust and relationships with families was seen as key.

> *Because a lot of families I may refer once, and then they will continue to do that, so they either feel that they trust the family, because that is a huge thing, of getting parents over the threshold, is trust in the staff that are there, and the other kids that are there, and because parents can be really protective of their children, so, and then they have often taken on to keep that regular stuff, because they have either built a relationship with one of the staff members, or they feel really trusting, of their, that they are looked after well, and the kids come back happy, and yeah. R6*

The non-judgemental approach of Cholmondeley staff and opportunities to develop this relationship over time were seen to enhance the benefits experienced by families.

> *I guess they, in their practice, are non-judgemental to families, so families feel that they feel good about the service, I don't think people feel stigmatised at all to have to use the service. From my interactions. And the families feel supported. The families also, I know some families that have been there whose children have been going sort of long term, and I know that families have felt, sort of, well, have grown through that long term intervention as well, which is very hard to measure, because there are so many variables, but I know Cholmondeley was open to supporting that family and those children for a long period of time, which I believe that is how change occurs when you build a good foundation over a long intervention, rather than a shorter intervention. And I guess that is more than respite care, because then you are getting to know the child and you are investing in a relationship with the child. R11*

Outcomes for the community

Outcomes for the community were also seen as an important component of Cholmondeley's achievements. These outcomes were depicted firstly as a reduction in problems for the community to deal with and secondly as providing a positive resource for the Canterbury community.

Reduction in problems

The experiences provided by Cholmondeley and the skills that the children learned there were seen to act in a preventative manner and to benefit the community by having fewer 'problem children' impacting on the community.

> *Well I suppose in some cases these kids could ultimately you know, by what they gain from going there, you know from what they learn and hopefully if they grasp onto some things that they take with them, then they are not going to be the ones that are out on the street causing havoc when they turn into teenagers. So that sort of thing.* R3

Similarly the impact that Cholmondeley was perceived to have in terms of keeping children in their families and connected to school was also seen to have a positive preventative outcome for the community in terms of social and economic benefits.

> *Well like I say, it is probably not rocket science to make a direct link between ... keeping kids in their families and keeping them in school is going to have massive advantages to our community. I mean the sorts of things that disengaged young adults get involved in is going to be of massive detriment to the community so I mean I see that there are kids that we have sort of got through school and got directly linked into high school that we may have failed with, if it hadn't been for Cholmondeley and for other organisations that do that sort of support stuff, so and they will be the kids out there committing crimes and ending up in jail and costing us millions of dollars anyway so I mean I am absolutely sure that there is a direct link between the work Cholmondeley does and keeping some of those kids on the straight and narrow. R5*

Similarly, benefits to the community were also seen in terms of reductions in referrals to government services both now and in the future.

> *I think there would be more likelihood of the community having less notifications to Child Youth and Family, and to the Police and all these different things that go on actually in the community. And because if children can make sense of it then they will know this isn't the way that we should live, or if they tell someone they trust those sort of things, so I think the community are benefitting by, it will be the future generations. R8*

Positive community resource

Secondly, the outcomes for the community were depicted in terms of the positive resource Cholmondeley provided to the community. In one sense this was seen as a resource that assured the community that they had a place for children in need to go to.

> *Yeah, I just think that the community can feel very comfortable knowing that there is a place for children to go, when they need to. I mean there is a huge pressure of not having to worry R7*

It was also perceived as an opportunity for the Canterbury community to show that they cared about the health and wellbeing of children

> *I think on a bigger, on a grand scale it sends a message that people in Canterbury care about their kids. And they are prepared to champion a service to support families when families are in difficult situations, so I think it promotes a beacon of care. …That the community cares, and I think the, I don't know terribly much about their funding, but I know, well I know from their fundraising and things that you see around, that there is a lot of community input, and so it allows people to show that they care and what they champion.* R11

Cholmondeley was also seen as a resource that supported community services to support children in a society that traditionally did not function from a community perspective.

> *I am not sure where the quote comes from, but it says "it takes two parents to create a child, but a community to raise them". And this very individualistic western society that we live in, I don't think that communities take very good care of children. So I believe that Cholmondeley is a community service that services our Christchurch and Canterbury service community very well.* R13

Cholmondeley staff

Similar to the referrers/brokering partners, staff were also asked to consider what the outcomes were for children, families and the community separately.

Outcomes for children

The main outcomes identified for children were having access to a safe place that allowed them to be children, have positive experiences and learn skills for life.

A space to be children

Staff members were very clear that one of the main outcomes they aimed for was to allow children to be in a place where they could relax, have fun and quite simply be given opportunities to 'just be children'. Staff perceived that this kind of space was best created in an environment that provided each child with structure, routine and boundaries.

Personal growth

Through the fun and structured environment and the daily interactions that occurred within that environment children were perceived to learn a range of skills that helped them during their time at Cholmondeley and to take into the rest of their life.

> *…we teach the children resilience, so they take, hopefully, they take that home and I mean, it is a process because you know, obviously they are not going to come in for 5 days and learn lots of new skills and, so it is a process but self-management, they learn how to self-manage, and rather than just get very anxious and very elevated and just verbally explode or physically, they can do that, but they learn at Cholmondeley that that is not acceptable, that is not the right way, there are other ways and so they learn other ways of managing themselves and then they take those skills home. S4*

As well as learning to manage their feelings and behaviour, children were also perceived to develop confidence and learn that there are people around that they can rely on and turn to in times of need.

> *I think the benefits for children is that they get to know a lot more about themselves by, I suppose, getting a lot more confident with addressing their concerns and their fears. That and also like, building as a person. Being a bit more appreciative of people around them, that they are not on their own and they don't have to just like, mull over things that perhaps they are unsure of, or obviously are decisions or things like that that are quite advanced for them. S8*

Developing resilience

Having opportunities for personal growth to allow children to better cope with the environment they live in was also seen as an important part of providing opportunities for children to develop resilience to help them flourish even in the face of adversity.

> *It really is about, I think, building up that confidence and building up that positivity and a resilience for the children I think actually being able to cope with what they are coping with and giving them, their family, those helping hand also so they can help themselves, and help their extended family. So I think it is providing the children with an environment that treats them as they are an individual, they are special, they can be confident about saying what they feel and what they think. And I think that is really important. S7*

A key component of resilience is the ability to have a meaningful relationship with at least one adult significant other. The safety provided by the structure and routine at Cholmondeley was seen not only to provide the fundamentals of life but important opportunities to develop meaningful relationships with adults within Cholmondeley who were able to model functional interactions between both adults and adults, as well as between adults and children.

> *They get to build meaningful relationships with adults; they get to see positive interactions between males and females, positive interactions between males and males. They get to have a break in a structured, safe environment, they get to have healthy food, they are well cared for, they are, we are meeting their basic needs, so they are warm, you know, shelter, love, nurture. S3*

Build positive memories they can hold to even when times are tough

Acknowledging that the longer term outcomes will not all be positive or straightforward for the children they work with, staff also perceived that another important outcome for children was to provide them with positive memories that stay with them through good and bad times.

> *Yeah, most definitely, I caught up with a little fella the other day, who is in youth justice sector now, and he still, he is 15 and he has still got a photo on his wall of him and I fishing at age 8, when he was 8, so*

something that he had held on to, you know really dearly, and I am sure he is not the only one. S3

A break

Similar to other respondents, Cholmondeley staff also saw that an important outcome for children was the opportunity to have a break from their day to day family environment.

I suppose it just gives, if the child is very hard to deal with, or yeah I suppose you could put it like that, because some children are quite hard to deal with, but sometimes it is just nice for the child to have break from the parents, not the other way around. S6

So yeah, and then for the child to come into a bit of structure and routine, quite often they can go home a lot, just a lot more relaxed, and you know, and able. Yeah, that doesn't always happen, some of them do say, "oh, he has come home and he is all over the place!" but generally, yeah, you know with the routine and stuff, but yeah, just the breather for parents. To be able to, and a breather for the child as well, to be able to just come and relax and quite often, more often than not with the stresses that are going on in the family, just be a kid, you know, and have some fun. S2

Outcomes for Families

The two main outcomes that staff perceived for families were having time out while knowing their children were safe and having a chance to regroup.

Having a break while knowing children are safe

The major outcome identified by Cholmondeley staff is the opportunity for carers and other family members to have a break while children stay at Cholmondeley.

I think too, yeah, definitely for the parent's to have a breather, to have a break to be able to re-parent after a bit of time out. It could be that a sibling, siblings may need a break as well. S2

Well, what I hear the parents say so often is, well the ones who are still bringing their children to Cholmondeley, they say when they leave, and they give their children a hug and they just say "see you in five days" or whatever, and because I do spend, I always make a point of talking to the adults, to the parents, and you often hear then say "Gosh I need this". "I really need this", yeah, so I think the main thing is, a break. S4

A major factor in allowing parents to get this break however, was for them to be safe in the knowledge that their children were safe and having a good time themselves.

Ah, the benefits for families again they get to have a break, they get to know that the child is somewhere safe…and then they start to build a rapport with the staff over time as well. S3

Building rapport with parents was seen as an essential factor not only in assuring parents about the safety of their children, but also in empowering parents to proactively seek help themselves.

I think for some of the parents, to be able to do it themselves, without having to have any external, doing it for them, it is a lot less stressful, and the impact it has on them as a parent is, you know, is lessened. Yes, they are asking for help, but they are not asking someone else to ask for them. So it is empowering for them as well. S3

Regrouping and stress relief

Time out for children and adults was seen as providing an opportunity for all family members to regroup, but the change in mindset of the children from their experiences at Cholmondeley were seen to help create a different dynamic within the family when the child(ren) returned home.

Most definitely. And at the end of the day, it helps strengthen the family unit, so the child comes out for a week or two, or whatever, and has a break, has a nice time, has a positive stay with positive influences and role models etc. etc. etc. But then they are moving back into their family unit in a completely different mindset, so they are more relaxed, therefore the family becomes slightly more relaxed and those stressors will probably build up again and then we will offer some more respite. S3

Cholmondeley's ability to provide ongoing planned visits, as well as emergency care if needed, was seen to facilitate positive outcomes for families, both during the times that their children were staying at Cholmondeley and in a preventative manner through security of knowing that a planned break was at hand.

Stressed children, acting out maybe at school. Stand-downs, probably a lot more of that, not because they are that type of children to start with, but just often the parents that do come here, they are going through some type of stress, it is you know, whether it is their own mental health, whether it is something, but there is usually some sort of stress in the family. So, I think for that stress to bubble over, as it were, that is what would happen if they didn't look at getting a break. Yeah, and being able to have that emergency, like our first-off referral too, you know, even though it might be two weeks away but they know that they are going to have a break. Yeah. So it works in both ways, so you have got your regular respite where they can look, "oh!" You know, "another three weeks and I have got a weekend whew!" and the other ones that, you know, you might do an emergency for, or they might just be a first-off, one-off of whatever,

and they know that they are going to be safe, you know, their kids are safe. That type of thing. S2

Outcomes for the community

Similar to referrer/brokering partners outcomes for the community were perceived in terms of the preventative benefits that result from children not getting into or causing as much trouble in the community.

> *So for the community as a whole, if you look at the school, it has a potential to relieve pressure within the classroom setting, by giving that child time to you know, rest, recover, recuperate, it also, depending on circumstances, I know that it keeps some of them off the streets, so we have got a few young, and not that they are causing trouble on the streets, but they perhaps aren't getting the amount of parental supervision that they need, and you know they are cruising around disturbing neighbours and you know just having fun, but at the end of the day it has a negative impact on the community, and then the community will view that parent slightly more negatively than before, so …S3*

The social interaction skills developed by children at Cholmondeley are also seen to be a benefit to the community as a whole as children are better geared to function in a community environment.

> *Well it just teaches the children to be more, I suppose sociable. To get on in a community, to help one another, and not be so aggressive perhaps, and bullying towards other people because a lot of people, oh! And a huge thing, a really, really big thing I find these days is respect, learning respect for one another. And that is a major thing, I feel that has gone from society. Is respect for one another. S6*

The other main benefit to the community that Cholmondeley staff identified was the accessibility and absence of red tape for those wanting to attend Cholmondeley.

> *Well I think the benefits for the community is that we are here and we are accessible and available, and that they are able to access our facility and the skills and things like that that we have, without having to go through a huge amount of red tape S8*

For others in the community this was discussed in relation to somewhat informal networks that provided accessibility to resources through information and advice that could be provided to the wider community.

> *... my friends will check in with me, and their friends that know of me, but don't really know me, they will ring and say, "oh hey, your mate that works at Cholmondeley, can you ask him this and this and this", or "my teenager is doing this and this and this, what services could we recommend?" So I will be able to bring that to our clinical team,*

and say, "hey look", just you know, well not on the quiet, but you know on a personal level, "hey look, some of my friends are experiencing this stuff, can any of you guys give me any agencies that might be able to support them?" And it is not just that you do that for your friends, you would do that for anybody in the community that approached you and say "oh are you that guy from Cholmondeley, this is what I am experiencing, can you offer me any advice?", so what I would say to them would be, "hey look, I will grab your phone number, and if you don't mind I will discuss it with our clinical team, and we will give you a shout back and say, hey look, these are the avenues you should be looking at", you know so and that is very community focussed. S3

Summary

Perceptions from carers regarding the impacts of Cholmondeley on their family were defined by the immediate or short-term positive results on their families, to more long-lasting impacts. Having access to immediate respite or relief had been beneficial for them, siblings and the child(ren) attending. Knowing that their children were in a safe environment, experiencing new things and having fun not only met, but exceeded their expectations of what the service provided in most cases.

Additionally, the long-term benefits to families were broad and equally positive. Many experienced family situations that had improved due to having some time apart, with carers having time to be able to rest or sort themselves out. Increased positive social interactions enabled the children to gain confidence which may have contributed to positive behavioural changes at home. Families may have disintegrated if Cholmondeley's respite care had not been available. Overall carer attitudes considered Cholmondeley as a lifeline.

These impressions were further reinforced by the professionals interviewed who observed a range of positive outcomes for children and their families. Cholmondeley was seen to provide fundamental domestic structures and routines for the children, while modelling positive role-modelling, in a safe, fun and nurturing environment, and allowing them to "just be children". Family outcomes were perceived to be enhanced by the opportunity for families to have time out knowing that their children were safe. Repeat visits were seen to further strengthen the relationships between children, carers, and the Cholmondeley family and their sense of belonging.

Children and carers overall impressions of Cholmondeley

Additional information provided by children and carer participants served well to provide an overall sense of how Cholmondeley's target market experienced their involvement with Cholmondeley. This has provided some valuable feedback to inform the areas that these key stakeholders perceive Cholmondeley does well and the areas where improvement could be made so as to better meet the needs of their target community.

What carers liked about Cholmondeley

In addition to the outcomes carers discussed above, they also highlighted some of the main things they liked about Cholmondeley and the reasons they thought Cholmondeley worked for them and their children. These included:

- good communication
- made to feel welcome and part of the Cholmondeley family
- helpful and supportive
- appreciated ongoing involvement of Cholmondeley in their family's life
- the natural setting
- great activities, events and adventures
- caring, understanding, non-judgemental and child-centred staff
- schooling could continue while at Cholmondeley
- pick up and drop off service
- feedback reports that come home with children, and verbal feedback from staff
- knowing staff will contact them if there are any problems
- Cholmondeley is always available to help in an emergency
- children love it and are happy to go there
- caregiver's know it is a safe place
- the large amount of time the staff spend with children

What children liked most about Cholmondeley

The children's discussions of what they liked most about Cholmondeley focussed very much on the many new activities and opportunities they got to do while they were at Cholmondeley. Children also spoke highly of individual staff members and the international volunteers and students who worked at Cholmondeley. School also featured as a highlight for some children with most commenting that Cholmondeley School was better than their own school because of the type of work they did, the fun experiences they had, and the range of things they learned. They also liked that they did not get told off if they did not get things right. Although many of the outdoor activities such as the monorail, swimming, balance bikes and rock wall featured frequently as favoured activities anumber of children also mentioned that learning to cook and bake, and learning to help others were some of the things they most liked about Cholmondeley.

What carers didn't like about Cholmondeley

There were however, also aspects of Cholmondeley that carers did not like, or they thought did not work so well. These included:

- the distance to travel to Cholmondeley to pick up and drop off children
- the access to Bell Bird Heights
- the cost (although this was recognised as a minimal charge)
- sometimes finding it difficult to get the days and lengths of stays requested

What children didn't like about Cholmondeley

The most common response to what children didn't like about Cholmondeley was "nothing". However, when questioned about this further, a few children discussed aspects of Cholmondeley that they weren't happy with. For the older children, by far the biggest thing they didn't like about Cholmondeley was the upper age limit of 13 and having to leave or

having already left Cholmondeley. The other main complaint that a few children had about Cholmondeley was the behaviour of some of the other children where they experienced or witnessed some bullying from other children. All children who mentioned bullying also commented that staff dealt with this as soon as they knew about it, but children were still affected by the bullying occurring in the first place.

Changes to make to Cholmondeley (Carers)

When asked about changes they would make to Cholmondeley the majority of carers reported that there was very little they would change about Cholmondeley. The changes they did suggest included:

- increase the upper age limit to over 13 years
- assist carers to develop a plan for older children when they have to leave Cholmondeley – discuss options etc
- develop more Cholmondeley's or increase the size of Cholmondeley to enable more children to go
- send home regular reports and photos of children's visits
- have a regular newsletter
- improve communication between staff on shifts
- improve communication with carers, especially an initial update about how children are getting on after they first arrive and follow up calls at the end of each visit
- advertise more
- include families in more events if they are in the local area
- have someone to help settle the children in when they first arrive
- give more parental advice and feedback/share parenting, behavioural management strategies
- enable opportunities for children to make contact with staff once they return home – children really miss staff and want to be able to talk to them
- reinstate the pickup and drop off service
- provide more opportunities to get to know staff
- remove cost if possible by getting more funding
- not having all people sign in and sign out at the same time to reduce waiting time
- reinstate not having to take own clothes policy

Changes to Cholmondeley (Children)

Overall the children appeared to be more than satisfied with Cholmondeley; however they did share ideas of some things they would like to see change at Cholmondeley. These included:

- increase the upper age limit
- have a time out area if someone does something wrong
- have more flat space to play outside
- have single bedrooms, only have 10 kids there
- have a big play area
- change fish and chip night back to Friday and get a PS3 (PlayStation 3)
- have movies nights twice a week, go to the pool more

- make a bigger dorm
- change bedtimes to allow half an hour for reading and talking
- have less stairs
- paint the stairs
- have no name calling
- make a water slide

Carers views about staff

Carers' comments about Cholmondeley staff very much followed the positive comments they made about Cholmondeley in general. Overall they classified the staff as being of a very high calibre, who gave a lot to the children and who were incredibly supportive and caring. These comments are reflected below:

- extremely supportive, talk through problems, give feedback/communication, marvellous, patient, child centred
- good staff who know their stuff, are there for the kids
- really friendly and helpful
- great, kids love all of them and made them feel welcome, treat them like they are their own children
- really nice, always friendly, happy, really good with child, polite
- lovely, approachable, have as much energy as the kids, everyone nice including admin staff, really great and helpful
- really lovely, willing to listen
- wonderful, give 150%, excellent, supportive and positive, they were there for my child
- totally friendly, could talk to them, communicated well, have been fantastic
- reasonable
- amazing, onto problems straight away, take care of child's particular needs, all great
- welcoming, friendly, nothing hidden, good communication, make you feel like you are part of the organisation, feel part of the place, their whole attitude to you as a parent is fantastic
- really nice, friendly and make you welcome, very supportive and caring
- Really good, consistency of longer term staff members, very supportive, fantastic people, get on well with them and so do the kids, can always talk to them or ask them questions
- really nice, lovely, get to know them, nice to get positive feedback about children from them
- didn't meet much but kids thought they were lovely and fun
- really nice people
- a good mixture of people in terms of gender, interests types of people etc.

Carers' perceptions of children's views of Cholmondeley

As well as asking about their own views of Cholmondeley, carers were also asked about what their children thought of Cholmondeley. With the exception of one family whose child experienced bullying during their time at Cholmondeley, carers overwhelming reported that their children viewed their time at Cholmondeley positively. These views are reflected in the following comments:

- love it and ask when they can go
- couldn't wait to get back there, would live there all the time if they could
- wanted to stay longer
- love going there, love the staff, always talking about Cholmondeley, the staff and what they do there, go running up to staff when they see them
- excited about going
- love it, love the group leaders
- homesick to start with, but then didn't want to come home, really enjoyed it
- really enjoys it, asked when was going
- love it
- feels like part of the family up there, so excited when knows is going, loves it
- they love it
- love it wants to go back
- like it, sometimes didn't want to come home
- enjoy going, look forward to it, they have everything packed waiting to be picked up, absolutely love it
- enjoyed it, had a great time, love it
- wanted to go back
- loved it, wants to go back

Children's perception of staff

Most of the children interviewed commented over and over about how much they liked and valued the staff at Cholmondeley. Staff were referred to as awesome, kind, caring, fun, cool and nice and as children talked about them there was a real sense that they felt very close to the staff at Cholmondeley. Children also mentioned that staff treated them with respect and took the time to teach them things and to play with them. One of the older children actually referred to the staff (talking in particular about the international volunteers) as older friends. Only one child, reported feeling that the staff did not care, as this child felt staff were not able to stop the other children being bullies.

Recommending Cholmondeley to others

Carers were also asked whether they would recommend Cholmondeley to their friends. Of the 22 carers 21 answered that they would do so and in fact seven reported that they had already recommended Cholmondeley to their friends. The following comments indicate carers' main reasons for recommending Cholmondeley:

- definitely, without fail they provide support for children and parents, great communication
- yes definitely, but I don't want them to take over so there is no room for my kids
- have recommended to quite a few people - they are awesome, they give children opportunities that some of us could never afford to give our children
- definitely, I think we are extremely lucky that it is there, they should get more funding. It is fulfilling a great need in the community
- definitely, best place to send child. Cholmondeley is for children, live for children. Words cannot say how thankful we are for them
- I have, definitely worth it for your own personal sanity, I totally believe they are doing something fantastic

- yes, thank you to Cholmondeley, it is good that there is something like this

Supporting Mana

Carers were also asked to comment on what Cholmondeley did to support the mana of their family. The responses given by participants to this question reflected the staff's ability to communicate with families and to promote ongoing communication between children and their families while they were at Cholmondeley. These themes are illustrated in the comments below:

- keep you informed of what going on, they never gave up, being so child-centred
- coming home with reports about what they have done and how they have been, phone communication to let you talk to kids and know what is going on, flexibility in any situation, give me photos of kids, seek permission for use of photos etc.
- by supporting the kids
- communication between staff and parents - go extra mile to support
- didn't work with family but facilitated communication with children while at Cholmondeley flexibility about establishing communication between children and family
- involve family in events where possible
- helped it to become a normal way of life for children - kids think everyone does it. Staff become part of the family. Get to know staff, have good fun with them.
- listened to us when there were issues and worked with us to resolve them
- explained everything and made me feel relaxed about being there, friendly and informative, ring anytime, kept informed of what they were doing

Concluding comments

Overall, carers and children liked their experiences at Cholmondeley and were very positive in their feedback. Carers mentioned that they felt welcomed, that Cholmondeley was a safe and fun environment for their children which provided schooling and activities for them during their stay. Children reported enjoying learning new skills, through the many activities and school, which was a highlight for some because of the way things were done differently from their own school. Individual staff and international student helpers were regarded highly and many liked the way they were not told off if they did something wrong. There was a real sense that the children felt very close to the staff at Cholmondeley.

In general, carers classified the staff as being of a very high calibre, who gave a lot to the children and who were incredibly supportive and caring. Carers overwhelmingly reported that their children viewed their time at Cholmondeley positively. Although both children and carers were, in the majority, upbeat about Cholmondeley, they both expressed a wish for the upper age limit of 13 to be increased. Carers mentioned that they would appreciate some assistance for their older children whose time at Cholmondeley had come to an end in order to develop a plan or discuss options for them.

For children the only other negative aspect for them was the behaviour of other children, particularly bullying. Carers' other challenges with Cholmondeley included the travel distance from their homes and the cost to them for each child. Nonetheless, the vast majority of carers said they would definitely recommend Cholmondeley to others, with several already

having done so. Families reported that they felt supported by Cholmondeley staff and that they service it offers is much appreciated.

Discussion

Key research questions asked in this study:

1. What is Cholmondeley's role in the Canterbury community and the Canterbury social services sector?
2. What impact does Cholmondeley have on the ability of families to keep their children safe, and prevent issues escalating to the point where care and protection concerns arise for the child?

At times, families have considerable and multiple stressors, which may cause normal family function to cease. Types and severity of stress experienced by families varies according to the interaction of individual, familial and environmental factors (Abidin, 1992). In New Zealand alone, one third of the country's most vulnerable children are under six (Centre for Social Research and Evaluation, 2011) and it is evident that families of children at risk need support to manage stress. Respite care typically exists to provide benefit for all family members: parents receive a break from care-giving, siblings of the cared-for-child may receive more beneficial interactions with their parents and the cared-for-child receives positive social and recreational experiences.

All, including society, benefit from the prevention of family breakdown and/or a child's placement in longer term out-of-home care (Jivanjee & Simpson, 2001). The difficulty in answering the questions posed for this study is that the relationship between Cholmondeley's role in the community and social services sector and their impact on children and their family's is inextricably linked. If anything Cholmondeley is fundamental to any social services system and an acute necessity for many families and children in the region.

The place of Cholmondeley in the community

For some families experiencing significant stress or difficulties in the Canterbury region of New Zealand, Cholmondeley provides emergency and planned short term respite care for children aged 3-12 years old. Professionals consider the core business of Cholmondeley as respite care. They also maintain that it provides a unique and essential service to the families of Canterbury. Without such a service, the majority thought that the effect to the families, children, and wider community networks would result in increased stress.

The research of Armstrong and Shevellar (2006), and Boothroyd et al., (1998) supports this opinion, contending that the aims of respite care are to temporarily relieve stress, promote wellness in parents which subsequently decreases mistreatment of children and encourages family unity. Referrers or broker partners reported that the knowledge about the reliability of Cholmondeley, the structure it provided, and the forward planning of visits were seen to enhance the benefits of families having a break. Families were able to endure difficult situations safe in the knowledge that they had the support of Cholmondeley to call on or that a planned break was on the horizon.

Achieving resilience

The literature tends to support the finding that following respite care the recuperative benefits for carers typically last for a limited period of time (McNally, Ben-Shlomo, & Newman, 1999), however, in this study Cholmondeley consumers – carers and children, and professionals – staff and referral services - tend to suggest that the benefits may be lasting. While there is little consensus on how family resilience is understood and therefore how it should be measured (Kalil, 2003), in the context of New Zealand social services, both consumers and professionals in this study, agree that the unique service offered by Cholmondeley improves the resiliency of families.

There exists a perception within the Cholmondeley community that this resiliency relieves pressures for the immediate family in the short-term and increases positive outcomes for the wider community in the longer-term. For some families in the community, multiple stressors can culminate in a lack of resiliency and ability for families to cope and function as normal. Although many carers had few pre-conceived expectations about the longer term impact of Cholmondeley on their families, they described outcomes for themselves, their children and the people associated with their children that suggest that attending Cholmondeley had far-reaching effects.

Attendance of children at Cholmondeley appears to have had a two-fold benefit for families: children gained skills that allowed them to approach situations in a different way, which perhaps eased tensions that were causing stress for families prior to attendance; and carers had a much-needed break allowing them to refresh, relax and allow them to be able to cope with day-to-day life.

Carers saw Cholmondeley's role to be of vital importance to the functioning of families in the community by assisting children to develop essential social and emotional skills, which was a view also supported by the staff of Cholmondeley. The staff considered that the opportunities for personal growth enabled the children to better cope with the environment they live in, allowing children to develop resilience to help them flourish even in the face of adversity.

Providing a safe and nurturing environment

The over-all sentiment from the report of the children's impressions of Cholmondeley is extremely positive. When viewed in relation to studies of attachment theory in children, Cholmondeley provides a safe, caring and stable environment where the children can develop meaningful relationships with adults. A key component of resilience is the ability to have an important relationship with at least one adult significant other, and comments from the children about their high regard for individual staff indicate that many felt they had such a connection with them.

What it does reinforce is Ungar's (2001) research on the constructive role residential placement plays in re-ordering disordered attachment. In other words, a child's involvement at Cholmondeley is likely to alter their negative identity stories if they are exposed to, and assisted in, developing more positive social interactions. Staff reiterated this feeling by suggesting that the main outcomes identified for children of Cholmondeley were having

access to a safe place that allowed them to be children, have positive experiences, and learn skills for life.

While many referrers/brokering partners acknowledged the importance of the child having a break from their normal family environment, most perceived that this break alone was not sufficient. It was the positive interactions with adults and the opportunities for learning during each stay that was perceived to really provide the greatest benefits to children.

According to Atwool (2010) there is an assumption that a foster family model of respite care is preferred due to the preference of the children themselves to know the people they were going to be staying with. The results clearly showed that children valued the familiarity of Cholmondeley. Once overcoming the hurdle of the first visit, the on-going and continued availability of Cholmondeley was a significant advantage

Stokholm (2009) believes this to be achieved through peer culture and existing social dynamics in residential care, and building resiliency through therapeutic teaching (Hawkins-Rodgers, 2007). In addition, the children's disappointment that their association with Cholmondeley would end at the upper age limit of 13 suggests that the children were emotionally engaged with the environment and the people of Cholmondeley. According to Hawkins-Rodgers (2007) and Atwool (2006), it is this engagement which promotes successful reorganisation of attachment behaviours. It could be perceived that perhaps there is a danger that the children's attachment to Cholmondeley is greater than that to their own family; however the short-term nature of the children's visits is likely to counter that issue.

Wider implications of Cholmondeley to the community

Although it is difficult to quantitatively measure how the intervention of Cholmondeley's respite care has positively impacted families, individual accounts from families that had remained together and whose general psychological wellbeing had improved were directly attributed to Cholmondeley. These findings correlate with the studies of effectiveness of respite for parents by Bruns and Burchard (2000), and an Australian Barnardos evaluation study by Voigt and Tregeagle (1996), which highlighted high rates of family preservation after a period of emergency out-of-home respite care for at-risk children.

After their children received respite care from Cholmondeley, carers reported specific positive outcomes resulting from the skills their children had gained during their visit, such as improved social interactions, confidence developed, their mood and behaviour improved, children learnt to understand themselves better and learned how to help and support others. The relationship between the observed adaptive changes of the children and the carer's perceived impacts in the home cannot be ignored. The skills the children acquired while temporarily attending Cholmondeley provided opportunities for the families to build on these positive behaviours and experiences when children returned home.

Time out for children and adults was seen as providing an opportunity for all family members to regroup, but the change in mind set of the children from their experiences at Cholmondeley was seen to help create a different dynamic within the family when the child(ren) returned home. Some explained how they felt supported because children experienced rules and consequences from other adults which affirmed their parenting role

and gave them confidence in being able to parent. The carers benefited from hearing positive comments about their children from others. The positive experiences the children had gave them something to talk about together and made both the child and their carers feel proud of the child's achievements.

The research conducted by Bruns and Burchard (2000) suggests that the longer term implications of temporary respite support from Cholmondeley for the wider community, in particular the continued involvement of referral and social services in these family's lives, is likely to be reduced. In some cases it was reported that family disintegration was avoided as home environments became calmer and more relaxed, and they became closer as a family. In others, carers retained, or regained, the custody of their children because of improvements in the home environment. Additionally, carers became more confident in their parenting as they received positive input from Cholmondeley's staff, programmes and activities that their children were exposed to, and the social interactions they as carers experienced through the Cholmondeley community - an idea reinforced by the research of Aldgate et al., (1996).

While both staff and referrers/broker partners acknowledged that the longer term outcomes will not all be positive or straightforward for the children they work with, they suggested that another important outcome for children was to provide them with positive memories that stay with them through good and bad times.

The two main outcomes that staff perceived for families were having time out while knowing their children were safe, and having a chance to regroup. The outcomes the staff perceived for the community were in terms of the preventative benefits that result from children not getting into or causing as much trouble in the community. Corresponding to Gutman's (2008) research on delivery of resiliency-promoting interventions, the staff considered that the social interaction skills developed by children at Cholmondeley would benefit the community as a whole as children would be better geared to function in a community environment.

The use of congregate care for the purposes of respite is unusual given the assumption that a foster family type model of respite care is preferred. Atwool identified that children find one of the most important things about respite is whether or not they know people they are going to be staying with (2010). It is clear that children valued the familiarity of Cholmondeley. Once overcoming the hurdle of the first visit, continued and on-going availability is a very significant advantage that is often not available in family based respite care.

It is important to highlight the advantage of congregate care in normalising the experience of respite. In congregate care they are with others in a similar situation and this reduces the stigma for children who often have an awareness that they are perceived to be difficult. It was very clear from the children's responses that going to Cholmondeley was an enjoyable experience and this has the added advantage of significantly reducing the risk that children feel punished or rejected by the experience of respite care.

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Appendix

Interview Schedule for Referrers and Brokering Partners to Cholmondeley

1. Tell me about your service and how it works with Cholmondeley?
    - How long has your service been associated with Cholmondeley?
    - What is your role within your service?
    - Where do your referrals come from?
    - What sorts of people do you refer?
    - Why do you refer to Cholmondeley?
    - How well does this process work?
    - What other ways do you work with Cholmondeley? (i.e. what services do they provide children and families who Cholmondeley work with? i.e. ascertain if they are also Brokering partners)
    - How well does this process work?

2. What do you perceive as the core business of Cholmondeley?
    - How well does it do this?
    - What would happen if Cholmondeley wasn't there:
        i. To your workload?
        ii. To outcomes for people you refer?
    - What does Cholmondeley do/provide that other services you work with don't? i.e. point of difference from other services?

3. What is Cholmondeley's role in the community?
    - What does it do?
    - What should it do?
    - Who should it do it to or with?
    - How should the organisation act and in the best interests of whom?
    - What other services provide the same service as Cholmondeley?
        i. In Canterbury?
        ii. In NZ?

4. What is the value of having Cholmondeley in the community?
    - What difference is Cholmondeley making in Canterbury?
    - What are the benefits for children?
    - What are the benefits for families?
    - What are the benefits for the community as a whole?
    - What are the downsides for children and how could these be overcome?
    - What are the downsides for families and how could these be overcome?
    - What are the downsides for the community and how could these be overcome?
    - What does Cholmondeley do really well?

- What could it do better/more of?

5. How would you like to see Cholmondeley develop in the future?

6. Any additional comments

Interview Schedule for Cholmondeley Staff

1. What is Cholmondeley's role in the Canterbury social service sector?
2. What impact does Cholmondeley have on the ability of families to keep children safe and prevent involvement of care and protection agencies?

The interviews with Cholmondeley staff will focus on answering both questions.

To answer this question, a representation of Cholmondeley staff will be asked the following questions:

7. What is your role at Cholmondeley?
    - How long have you been in this role?
    - How long have you been associated with Cholmondeley?
    - Have you had any other roles with Cholmondeley?

8. What is the core business of Cholmondeley?
    - How well does it do this?

9. What is Cholmondeley's role in the community?
    - What does it do?
    - What should it do?
    - Who should it do it to or with?
    - How should the organisation act and in the best interests of whom?

10. What is the value of having Cholmondeley in the community?
    - What difference is Cholmondeley making in Canterbury?
    - What are the benefits for children?
    - What are the benefits for families?
    - What are the benefits for the community as a whole?
    - What are the downsides for children and how could these be overcome?
    - What are the downsides for families and how could these be overcome?
    - What are the downsides for the community and how could these be overcome?
    - What does Cholmondeley do really well?
    - What could it do better/more of?

11. How would you like to see Cholmondeley develop in the future?

12. Any additional comments

Interview Schedule for Families

3. What is Cholmondeley's role in the Canterbury social service sector?
4. What impact does Cholmondeley have on the ability of families to keep children safe and prevent involvement of care and protection agencies?

The interviews with families will primarily be focussed on answering the second question.

To answer this question, families will be asked the following types of questions once time has been spent establishing rapport and consent has been gained from family members to be involved:

- How did you get to know about Cholmondeley?
    - How did you make contact/know where to make contact?
- What other options were available to you at the time when you were deciding whether or not to have your children go to Cholmondeley
    - If appropriate, why did you choose Cholmondeley over other options?
- What sorts of options would you liked to have had available to you at the time you were making the decision whether or not to have your children go to Cholmondeley?
- What did you know about Cholmondeley before your child(ren) went there?
    - Looking back, what else you would have liked to have known?
- What did you expect would happen for you:
    - While your child(ren) were at Cholmondeley?
    - When they left Cholmondeley?
- What did you expect would happen for your child(ren)
    - While they were at Cholmondeley
    - When they left Cholmondeley?
- What actually happened for you
    - While your child(ren) were at Cholmondeley
    - When they left Cholmondeley?
- What actually happened for your children
    - While they were at Cholmondeley
    - When they left Cholmondeley
- How long have your family been involved with Cholmondeley?
    - What keeps you going back?
    - What stops you from going back?
- What was your involvement with Cholmondeley:
    - While your children were there
    - After they left
    - Now
- What were the benefits of your children being at Cholmondeley
    - For your children
    - For you
    - Your partner (if appropriate)
    - Your family/whanau
- What were the downsides of your children being at Cholmondeley

    - For your children
    - For you
    - For your partner (if appropriate)
    - For your family
- What changes did you notice in your child(ren) after they had been to Cholmondeley
    - The first time
    - Subsequent times
    - Good changes
    - Not so good changes
    - Why do you think these changes occurred?
- What changes did you notice in your family after your children had been to Cholmondeley?
    - The first time
    - Subsequent times
    - Good changes
    - Not so good changes
    - Why do you think these changes occurred?
- What changes did you notice in yourself after your children had been to Cholmondeley
    - The first time
    - Subsequent times
    - Good changes
    - Not so good changes
- What do you think would have happened if your child had not been involved in Cholmondeley
    - To your child(ren)
    - To yourself
    - Your partner
    - Your family
- What were the main things that happened at Cholmondeley/that you/your child learned from Cholmondeley that helped
    - Your children
    - You
    - Your partner
    - Your family
- How did Cholmondeley work with you to support your family/the mana of your family while your child(ren) was at Cholmondeley?
- What were the things about Cholmondeley that didn't work for you?
- What do you think your children think about Cholmondeley?
- What concerns do/did you have about your children being at Cholmondeley
- What changes do you think Cholmondeley could make to improve the way they help children and their families?
    - What would you like to see Cholmondeley do more of?
    - What would you like to see Cholmondeley do less of?
- How did you find the staff at Cholmondeley?
- Would you recommend Cholmondeley to your friends?

- If yes, why?
- If no, why not?

Interview Schedule for Children

5. What is Cholomondeley's role in the Canterbury social service sector?
6. What impact does Cholmondeley have on the ability of families to keep children safe and prevent involvement of care and protection agencies?

The interviews with children will primarily be focussed on answering the second evaluation question.

To answer this question, children will be asked the following types of questions once time has been spent establishing rapport and consent has been gained from the child to be involved:

- How come you got to go to Cholmondeley
- Who told you you were going there?
- What did you think it would be like going to Cholmondeley/What did you think would happen there?
- Was that what it was like? / How was it the same/different from what you thought it would be?
- What was it like for you when you first got there?
- What did you do when you first went there?
- What sorts of things do you do when you are at Cholmondeley?
- How are those things different from what you do at home?
- How do the things you do/learn at Cholmondeley help you at home?
- What are the things you like most about going to Cholmondeley?
- What the things you don't really like about going to Cholmondeley?
- What were the staff/people that looked after you like at Cholmondeley?
- What were the other children like?
- How many times have you been to Cholmondeley?
- What was it like for you to leave Cholmondeley?
- Where did you go when you left Cholmondeley? What was it like there?
- If gone home – what was it like to be home? Any changes since before you went to Cholmondeley?
- Would you like to go back to Cholmondeley? Why/Why not?
- Why do you think other children go to Cholmondeley?
- Do you think it is a good place for children to be able to go? Why/why not?
- What changes would you make to the things you do/things that happen at Cholmondeley?

Cholmondeley

Value Our Children

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