Relationships Matter?

Multiple perspectives on children’s attachment experiences in group home settings

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ABSTRACT

Children who are admitted into residential care often have a history of abuse, neglect, experienced trauma and have had multiple failed placements. Caring for these children can be challenging due to their complex behavioural issues. Using an attachment framework and the evidence-base of neuroscience, this study looks at what works for children with a history of trauma.

This study explores what matters to children living in residential group homes through hearing the voices of eight children residing in three group homes in New Zealand. The children interviewed were within the age group of 10 to 17 years old. Using semi-structured in-depth interviews, children were interviewed regarding their experience of care and the importance of relationships within group homes. In order to gain multiple perspectives on this topic, six biological parents and two legal guardians of children were interviewed and focus group discussions were also held with staff members from the three various group homes.

The findings from this study and knowledge from neuroscience indicates that children in residential care need to experience relationships as a secure-base in order to heal from their traumatic experiences. This research recommends the importance of relationship-based interventions and trauma-informed practice while working with children in residential care settings.
Acknowledgements

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“If i have seen further it is by standing on the shoulders of giants” – Sir Isaac Newton
# Table of Contents

<table>
<thead>
<tr>
<th>Title Page</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>v</td>
</tr>
<tr>
<td>List of Figures, Graphs and Diagrams</td>
<td>ix</td>
</tr>
<tr>
<td>List of Abbreviations</td>
<td>x</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
</tbody>
</table>

## Chapter One: Setting the Scene
- Introduction | 5
- New Zealand Legislation | 5
- Definition of Care and Protection | 5
- Pathway into care | 6
- Range of care placements | 6
- Terminology | 10

## Chapter Two: Literature Review
- Introduction | 11
- The Origins of Attachment Theory | 11
- Attachment theory and its relevance to this thesis | 12
- The attachment system | 13
- Internal working Model | 14
- Application of attachment behaviour | 16
- Attachment styles | 17
- Application of attachment styles | 19
- Definition of trauma | 20
- The role of attachment in brain development | 21
- The effects of neglect, abuse, and traumatic experiences | 25
- The brain under threat | 27
- The current SGH model | 28
- Critique of the current model | 32
- Residential Programmes | 35
- Weaving the attachment and behavioural model together | 38
Chapter Three: Methodology

**Part A - Theoretical Framework**
- Paradigm and research question 45
- Epistemology – the theory of knowledge 47
- Practice-based research, action research and social research 48

**Part B - Methodological Approaches**
- Case study inquiry 52
- Narrative inquiry 53
- Research methods 54
- Validity procedures 54
- Sampling procedures 56
- Interviews 57
- Focus Group 58
- Settings interviews were held 58

**Part C - Data Analysis Section**

**Part D – Access to participants and ethics section**
- Ethics approval 60
- Access to participants 60
- Informed consent 61
- Limits of confidentiality 62
- Storing data 62
- Dual role 62
- Ethical considerations for interviewing colleagues 63
- Children as research participants 63
- Children’s informed consent 64
- Safety issues 65
- Strengths and limitations of research 65

Summary 66

Chapter Four: Findings

**Part A – Findings from the children interviews**
- Theme One: Children’s admission into group homes 68
- Theme Two: Importance of family relationships 71
- Theme Three: Relationships with staff 74
- Theme Four: The SGH environment and sub theme food 79
Theme Five: The importance of Inclusion and involvement 82
Theme Six: Peers, mix of home 84
Theme Seven: Gender 86
Theme Eight: Points system 87
Theme Nine: Goal setting 89
Theme Ten: Social workers role 91
Theme Eleven: Staffed facility 92
Theme Twelve: Structure and rules 93
Theme Thirteen: Moving to independence, need for flexibility 97
Theme Fourteen: Transition from group home 98
Theme Fifteen: What can make it better? 99
Theme Sixteen: Progress, what made the difference 100

Part B – Findings from the parent interviews 102
Parents view of themes raised by children 102
Theme Seventeen: Parents on-going issues 135
Theme Eighteen: The effect of multiple placements and the message of unconditional care 135

Part C – Findings from staff focus group discussions 140
Staff’s view on themes raised in parent and children interviews 141

Summary 160

Chapter Five: Discussion 162
Healing traumatised brains from the base up 163

Healing traumatised brains from the base up: The brainstem 166
The importance of relationships 168
Theme of parents on-going issues 170
Summary of section 171

Healing traumatised brains from the base up: The midbrain 172
Theme of admission 174
Theme of food 175
Perception of SGH theme 177

Healing traumatised brains from the base up: The limbic system 179
Functions of the limbic system 180
The function of the amygdala 181
The effects of trauma on the limbic system and amygdala 181
The importance of attachment relationships – contact with birth family 182
Attachment relationships – relationship with social worker 185
Attachment relationships – relationships with peers in the home 186  
Enhancing emotional regulation 188  
Emotionally intelligent workers 189  
Integrating the ‘upstairs’ brain 190  

**Healing traumatised brains from the base up: The cortex** 191  
Functions of the cortex 191  
Cortical modulation ratio 193  
Managing behaviour from an attachment-based and neuroscience perspective 194  

Summary of chapter 202  

**Chapter Six: Recommendations and Conclusion** 203  
Recommendations for healing traumatised brains from the base up: 203  
Brain stem  
Recommendations for healing traumatised brains from the base up: 205  
Midbrain  
Recommendations for healing traumatised brains from the base up: 207  
Limbic system  
Recommendations for healing traumatised brains from the base up: 210  
Cortex  
Other recommended evidence-based and trauma-informed models 211  
Recommended therapeutic clinical model for residential care 213  
Conclusion 215  

**Bibliography** 216  

**Appendices**  
Appendix A. Consent forms and information sheets for research participants 245  

Appendix B:  
Recommended therapeutic clinical model for residential care 257  

Appendix C: University Ethics Application 258  

Appendix D: CYF Research Access Committee correspondence 268  

Appendix E: Interview Questions Outline 294  

Appendix F: Ngai Tahu Consultation 297
List of Figures, Graphs and Diagrams

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1:</td>
<td>The human brain, divided into its four interconnected areas</td>
</tr>
<tr>
<td>Figure 2:</td>
<td>The Acute Response to Threat</td>
</tr>
<tr>
<td>Figure 3:</td>
<td>Triangulation method</td>
</tr>
<tr>
<td>Figure 4:</td>
<td>The brainstem</td>
</tr>
<tr>
<td>Figure 5:</td>
<td>The midbrain</td>
</tr>
<tr>
<td>Figure 6:</td>
<td>The limbic</td>
</tr>
<tr>
<td>Figure 7:</td>
<td>The cortex</td>
</tr>
<tr>
<td>Graph 1:</td>
<td>Summary of children and parent/guardian themes 1-10</td>
</tr>
<tr>
<td>Graph 2:</td>
<td>Summary of children and parent/guardian themes 11-19</td>
</tr>
<tr>
<td>Diagram 1:</td>
<td>Recommended therapeutic clinical model for residential care</td>
</tr>
<tr>
<td>Diagram 2:</td>
<td>Artwork by anonymous child</td>
</tr>
</tbody>
</table>
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ARC</td>
<td>Attachment, Self-Regulation and Competency</td>
</tr>
<tr>
<td>CPS</td>
<td>Collaborative Problem Solving</td>
</tr>
<tr>
<td>CYF</td>
<td>Child Youth and Family</td>
</tr>
<tr>
<td>MSD</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>MTFC</td>
<td>Multidimensional Treatment Foster Care</td>
</tr>
<tr>
<td>NMT</td>
<td>Neurosequential Model of Therapeutics</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PPC</td>
<td>Positive Peer Culture</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RAC</td>
<td>Research Access Committee</td>
</tr>
<tr>
<td>RLF</td>
<td>Relational Learning Framework</td>
</tr>
<tr>
<td>SAGE</td>
<td>Safety, Affect regulation, Grieving and Emancipation</td>
</tr>
<tr>
<td>SGH</td>
<td>Supervised Group Home</td>
</tr>
<tr>
<td>TFH</td>
<td>Teaching Family Home</td>
</tr>
</tbody>
</table>
Introduction

New Zealand is a beautiful country, with remarkable mountains, pristine waters and untouched nature. Yet, beneath the beauty lies some grim realities.

New Zealand has the fifth worst child abuse record out of 31 OECD Countries (The Glenn Inquiry, 2014). Every hour, two children in this country are physically, sexually or emotionally abused (Ministry of Social Development, 2011). In the year ending June 2013, Child, Youth and Family received 148,659 notifications (reports of concern), including family violence referrals from police (Child Youth and Family, 2013). 22,984 of these notifications were substantiated findings of emotional, physical, sexual abuse and neglect (Child Youth and Family, 2013).

The sad fact is children who have suffered abuse and neglect especially in their early years are more likely to have poor health, fail at school, abuse alcohol and drugs, commit crimes, end up in prison, become a parent at a young age, and the cycle of abuse repeats itself (Kelley, Thornberry, & Smith, 1997). This has to stop. The cycle of abuse must be broken.

This thesis aims to bring change and hope to the lives of children who have suffered maltreatment. I am a social worker working alongside children who have suffered abuse and neglect in their early years. Approximately ten to fifteen years later, these children have grown up into teenagers but continue to live with the consequences of their traumatic experiences and the pain from their past. These children were living in residential group homes called supervised group homes in New Zealand when I interviewed them for this thesis.

Children who are admitted into residential group homes have experienced a history of abuse, neglect or trauma and many have had multiple failed placements. Caring for these children can be challenging due to the complex behavioural issues they present with. Through their experiences of maltreatment and multiple failed placements, many of these children form beliefs about themselves that they are unloved, rejected and unworthy. They often view relationships as unreliable and unsafe
and these beliefs trap them in a continuous negative cycle. As a social worker working alongside these children, I found myself asking some tough questions like “how do you look after children who don’t know what it is like to be cared for or loved? How can we make a lasting positive impact to their lives? How do we break the cycle of abuse?” These complex questions motivated me on this research journey. The essence of social work is about making positive change, bringing hope and empowering the vulnerable. This thesis is a practice-based research project that echoes the importance of making a positive difference in the lives of New Zealand’s most vulnerable children.

Using an attachment framework and the evidence-base of neuroscience, this study looks at what works for children with a history of trauma. Relationships matter? My research looks at the importance of children living in residential group homes re-experiencing ongoing relationships that are positive, consistent and nurturing. When children who have suffered abuse and neglect experience repeated trusting relationships over time, it changes their negative beliefs about themselves from “I’m unloved and rejected” to “I am loved”, “I am cared for”, and “I am wanted”. It is about finding opportunities to re-shape the image of how they view themselves and create positive cycles of trusting relationships.

This study explores what matters to children living in residential group homes through hearing the voices of eight children residing in three supervised group homes in New Zealand. Using semi-structured in-depth interviews, children were asked about their experience of care and the importance of relationships within residential group homes. In order to gain multiple perspectives on this topic, eight parents or guardians of children were interviewed and focus group discussions were held with staff members from the three group homes.

This project explores how children experience relationships while residing in a group home and how we could use ongoing positive relationships as a form of treatment when working with children who have suffered abuse and neglect. The findings from this study and knowledge from neuroscience indicates that children in residential care need to experience relationships as a secure-base in order to heal from their traumatic experiences. This research recommends the importance of relationship-based interventions and trauma-informed practice while working with children in
residential care settings.

**Thesis outline**

In chapter one, ‘setting the scene’, I place a context around my thesis and explain New Zealand’s child welfare legislation that allows the state to intervene if there are care and protection concerns. The concept of supervised group homes is explained and I highlight how the supervised group home provides care for children within the continuum of care framework in New Zealand.

In chapter two the ‘literature review’ chapter is where I provide a context of how my piece of research fits into the literature relevant to my research topic. I discuss attachment theory and demonstrate the link between attachment theory and the evidence-base of neuroscience. A critique of the current therapeutic model implemented at the supervised group home is provided. I also review models that have been implemented in residential care internationally and discuss the gap in New Zealand research for children in care.

Chapter three the ‘methodology’ chapter has four parts. I outline the theoretical framework that underpins my research through exploring my paradigm and the research question that initiated this study. I go on to establish my epistemological viewpoint and discuss the elements of practice-based and social work research in this project. The methodological approach used in this thesis is highlighted. I then outline the data analysis methods used and emphasise the ethical considerations taken into account for this research project. Finally, the strengths and limitations of the research project are discussed.

Chapter four is where I present the findings from the interviews with the children and parents or guardians of the children in thematic categories. I also present the findings from the two focus groups held with staff members who work at the supervised group homes.
In chapter five, I answer the research question by integrating the findings from the interviews with children, parents and staff members with the knowledge learnt from attachment theory and the evidence base of neuroscience. To illustrate how the findings from the interviews and the knowledge from the literature reviewed link together, I structure this chapter according to how the brain develops sequentially from the brain stem up to the cortex.

Finally, in chapter six I summarise the recommendations for a residential context, highlighting how attachment theory and neuroscience can be implemented into practice in residential settings. In this chapter, I re-cap the main themes from the findings chapter and structure the recommendations for practice in the same way as the discussion chapter; according to how the brain develops sequentially from the brainstem up to the cortex. I conclude this chapter with recommendations of evidence-based models that we can adopt into the residential context.

I turn now to a discussion of how supervised group homes fit within New Zealand’s continuum of care.
Chapter One
Setting the Scene

Introduction

In this chapter, I set the scene for my thesis by giving a context around New Zealand’s child welfare legislation that allows the state to intervene if there are care and protection concerns. I also explain the concept of supervised group homes and outline how the supervised group home provides care for children within the continuum of care framework in New Zealand. Finally, terminology used in this thesis is also clarified.

New Zealand Legislation

The Children, Young Persons and Their Families Act 1989 is New Zealand’s child welfare legislation that determines how the state can intervene with a child or young person who is in need of care and protection or who is offending against the law (Children Young Persons and their Families Act, 1989). The Act has two main divisions, care and protection and youth justice. The act applies to young people up to age 17 years of age. It defines a ‘child’ as a boy or girl under the age of 14 years of age and a ‘young person’ as a boy or girl over the age of 14 years.

The two important principles of the act are that the interests of the child or young person is paramount (Section 6, Children Young Persons and their Families Act, 1989) and secondly, the family should participate in decision making and be empowered to care for its children and young people. Child, Youth and Family (CYF) is the statutory department that implements the act in New Zealand. The act gives permission for CYF to intervene if a child is in need of care and protection.

Definition of Care and Protection

Section 14 (1) (a) to (i) of the Children, Young Persons, and Their Families Act 1989 defines what it means if a child or young person is in need of care and protection. I have decided to focus on section (1) (a) and (b) of the act as these are the two most common grounds leading to state intervention in children’s lives. Section 14 (1) (a) states that a child is in need of care and protection when a child or young person is being, or likely to be, harmed (whether physically or emotionally or sexually), ill-
treated, abused, or seriously deprived; and Section 14 (1) (b) the child's or young person's development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable (Children Young Persons and their Families Act, 1989). Care and protection concerns are raised if there is belief that a child or young person is at risk of harm, if their behaviours are harming themselves or there are concerns that their behaviours may cause harm towards others.

Pathway into care

On the grounds specified in section 14(1) of the Act, the court may, on application, make a declaration under section 67 that a child or young person is in need of care and protection (Children Young Persons and their Families Act 1989). Where the court makes a declaration under section 67, in relation to a child or young person, it may make an order (section 101) placing that child or young person in the custody of the chief executive, an iwi social service, a cultural social service, the director of a child and family support service or any other person (Children Young Persons and their Families Act, 1989).

Range of care placements

There are a range of care placements provided for children or young people who are in need of care and protection and who are not able to live with their family/whanau in New Zealand. The type of care placements matches the level of need (low, moderate, high or intensive) with an appropriate option for care.

On the lowest scale, children or young people will live at home with family/whanau or at home with kin care. As the needs of these children and young people increase, there is a greater need for more specialist and therapeutic services. On the moderate scale, children are placed with caregivers who are trained. The next level of care options are for children with ‘high’ needs. Caregivers and staff provide trained and specialised care for children and young people on this level. The highest level provides care options for children with ‘intensive’ needs. The placements provided on this level are specialist services that provide therapeutic interventions.

In New Zealand, Supervised Group Home (SGH) provides care options for children and young people who have high to intensive needs. The SGH sits between the
trained level of care provided for by foster carers and the specialised and therapeutic levels of care provided by residential programmes and CYF youth justice or care and protection secure residences. In New Zealand, SGHs are managed by care and protection residences and come under the umbrella of residential care.

Background of Supervised Group Homes (SGH)

Children who require residential care in SGHs or secure residences are amongst the most complex in New Zealand. The majority of these children have experienced trauma, abuse and neglect and by the time they enter residential care, they often have complex needs and challenging behavioural issues (Child Youth and Family, 2010c).

In 2010, the government highlighted a gap in the care continuum in New Zealand for children aged between 12 and 17 years old with complex behavioural issues. In order to meet the need of children in this age group, thirteen CYF SGHs were started in various parts of New Zealand (Bennett, 2010).

How children are admitted into SGHs

When a decision is made to place a child or young person in a CYF SGH, it is often a situation where the child or young person has complex needs that cannot be met by their family/whanau/kin placements or CYF foster care (Child Youth and Family, 2013). These children and young people are admitted into SGHs as they require intensive supports in order to keep them safe (Child Youth and Family, 2013).

Before a child is admitted into the SGH, the child’s social worker would have to complete a referral to the CYF regional hub for high needs placements (Child Youth and Family, 2010b). The regional hub manages referrals, applications and placements to CYF’s care and protection residences and SGHs. The hub consists of practice advisors, clinical practice leaders from residences and care services managers within the region. The regional hub can provide advice and support options for children and young people with complex or high needs. Once the regional hub approves the referral to a SGH, a group impact assessment is convened for the child.

The group impact assessment is an important tool in determining the suitability of a child or young person being placed in the SGH, and for analysing and managing the group dynamics within the home (Child Youth and Family, 2010b). The group
impact assessment is completed by the team leader of clinical practice as part of the process for assessing the child or young person’s suitability for a SGH placement. The group impact assessment takes into consideration the following:

- Gender, age and developmental needs of the young people in the home.
- Strengths, vulnerability and risks of the young people.
- Existing peer relationships and any conflicting group behaviours and attitudes which may arise (Child Youth and Family, 2010b, p. 15)

Once the group impact assessment is completed and SGH placement has been recommended as a suitable placement for the child or young person, planning for a child or young person’s entry is then made with the child’s social worker, team leader of the SGH and the family engagement worker of the SGH (Child Youth and Family, 2010b).

**Purpose and Aim of the Supervised Group Homes**

All children who reside in CYF SGHs are in the custody of the chief executive and often have a significant history of care and protection issues. The primary aim of the SGH is to provide quality care and support to address children’s complex behavioural issues (Child Youth and Family, 2010c). The structured programme in the group home is designed to decrease problem behaviours and to help the child develop pro-social behaviours with the aim of transitioning them to less intensive and supervised care settings (Child Youth and Family, 2010c).

The SGHs operate 24 hours a day, 7 days a week (divided into three shifts). Children and young people are cared for day and night, on weekends, public holidays and school holidays (Child Youth and Family, 2010b). The SGHs are not a secure facility. While the physical features of the SGH differs from home to home, all the SGHs have communal living, dining and kitchen areas, outdoor areas and spaces allocated for meetings. Each child or young person has their own bedroom when they reside at the SGH.

Each SGH can have a maximum of five children at one time. On each shift, there are two staff members working, making the staff to children ratio 2:5 when a
home has full occupancy. At the time when the interviews were held, majority of the SGHs had single gendered occupancy.

While the children are residing in the supervised group home, they are expected to be in school or training during the day. The staff will also work on each young person’s individual plans for the future and help support them in gaining necessary skills for life (Child Youth and Family, 2010b).

In the next chapter, I will discuss the therapeutic model and programme currently utilised in the SGH in greater detail.

Practitioner-researcher role

While we are setting the context for this thesis, it is important to mention that while I was completing this research project, I was working in one of the SGHs as the family engagement worker. Working in the SGH as the family engagement worker alongside vulnerable children sparked an interest in me undertaking this practice-based research project. I elaborate on the dual role I had as an employee of CYF and as a student researcher in the methodology chapter.

Terminology

In this thesis, I have chosen to use the term ‘child’ or ‘children’ to refer to both children and young person even though some of the participants may have been over the age of 14 years old. I have done this to protect their anonymity and to provide consistency throughout the thesis.

Staff members who work alongside the children at the SGH providing mentoring, support and care for them are known as care workers. However, as some of the participants interviewed had other roles in the home such as team leader, family engagement worker, senior care worker and residence manager, I have chosen to use the generic term ‘staff members’ to encompass the various roles.

While there is a diverse range of language describing children not living with their family of origin, I have chosen to refer to children’s family of origin as birth families and the term ‘parent(s)’ refers to the child’s birth parents. The term ‘guardian’ used in this thesis refer to the child’s legal guardian. According to section 15 of the
Children, Young Persons, and Their Families Act 1989, a guardian is someone whom the law has given all duties, powers, rights and responsibilities to make major decisions regarding a child or young person’s upbringing. This includes decisions regarding personal names, education, housing, travel, religion and health care. Under section 110 of the Children Young Persons and their Families Act 1989, the Court can appoint a guardian, which may include the Chief Executive of the Ministry of Social Development (Children Young Persons and their Families Act, 1989).

In the next chapter, I review the literature and discuss how my piece of research fits into the literature relevant to my research topic.

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¹In November 2013, a review of Supervised Group Homes was conducted by Child, Youth and Family and the outcome of the review was that only four out of the thirteen homes were to remain operating as Supervised Group Homes. Some of the Supervised Group Homes were converted to Teaching Family Homes and some as homes needed for emergency placements.
Chapter two
Literature review

Introduction

In this literature review chapter, I provide a context of how my piece of research fits into the professional literature on my research topic. I start off this chapter by discussing the main concepts of attachment theory. Through the lens of attachment theory, the meaning of attachment styles and importance of understanding the different attachment styles of children living in group homes will be explored. I then demonstrate how neuroscience provides an evidence-base for attachment theory. I explore the definition of trauma and pain-based behaviours, and argue the importance of therapeutic programmes understanding the effects of trauma. A critique of the current model implemented at the supervised group home is provided. Literature that links attachment theory and complex behaviours of children residing in group home settings is reviewed. I will then discuss how the literature translates attachment theory into practice with particular references to the residential care. I then review other models that have been implemented in residential care internationally. Using the outline stated above, I will highlight how the current research has created a gap for my research topic and how my research topic will help in filling that gap.

The origins of attachment theory

Attachment theory is a theory of child development that emphasises the impact of early relationships on the child (Golding, 2008). The theory suggests that the child’s relationship with their primary attachment figure influences subsequent development and their capacity to form relationships (Golding, 2008). Attachment theory was founded by John Bowlby (Bowlby, 1969) and was expanded by Mary Main (Main & Solomon, 1986). During the time when John Bowlby began his work, institutional childcare was regularly used when children were not able to be cared for by their families. After graduating, Bowlby performed volunteer work at a school for maladjusted children. During this time, he had experiences with two children who sparked his interest in attachment theory. One child was socially isolated, affectionless, was expelled from his previous school for stealing and had no stable maternal figure
(Bretherton, 1992). The other child was an anxious boy who was around 7 or 8 years old who followed Bowlby around constantly (Bretherton, 1992). Bowlby began to observe how early relationships influence behaviour and personality development. Furthermore, in the 1950s, new-born babies were separated from their mothers for weeks at a time and mothers were restricted from visiting their new-born babies in hospital (Bowlby, 1973/1998). Bowlby challenged the common belief during that time that babies do not experience separation and loss and developed his interest on how separation and loss affects child development. From its origins, attachment theory attempted to understand behaviour within the environment.

**Attachment theory and its relevance to this thesis**

Attachment theory places an importance on a child’s earliest relationships and how that influences their social, emotional development and ability to form close relationships later on in life (Golding, 2008). Infants are born with a biological predisposition to form relationships from which they can experience safety, comfort and ensure survival (Howe, 2005). It is through the early experience of attachment relationships that a cognitive model (internal working model) develops (Bowlby, 1988). The internal working model forms a blueprint for how they view themselves and relationships around them. Attachment theory seeks to understand behaviour within relationships and the environment.

This theory has implications for children growing up in out-of-home-care as children living in out-of-home-care arrangements such as foster care and residential care have had disruption of early relationships and separation and loss from their birth families (Golding, 2008). I have chosen to use attachment theory as the theoretical framework for this thesis as it can guide our understanding of the effects of early abuse, neglect, separation and loss on the impact it has on later development. Attachment theory can enable us to see how early adverse experiences impacts on current behaviours. I will continue to elaborate on the main facets of attachment theory and how it links in well with my research project.
The attachment system

You hear the sound of your baby crying. It has been about three hours since he was last awake. Is my baby hungry, when did he last have a feed, is my baby in pain or is it wanting some reassurance from me? These are some of the questions that race through your mind as your instinctively approach your baby to find out if he is okay. You respond to the baby’s crying by approaching the cot and saying “It’s okay, mummy’s here, you must be feeling hungry are you?” You then pick up your baby up, comfort him and feed him. Your baby’s crying stops as soon as you begin to comfort him.

The scenario above is an illustration of attachment theory. Attachment theory, is a protective system where vulnerable infants have the ability to sense danger or threat and seek protection (Howe, 2005). All mammals are born with an attachment system which is nature’s way of survival and protecting the young and vulnerable.

Between six to nine months of age, children develop a range of attachment behaviours they can use to gain proximity to their primary attachment figure (Golding, 2008). The attachment system is a behavioural system which is activated when an individual is in need, distress or feels threatened or in danger (Howe, 2011). In the case of the illustration above, the baby was feeling hungry and in need of being fed. The baby’s attachment system was activated by setting in motion attachment behaviours to achieve the goal of gaining physical or psychological proximity with a caregiver who is able to provide safety and protection (Howe, 2011). Crying, whining, fussing, are forms of attachment behaviour designed to signal to the caregiver to respond (Howe, 2005).

To say a child is attached to or has an attachment to someone means that the child is “strongly inclined to seek proximity to and contact with a specific figure in certain situations, notably when frightened, tired or ill” (Bowlby, 1991, p. 371). Bowlby believed that the quality of attachment in the early stages of life had an impact later on in life.

Sadly, not all babies’ needs are met in the secure way like the illustration above. Some babies are left to cry for hours in their cot unattended because their caregiver is unavailable to meet their needs in a consistent and responsive manner due to issues such as alcohol or drug abuse, mental health issues or their own history of trauma and maltreatment. This scenario of babies being left unattended in a cot for hours, what we
know as neglect, is a common historical experience of children who reside in care and protection supervised group homes.

As mentioned in the previous chapter, all children who are admitted into SGHs have need for care and protection. Often, children who have experienced abuse and neglect fail to form secure attachments early in life which often has a negative impact on behaviour in later childhood and throughout their life (Moore, Moretti, & Holland, 1997). When working with children with complex behavioural issues, the underlying reasons of why these behaviours exist cannot be ignored. This means that it is important to take into account the historical issues that have contributed to the present behaviours (Levy, 2000). Attachment theory helps us understand the adverse experiences that these children have been through, and provides a framework for understanding their current behaviours. This concept will be explored further in the literature review.

Internal working Model

Attachment theory holds the view that mental representation of early attachment relationships is developed into a cognitive model, what Bowlby called the internal working model (Golding, 2008). Based on the nature of early attachment patterns with primary caregivers, children construct beliefs about the self, others, and the relationship between self and others (Howe, 2005).

How the internal working model is formed

The internal working model of the self, others and relationships are constructed through repeated experiences and interaction (Holmes, 2014). The mental representation of the self and others are developed through memories, experiences and feelings that occur in relationships, predominantly with the attachment figure during times of need (Howe, 2005). The internal working model becomes a part of a child’s personality around the age of three and affects their view of the world and future interactions with others (Schore, 2000).

It is important to understand how early experiences creates a road map for how relationships are viewed in the present (Holmes, 2014). Young children learn about the self and others as they relate with their attachment figures (Howe, 2011). The quality of
these close relationships shapes not only how the self, others and relationships are viewed and understood during childhood, but also in adulthood (Howe, 2011).

Secure attachments and internal working model

The child whose caregiver is caring, loving and consistently responsive is likely to approach the world with confidence and trust (Howe, 2011). A caregiver who provides nurturing, unconditional love will develop a child with a secure attachment. Children with a secure attachment will store an internal working model of the self as worthy of love and care and will bring these beliefs into all other relationships (Holmes, 2014). Children with secure attachments will perceive the self as “I am good, I am wanted, I am worthwhile, and I am lovable”. They will perceive caregivers as “appropriately responsive to my needs, sensitive, caring and trustworthy”, and will perceive life as “the world is safe, life is worth living” (Levy, 2000).

Insecure attachments and internal working model

Conversely, the child whose caregiver is frightened or frightening, indifferent and unresponsive will approach the world with fear. The world will be viewed as unpredictable, unsafe and unreliable (Howe, 2011). Children with an insecure working model will view their caregiver as dangerous and view relationships around them with caution, and their view of themselves may be one of being unworthy of love and attention (Holmes, 2014). Children with insecure attachment styles will perceive the self as “I am bad, unwanted, worthless, helpless, and unlovable”. They perceive caregivers as “unresponsive to my needs, insensitive, hurtful and untrustworthy”. Life is understood by them to be “unsafe and life is not worth living” (Levy, 2000). I will explore the different attachment styles in a later section of this literature review.

The purpose of attachment behaviour.

Attachment behaviour is when the child engages in any form of behaviour to gain proximity to the caregiver (Bowlby, 1991). Attachment behaviours and strategies are efforts to “thrive and survive” (Crittenden, 2008, p. 16) especially when threat or danger is experienced. These attachment behaviours are what Bowlby calls a “safety-regulating system” (Bowlby, 1991, p. 374). The safety-regulating system is a series of activities the child uses to get the parent to respond. The goal of attachment behaviour
is to gain proximity to caregiver at times of need, so that safety can be increased (Howe, 2011).

In order to increase parental responsiveness, children increase their displays of distressed behaviour by crying, fretting, whining, fussing, displaying attention seeking behaviours or being very demanding (Howe, 2005). They “hyperactivate their attachment behaviour in order to get noticed, break into the parent’s preoccupied state, and thereby overcome the caregiver’s failure to be aware and respond” (Howe, 2005, p. 36).

An example of how children use attachment behaviours to get parents to respond is when a child is running, trips and falls down. The child starts to cry immediately. The crying grabs the attention of the caregiver who approaches the child to find out if he is hurt. A caregiver with a secure attachment style will be attuned to the child’s distress signals will comfort the child by checking his knee and respond giving the hurt knee a ‘magic’ kiss that makes the pain disappear. The child is comforted, gets up and starts running again. In this example, the child’s attachment behaviour of crying was triggered by a sense of distress (falling down and hurting knee). The goal of the attachment behaviour was to get the caregiver to come over and respond by comforting the child, which resulted in the child feeling safe and his distress levels decreasing. Attachment behaviour, therefore, helps the child regulate their sense of safety by reducing the risk of harm they are experiencing. The aim of attachment behaviours is for the child’s anxiety to be allayed and sense of security to be increased (Howe, 2005).

**Application of attachment behaviour**

The attachment framework provides a foundation for understanding the complex nature of behaviours that the children exhibit in SGHs. Bowlby describes these behaviours that surface in times of distress as attachment behaviours (Bowlby, 1991). It is important to have an understanding that attachment behaviour is organised to increase protection under situations of danger (Crittenden, 1999). Often, children who have not experienced secure attachments especially during their formative years display distressed behaviour when they feel threatened or unsafe. Instead of viewing these behaviours as ‘attention-seeking’ behaviours, they need to be viewed as
‘attachment-seeking behaviours’. Attachment theory informs us that during these times caregivers need to respond appropriately to their need for safety rather than further ‘punishing’ the children for their behaviour (Moore, et al., 1997).

**Attachment styles**

Another aspect of attachment theory that is important to discuss is the concept of attachment styles. An understanding of the different attachment styles children have in the SGH gives understanding to the types of behaviours that they exhibit.

As mentioned above in the discussion of attachment behaviour, children organise their behaviour to gain proximity to caregiver to achieve a sense of security (Howe, 2011). Each pattern of attachment behaviour, is a strategy adapted to suit different parenting systems (Howe, 2011). Children adopt attachment strategies so that they can stay close and connected to their attachment figure at times of intense negative arousal no matter what type of caregiving they receive (Howe, 2011). These attachment strategies, known as attachment styles were developed by Mary Ainsworth in her “strange-situation experiment”.

Ainsworth and Bell (1970) expanded upon Bowlby’s work and completed the “Strange Situation” study which involved observing children’s response to a situation where they were briefly left alone and then reunited with their mother (Ainsworth, & Bell, 1970). These children were between the ages of 12 and 18 months and were observed for twenty minutes each. Four different aspects of the children’s behaviour were observed through this procedure. Firstly, how much exploration a child participates in. Secondly, how the child reacts when the caregiver departs. Thirdly, how the child reacts when alone with the stranger and lastly how the child responds and behaves when reunited with the caregiver.

Based on these observations, Ainsworth argued that there were three major styles of attachment- Secure attachment, ambivalent-insecure attachment and avoidant-insecure attachment (Ainsworth, & Bell, 1970). Later on, Main and Solomon (1986) added a fourth attachment style known as disorganised- insecure attachment which
children who have experienced abuse and neglect often display (Main & Solomon,
1986).

**Secure attachment style**

Children with secure attachment styles approach their carers with confidence
knowing that their feelings of distress and upset will be responded to unconditionally
with comfort and understanding (Howe, 2011). Their caregivers provide sensitive,
loving, available and consistent parenting and the children develop a secure attachment
style where they are able to explore freely and seek their parent without avoidance or
resistance (Schacter, Gilbert, & Wegner, 2011). It is not that these caregivers don’t
upset the parent-child relationship; there may be times where the parent ignores the
child, misunderstands the need or unintentionally distresses the infant. However, when
that occurs, the caregiver recognises the distress the child is experiencing and the
disruption in the parent-child relationship that is occurring and the caregiver is sensitive
enough to repair the relationship that is under temporary stress (Howe, 2005).

**Insecure avoidant style**

Children with insecure avoidant attachment styles show minimal displays of
emotion. Rather than seeking comfort or contact with their caregiver, they look or turn
away (Ainsworth, Blehar, Waters, & Wall, 1978; Howe, 2005). From the view of the
child, the caregiving relationship is rejecting and unresponsive to distress (Crittenden,
1999). When children display distress it appears to annoy and irritate the caregiver.
Rejection is therefore not of the child, but when the child is being vulnerable, needy or
reliant (Howe, 2005). Displays of attachment behaviour is often rebuked and infant’s
needs and anxiety is dismissed (Howe, 2011). Children with avoidant attachment styles
adapt their attachment behaviour by minimising affect and downplaying or impeding
their feelings of need (Howe, 2005). These children often de-activate their attachment
behaviour in order to gain parental proximity (Howe, 2005).

**Insecure ambivalent style**

Children with insecure ambivalent attachment styles need to hyperactivate their
attachment behaviour in order to be noticed by the caregivers (Howe, 2005) “who are
insensitive, unreliable and inconsistently responsive” (Howe, 2011, p. 45). The
attachment behaviour is exaggerated and overplayed in order to get the caregiver to notice the child’s need or distress (Howe, 2011). The attachment strategy is known as ambivalent because the child wants proximity but it is often mixed with angry behaviour (Ainsworth et al., 1978). When the child manages to grab the attention of the caregiver, “the child does not trust the parent to remain involved and resists being soothed, comforted and regulated” (Howe, 2005, p.36). If the hyperactivated attachment strategy fails, the individual experiences rejection and feelings of aloneness. This does not last long before the individual creates some form of crisis or drama in order to generate attention and to get noticed by others (Howe, 2005).

Disorganised attachment style

Main and Solomon (1986) added a fourth attachment style to Mary Ainsworth’s three original attachment styles known as disorganised-insecure attachment which children who have experienced abuse and neglect often display. The disorganised attachment style as the term disorganised indicates is fearful, odd and overtly conflicted (Ainsworth et al., 1978). Children who develop this attachment style have a lack of coherence and no organised strategy for dealing with the stress of separation (Ainsworth et al., 1978). Disorganised attachment style is caused by frightening or frightened parent behaviours (Howe, 2005). Abusive, violent, drunk or depressed carers can frighten children. Carers who have unresolved trauma themselves can be frightened by caregiving as it triggers fear and distress for the caregiver when a dependent and vulnerable child is in need of care (Atkinson & Goldberg, 2004).

Application of attachment styles

When working with children who have suffered abuse, neglect and traumatic experiences, it is important to understand the insecure attachment styles they have adopted in order to cope with the distress experienced. “Children who begin their lives with seriously compromised or disrupted attachment often become impulsive, extremely oppositional, lacking in conscience and empathy, unable to give and receive genuine affection and love, angry, aggressive and violent” (Levy, 2000, p. 9). Without an understanding of the attachment styles that these children exhibit during times of distress, their behaviours could often be misinterpreted as being just ‘bad’ or ‘bad behaviours’.
In SGHs, overt behaviours are commonly manifested through defiance to rules, disruptive behaviour and aggressiveness towards others or internalised behaviours such as extreme withdrawal, sulkiness, and self-harm. Using an attachment framework helps us to understand these behaviours in the context of the child’s traumatic history. Pearce and Pezzot-Pearce (1997), discuss how children with a history of maltreatment develop behavioural strategies like poor regulation of emotion, hyper-vigilance, distrust of others, explosive hostility, social non-engagement and anxiety as strategies to cope with their traumatic past (Pearce & Pezzot-Pearce, 1997). Therefore, it is important when working with children with a traumatic historical background that interventions are used to understand their current coping behaviours and how to introduce new healthy coping behaviours through re-experiencing relationships as safe, predictable and consistent.

It is crucial that interventions used do not re-traumatise them by using a shame-based authoritarian model that re-creates for them feelings of being unsafe, threatened and even re-traumatised (Cimmarusti, 2009). Instead, Bowlby (1988), in his book *A secure base* talks about the importance of the worker providing a secure base from which clients can explore painful experiences of the past which clients may find difficult to revisit without a relationship of trust which provides support, reassurance, compassion, and, on occasion, guidance (Bowlby, 1988).

Since I have mentioned the term ‘trauma’, ‘traumatic experiences’ and ‘trauma history’, it is important to clarify this definition and how it relates to children living in the SGH.

**Definition of trauma**

“Trauma is a psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness” (Perry, 2014, p. 15). The individual may experience the events as a direct victim or as a witness. According to Terr (2013), childhood trauma can take the form of children experiencing repeated assaults, sexual abuse, neglect, and mistreatment. Loss of a sibling or parent to death, resulting in disrupted attachment can also cause trauma for the child (Terr, 2013). Even though many children are not formally diagnosed with post-traumatic stress disorder (PTSD) or complex trauma, it is important to take into
account the impact that traumatic experiences can have on a child. “In children, traumatic complexities frequently lead to such problems as ongoing depressions, numbing of emotions, character changes, and aggressive, destructive behaviours” (Terr, 2013, p. 52). These are complex behavioural problems that children at the SGH often exhibit. There are several debates around diagnosing a child and it is difficult to determine the right diagnosis for children who exhibit complex behavioural issues. Common diagnoses of children admitted to specialists placements like care and protection residences and group homes often have diagnosis of ADHD, conduct disorder, attachment disorders or depression or other diagnosed behaviour problems (Child Youth and Family, 2013). Whatever the diagnosis or complex behaviour problem may be, if trauma is part of the child’s life experience, it is crucial that the understanding of the effects of trauma must become part of the child’s treatment (Terr, 2013).

Anglin (2013) completed a 14-month study of 10 staffed group homes in British Columbia and highlighted the importance of residential staff members understanding the trauma experienced by young people living in residential settings. Anglin (2013) coined the term ‘pain-based behaviours’ to counteract misinterpretations and misguided reactions toward children in residential care. “Young people who have experienced trauma are literally living in a world of pain which shows in their challenging behaviour” (Anglin, 2014b, p. 53). He highlights that responding appropriately and effectively to children’s psycho-emotional pain is the primary challenge that workers in residential settings face on a daily basis (Anglin, 2013). In addition, “care workers need to be aware of their own pain-based anxieties in order to be responsive rather than reactive or coercive” (Anglin, 2014a, p. 98). I move on to demonstrate the link between attachment theory and neuroscience.

**The role of the attachment relationship in brain development**

Nature or nurture? Are we a product of our genes or the environment? The debate of nature versus nurture has been around for years. Brain research has shown us that this debate is futile because human beings are a result of both nature and nurture (Perry, 2002). Genes and the environment are interdependent. Humans are born with genetic potential and without the environment shaping these genes nothing will be created (Perry, 2002). The brain is the organ most sensitive and responsive to being
shaped by the environment (Roth & Sweatt, 2012). This important fact helps us to understand the crucial role the attachment figure plays in the development of the child’s brain especially during the formative years.

The brain is undeveloped at birth and most of the development of the brain occurs in early childhood (Perry, 2006). By the age of four, a child’s brain will be 90% of the adult size (Perry, 2006). During the early years, our brain is ‘hard wired’ according to the quality and amount of experience (Rowley, 2011). The developing brain is very malleable and responsive to the environment and the experiences of early childhood has a significant and enduring effect on brain organisation and functioning (Perry, 2006). There are critical windows of opportunity in which brain development occurs, after which it becomes difficult to re-work those developments (Rowley, 2011). Brain plasticity decreases, meaning it is less responsive to the environment once an area of the brain is organised (Perry, 2006).

With this knowledge on brain development, it is important to consider how healthy attachment with a caregiver contributes to brain growth and organisation.

Attachment and bonding

Before we explore how attachment contributes to brain development, it is important to re-visit the meaning of attachment and bonding.

Attachment is a deep and enduring emotional bond that connects one person to another across time and space (Ainsworth, 1978; Bowlby, 1969). The capacity to bond and form an attachment is driven by survival (Perry, 2001). All mammals are born with an attachment system, and under stress, threat or perceived danger, the baby activates a series of attachment behaviours in order to achieve physical or psychological proximity with their parental figure (Howe, 2011). The end goal of the attachment system is to achieve safety and protection.

Infants are born defenceless and are dependent on the caregiver to meet its basic needs. It is through this relationship of dependence and the caregiver’s response to dependence that a relationship develops (Perry, 2001). The quality of the parent-child relationship is dependent on the amount of bonding that occurs between a parent and a
child. Bonding is a set of behaviours that helps build an emotional connect, known as attachment (Perry, 2001).

Bonding experiences are acts of nurturing behaviours that a caregiver does, for example cuddling, rocking, gazing, talking to the infant, eye-contact, holding, hugging and touch. In childhood, the quantity of bonding experiences does matter (Perry, 2001). When a parent provides bonding experiences for the child, this results in neurochemical activities in the brain that are responsible for attachment (Perry, 2001). Therefore, the amount of bonding experiences between a parent and a child is important to help foster healthy attachments.

Not only does bonding experiences help promote healthy attachment, it also helps the baby’s brain form connections. There are critical periods during the first three years of life for connections to be made (Perry, 2001). Critical periods are windows of opportunity when the brain is most ready to learn and acquire new skills. The brain is programmed to make sense of experience but requires experiences in order to make sense of it (Howe, 2008). The lack of experiences that stimulates the brain during critical periods can have a lasting impact. A good example of this would be visual development. If a child does not focus one eye appropriately during the critical period of visual development, the child will not achieve normal vision in that eye. This occurs because the brain was not stimulated during the critical period of visual development (Howe, 2008). Bonding experiences like touch, eye-gazing, talking to a child helps to form connections in the brain. The lack of these stimulating and sensory experiences, results in severe problems later in life (Perry, 2002).

In the following section, we will explore how healthy attachment helps to foster the developing brain.

What brain research says about attachment?

Developmental social neuroscience is the science behind parent-child connections and the research informs us that early experiences with parental figures literally “build” a child’s brain (De Haan & Gunnar, 2009). Parenting is particularly important early in a child’s life when the brain is in a sensitive period for social and emotional learning and vulnerable to stress (Hughes & Baylin, 2012). Children’s brains
flourish when relating with an adult’s brain that has the ability to love them unconditionally, be emotionally responsive to the child’s needs and comforting the child effectively and consistently when they are stressed (Hughes & Baylin, 2012). In a secure attachment relationship, the caregiver consistently attunes to the changing emotional states of a baby. When parents effectively attune to the child’s emotions, it regulates their stress levels and promotes healthy brain development (Schore, 1996).

The left hemisphere of the brain deals with logic, language, cause-and-effect thinking, calculation, reflection and analysis (Howe, 2008). The right hemisphere of the brain controls the non-verbal, emotional processing, facial recognition and interpretation (Howe, 2008). The right brain is experience-dependent, and that this experience is embedded in the attachment relationship between the infant and primary caregiver (Schore, 2000).

As brain functions are split into left and right brain tasks, the integration of emotional and logical processing is crucial. Children who are raised in environments where emotions are recognised, named, discussed, talked about, managed and understood grow up with an integrated brain (Howe, 2008). To be specific, the linkage between the amygdala (located in the limbic system) and the orbitofrontal cortex occurs best when children have experienced emotionally attuned parenting.

The orbitofrontal cortex is developed dominantly during the first year of life (Schore, 2000). The orbitofrontal cortex is often known as the thinking part of the emotional brain (Hart, 2008) which regulates interpersonal behaviour. The orbitofrontal cortex is the part that controls our ability to infer the emotional states of others (Baron-Cohen, 1995), assists social adjustment, mood control (Cavada & Schultz, 2000), ability to cope with stress and affect regulation (Schore, 1994).

Parents who provide a secure-base for their children sculpts the child’s brain for emotional resilience, social competence (Hughes & Baylin, 2012) and emotional regulation. Parenting styles that provide a secure-base develops the child’s capacity to trust other people and to sustain positive, caring relationships (Hughes & Baylin,
These children develop compassionate and empathic brains which equips them to be emotionally intelligent individuals in the future (Howe, 2008).

The attachment relationship is crucial in providing a template for the formation of future relationships (Perry, 2001). Failure of the attachment relationship occurring will result in problems later on in life including the inability to form trusted relationships with others (Rowley, 2011). In the next section, I will explore how abuse, neglect and traumatic experiences impair the development of the brain.

The effects of neglect, abuse and traumatic experiences on the brain

“These children are just naughty, they need consequences and firm boundaries to change their behaviour” is a common phrase you hear from well-meaning individuals involved in working with traumatised children. Are these children just being naughty or is there more than meets the eye? This section discusses what brain research tells us about the effects of neglect, abuse and traumatic experiences on the brain.

![The Human Brain](http://www.childtraumaacademy.com)


The figure above shows how the brain develops sequentially at birth from the brainstem to the diencephalon (midbrain), to the limbic and to the cortex (Child Trauma Academy, 2002); the brain develops from the “bottom” up and the “inside out” (Perry,
The brain is also organised in a “hierarchical fashion” (Perry 2006, p. 30) “from the most simple (eg: fewest cells- brainstem) to most complex (eg: most cells and most synapses-frontal cortex)” (Perry 2006, p. 31).

During infancy and childhood, the lower, more primitive parts of the brain develop first as they control the autonomic functions necessary for life, like breathing, heart rate, blood pressure, appetite and sleep (Child Trauma Academy, 2005). Over time, the “output of these areas is shaped, modulated, modified in more mature fashion as the higher brain areas develop” (Perry, 2004, p. 12).

Neurobiological findings have indicated that early stress and maltreatment causes structural and functional changes to the brain (Brainwave Trust Aotearoa, 2012; De Bellis, 2005; Hughes & Baylin, 2012; Perry 2006; Teicher et al., 2003). Disruption in development through neglect, maltreatment or traumatic experiences can ‘overdevelop’ the midbrain and brainstem or ‘underdevelop’ the limbic and cortical areas (Perry, 2004).

When working with children who present with challenging behaviours, it is important to understand how trauma and neglect in the early years of life affects the development of the brain (Perry, 2002). Depriving a child of sensory experiences especially during sensitive periods of brain development can cause disruption of critical neurodevelopment cues in the brain (Perry, 2002). Another major factor that causes disruption of critical neurodevelopment cues in the brain is extremes of experience for example traumatic stress (Perry, 2002). De Bellis (2005) discusses how neglect and many other adversities children experience in their childhood may contribute to adverse brain development and compromised neuropsychological and psychosocial outcomes. Neurobiological findings have established that neglect in early childhood results in problems like developmental delays, impulsivity, disorganised attachment, attention deficits and hyperactivity (Perry, 2002).

A study was completed on Romanian adoptees who lived in Romanian orphanages that had extremely poor conditions by Rutter et al (2007). There was a ratio of 1 staff to 30 children, and there were no toys or educational activities, feeding was
done using propped up bottles with large teats and children with washed down with a hose and cold water (Rutter et al., 2007). The result of this extreme neglect was children having physical deficits, cognitive delay, developmental impairment, attention deficits and for some conduct disturbances (Rutter et al., 2007).

In order for us to understand how traumatic experiences alter the brain, we need to understand how the brain organises, functions, develops and processes threat (Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

**The brain under threat**

The figure below (figure 2) shows us what happens to our brain under threat. The threat continuum starts from calm, arousal, alarm, fear and moves to terror as threat increases. When in a state of calm, the brain is able to access the cognitive, abstract, and thinking parts of the brain. As threat increases, this alters the mental states, styles of thinking and physiology (Perry et al., 1995) As different parts of the brain controls mental and physical functioning, the more threatened an individual is results in more “primitive” styles of thinking and behaving (Perry et al., 1995). The brain’s primary aim under severe threat is survival. When this occurs, the brainstem is accessed, cognitive functions diminish and increased heart rate, muscle tone and rate of respiration occurs (Perry et al., 1995).

![The Acute Response to Threat](http://www.childtraumaacademy.com)


The brain is designed with neural systems that are dedicated to respond to stress. This is what is commonly known as the “fight” or “flight” response which is how
the brain is designed to respond to threats from internal or external sources. Anxiety activates biological stress response systems and contributes to adverse brain development (De Bellis, 2005).

Understanding how the brain adapts to threat is crucial to the way we work with traumatised children. A child who has experienced trauma will often have a base-line of low level fear (Perry et al., 1995) and this can be observed through the regressed state of the child’s emotional, cognitive and behavioural functioning. The way traumatised children will react to stressful or threatening situations would be to utilise hyperarousal or dissociative adaptive responses, for example aggression, numbing, defiance and even fainting (Perry et al., 1995). When a traumatised child is in a state of alarm, this hinders their ability to concentrate and they will be paying attention to non-verbal cues like body posture, tone of voice and facial expressions (Perry et al., 1995).

The question we posed earlier in the introduction about whether children who have experienced trauma are just being naughty when we see behaviours such as defiance, aggression and withdrawal could be the fact that their brain is under threat and these behaviours are their adaptive ways of coping. This understanding of how trauma and neglect affects the brain, can inform our practice with children who have experienced trauma. It is important for individuals working with traumatised children to have an awareness of attachment behaviours and how stressful situations can activate stress response systems (Perry & Hambrick, 2008). Stress response systems can be manifested in the function of violence, aggression and other troubling behaviours. An understanding of how trauma affects the brain will guide our practice to be more attuned to the children’s dynamics, thus creating a greater sense of psychological safety (Moore et al., 1997).

The current SGH model

Up to this point, we have discussed attachment theory and its link with neuroscience. I have also highlighted the effects of adverse early experiences on brain development. In this section, I go on to outline the current therapeutic model and behaviour change model of the SGH and provide a critique of this model.
The SGH is made up of two core models; the therapeutic model and the behaviour change model (Child Youth and Family, 2010). The therapeutic model is what sets the environment and the behaviour change model is the application of the model (Child Youth and Family, 2010).

The current therapeutic model

The therapeutic model of the supervised group home is based on a structured programme which has four core elements; predictability, consistency, routine (having a plan) and learning (goal setting) (Child Youth and Family, 2010). These four elements are the foundations of the therapeutic programme and are essential to the success of the programme.

Predictability is a crucial concept of the therapeutic programme which requires a level of standardising programmes in the child’s day (Child Youth and Family, 2010). Providing a sense of predictability in terms of routine and structure helps decrease any anxiety the child may experience if they are living in a hyper aroused state (Child Youth and Family, 2010). Predictability also includes the way a staff member delivers instructions to a child (Child Youth and Family, 2010).

Consistency is the next core concept of the therapeutic model. Consistency includes staff’s practice, language used and expectation of the staff from the children (Child Youth and Family, 2010). A consistent environment allows the child to adjust their behaviours within consistent boundaries and expectations (Child Youth and Family, 2010).

Thirdly, routine or having a plan that is transparent for both the staff and children encourages an environment where the children can learn responsibility once they know what is expected of them (Child Youth and Family, 2010). Within the group home, having a routine and sticking to one is key to the rewards and consequences process which will be explored further under the behaviour change model (Child Youth and Family, 2010).

Lastly, learning or goal setting is the fourth important element of the therapeutic model. Goal setting needs to be specific to the needs of the child and the child must be aware of this goal (Child Youth and Family, 2010). The learning comes in through
teachable moments that staff have with the child where opportunities are used to teach them new skills or pro-social behaviours (Child Youth and Family, 2010).

*The characteristics of the programme*

Within the home, the programme covers behaviour management of the child, encourages pro-social interaction, enhancement of decision-making skills and emotional control (Child Youth and Family, 2010). The programme must also include life skills such as nutrition, hygiene, cooking, physical and sexual health (Child Youth and Family, 2010). As the children and young people are living in a group setting, group processes are utilised to increase skills in socialisation and developing relationships (Child Youth and Family, 2010). The programme must also include a structured 24 hour plan of constructive and purposeful activities that enhance learning (Child Youth and Family, 2010).

External to the home, children or young people’s needs must be identified and referrals to appropriate services and supports in the community should be made. Young people should also be encouraged to link into community, sports or hobby groups to promote new peer group development (Child Youth and Family, 2010). As part of the programme, the child must be enrolled in education, training or employment during the day (Child Youth and Family, 2010).

*Principles of the behaviour model*

The behavioural change model implemented in the supervised group home is founded on principles of the behavioural model. One key aspect of the behavioural model, termed operant conditioning, was coined by B. F. Skinner (Ullmann & Krasner, 1976). A key assumption and concept of the behavioural model is the observation of overt behaviours (Hoge, 2001). Another principle of the behavioural model is that adaptive and maladaptive behaviours are acquired through learning processes that are dependent on rewards and costs and exposure to new modes of functioning (Hoge, 2001). The behavioural model focuses on present circumstances rather than historical factors. The underlying principle is that behavioural patterns were formed through past experiences, however they are currently under the control of current circumstances and changing these behavioural patterns is dependent on effecting change in the current environment (Hoge, 2001). The overall goal of behavioural treatment is to replace any dysfunctional behaviour with adaptive ones.
The behaviour change model utilises concepts of the token economy system which is based on principles of operant conditioning (Bailey, Gross, & Cotton, 2011). The aim of a token economy system is to increase positive behaviours and decrease misbehaviours (Spiegler & Guevermont, 2003) by allowing children to access privileges when they perform desirable behaviours (Resetar Volz & Cook, 2009). The main aims of the behaviour change model are to:

1. Increase motivation for change.
2. Decrease the occurrence of anti-social behaviour.
3. Increase the occurrence of pro-social, replacement behaviours
4. Develop pro-social skills (Child Youth and Family, 2010)

In order to achieve behaviour change, the system of token economy has been translated into a point-based level system. The points level system is a common component in residential treatment programmes (Drumm et al., 2013) and is designed to alter clients’ behaviour through the reduction or rewarding of points for adhering to rules or behaving as expected (Drumm et al., 2013)

In the SGH, four specific behaviours are targeted for all children or young people in the group home regardless of age, gender, background and ethnicity. In order for the children or young people to earn their points, they must demonstrate positive behaviour in the following four categories- Respect (how they respect each other and staff members), routine (whether they follow the structured routines), property (how they treat their own property and property of others) and personal goals (based on their specific behavioural goals) (Child Youth and Family, 2010). A child is awarded points when they display appropriate and desirable behaviours, and they receive a loss of points when misbehaviour or undesirable behaviours are exhibited. Points are recorded at various intervals and assessed to determine what level the client has reached or what rewards they should be awarded (VanderVen, 1995).
The total points each child receives is summed daily for a maximum of 350 points and is averaged over a four day period. Depending on the number of points a child achieves, it determines which level they are on (level 1, 2 or 3). Children progress or regress through the three levels when their average point scores go above or below the limits of a specific level. Being on level three, the highest level is associated with increased privileges and being on level one, the lowest level is associated with a decrease in privileges (Child Youth and Family, 2010).

The aim of the programme is to target specific behaviours through the use of tokens or conditioned reinforcers (Field, Nash, Handwerk, & Friman, 2004). Through this programme, it aims to replace maladaptive behaviours with adaptive ones.

**Critique of the current model**

In this section, I will provide a critical analysis of the current model implemented in SGHs. A review of literature on the points and levels system highlights some strengths of the model. Firstly, the points and levels system is considered an inexpensive behaviour modification technique in terms of time and resources used (Drumm et al., 2013). It is a system which provides an avenue for external motivation for youth which encourages them to achieve personal goals in a focused environment (Pazaratz, 2000). Some researchers have also highlighted the use of the points and levels system as a motivator for youth (Resetar Volz & Cook, 2009).

The studies noted above have found positive aspects of the behavioural change model, however, other research also highlights the deficits in this model. The behavioural change model focuses solely on current behaviour and does not take into account the historical issues of trauma, abuse and neglect that children have experienced. Bailey et al. (2011) completed an evaluative study on the challenges associated with using a token economy system in a residential setting. One of the findings that they present was that the one-size-fits-all approach did not take into account the differences in abilities and needs of individual residents (Bailey et al., 2011). The behavioural change model does not take into account the individual characteristics of each child (VanderVen, 2000). The expectation to conform to a model can result in increased frustration and anger from youths which inhibits their positive
learning experience (Drumm et al., 2013). While the behavioural change model has its advantages, it needs to be used in conjunction with an understanding of each individual’s trauma history and unique needs.

The behavioural modification model and the token economies system have been known to be an effective method for teaching new skills and encouraging new behaviour (Spiegler & Guevermont, 2003). Learning new skills and adaptive behaviours through a token economy system requires the use of cognitive and verbal interventions. The points and rewards model requires a staff member to provide cognitive reasoning and verbal explanations to a child when points are lost due to behaviour. The aim of providing cognitive reasoning and verbal explanations is to give the child the opportunity to reflect and connect their behaviour with the loss of points and privileges. As this process is repeated, the aim is to reinforce positive behaviours and choices.

When working with traumatised children, the change process is not linear. In fact it is crucial to understand that the stress response from trauma is triggering emotional and behavioural symptoms (Perry & Pate, 1994). This stress response accesses the primitive parts of the brain known as the brain stem and the midbrain (Perry & Pate, 1994). When dealing with a traumatised child, no amount of talking interventions or reasoning with them about their behaviours will alter the emotional memories of trauma implanted in their midbrain and brain stem (Perry & Pate, 1994). Telling a child to correct their behaviours that are a stress response to trauma will not alter the behaviour. This does not mean that the behaviours are to be minimised or ignored, nor does it mean that those parts of the brain that have been altered by traumatic memories cannot change. In fact, it is about using a trauma-informed approach to understand where these behaviours are coming from and choosing to utilise therapeutic modalities which help to alter the brain stem and midbrain. Therapeutic modalities that are relationship-based and provide support, nurturing, predictability which makes the child feel safe and loved (Perry & Pate, 1994) have proven to be effective when working with traumatised children. “The less anxious a child feels, the higher probability is that you may be able to replace and re-route painful affective memories” (Perry & Pate, 1994, p.140).
Moore et al (1997) discuss the limitation of using traditional models based on behavioural strategies that emphasise control and containment of behaviour. According to their research, “programmes that emphasise control and containment of behaviour can, in effect, undermine already fragile attachments of troubled youth to adults and instigate power struggles that inevitably fail in helping youth to develop a sense of personal responsibility for and control of their actions” (Moore et al., 1997, p.2). Children who reside in SGHs often have internal working models of themselves and others which are negative, for example, “I am rejected”, “I am unwanted”, “I am bad”, “I don’t trust others”. A system that emphasises rewards and consequences creates an environment where children are in competition with each other and staff members who implement the system are perceived negatively (Drumm et al., 2013). Instead of seeing the adult staff member as the empathetic role model that one can trust, the child experiences the staff member as controlling through the removal of points and privileges when misbehaviour occurs (VanderVen, 2000). This system may inevitably reinforce the negative internal model of themselves and others, resulting in further mistrust, rejection and isolation (Drumm et al., 2013).

The behaviour management system has been found to be an intervention that is useful within a treatment facility, however, loses its ability to be applicable in a normal day-to-day life outside of a residential facility (VanderVen, 2000). Furthermore, the use of the points and levels system emphasises external behaviour change, but fails to enhance internal changes to attitude (Pazaratz, 2000). When youths who resided in residential treatment centres in America were interviewed about their perspective on the points and levels systems, their comments were that it was “arbitrary and not responsive to their individual needs or relevant to real-life situations they will be in after discharge” (American Association of Children’s Residential Centers, 2009, p. 2). It is important to take into account what works for children and implement a model that is relevant and applicable to their needs.

Since we have established that the children who enter into a SGH have attachment issues and traumatic experiences, it may be appropriate to review models that enable us to understand how trauma affects current behaviour. In the next section, I
review the literature of residential settings that use an attachment and trauma-informed model.

**Residential Programmes that implement an attachment model**

Children in residential care that have not experienced a secure base in their primary attachment relationships require a “second chance secure base” (Graham, 2006). A secure-base is a relationship where a child feels safe, nurtured emotionally and physically, reassured consistently when in distress and comforted when afraid (Graham, 2006). Joseph, O’Connor, Briskman, Maughan, and Scott (2014) completed a study of adolescents in foster care and their findings demonstrated that there is significant potential for adolescents to develop subsequent secure attachments even in adolescents. In residential care, workers have the opportunity to provide a secure-base for children (Graham, 2006) and use relationship and engagement as a treatment process (Sprinson & Berrick, 2010).

Cunningham and Page (2001) completed a case study on a thirteen year old boy, Eric, who experienced maltreatment. They used this in-depth case study to inform the treatment model at a residential programme evaluating what was effective while working with this boy. This case study highlights the effectiveness of staff relationships with children in residential treatment centres and how attachment theory can provide meanings to disruptive behaviour. The article emphasises the need to place a “primary emphasis on children’s therapeutic relationships with specific, committed adults, and the children’s individual developmental needs” (Cunningham, 2001, p. 351). Children like Eric, who have experienced maltreatment, need to experience a supportive and consistent relationship like one provided by his therapist. A programme that focuses solely on a social learning model (behavioural model), isolates children like Eric and creates feelings of antagonism towards the residential environment and towards staff.

Another residential programme that utilises an attachment model is Jasper Mountain Centre. The main focus of Jasper Mountain is to create a family environment (Ziegler, 1994). Changing the behaviour of the child while they are residing at Jasper Mountain is important, however it is recognised that behaviour change is only the beginning of the treatment process. In fact, relationships are seen as the key where
through repetition and consistency, children learn that they are safe and they would not be abused (Ziegler, 1994). At Jasper Mountain, children are taught how to make progressive steps towards relationship and learn about the normal exchange in relationships through the relationships they experience from staff (Ziegler, 1994). Time is an essential quality in the interventions with children with attachment difficulties and at Jasper Mountain, cases are never closed if they require more time and interventions (Ziegler, 1994). The important message that the attachment model sends to the children residing at Jasper Mountain is that they can achieve closeness in relationships rather than seeing relationships as using others and being lonely (Ziegler, 1994).

Residential programmes that implement a trauma-informed model

Children in residential care have been impacted by the experience of violence, abuse, neglect and other traumatic experiences (Bloom, 2005). Trauma theory informs us that the structure and functioning of the brain is impacted by traumatic experiences (Perry 2006). The trauma history of children must be taken into account as “traumatic experience has the capacity to disrupt the functioning and development of affected children” (Sprinson & Berrick, 2010, p. 21). In order to enable children to heal from their experiences of trauma, trauma-informed care needs to be integrated into our residential programmes.

In Cimmarusti and Gamero’s (2009) article on compassionate accountability in residential care, they utilise several case studies to highlight the importance of using a trauma-informed model when working with children with a history of trauma. Their article states that for “traumatised individuals, more traditional approaches to accountability do not validate their perspective or feelings and most likely, threatens them” (Cimmarusti, 2009, p.181). Instead of using a shame-based authoritarian model that traditional models in residential service use, they suggest using the term “compassionate accountability” which improves relationships between staff and youth by using “connection to teach taking personal responsibility”(Cimmarusti, 2009, p. 183). Trauma-informed care takes into account what children have been through (Cimmarusti, 2009) and looks at “what is in-the-moment experience driving their behaviour” (Cimmarusti, 2009, p. 183).

The Sanctuary model of organisational change for children’s residential treatment is a trauma-informed whole system approach (Bloom, 2005). The Sanctuary
model discusses how complicated, parallel process exchanges can occur between traumatised children, stressed staff and pressured organisations (Bloom, 2005). The assumption of the Sanctuary Model is that “traumatised children cannot heal within traumatising or traumatised organisations” (Bloom, 2005, p. 66). Organisations need to continually ask the question “is it working?” so that the strategies that are not working are not repeatedly used with children. It is important that ineffective approaches are evaluated so that the failure of these strategies are not attributed to the children (Bloom, 2005). Healing from trauma needs to be a whole system approach and involves introducing a trauma-informed culture (Bloom, 2005). The model focuses on safety, affect regulation, grieving and emancipation (SAGE) (Rivard et al., 2004) within the context of safe, supportive, stable, and socially responsible therapeutic communities (Rivard et al., 2003).

The Attachment Regulation and Competency framework (ARC) is an evidence based and trauma informed treatment framework that has been utilised with youth in residential treatment centres (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). The ARC framework is an intervention with youths and families who have experienced trauma, and focuses on three domains: attachment, self-regulation and competency. The model identifies 10 core intervention targets listed below (Trauma Center, 2007).

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Self-Regulation</th>
<th>Competency</th>
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<tbody>
<tr>
<td>Caregiver affect management</td>
<td>Affect identification</td>
<td>Developmental tasks</td>
</tr>
<tr>
<td>Attunement</td>
<td>Affect modulation</td>
<td>Executive functions</td>
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<tr>
<td>Consistent response</td>
<td>Affect expression</td>
<td>Self-Development</td>
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<tr>
<td>Routines and Rituals</td>
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The ARC model intervenes with the child-in-context and understands that systemic change is necessary for lasting outcomes. The ARC framework has been applied in various settings including juvenile justice facilities, residential treatment centres, group homes, therapeutic foster care and outpatient treatment (Ford & Blaustein, 2013).
Weaving the attachment model and behavioural model together

The attachment theory and social learning theory can be viewed as differing models as attachment theory focuses on the importance of early experiences but social learning theory takes into consideration current behaviours. In the field, there appears to be a duality between a relational approach versus a structured approach and a focus on internal experiences (thoughts and feelings) versus external experience (behaviour) (Sprinson & Berrick, 2010). In the context of working with children who have had traumatic experiences, it is important to have a model that understands both historical experiences and current behaviours. The weaving of these two models, attachment theory and learning theory can complement each other. A residential programme that integrates attachment theory and learning theory successfully is the Seneca Center’s Residential Programme in California, U.S.A. In this section, I will be referring to Seneca’s model as a case example.

Translating the principles of attachment theory into practice is what Seneca Center calls “relationship-based treatment” (Sprinson & Berrick, 2010, p. 56). Relationship-based treatment is based on the principle of unconditional care. Unconditional care is defined “as a commitment to never discharge clients for showing the behaviour that originally led to their referral for treatment of placement” (Sprinson & Berrick, 2010, p. 1). Children will not be able to benefit from any intervention without having the confidence that their placement, relationships with staff and care workers is stable and secure (Sprinson & Berrick, 2010). When children have experienced multiple failed placements, they internalise these experiences and engage the world from a stance of “I have always been rejected, I am confident that you will reject me, and, in fact, I am fairly certain that I can provoke you to reject me” (Sprinson & Berrick, 2010, p. 34). Unconditional care must be the core foundation of our work and has to be actively applied in all exchanges between staff and clients (Sprinson & Berrick, 2010).

Another way in which relationship-based treatment can be implemented in practice is utilising a child’s internal working model to determine treatment methods. The internal working model is a child’s story of who he is, how he should be treated, and what he expects from others (Sprinson & Berrick, 2010). This sets out a series of behaviours to re-confirm the view of self and view of others (Howe, 2005). It is
important that staff provide clients with disconfirming experiences so that their internal working model can be modified (Sprinson & Berrick, 2010), also known as “corrective emotional experience” (Alexander & French, 1946). How staff members respond to children’s behaviours can disconfirm or affirm the child’s view of self.

The first step in working with these children is to utilise an assessment process to describe the child’s internal working model based on historical experiences. A tool which enables workers to work out the internal working model of a child based on their past experiences and current behaviours is the “relational learning framework” (Kelly, 2011). Once the internal working models of a child is figured out, staff can then formulate a treatment plan which disconfirms and modifies their internal working model by being strategic in how staff respond to the child’s behaviour (Sprinson & Berrick, 2010). This planned response is how the two models- attachment theory and behavioural interventions are weaved together.

Behavioural intervention “must start with recognition of children’s fundamental, biologically based needs for proximity and containment by emotionally attuned, unconditionally available caretakers” (Sprinson & Berrick, 2010, p. 114). A client is conditionally rewarded for the use of new, adaptive behaviours but the willingness of staff to engage and support the client needs to be unconditional (Sprinson & Berrick, 2010). Instead of behavioural interventions being seen as contrasting the relational model, behavioural interventions support relationship by providing staff with a clear set of methods that modify and guide staff’s interventions with clients (Sprinson & Berrick, 2010). When relationship-based interventions and behavioural interventions are used together successfully, it results in staff utilising effective and positive strategies to replace negative and reactive exchanges (Sprinson & Berrick, 2010). This results in an increase in confidence and competence for the caregiver and an improved experience of safety and emotional regulation for the child (Sprinson & Berrick, 2010). Structure and relationship, or behavioural and relationship-based interventions function in a “synergistic fashion”, requiring the other to be present (Sprinson & Berrick, 2010, p. 116).

**Review of evidence-based programs in residential care**
There has been an increase in emphasis on evidence-based programs by scientists, policy makers, public funding agencies and providers, yet there has been limited scientific evidence for models of residential care and treatment (Thompson & Daly, 2014). Internationally, residential treatment appears to be like a ‘black box’ where there has been a lack of outcome studies (Andreassen, 2014). Gustavsson and MacEachron (2007) argue that the lack of evidence-based outcome studies in ‘real-world’ settings could be due to the ethics involved in interviewing vulnerable youths and the barriers involved in accessing this population living in residential centres. However, James (2011) completed a recent review of treatment models relevant to group care and residential treatment settings for children. This structure review initiated and guided by the California Evidence-Based Clearinghouse for Child Welfare, found some models to be evidence-based. These models are the Positive Peer Culture, Teaching Family Home, and the Sanctuary Model that I referred to previously. Due to the limits of this thesis, I am unable to go into greater details on all the evidence-based models, but I provide an overview of some of these models below.

**Positive Peer Culture**

Positive Peer Culture (PPC) treatment model was developed by Vorrath and Brendtro (1985) in response to the lack of effective treatments dealing with negative peer pressure among troubled youth (James, 2011). Grounded in social psychology, PPC uses the group context to transform negative peer dynamics into a positive peer culture. The PPC model targets negative peer influence into care and concern for others, empowers youth and encourages them to take responsibility (Laursen, 2010). The role of the adult authority is deemphasised, and the development of trust and respect are encouraged through group norms like mutual responsibility, pro-social attitudes and social concern (James, 2011). There are four treatment features of the PPC model:

1. Building group responsibility
2. The importance of the group meeting as the problem-solving arena
3. Service learning where youths are engaged in multiple community projects
4. An emphasis on teamwork where staff teams are organized around distinct groups of children (James, 2011).
I refer to the PPC model again in the discussion chapter.

**Teaching Family Model (TFM)**

The Teaching Family Model is the most described and researched of all group home models (Phillips, Phillips, Fixsen, & Wolf, 1974). The TFM was first introduced in 1967 and is best known for its implementation in Boys Town (James, 2011). Currently, Boys Town Family Home Program serves 1200 youth annually at ten sites from New York City to Orange County, California (Thompson & Daly, 2014). There are five core elements of the TFM programme: teaching skills, building healthy relationships, supporting religion and faith, creating a positive family environment, and promoting self-determination (Thompson & Daly, 2014). Family-style living is another key element of the programme where trained married couples, called family teachers live with the children 24 hours per day (Thompson & Daly, 2014). This makes the TFM different from other residential care models. TFM is an evidence-based model that has had over 200 studies completed to validate its effectiveness (Ministry of Social Development, 2014). Currently in New Zealand, the TFM is being implemented in Teaching Family Homes (Ministry of Social Development, 2014)

**Multidimensional Treatment Foster Care (MTFC)**

MTFC is similar to the TFM where children with severe behavioural difficulties are placed with trained foster parents who are provided with ongoing support from trained therapists (Fergusson, Boden, & Hayne, 2011). Placements last between 6 to 9 months and involves a structured behavioural management system for the child and support and family therapy for the child’s birth family (Fergusson et al., 2011). The TFM and the MTFC models have been reviewed to be effective for children with conduct problems within the Youth Justice system (Fergusson et al., 2011). There still remains a gap for children in care who have attachment difficulties and a trauma history but do not necessarily have conduct problems.

*The gap in therapeutic residential care*
“Therapeutic residential care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources” (Whittaker, Del Valle, & Holmes, 2014, p. 24)

Residential care needs to be “therapeutic” where the care environments need to be specialised and theoretically informed about the nature of trauma suffered by children from an early age (Jakobsen, 2014). In Denmark and other Nordic Countries, the context of “milieu-therapy” takes into account the importance of the arranged setting as part of the treatment (Jakobsen, 2014). Jakobsen (2014, p. 91) defines the “milieu-therapeutic” residence as “a purposefully constructed, multi-dimensional living environment for children suffering early-age trauma”. All residential care needs to be therapeutic in nature, where children’s deep psycho-emotional pain (trauma) can be effectively addressed (Anglin, 2014a).

Anglin (2013) completed a study of 10 group homes in British Columbia and highlighted that responding to pain and pain-based behaviour is the major challenge that carework staff in residential homes. Beneath “the mere incidents of the surface”, referring to the externalising behaviours of children in residential homes, lies the “inner truth of the pain within the daily reality of group home life and work” (Anglin, 2013, p. 370). Carework staff have a major task of guiding the residents out from their “heart of darkness into a collective sense of normality” (Anglin, 2013, p. 370). Yet to do so, “requires consistency, reciprocity and coherence throughout child and youth care practice” (Anglin, 2013, p. 370). Anglin (2013) refers to this as the “struggle for congruence” where the intention of group homes are to service the “children’s best interests” but at the same time this is competed with personal, organisational and Ministry needs (Anglin, 2013). I elaborate on the term “struggle for congruence” in the discussion chapter.
New Zealand Research

The literature that I have reviewed has extensive references to articles from the USA and Canada. In New Zealand, there is limited research completed on children in foster care. In Atwool’s thesis (2008), she explored the perspectives of children on their care experiences and highlighted the absence of children’s participation in the decision-making process in her findings (Atwool, 2008).

There has been some interest made on finding evidence-based solutions for childhood conduct problems in New Zealand, and this was featured in the report ‘improving the transition’ (Office of the Prime Minister's Science Advisory Committee, 2011). The Church report (Church, 2003) investigated the development and treatment of severe behaviour difficulties in children and adolescents. Their findings indicated that interventions which appeared to have the largest effect in reducing the offending of antisocial adolescents are Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care and Teaching Family Model (Church, 2003).

There is currently limited research completed for children who reside in residential care and on children’s perspectives specific to residential care settings in New Zealand.

Summary

In this literature review chapter, I have explained the main tenets of attachment theory and emphasised the importance of using the attachment framework to understand children’s behaviours in group home settings. The link between attachment theory and neuroscience was established as I discussed how the brain’s development is influenced by attachment. I explored the definition of trauma and pain-based behaviours, and highlighted the importance of therapeutic programmes understanding the effects of trauma. A critique of the current model implemented at the supervised group home was provided. I then presented the different models used in residential settings internationally. Lastly, the lack of New Zealand research for children in care and children residing in residential settings was discussed.
In the next chapter ‘methodology’, I provide an outline of the theoretical framework that underpins my research through exploring the research question and discuss the methodological approach used in this thesis.
Chapter Three
Methodology

Introduction

In this chapter, I discuss the theoretical framework that underpins my research in part A of this section through exploring my paradigm and the research question that initiated this study. I go on to establish my epistemological viewpoint and discuss the elements of practice-based and social work research in this project. The conflict of the insider-outsider positioning is raised.

In Part B, I outline the methodological approaches used such as case study inquiry and narrative inquiry. The methods used to ensure research validity is also outlined. I go on to detail the sampling procedures used, how the interviews and focus group discussions were conducted and talk about the settings that the interviews were held at.

Part C of this section highlights the data analysis used and part D of this section emphasises the ethical considerations taken into account for this research project. Topics discussed in section D includes ethics approval, access to participants, informed consent, limits to confidentiality, dual role, storing of data, ethical considerations for interviewing colleagues, children as research participants, informed consent of children and safety issues considered. Finally, the strengths and limitations of the research project are discussed.

Part A- Theoretical framework

Paradigm and research question

A paradigm is ‘a cluster of beliefs and dictates which for scientists in a particular discipline influence what should be studied, how research should be done, how results should be interpreted’ (Bryman, 2012, p. 630). A paradigm is based on ontological, epistemological and methodological opinions (Guba & Lincoln, 1994). It is
the lens in which you view the world from that has an impact on the type of knowledge acquired (Guba & Lincoln, 1994; Higgs, 1997). When carrying out research, it is important for the researcher to understand the paradigm adopted as it influences how research is carried out.

The term paradigm was first developed by Kuhn (1996) for the natural sciences. This concept was developed for the social sciences by researchers Guba and Lincoln (1985) who distinguished three main paradigm assumptions: post-positivist, constructivist and critical influence, that influence the choice of validity procedures (Creswell & Miller, 2000; Guba & Lincoln, 1985; Guba & Lincoln, 1994).

In the past two decades, there has been a methodological revolution in the social sciences. Previously, where statistics, experimental designs, survey research were the only methods recognised, research has now opened up to other methodologies like interviews, ethnography, case studies and narrative inquiry (Denzin & Lincoln, 1994). Qualitative inquiry was developed as human beings cannot be studied the same way as objects are in the hard science or experiments (Minichiello & Kottler, 2009).

My research question that initiated this journey was “does the quality of relationships with staff members have a positive impact on outcomes for children who reside in group home settings?” As I explored this research question, I discovered several sub questions that I wanted to answer through my research project.

These were my sub research questions:

- What matters to children residing in group home settings?
- What do the children SAY makes a difference to them when they are in the group home?
- What works for young people in a group home setting?
- Is there a relationship between quality of relationship between staff and children and the level of engagement of children in the supervised group home?
- What effect does positive staff engagement have on children with attachment issues?
Attachment framework uses a nurturing, engaging, supportive stance what effect does this have on children with attachment issues?

My study aims to capture the voices of children regarding their experiences of staff relationships in three group homes in New Zealand. It seemed appropriate to answer the research question using a qualitative approach as it involved hearing the perspectives and experiences of children residing in group homes. Unlike a science experiment where the researcher ‘does to’ the object, qualitative research allows for an interchange and interdependence in the process of inquiry (Higgs, 1997). Qualitative interviewing allows us to see the world from of our research subjects’ point of view (Miller & Glassner, 1997).

**Epistemology - the theory of knowledge**

Aristotle states in the metaphysics that “All men by nature desire to know”. Humans have an innate desire to gain knowledge and understanding. Research is a systematic attempt using socially approved methods to extend our knowledge and understanding of the world (Killam, 2013). How do we come to know what we know? How do we discover knowledge? Epistemology explores the relationship between the researcher and knowledge (Killam, 2013). The term epistemology derives from the Greek word “Episteme” meaning knowledge, and “ology” meaning doctrine or study of (Killam, 2013). In other words, epistemology is the study of knowledge or the theory of knowledge.

In order to gain knowledge and understanding of my research topic, I chose a multi-method study under the constructionist paradigm (Crotty, 1998; Guba & Lincoln, 1994; Killam, 2013). Within this paradigm, knowledge is not found but constructed (Crotty, 1998; Killam, 2013).

In social constructionism, there is no objective truth to be found, but meaning is discovered from our interaction with reality (Crotty, 1998). In this research project, meaning was discovered through conversation, use of language and hearing the narrative of research participants (Rodwell, 1998). The process of creating meaning was interactive and co-created between the researcher and participant (Guba & Lincoln,
In constructionist research, meaning is found in the experiences of individuals and it is possible to have multiple constructed realities that are equally correct (Higgs, 1997). Hence, “there is no need to find the right answer because a variety of possible answers can be considered” (Rodwell, 1998, p. 4).

The terms constructionism and constructivism tend to be used interchangeably in the literature reviewed, however there is a slight difference in the terms which I would like to highlight. According to Young and Collin (2004), constructivism pertains to how individuals mentally construct their experiences through cognitive processes whereas social constructionism focuses on a social rather than an individual level. In social constructionism, an overall approach to generating knowledge and obtaining social change is the focus (Hardina, 2002, p. 58). Social workers have commonly used the term constructivism to refer to the application of constructionism into research or practice (Rodwell, 1998). The constructivist inquiry parallels social work practice and values in several ways (Rodwell, 1998); the belief in the respect for human condition; maintaining client dignity; promoting individuality; empowering individuals and upholding social justice (New Zealand Association of Social Workers, 1993; Rodwell, 1998).

My research paradigm has been influenced by my own values of how I work with people as well as social work principles of the profession. As a social work practitioner working alongside children residing in a supervised group home, the framework of practice I refer to is relationship-based, strengths focused and child-centred. When social workers carry out research it is important that they choose a topic that they find relevant and useful to their practice (Gibbs & Stirling, 2013). My research project, “Relationships Matter?” has a primary focus on the importance of key positive relationships in improving outcomes for children who reside in group homes. This chosen topic fits well with my practice framework as a social worker and my research paradigm.

**Practice-based research, action research and social work research**

My research journey began with questions that I found myself asking as a practitioner working alongside children who reside in supervision group homes. ‘How
do you look after children who don’t know what it is like to be cared for or loved? How can we make positive changes to their lives? How do we break the cycle of abuse? These are indeed difficult questions to ask, and even more challenging to answer. However, as a practitioner in the field wanting to make an impact and difference in the lives of New Zealand’s most vulnerable children, this caused me to embark on this research journey.

Having a dual role of practitioner and researcher, it is important to discuss the term practice-based research and its role in this research project. Practice-based research is referred to “professionals working in health, education and social care who are undertaking research” (Fox, Martin, & Green, 2007, p. 1). The purpose of practice-based research is to create “a synergy between research and practice for the practitioner researcher in that practitioners engaged in research are more successful practitioners and researchers engaged in practice are more successful researchers” (Fox et al., 2007, p. 2).

Similar to practice-based research, this research project borrows from principles of action research. Action research is an applied research that “attempts to solve specific problems or help practitioners achieve certain goals” it “starts from the idea that research should do more than understand the world, it should help change it” (Hill & Capper, 1999, pp. 243-244). Gibbs and Stirling (2013) discuss how the process of research and research outcomes should be transformative in nature. Practice-based research and action research fits well with the ethos of social work. Fundamentally, social work is a “profession that promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being” (International Federation of Social Workers, 2012)

There have been several discussions in the literature about what social work research is and how it is relevant to social work practice. Shaw and Lunt (2011) discuss social work research as working collaboratively with participants in an ethical way to ensure benefits for clients. McDermott (1996) emphasises practitioner research from an ecological perspective and “as an intervention leading to the possibility of
constructive change” (McDermott, 1996, p. 6). Dominelli (2005, pp. 229-230) discusses four main purposes of social work research:

1. “It is a field that investigates the well-being or lack of human interactions”.
2. “Social work research usually focuses on marginalised groups of people who have limited social power”.
3. “It seeks to bring social change that enhances human well-being”.
4. “Social work research should engage with practice and transform it”.

Social work research should promote social justice, social change and social inclusion (Dominelli, 2005), strengthen theory and knowledge about social work, and provide evidence about practice to improve decision-making (Shaw & Lunt, 2011). Sheppard (1998) emphasises the importance of research taking on the form and nature of social work, that it should not just have theoretical validity but also practical validity. Throughout this research journey, the two worlds of practice and research have united to produce both theoretical validity and practical validity.

This research project seeks to strengthen social work practice with particular attention to improving outcomes for children in statutory care. Children’s voices are at the centre of this research project, and the aim is to strengthen child-centred practice delivery in residential services. Marsh and Fisher (2005, p. 13) encapsulate this well, stating that “social care knowledge production needs research that can be used in practice. It needs research that begins and ends in practice: that begins with practice-relevant questions, and that ends with relevant material that can be applied in practice”.

**Insider-outsider positioning**

While completing this research project, I was employed by Child, Youth and Family, working as the family engagement worker alongside children and staff in one of the supervised group homes in New Zealand. Being a practitioner-researcher working within the field of my research topic, it is crucial to discuss the term insider-outsider position.
The insider-outsider position is a dual role that can create tension in research (Acker, 2001; Shaw, 2005). It is a paradoxical position; on one hand it gives deeper insight into one’s experiences and meanings, yet on the other hand one must be aware of one’s biases that may influence your interpretation of data collected (Maykut & Morehouse, 1994).

Despite this tension of dual role, there are several advantages being an insider brings to the research project. Hockey (1993) acknowledges the benefits of an insider position:

“the advantages of researching in familiar settings, for example the relative lack of culture shock or disorientation, the possibility of enhanced rapport and communication, the ability to gauge the honesty and accuracy of responses, and the likelihood that respondents will reveal more intimate details of their lives to someone considered empathetic are juxtaposed with the problems that proponents of insider research nevertheless acknowledge”. (Hockey, 1993, p. 199)

As Hockey describes above, being an insider meant I had the privilege of gaining an inside perspective of children’s experiences living in supervised group homes, practical knowledge regarding the day-to-day running of the homes, an awareness of staff’s roles and insight into the organisational culture. Conversely, I was aware of my bias and the need to put several methods in place to minimise this. Ethically, I had to ensure that all participants understood the different hat I was wearing as a student researcher when I was conducting the interviews. I will discuss how I managed this dual role in more detail under the section of ethical considerations.

Le Gallais (2008) and Hellawell (2006) discuss how the insider-outsider position can enhance reflexivity as the researcher becomes self- aware throughout the research process. As an ‘insider’ completing research, I had to be aware of how my own values, beliefs and perceptions was influencing my research (Le Gallais, 2008). The key to becoming a reflexive researcher is reflecting on the self and the impact on research (Denscombe, 2000). To ensure I remained reflective throughout the research
process, I had regular reflective discussions regarding the research process with my academic supervisor, Dr Nicola Atwool.

**Part B: Methodological approaches**

**Case study inquiry**

This research is an exploratory study on children who reside in residential care, using three care and protection supervised group homes as case studies. Qualitative case study was chosen as the methodological approach in this research as this study is an exploratory research in real-life settings (Yin, 2009). In order to explore children’s experiences while living in a group home, case study inquiry was chosen as it focuses on “specific situations and providing a description of individual and multiple cases” (Cronin, 2014, p. 20).

Case study research sits within the constructivist paradigm (Stake, 1994), focusing on interviewing a small number of participants ‘in the field’ (Yin, 2009). It is a systematic inquiry of a unit of analysis where in-depth data is obtained (Walsh et al., 2000). The unit of analysis (case) in this research were children living in supervised group homes. Collective case studies (Stake, 1994) or multiple-case studies (Baxter & Jack, 2008) was used as the focus, where several cases were examined to give insight into a particular population (children in care) and situation (children residing in group homes) (Stake, 1994). Using collective case studies, *how* children experienced living in group homes was explored. In order to gain multiple perspectives, parents or guardians were interviewed and staff’s views were captured through focus group discussions.

The target sample size for this study was a total of twelve children participants; twelve of their parents or guardians and three focus groups with staff from the three various group homes. Eight children and eight parents or guardians were interviewed in total and two focus groups were conducted with staff from two homes, making this a smaller number of participants than the target number. With the small number of participants, interview questions were designed to elicit in-depth descriptions of children’s experiences living in the group home. Their parents or guardians were asked to describe their perceptions of their children’s experiences living in group homes and
to talk about their views on group homes. Case studies can have multiple perspectives (Jones & Lyons, 2004) and using multiple methods (interviews and focus groups) maintains rigour, verifies data and strengthens the significance of the findings (Cronin, 2014).

**Narrative inquiry**

Alongside the case study research method, I utilised narrative inquiry which focuses on stories as data (Savin-Baden & Van Niekerk, 2007) and helps us to understand the phenomenon of human experience (Caine, Estefan, & Clandinin, 2013). Semi-structured in-depth interviews with thick descriptions were held with children and parents/guardians. Narrative inquiry captures the voice of participants and gains depth to their experiences through the use of stories (Gemignani, 2014). In this research, qualitative interviews were conducted as an active process where participants co-constructed meanings (Gemignani, 2014).

Narrative inquiry is a methodological approach that fits well with attachment theory which is the theoretical framework of this research. The attachment model is a relational model that emphasises the importance of relationships, and narrative inquiry used in qualitative interviews is a relational process (Gemignani, 2014). The process of listening to someone’s experience “extends beyond data collection to allow the possibilities of the telling, the told, and the understood” (Gemignani, 2014, p. 131). When one is recounting their experiences, the focus is not solely on the content being relayed, but the process of telling, listening, the pauses, the sighs, the laughter and the silence; all which have meaning. It is about the researcher being immersed in the discourse (Gemignani, 2014), which can only be done on a relational level.

Savin-Baden and Van Niekerk (2007) discuss important points that I endeavoured to implement while undertaking narrative inquiry in my research interviews:

1. listen to participants’ stories;
2. acknowledge the mutual construction of the research relationship (both researcher and participant have a voice with which to tell their stories);
3. acknowledge that people are both living their stories in an ongoing experiential text and telling their stories in words as they reflect on life and explain themselves to others. (Savin-Baden & Van Niekerk, 2007, p. 463)

In order to step into the world of children in care and understand what it is like for them to live in group homes; it was important that an approach was used that allowed their voices to be heard. In New Zealand, there has been limited research completed on children living in statutory care and it is important that children in care are empowered to have a voice. “It is through the telling of story that people are able to understand, make meaning of, and relate experiences, because story is how people make sense of their existence” (Caine et al., 2013, p. 576). Using a narrative inquiry with semi-structured in-depth interviews has given me the privilege of capturing the realities of children in care. In a narrative inquiry, “stories are not just for the purpose of learning, development, or transformation, but also a life” (Caine et al., 2013, p. 578). In order to do justice to the stories captured, my findings chapter accounts for these stories authentically.

**Research Methods section**

In this section I discuss the methods used to ensure validity in the research, the sampling approach adopted and the procedures used to gather data.

**Validity procedures**

In qualitative research, it is essential to demonstrate validity and credibility of the study (Creswell & Miller, 2000). In my research, I have used several validity procedures to establish this.

The first method used to establish research validity was methodological triangulation, also known as mixed method research in the literature (Creswell & Plano Clark, 2006). “Triangulation is a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study” (Creswell & Miller, 2000, p. 126). In using methodological triangulation, more than one method is adopted in order to provide rigour, reduce bias to the findings and strengthen the outcome of the study (Bekhet & Zauszniewski,
In my research project, I chose to interview children and parents/guardians using semi-structured interviews and held focus groups with staff members. The purpose of interviewing children, their parents/guardians and holding focus group with staff members was to gain different perspectives on children’s experiences living in supervised group homes. Using triangulation, multiple forms of evidence were gathered rather than relying on one source of data (Creswell & Miller, 2000). Figure 3 below illustrates the multiple perspectives gained through the use of methodological triangulation.

**Figure 3 Triangulation method**

![Triangulation method diagram]

Another form of validity procedure used in this research project was the use of member checking. This procedure consisted of “taking data and interpretations back to the participants of the study so that they [could] confirm the credibility of the information and narrative account” (Creswell & Miller, 2000, p. 127). In this research project, I provided all participants with the opportunity to review and make any necessary changes to the transcripts of their interviews before the transcripts were analysed. Another form of member checking that I utilised was presenting my findings to staff members in focus groups. This gave staff members the opportunity to provide peer review on my findings.
Throughout the research process, I have practiced researcher reflexivity by being open and transparent regarding my own assumptions, beliefs and biases. This was discussed in the dual and insider role I have as a researcher and employee of the supervised group home. When researchers report on how their personal beliefs, values and biases shape their inquiry this increases the validity of the research process (Creswell & Miller, 2000).

Lastly, the use of thick, rich description establishes credibility of the research (Creswell & Miller, 2000). In my findings chapter, I use thick descriptions that provide “deep, dense, detailed accounts” (Denzin, 1989, p. 83) which reflect an accurate picture of the narratives told during the interviews. Using a constructivist approach, credibility is established as readers are brought into the setting and situation of the interview, making the research real and authentic (Creswell & Miller, 2000).

**Sampling procedures**

Robinson (2014) discusses a four-point sampling approach that I have chosen to use in my research. The first step is to define the “target population” (Robinson, 2014). Three supervised group homes in New Zealand were selected to be part of my research project based on geographical distance. The target population were children residing in three supervised group homes, the parents or legal guardians of the children and staff members who worked in the supervised group home. The inclusion criteria was that children needed to be currently placed in the supervised group home, they were over the age of 10 years (ability to give informed consent) and that they were not in a state of crisis.

The second point is to “select the sample size” (Robinson, 2014). The original plan was to interview four children and four parents/guardians in each group home, making it a total sample size of twelve children interviews and twelve parent/guardian interviews. However, not all the supervised group homes had four children placed in the group home, so this number was reduced to suit the circumstances of each home. A total of eight children and eight parents/guardians were interviewed.
Thirdly, a maximum variation purposive sampling strategy was used to select participants. Maximum variation sampling is used to sample the population in a strategic way so that sample members differ from each other and people and sites are selected because of the relevance to the research question (Bryman, 2012). In my research project, I wanted to explore how children experience relationships in supervised group homes. To ensure the information collected describes a range of possible experiences, maximum variation method of sampling was utilised. Examples of maximum variation sampling was selecting the child who had been living at the supervised group home the longest, and interviewing the child who had been at the supervised group home the shortest period of time. Another sampling method was interviewing a female resident, and a male resident. Interviews were conducted with the oldest child in the group home and the youngest person in the group home and young people of different ethnicities.

Lastly, sourcing the sample and recruiting participants was the final step. Information sheets were given to the team leaders of each group home to distribute to children and their parents/guardians. In order to ensure that participation was completely voluntary and that no coercion was used in recruitment of participants, I was completely removed from the recruitment of participants. No participants were approached by me until a written consent to participate was received from them. Children were only approached by the team leader regarding their willingness to participate after written consent was received from their parent/guardian. I discuss the access to participants in more detail under the section of ethical considerations.

**Interviews**

Semi-structured interviews were used during the interviews with children and parents/guardians (refer to appendix E for attached list of questions). The list of interview questions guided me with prompts of questions to ask. During the interview, I used an open-questioning technique where the precise nature of the questions were not determined but depended on the way the interview developed. Each interview lasted for approximately an hour and all interviews were audio recorded.

In order to make my interviews with children participants child-friendly, I had a set of picture cards that I used as scaling questions with some children who struggled to...
express themselves verbally. The cards had different expressions of faces on them and I lined them up on the floor on a scale from 1 to 10 (sad to happy). This enabled the children to have a visual reference and allowed them to score their experiences of living in a group home using the picture cards. This was a good tool to use as it enabled children to make conversation easily through the use of pictures. Another tool I utilised in my interviews with children was sheets of A3 paper and crayons for children to draw pictures or write down words as a way of talking about their experiences living in group homes.

**Focus group**

Focus groups were held with the staff members of each supervised group home. The original plan was to present the final findings of interviews in three of the group homes. However, by the time I had completed my interviews, one of the supervised group home was no longer in operation. I returned to two of the group homes and presented my final findings to the staff members in order to receive their feedback. The focus group discussion lasted approximately an hour and the focus group discussion was audio recorded.

**Settings interviews were held**

All interviews with children were held at the supervised group home they were residing in. All children were given an option of having an adult of their choice participate and support them during the interview. The interviews with the children were held in a private room in the supervised group home.

Parent/guardian interviews were held in the homes of participants. Parents/guardians were given the choice of being interviewed at the supervised group home or at their home and all parents/guardians chose to be interviewed in the lounges of their own homes. Interviewing parents/guardians in their own home enabled them to be relaxed and familiar with their own environment.

The focus groups were held in the lounge of the supervised group homes as this was a convenient meeting place for all staff members. The focus group was held on the
same day as their staff meeting so that staff did not need to work outside their normal working hours.

**Part C: Data Analysis section**

The method I chose to analyse the data was thematic analysis. Thematic analysis is a ‘matrix based method for ordering and synthesising data’ (Ritchie, Spencer, & O’Connor, 2003, p. 219). According to Braun and Clarke (2006), thematic analysis is a method used for identifying and analysing themes within the data. As I analysed the data, I looked for repeated patterns (themes) that emerges in the data which was relevant to the research question (Braun & Clarke, 2006).

I transcribed each interview verbatim and the data was then read and re-read to ensure thorough comprehension of the data (Bryman, 2012). I gave each interview a specific non-identifiable alpha numeric code to enable me to identify which group home the participant was from and whether he or she was a child or parent. As I read through the transcripts line by line, I noted down repeated topics at the bottom of each page as I saw them appear in the data. Next, I conglomerated the repeated topics into dominant themes and sub themes (Bryman, 2012). I assigned a colour code to each theme and sub-theme and went through each hard copy transcript to colour code the themes with different coloured felts. With the use of Microsoft Access, I copied each colour coded section of the transcripts into the respective themes. Microsoft Access was able to generate a report of the data in each theme.

There were a total of 16 dominant themes that emerged from the interviews with children and 18 dominant themes that emerged from the interviews with parents/guardians. 16 themes were similar in both parent and children interviews but 2 themes emerged that were specific to parents’ experiences. In the next chapter, I will highlight the dominant themes that came through in both parent and children interviews.
and will also specify the themes that were specific to children interviews and parent interviews.

**Part D- Access to participants and ethics section**

Ethics plays a crucial role in ensuring quality in practitioner research (Mockler, 2013). Mockler (2013) argues that in order for sound and ethical practitioner research to occur, there needs to be “an alignment between the ethical framework employed in the research enterprise and the ‘everyday ethics’ of practice” (Mockler, 2013, p. 156). While completing my research, I have ensured that my research with participants has been ethical and have aligned this with social work values and ethics. The section below highlights the processes I have undertaken to ensure that my research was ethical.

**Ethics approval**

Ethical approval was sought and gained from the University of Otago Human Ethics Committee on 7th February 2013 (approval number 13/008) before any research was carried out. In order to gain ethical approval, information was given on the purpose of the research project, the aim of the project including research questions the project intends to answer, the experience and qualifications the researcher and academic supervisor has in this research area. To ensure that research participants were kept safe during the research process, information was provided about the proposed participants, method of recruitment, consent processes, storage of data, and methods of collecting, coding and eventual disposal of personal information. Information was also given on how to manage potential risks if they arose during interviews and precautionary measures to ensure no harm or discomfort was caused during the course of the research process. All information sheets and consent forms were attached (please refer to appendix A). The University Ethics Committee confirmed full ethical approval to proceed with the research project.

**Access to participants**

The Ministry of Social Development (MSD) Research Access Committee (RAC) must approve any research involving MSD clients and staff. According to their guidelines, approval from the university human ethics committee must be received before the application to MSD RAC is made. Once I received full approval from the
Before any participants were approached by the researcher, they were given an information sheet inviting them to participate. This information sheet was distributed by the team leader of the supervised group home as requested by RAC. The information
sheet was written in age appropriate language detailing that this research project is for a Master’s thesis project and the final results will be in a thesis kept in the university library (refer to appendix A for information sheet). It was emphasised that participation is completely voluntary and there will be no negative consequences if a participant chooses to decline participation. During recruitment, researchers need to emphasise the voluntary nature of participation so as to prevent the perception of coercion (Mcdermid, Peters, Jackson, & Daly, 2014). All participants were also informed that they can decline to answer any questions and ask for the tape to be turned off at any time.

Free and informed consent was sought from all participants (refer to appendix A for copies of consent forms). Written consent was obtained from all participants before any interviews were carried out. Participants were informed they can withdraw their participation at any given time. It was emphasised that there will be no negative consequences on them or their child if they choose not to participate in the research project or withdraw their participation.

**Limits of confidentiality**

The limits of confidentiality, specific to safety concerns were explained before research was carried out. Safety concerns are when the researcher considers an individual at risk of harming themselves, harming someone else, or someone harming them. Before carrying out research, it is important to consider what to do when someone’s safety is at risk (Punch, 2005). It was discussed with my academic supervisor that if someone’s safety was compromised, I would discuss the safety concern with my academic supervisor in the first instance. When explaining confidentiality with participants before the interviews, they were advised that if any information concerning safety was raised, it may be necessary to discuss this with Child, Youth and Family.

**Storing of data**

All hard copy data was stored in a locked cabinet at the researcher’s home. Audio recordings of interviews will be destroyed at the conclusion of the project and all other data will be handed into the university to be stored for five years. All information in soft copy format will be stored in a password locked laptop and deleted after the
conclusion of the project.

**Dual role**

While completing this research, I had a dual role of being an employee of Child, Youth and Family as well as being a student researcher. Throughout the research process, it was important to be clear on the difference between my role as family engagement worker and researcher. Being aware of the impact of dual role as well as interviewing colleagues is important in research as it can affect the quality and interpretation of data (Brannick & Coghlan, 2007). To ensure there was clarity of the different roles, I had a conversation about the distinctions of roles with each participant before any interviews were conducted. In order to aid the difference in roles, I wore a University of Otago t-shirt when I was carrying out my research interviews. Whenever participants raised questions during the interview that pertained to my role as family engagement worker, I acknowledged the question they were asking and said that I would note it down and answer their question when I am in the family engagement worker role.

**Ethical considerations for interviewing colleagues**

The initial plan for this project was to interview staff members on their perceptions about their clients at the supervised group home. However, after considering the ethical issues regarding professionals discussing about vulnerable clients, I decided to change the approach to accommodate this ethical consideration. I chose to complete focus groups with staff members to present the final findings of the project with them. This ensured that staff members could not identify the information given from the clients interviewed. This approach resolved the ethical issue of staff members talking about their clients and also served to provide a form of peer review for my research findings.

**Children as research participants**

Ethical issues must be considered when research is conducted with children (Young & Barrett, 2001) who are “actively participating and are expressing their views and opinions” (Powell, 2011, p. 4). The United Nations Convention on the Rights of the
Child (UNCRC) emphasises children’s rights to participate. However, when children participate in research, it is crucial to consider ethical issues surrounding the research. The purpose of a research project involving children needs to be in the best interest of the child as children are vulnerable subjects who need protection from research risks (Kodish, 2005). Key ethical issues that need to addressed are informed consent, protection of children, anonymity and confidentiality and payment of research participants (Powell, 2011, June). While undertaking this research project, I have considered the ethical implications of interviewing children and addressed ethical issues stated by Powell (2011) to ensure that research was carried out in an ethical and safe manner.

**Children’s informed consent**

Informed consent was sought from all children participants. Three main elements according to Department of Health (2001) were considered before seeking informed consent from children. The individual needs to be capable and competent of making the decision; it must be completely voluntary without coercion; and they must be provided with sufficient information to make an informed decision (Department of Health, 2001). In order to ensure that children had the capacity to make an informed decision, only children aged between 10 and 17 years were interviewed.

Before any interviews were carried out, the guardians of the child participants were approached first to give their written consent for their child to be interviewed. After written consent was given by the guardians, the children were given a consent form to sign stating that their confidentiality and anonymity will be kept. Children’s real names have not been used in the research project and children were given the option of choosing a name to identify themselves.

The consent form also stated clearly that they can change their minds at any point in time and decide not to be part of the research project or interview (refer to appendix A for copy of consent form). It was important for participants to understand that participation in research project had no bearing on the child’s current placement and the research was completely separate from on-going social work processes.

All children participants were given a small token for their participation in the project. This was a fancy pen under the value of five dollars. If a child decided to
withdraw participation, the small token was still given. All children were also given an option to have a family member, legal guardian or staff member of their choice present at the interview. No data was collected without the written consent of a child and their parents/legal guardians. In order to protect the anonymity of children, no information that made the children identifiable was used in the research. This included the city of the supervised group home where the child was interviewed at, name of child, and date of admission and date of discharge.

**Safety issues**

While interviewing vulnerable children, there was a potential for children to raise unresolved issues related to past experiences or their current placement. I am an experienced and qualified social worker, and if those issues arose during the interviews was able to negotiate an appropriate and safe action with the child. If any abuse was disclosed during the course of the interview, the child was informed that the disclosure would be discussed with their social worker.

**Strengths and limitations of research**

There are several strengths as well as limitations to this research project. The first strength of this project is that data are collected from multiple perspectives, and the method of triangulation provides rigor to this research. The in-depth interviews with children and their families provide depth and richness that will not be able to be achieved via quantitative methods. This project has reflected social work research well as it has empowered children through hearing their voices and has the potential to enhance practice for children-in-care.

The dual role of being an “insider” in the organisation completing research has its advantages and disadvantages. While completing this research project, I was working in one of the SGH’s as the family engagement worker which helped to provide in-depth perspective into the living environment of the SGH. This however had limitations too as being an “insider” brings bias that could influence my perception and analysis of the data. However, in order to ensure that this project was rigorous, I have put several things in place to minimise the bias discussed previously in this chapter.
Another limitation of this project was the sample size of three group homes. Due to time limitations, a small sample size was chosen. Unforeseen circumstances also resulted in less individuals being interviewed as one of the SGH ceased to operate part way during the interviews. Due to the closure of one home, this meant that only two staff focus group discussions were held instead of the original plan to hold three discussion groups. It is important to consider that individuals interviewed from the three group homes are not representative of the views of all children, parents and staff involved in residential homes in New Zealand. However, this project has provided a good snapshot of the perspectives on several key issues. I would recommend that more children, parents and staff members involved in residential group homes be included in any future research projects.

**Summary of methodology chapter**

This chapter outlined the theoretical framework that underpins my research through discussing my epistemological standpoint and my research question. The methodological approaches employed in this study were discussed and the methods I adopted to ensure research validity was highlighted. I outlined the sampling procedures used and highlighted how interviews and focus group discussions were conducted. The use of thematic analysis was discussed in the data analysis section. Ethics was a major part of this project and the ethical considerations were deliberated in detail. Finally, the strengths and limitations of the research project were discussed with mention of future directions for research. In the next chapter, I present the data collected from the interviews with children, parents and staff members into dominant themes.
Chapter Four

Findings

Introduction

In this chapter, I present the dominant themes that emerged from the interviews with children, parent and staff into three parts. In part A, I present the findings from the interviews with children. In Part B, I present the findings from the interviews with parents and in part C, I present the findings from the focus group discussions with staff members. In order to maintain the anonymity of all participants interviewed, I have not specified which quotation belongs to which participants. However, in order to differentiate between quotations, I have separated them into different paragraphs.

The dominant themes that emerged in both children and parent interviews are listed below.

Theme 1: Children’s admission into group homes
Theme 2: Importance of family relationships
Theme 3: Relationships with staff
Theme 4: How they perceived the home environment and food
Theme 5: The importance of Inclusion and involvement
Theme 6: Peers, mix of home
Theme 7: Gender
Theme 8: Points system
Theme 9: Goal setting
Theme 10: Social workers role
Theme 11: Staffed facility
Theme 12: Structure and rules
Theme 13: Moving to independence, need for flexibility

Theme 14: Transition from group home

Theme 15: What can make it better?

Theme 16: Progress, what made the difference

Two themes that emerged from the parent’s interviews but not during children interviews were the themes of:

Theme 17: Parents on-going issues

Theme 18: The effect of multiple placements and the message of unconditional care

For the themes that emerged in children and parent interviews (part A and B), I provide a summary at the start of each theme on what the questions children and parents were asked, supported with quotes from the interviews. At the end of each theme, I provide a summary of the main points discussed under each theme. At the end of the children’s and parent’s findings section, I present a summary of the data collected in children and parent interviews in the format of a visual graph which summarises how many participants discuss each of the themes. The last section of this chapter is where I present the data from the focus group discussions held with staff (Part C). Again, I present the data from the focus groups under thematic categories and present what staff discuss from the two SGHs.

**Part A Findings from the children interviews**

**Theme One: Children’s admission into group homes**

Children were asked their views regarding their admission into the SGH. Some of the questions the children were asked were whether they had a choice in living at the group home, if they knew anything about the home before they moved in, how they felt when they first came to the group home and how the staff made them feel when they first arrived. Five out of eight children discussed the theme of admission during their interviews and talked about not having a choice in living at the SGH.
Researcher (R): Did you have a choice in living here?
Child (C): Nah, I got shipped down the day after I got told.

R: Okay, and how was that for you?
C: Horrible.
R: Mmm
C: I’ve never lived in X city before.
R: Yup. So what do you think would have helped?
C: Staying in the same city.
R: Ok. So having a placement closer to family?
C: Mmm hmm.

Five out the eight children talked about not knowing anything about the SGH before shifting in:

C: [I knew] absolutely nothing! I just knew it was in city X and knew it was a home. And I didn’t even get to come down for a visit first and everyone else gets visits. I just got chucked in… Yeah and they told me I was going… in 3 weeks. It was the next day! My Social Worker rang me that night, oh no and said I was coming down tomorrow.
R: Yup so you didn’t get any notice
C: Or sleep… It was horrible.

R: Did you know anything about this place before you came here?
C: No, I didn’t know anything
R: You just arrived and then
C: Yeah and they told me everything (laugh) and then I was like what the hell (laugh)
R: So obviously it sounds like you were quite angry?
C: Yeah.

R: So before you came here did you know anything about this place?
C: Mmm no
R: How did the staff make you feel when you first came? To the home?
C: Scary
R: Scary?
C: They were scary
R: What did they do that was scary?
C: (annoyed tone) they kept getting in my face and they went through all my stuff without permission… They were trying to say hello and they were scary.

Two children talked about having a familiar face in an unknown environment helping them settle into living at the SGH:

R: so staff member from the residence came down and spend abit of time with you to settle you in.
C: Yup that helped. I cried when she left too.
R: aw that must have been hard. Anything else that staff did here to help you?
C: Organise for the staff members I knew to come down.

R: How do you find living here?
C: Ermm I knew the people here before I came here
R: Okay, as in the young people or the staff?
C: Yeah the young people
R: Oh the young people okay. So do you think that helped you settle in abit better?
C: Yup.

Two children talked about their perception of how staff changed over time:

R: Yeah, so let’s start from the beginning. You said initially it was good. What was good when you first came?
C: I was on level 3, I got away with most things. I got you know, I got to do things the other kids weren’t allowed to do.
R: For example?
C: Like I got tea cooked for me, I didn’t have to do chores for a wee bit and if I disagreed on something they didn’t nag me about it but now they do.

R: How do you think the staff made you feel when you first arrived?
C: They were nicer (laughs)…they were nicer when I first came.

Summary of children’s view on admission into the group home

Five out of eight children felt they did not have a choice in living at the group home and did not know anything about the home before they moved in. The children expressed that not having prior knowledge of the home and not having familiar relationships at the group home was often a fearful experience for them. Having a visit to the home before they are admitted would help the transition process. Children felt more at ease when they knew a familiar face coming into a new environment. Children expressed that it was important staff members remained consistent in their approach right from when they entered the home.

Theme two: Importance of family relationships

“everybody needs their family. No matter how old they are”- child interviewed

All eight children talked about the importance of family relationships in their interviews. Children were asked about their views on what is important to them living in the SGH, how regular their contact was with family and their views on living away from family. They were also asked who they felt cared for them outside of the SGH. All eight children interviewed mentioned how important family is to them and the importance of having regular contact (face-to-face) with them and phone calls being an addition to that. One child who lived in a different city from her family discussed how difficult this was for her.

R: How about contact with family? Cause you mentioned that family being in a different city is quite difficult.
C: Its crap. Horrible. Cause I have to watch other people walk out of the house with their family and I mean mum can’t even come down because they can’t fund for her. And it’s difficult being in a different city to my family.

Two children interviewed raised their objection to family contact being behaviour dependent:

C: Cause I really do miss my mum and I haven’t seen her in ages and I am not allowed to go see her if I have been naughty… Yea, CYFS rules!

C: This staff member she goes “if you don’t do this if you don’t behave you won’t be able to go to your aunty’s or anybody’s or we will just make you late”. Sometimes they go if you do something bad then we will just wait until you are ready and we will add 30 minutes on and you will be just late, and then like everytime I say you can’t, cause I rang [the manager] about it, and they said no you are not allowed to do that… Oh, you can’t threaten me about my family, [the manager] said you are not allowed to.

C: Yeah, and I just don’t like how the staff say (in deep voice) “Oh I am going to cancel your visit because you’ve been unsettled” like its like you don’t do anything wrong, I mean sometimes you do things wrong but they shouldn’t use that as a blackmailing kinda thing or threat or if I say “are you threatening me?” They say “no it’s a promise”. I’m like what the heck.

R: So when they say that kind of thing how does that make you feel?
C: Makes me feel much more annoyed than I was before. Because they shouldn’t use that as a like a threat. I know what’s going to happen if I continue, but they should not like rub it in you know, makes me feel more (sigh)

R: Annoyed?
C: More than annoyed.
R: Yeah?
C: Really really really really really really angry. Cause they don’t listen to me and I feel depressed, what’s the point of this.
One child expresses her view on family contact giving her hope:

C: I have too many things to look forward to.
R: Mmm, what are some things you are looking forward to?
C: Going to see my family.

This child expresses her desire to live with family. She recognises that some children are happy in a staffed facility like the group home, however is clear that living in a SGH does not meet her need for love and belonging:

C: With some people it’s whether they are happy in their environment and stuff, sort of the same with me but like the other kids can easily live here if they are happy. I can’t. I need my family. I can’t stay here forever without my family, I need them. Not want them, I need them. They can live without their family, literally they do that they are happy most of the time, I have been happy like maybe like past two three weeks that’s because I’ve had good communication with my mum and family and I can go see baby and stuff.

R: So if you could change something what would that be?
C: For myself? If I could change something I would try my very hardest to be back with my family.

Summary of children’s views on theme two: Importance of family relationships

All eight children talked about the importance of family during their interviews. Seven of them expressed wanting more contact with family. Children felt it was important they had regular face-to-face contact with family and phone calls being addition to that. Children who lived in a different city to their family struggled with having limited access with them. One child expressed in the interview that it is very difficult emotionally being in a different city to her family and that family contact needs to be accessible. Placements need to be in the same city in order to facilitate regular face-to-face contact.

Two children expressed their frustration towards staff members who used family contact as a condition for good behaviour. Another child expressed missing her
mum but has been denied contact due to her behaviour. Both children perceived staff members using family contact as a threat in order to get them to behave. The children felt this was not fair and instead of helping them settle down in their behaviour, being denied family contact created more anxiety and stress for them.

The importance of family came through in all interviews, and when children were asked the question “who do you think cares for you?” All eight children said “family”.

**Children’s views on theme three: Relationships with staff**

All eight children discussed the theme of relationships with staff during their interviews. In order to explore how children viewed their relationships with staff in the SGH, they were asked how they found staff members in the SGH and to describe staff members they liked and disliked. Children were also asked if they trusted anyone in the group home and to talk about what made them trust that person. They were also asked if they felt staff listened to them and to talk about whom they feel cares for them while they live at the SGH. Children’s perception on relationships with staff members are presented below.

Children’s views on staff members they liked:

**C:** The nice ones, why I think those people it’s because they don’t exactly supervise me all the time, they let me have my space, they shouldn’t always supervise you even when things aren’t even bad, all settled, they still you know. That’s what I feel should be done...

**R:** So you feel they trust you

**C:** Yup.

**R:** What else do you like about staff X?

**C:** I don’t know, it’s just her attitude towards us.

**R:** Yeah

**C:** It’s just cool.
R: Okay
C: She doesn’t think negative like a lot of the other staff.
R: And ermm, how about her tone of voice?
C: It’s just like real, like she’s a real happy person (laughs)
R: Alright, so I am hearing you say that staff member coming to work happy is very important to you guys.
C: Well its better than them coming to work with a shit as attitude and everything.

C: She always trust me, she feels like I am in a happy enough mood to behave like last time but she always gives me a chance
R: yeah
C: She just goes for it, she gives me a chance all the time
R: Yeah, so everyday is like a new day for you.
C: Yeah.

Children’s views on staff members they disliked:

C: I don’t like staff x because x is mean to me like arguing with me about stuff I did not do, and smiling when I get in trouble… She was loud, and she smelt really badly…she was pushy… she was really touchy…And she was just really annoying… And she was quite embarrassing too.

C: And also I get annoyed when staff are real strict and they go “rah rah rah rah rah” (in grumpy tone) and they start like being real frustrating and they start like getting real aggro for now reason and they come in here and go “get off there! Rah rah rah! (in very stern deep tone)... Like they started being pushy and mean, yeah.
R: Yeah, so they started to become more strict and
C: Strict and mean and bullying.

C: She has this thing that really irritates you like she states the obvious like she is really bad for stating the obvious
C: With the horrible people [referring to staff she dislikes], they just they don’t listen to me, they ignore me, they don’t do anything about it, they just make me feel really annoyed…and then they accuse me and put me on level 1 when I didn’t hardly do anything.

This child discusses how staff’s inaction in dealing with another child’s emotional distress was very distressing for her. She stated that she did not like staff who were not able to attend to their distressed emotional states as she felt uncared for:

C: Cause when we are upset and are crying they go “oh I don’t want to deal with a crying kid”. Go and see what another child is up to. They just like leave you there. Like when [child’s name] was in the hallway crying, she was all I can’t breathe, I felt really sorry for her.

R: Mmm because she was so upset.

C: She was so upset, she was like building herself up to you know like you know… Yeah and they were like just standing there in the hallway, staff were just standing there talking to each other… leaving [child’s name] crying over there, and she was like going to puke, she was crying so much, her tummy was so empty she was feeling real sick and sore and stuff. And she was huddled in the thing and she couldn’t stand because she was overwhelming herself and the staff just stood there… like if that was my daughter I would be like, aw, I would cradle her and go its okay… Don’t cry.

**Children’s views on “how do you know a staff member cares?”:**

C: They take me to school.

C: They give you a house, they give you food, they give you a bed… they respect you, they give what you want if you’re nice so that’s all I know.

C: Ermm, she hugs me when I am sad… And yeah she tries to help me she physically tries to help me like with my Aunty and stuff.
R: Yeah, okay so you feel she cares not only about yourself but your family
C: Yeah.

C: But like coming to CYFS and being in this home is supposed to make everything better, supposed to be safe, supposed to be like caring loving, blah blah blah, but it feels like the staff are just here to do their job, they are not here to care about the children except for x, what x did today was really nice.
R: Yeah. So what you are saying is that you don’t want staff just to come here and do their job but to come here and care for the young people.

R: Oh yeah, so what do they do to let you know they care for you?
C: They just kinda listen to me, they all sweet and kind, they make, occasionally make things happen and stuff, that makes me feel better.

C: When a staff member was spending time getting to know me, listening and talking to me when I first arrived, took me shopping for my school books. I felt safe.

Children’s views on how relationship with staff can be better:

C: Probably, have staff supporting and staff like ask you like ask you like ask you the separate staff like asking you like what do you think I should, how would you like me to be for you, what do you think of me and blah blah blah you know like starting to get to know the staff if you know what I mean.
R: Mmm hmm, so like building relationships with the staff? And they getting to know you and you getting to know them?
C: yeah.

C: That’s all I can say, they listen to you at times, sometimes they will sometimes you ask can I have my scooter, they say yes and then you don’t get it.
R: Oh okay, how come?
C: I don’t know, they probably playing games at me probably.

C: Especially in the mornings, they will just open my door, get up! Like real loud and oh my god its morning, (sigh) and it’s so early in the morning, points taken off if you sleep in, points taken off if you don’t have breakfast at a certain time, I don’t actually care about the points. Its more you shouldn’t be starving me.

R: Mmm

C: You are starving me, and they go, its not starving you if you do as you are told. Just like I can’t do as I’m told if you are yelling at me to get up early in the morning.

R: So it starts right from?

C: From the morning

R: So it about how they wake you.

Summary

All eight children talked about the importance of having positive relationships with staff members. Children expressed that they liked staff members who were positive in their engagement and attitude, who showed the child they cared through their tone and actions and staff who modelled trust in the relationship. On the other hand, staff members that were disliked by the children were those who had a negative or grumpy tone, those who failed to listen and attend to the child’s emotions and those whom the children felt were unfair. One child was specific in stating that staff members who did not attend to another child’s distressed emotional state caused her and the other child to feel uncared for. It was upsetting for her to watch another child be in a state of emotional distress and not being able to do anything about it.

Children were specific in stating how they knew staff member’s cared for them and this was often in practical ways eg: taking them to school and providing their basic needs. Children wanted staff to care for them rather than coming to work to do a job. They wanted staff to take time to get to know them and to listen. In my interviews with the boys, they all expressed their desire for staff to spend quality time with them doing shared activities eg: taking them to library, going swimming, playing xbox. The boys
talked about wanting to do things with staff members and quality time was important to them. Children who appeared to be settled and engaged in the placement were able to identify at least one staff member whom they trusted.

**Children’s views on theme four: How they perceived the SGH environment**

Seven out of eight children interviewed talked about their perception on the SGH environment. Several children commented that the SGH was more homely than residence, however, children struggled with everything being locked and needing to ask for staff to open rooms, fridge, toilet and to get TV cords. They perceived it as a lack of independence, freedom and normality.

C: the only places that should be locked are the office, the staff’s bedroom, ermm and the bedrooms, not the bathrooms, not the toilet, not the kitchen, not the lounges…the laundry should be locked because people can run away. That’s the only reasons why the other rooms should be locked 24/7.

One child expressed how the SGH does not meet her need to belong to a family:

C: and ever since I’ve been in this home, everything has been quite Depressing and everything has gone bad for me down here in this home, not down here, everything outside of this home is absolutely fine, I love it, whenever I am in this home I am always angry, upset even depressed

R: yeah. Why is that?

C: It’s not a normal family, I hate living with strangers, I hate it when they fight, it’s just so annoying like why do you even bother?

This child struggled with the fact that the SGH is a care and protection home yet she is made to feel like she has done wrong due to the rules and restrictions placed on her:

C: Because this is a step down from residence homes and half of us didn’t even come from residence so we are wondering why we have all these rules when we done nothing wrong? Sigh.
R: So the point system makes you feel like you are doing wrong?
C: Yeah, just like the rules here it’s like what did we do?
R: Mmm
C: We didn’t come from residence.

This boy used humour to describe what it felt like to live in the SGH. Using a robot and monotone voice, he expressed that the home’s structure and routine was rigid and repetitive:

R: What are some things you have learnt being here?
C: (Using a robot voice) learnt to be good, and to respect and to do all the things I shouldn’t be doing, learn to get up, learn to make my bed, learn to clean my room, learn to go to toilet. Nah.
R: (Laughs)
C: learn to do things that you do in life.

Sub theme: Theme of food in the SGH

While interviewing children on their experiences living in the SGH, four out of eight children talked about how important food was to them. Food came up as a dominant theme during the interviews when children were asked about what they liked about living at the SGH.

This child expressed how they loved the food staff made for him:

C: They make me the best lunches ever!
R: What is good about living here?
C: Er, get fed… I love schnitzel and lasagne.

Food was a symbol of being looked after and nurtured by staff members. This child commented on staff’s approach to cooking meals for the children:

C: Ermm [staff name], she always likes cooks for us.
R: Oh nice
C: And when [staff name] is not here no one cooks for us (laughs)
R: Oh okay
C: So its kinda like fend for yourself when she is not here.

This same child had an experience of a padlock being used on the fridge at the SGH she was residing at “because people steal food”. This was her perception of it:

R: okay, so I am really curious on the lock on the fridge, so when you are hungry what happens?
C: You just gotta go. We have set times of when we are allowed to eat which is normal times
R: Yeah
C: And we just have to go ask for staff to open the fridge or open the pantry
R: So that’s say you come back from your course and you are hungry can you have food, can you just ask the staff for food.
C: Yeah, so you get in the morning something to eat, after school then you wait for tea and then we have supper. (sigh)
R: So in between times if you want a snack?
C: No yeah
R: How’s that?
C: Hmm?
R: How does that feel if you are hungry?
C: I reckon its dumb
R: Mmm okay. So if you could change that you wouldn’t put a padlock?
C: No, it’s like we are treated like not humans.

The child above felt that the padlock deprived her of her of one of her basic necessities, food. The impact of the padlock on the fridge made her feel like she wasn’t treated like a human. This was her suggestion to improve things:

R: Yeah, that’s a very good point. Mmm okay, so if you were running this place you would take away the padlock and trust the young people?
C: Nods. I would give them more of a say to what they want.
Summary of children’s views

Overall, children felt their physical needs were well provided for at the SGH. This included things like food, a bed, xbox and playstation. Children expressed struggling with the fact that everything was locked and wanted more normality. One child also expressed that she felt she was being punished by the rules and restrictions of the SGH even though she had not done anything wrong. It was clear that the SGH environment does not meet the needs of all kids as some need a family-like environment. Food came through as a symbolism of being looked after and nurtured by staff and it was important that food was accessible to the children.

Children’s views on theme five: involvement and inclusion

Five out of eight children felt they did not get a choice in living at the SGH and talked about their need to be involved in their plans and to be included in decision making.

This child expresses the lack of her involvement in where she lived. By this stage, she had numerous caregiver placements:

C: I never get a choice where I go…cause I’m in custody.

This child expressed that no one is given a choice about coming to the SGH and it would make a difference if they had a choice:

R: Okay. So did you have any choice about coming here?
C: Nah, I don’t think anybody does. Except apparently I heard this dude he came here for a visit and yeah he didn’t come here.
R: Mmm. Do you think that would have made a difference if you were given the opportunity?
C: If I had the choice? Yeah.
This child expressed that she had to be at the SGH as a condition to return home:

**R:** No? So did you have a choice in coming here?
**C:** No I didn’t

**R:** How did you end up here, what happened?
**C:** Cause I have to be here… or otherwise I can’t go home.

This child expressed that every child requires an individualised plan to suit their unique needs:

**C:** But you know you hear a lot that their plans aren’t working, whether it is or not I don’t know… yeah everybody has different needs.

This child highlights the lack of a complaints process at the SGH for children. She experienced staff treating her unfairly and wanted to complain to the manager about it, however this was not a child-friendly process:

**R:** So it’s really good that you could talk to the manager about it.
**C:** Yeah laughs

**R:** Do you feel it was easy for you to just like ring her?
**C:** oh, it took me a wee while. Because they [staff members] were like no you are not allowed to ring anybody except if it’s something good. So I had to say it was something good and then they were all like oh yeah, and then I have to tell them it was something bad but ermm yeah and then it was easy to tell her and she asked me to write it down and complain about it… I wrote complains and reasons and stuff and then… I think I gave it to the staff.

This child also highlighted the need for someone neutral eg: child advocate when there is a disagreement with a staff member:

**R:** Mmm okay. Did you feel with the way staff member X treated you, do you feel you could talk to anyone about it?
C: no
R: no? not at all? How about the manager could you go to her about it?
C: [manager’s name] will probably say she is a staff member you got to respect her and she will probably say that if you respect her she will respect you…Yeah, every time I respect her she doesn’t respect me…And every time I try to complain about it, the staff member turns it back like I did something wrong.

Summary

The interviews with children highlighted their lack of involvement in having a choice in living at the SGH. The placement at the SGH was likely to be more successful when children were involved in the decision making process. Children also expressed wanting individual plans and not a “one size fits all” approach. It was important to children they had an opportunity to have a say and a voice. The lack of a child-friendly complaints process was highlighted as a gap and children needed someone neutral they could approach if things were not fair.

Children’s views on theme six: Peers and mix of the home

Seven out of eight children discussed the theme of peers and mix of the home in their interviews.

Several children expressed the difficulty in living with other children in the SGH:

C: The other young people, it’s hard to get along with them…And when you are living here with them.

Some children mentioned about the age range not being too big at the SGH as different ages had different needs:

R: If you could make changes to this place what do you think that would be?
C: The combination of young people coming in…So if there is [older teens], perhaps not put a [young child] just to say that…I’m not putting it down to him.
But you know because the programs we did were more to his age. He got bored really easily… And everyone was trying to entertain him because he was getting bored and we were sick of pretty lame programmes … And we had to do some pretty weird programs because of him… Cause the older ones, we got sick of it … yeah cause there are people that are really immature and digs into you. It’s hard!... Yeah cause you got to live with them. You can’t just say ok I’m going bye.

This child found it difficult that her schedule was dependant on another child’s behaviour. She found it frustrating that she had to wait for this child who made her late for school:

C: And it’s not fair because I have to wait for a young person [child’s name] to hurry up in the morning, and I was late for school this morning and it really p* me off (she was running late) purposely!

Children were asked how they found living with other children in the SGH. This child struggled with the negative behaviours of other children:

C: Ermm, it’s good because you can have a bit of company but most of the time it’s pretty shit… well they kinda wind you up kinda thing and they keep yelling or swearing or slamming doors… or you can’t take that iPod away from me stuff like that kinda thing, or that’s in my plan I need to talk to my Social Worker or I need to talk to [Staff member] and she slams the door and has a big sulk about it… and I am like please shut up.

R: how do you get on with the other young people?
C: ermm, at the moment there is only one here so really well… well when [children’s names] were here, oh it was a nightmare… we never got on
This is one’s child’s experience of being bullied by peers in the SGH:

C: I just don’t like it here
R: Yeah? what don’t you like about it?
C: That I am being hurt here
R: You are being hurt? Okay. Who is hurting you?
C: The boys in particular, but one’s left.
R: Yup, so as in? Their words are hurting you or?
C: Threatening, kicking, they ermm, that’s mostly it.

Summary

Several children expressed the difficulty in living with a range of children with complex behaviours and that you can’t choose who you are living with. Children felt the mix of the home was important eg: age range. Depending on the mix of the home, there could be a lot of fighting, arguing or bullying behaviour. Some children expressed enjoying the company of others when things were going good.

Children’s views on theme seven: Gender

All the girls interviewed (five out of eight children) talked about how difficult it was living with all girls:

C: We need more boys here… Cause boys don’t argue… having girls they are always trying to find something to argue about. Because they [boys] are easier to get on with. Because you know you both like different things.
R: So you are struggling with the current mix of young people. What’s difficult about living with them?
C: Mmm. Do I really have to answer that?
R: No, you don’t have to.
C: Laughs. It’s kind of obvious. They’re too catty.

C: Oh I hate it… I DON’T WANT ANY GIRLS! Can I make it clear, I don’t want any girls. I hate girls, I just hate them. They are all bitchy and then they steal your shit out of your room…why can’t I be surrounded by boys and girls,
because being with all girls is catty, bitchy, it’s just horrible! Why just can’t I be the only girl? Not that I like boys or anything, not in that kind of way… but like I just don’t want to be with girls it’s just disgusting, they leave tampons around and everything and then they accuse me for it

This child talked about the negatives of having an all-female environment including staff:

C: I think its cause we are girls and we cause drama… And we get in a bad mood so does the staff (laughs)
R: Oh okay. Are you talking about female staff or males?
C: Oh there are not really males on.

Summary

All the girls interviewed said that living with all females was difficult because of the cattiness. Children preferred a mixed gender home as it felt more normal. One child commented on the negative impact it had having an all-female environment, including have all female staff members.

Children’s views on theme eight: Points system

Six out of eight children discussed disliking the points system in their interviews. This child expresses how the points and level system in the SGH does not work for her:

C: Oh, I don’t actually care about them about the points and levels thing, I think everybody knows that I don’t care about it. But yeah… I don’t actually think it’s a good idea, I mean like other staff members are like, yeah it’s a good idea, it’s a good idea, it works really well, but it doesn’t.

She continues about how the points system feels like a bribe to her:

C: Yeah, cause I don’t really care about the levels. But ermm, yeah like the children aren’t being themselves, they are purposely, they have to be good to be
on level 3... Cause it’s like seems like a bribe. [child’s name] and me pretend to be good in here but outside we are dare devils. it doesn’t (work) because it’s a bribe, because level 3 you get to buy cheaper things and you get to spend points and blah blah blah, and you can be on Facebook when you are on level 3, so I was looking to get on level 3 so I could get on Facebook.

This child feels that level 3 (the highest level) is difficult to attain and has given up:

C: I reckon they are dumb… Yeah cause they changed our BMS points system and like there are 3 levels. And it gets better the higher you are. And now it’s real hard to get to level 3 so all of us are on level 1.Laughs. Yeah it’s just like no (laughs) don’t feel like trying anymore.

This child does not find the points system to be normal. She speaks of times when she is having a bad day because she is missing her family and feels like she cannot be real with her emotions because she may get further penalised through the loss of points:

C: But you have to be on level 3 (sarcastic tone) to do this and this and this so you have to, you can’t choose to be good, you have to be good, you have to be fake, you have to be what the staff want you to be… you can’t be yourself… want this home like more normal, and if you having a bad day you can be real with staff and you won’t lose point just because you are having a bad day because you miss your family.

This child expresses wanting a system that is normal and applicable when she leaves the SGH:

C: They are just making us do this [points and levels] and what are we going to learn from it, we are just going to go back home and not learn from it. We don’t do points at our own house. It’s a waste of time.
R: do you want something a bit more normal.
C: yeah that we are going to go back and actually do.

Children’s views on what can be better:

C: I think everybody should have a reward chart. Serious… so everyone gets rewarded whether they are on level 1 or not. Cause if I am really naughty today, and then tomorrow I am really good for the next 8 days I’m really good, I’m really good, we can still get rewards for that. Instead of waiting for so long to be able to do anything. And with having my family in [different city], I can’t even go out when I am on level 1 or 2. I can’t even go anywhere.

R: mmm, so what would work well for you?

C: For me? Just like what we’ve been doing, the individual goals and stuff.

Summary

Six out of eight children interviewed expressed frustration at the points and levels system. They commented that it did not feel normal and did not allow them to be themselves. One child described it to feeling like a bribe and another child said it was too difficult to attain level three so they had all given up. Children felt that individual goals would work better than the points and levels system. On the points and levels system, when children drop down to level one, they have to wait eight days before they can redeem privileges and rewards. Eight days felt like a long time to the children and they thought a rewards system could be put in place to reward them for good behaviour during that period of time.

Children’s views on theme 9: Goal setting

All eight children discussed the theme of goal setting during their interviews. Even though children expressed frustration at the points system, they still saw the importance of setting goals. Children were asked if they had any goals they wanted to achieve when they first arrived at the SGH and if being at the SGH has helped them achieve any of their goals.
This child talks about improvement at school and improved relationships in her life:

R: What other goals have you achieved?
C: Well, I’ve improved my school. I’ve improved my relationships with some people, ermm like my friends, family and stuff… I’m learning to forget the past and move forward. Some people remind me at school what I did in primary and stuff but I just feel like I regret it but I still feel down and upset but who cares what they think they obviously don’t realise that (I’ve) changed, that made me think, hey I have changed you know.

Children were asked “What have you learnt here at the SGH?” This is their response:

- “Discipline, a lot of it (laughs)”.
- “My manners”.
- “I am changing my behaviour a lot… I’ve stopped my violence… I’ve stopped being too abusive, my mouth still can be abusive but not as serious as I was when I was younger and stuff like that… there is no point even doing it because it’s not going to get you anywhere in life and you can be in prison when you grow up and you want to succeed in your life kind of thing and it makes me realise I could stop you know, think of a better solution you know”.

Some children noticed a change in their behaviour since being at the SGH:

- “attitudes, swearing”.
- “I have not threatened anybody yet”.

Children were also asked if they had any goals they wanted to achieve:

- “Well, to keep me safe. Is to stop running away, stay at home, you don’t get hurt here basically, out there you could. You never know”.
- “Just go by my goals so I can go back home… ermm get all my community service hours done and all that and get all my court finished and then I’ve done basically everything. And now I’m doing my transitioning out of here”.
- “going into drug and alcohol counselling”.
“at the moment, my goal is to be good until I go to mum’s and then when I come back I will just be my usual self”.

Summary

All eight children talked about the importance of achieving goals in their interviews. Even though six children expressed disliking the points and levels system, the children saw benefits and the importance of goal setting. There were several things that children learnt while that being at the SGH. Some of these goals that they achieved were doing well at school, managing anger, improved relationships with friends, family, making better choices, improving attitude, not swearing and not running away. Children tended to achieve goals that they set for themselves and which had meaning to them. Children had goals they wanted to achieve like completing alcohol and drugs course, seeing family and returning home.

Children’s views on theme ten: Social Worker’s role

Six out of eight children discussed the role of their statutory social worker while they lived in the SGH. Some of these roles children saw their social worker’s role to be were:

- Attending multi-agency meetings at the SGH.
- Writing up plans for the child.
- Finding a caregiver placement.
- Organising visits with family.
- Deciding where the child lives.
- Visits every eight weeks.

Some children had a strong relationship with their Social Worker and spoke favourably of them:

C: My social worker he is always there when I need something and need something done.
Other children who did not have a good relationship with their Social Worker talked about the Social Worker making decisions on their behalf which they were not happy with:

C: yeah, but the MAT meetings they are unpredictable… because you don’t know if [Social Worker’s name] is going to say no or yes or if I am going to get upset if she says no or yes… I have no control… you see if [Social Worker’s name] says no I can’t go see my family anymore I am just going to go to how I usually was, running away, smoking legal highs, destroying my life pretty much.

This child is not happy with the plan currently with regards to contact with family but feels they cannot talk to anyone about it:

C: Nah, I can’t [talk to anyone]. They can’t do anything about it because its CYPS… But that’s my point of view.

Summary

Children saw the role of their statutory Social Workers as having decision-making power around things that were important to them eg: where they lived, finding a placement, managing their plans and contact with family. Some children had a strong relationship of trust with their Social Worker whereas others saw the relationship as an imbalance of power and Social Workers making the decisions for them which they were not happy with.

Children’s views on theme eleven: Staffed facility

Four out of eight children discussed what it was like living in a staffed facility. Living in a staffed environment brings its advantages and disadvantages.

Children identified several benefits of the SGH being a staffed facility:

- Having a keyworker at the group home to work through individual plan with child.
- Not having the same staff with you all the time as staff are on shift rosters.
- Different staff members that have different interests and personalities.

This child struggled with the fact that everything is communicated to other staff members through the use of shift notes:

C: But yeah if I talk to one staff member they put it in the notes. They even put when we have our periods! Seriously! And there are male staff too!

This child would like the staff to make the SGH more normal by not hanging their keys on their neck when in public:

R: What else would make it friendly?
C: Ermm not having keys or something in public, like the work keys in public.
C: yeah cause it makes me feel bit what’s the word un-normal… like people thinking, what the heck?
R: People wondering why she is going around with someone with keys?
C: yeah why can’t we just have a normal kind of area, when it’s the public it’s the public you don’t want the public to have bad reputation on you or thinking what the heck you know what I mean?

Summary

Children saw the benefits and disadvantages of living in a staffed facility. Children enjoyed working with their designated keyworker on their specific plan and enjoyed having a variety of staff. However, children struggled with staff members discussing every single detail about children and not making it normal by displaying their staff keys in public.

Children’s views on theme twelve: Structure and rules in the SGH

Six out of eight children expressed their views about the rules and structure of the SGH. Some children struggled with the fact that it did not feel like a ‘normal’ environment for them:
C: It is hard because we can’t go out much and we can’t have sleepovers… Like my friends will ask me do you want to come over for a sleepover? I kind of can’t, cause I live in a group home?

C: you are not allowed your cellphone… You go to bed early… I have to go to bed at 830 it’s so early… in my other family’s home I went to bed at 9:00. And at my house I go to bed whenever I want… and no smoking.

This child talked about what could make it more normal for her:

R: So what do you think would make it better for you as a teenager living in a group home with other young people?
C: Being allowed my space… Being able to go out… I reckon everybody should be allowed at least an hour a week to go out whether they are on level 3 or not to have down time.
R: Mm okay. So away from the group home where you can hang out with friends?
C: mmm. Or go to the park for a run or you know, and go get a coffee.
R: Yeah so not so restricted?
C: mmm.

This child found the inconsistency of rules difficult:

C: And I feel like the other young person she swears all the time and slams doors and the staff are used to her swearing and they don’t put her down and they don’t put her down the levels straight away but with me it’s like oh, you know.

This child expressed that she was not told the rules of the SGH when she first shifted in and this made her feel frustrated as she felt the rules changed:
C: They just they didn’t really tell me about the rules at the start… And then not long ago they started bringing up all the rules again and I was like okay, didn’t know that (sigh)… The rules that they have they are making them stricter.

R: Do you want to give me some examples?

C: Like there is a padlock on the fridge (laugh)… Ermm it’s because people steal food (laugh)… that’s what it’s about. Ermm, not allowed cellphones.

R: So were you allowed that initially?

C: Yeah I thought I was I kept it for a couple of nights and then they were like can I have your cellphone? I was like what? (laugh)

R: hmm okay, so do you think it would have been more helpful if you knew the rules right from the start?

C: Yeah

R: Yeah, okay. Do you guys get a booklet to tell you all about the home when you first arrive?

C: Yeah but they don’t say that stuff.

R: Oh right so they don’t say that stuff. So its not clear. So must have been confusing for you?

C: Yeah.

This child felt that she was singled out by the staff members even though other children were misbehaving too. She felt this was not fair. The consequence that was given by staff felt harsh and punitive to her:

C: We were all naughty, and [staff member] just took out only took out my stuff out from my room, and he took my blanket and my pillow and only left me with a sheet and no pillow and one little blanket and some posters on the wall and he took all my shoes and my duchess out… because we were all being naughty and he only did it to me… and all the other girls, [children’s names] got all their things in their room… no it was not fair! no because they did not care. They were like, nah, you are being naughty tonight. They didn’t care!

R: What were you doing that was naughty?
C: We just didn’t go to bed but they only took my stuff out of my room not [children’s names]
R: Mmm okay. Mmm, so you like things to be fair. Okay.

This child felt that some rules were implemented because previous young people had misbehaved. Children perceived this as being unfair and a lack of trust Eg: stealing food, damaging vehicle/property:

C: No like if I could change everything I would because some of the stuff is unfair for the young people here.
R: Yup, so tell me a bit more about that what would you change to make it more fair?
C: more of a home. Yeah I just wouldn’t have all these stupid rules like you are not allowed to talk to your family for that long, you shouldn’t need to go ask can you come open my room for me and other young people are aren’t allowed in other people’s rooms. And you are not allowed to sit in the front seat (of the SGH van).
R: why is that?
C: because [previous children damaged the van]
R: oh so it was damaged
C: Yeah and it [the repairs cost a lot of money]… so no one is allowed it… yeah why, we didn’t do it so… and the padlock on the fridge… it was previous young people [who stole food].

Summary

Most of the children that expressed frustration around the rules at the SGH were older and wanted more normality. The children struggled with the rules being inconsistent and emphasised the importance of fairness. Children expressed they would prefer if they were informed of the rules when they first arrived rather than the rules changing on them. One child expressed that it felt unfair that rules were implemented because of previous children who had lived in the home eg: having a padlock on the fridge and not being allowed to sit in the front seat of the van.
Children’s views on theme thirteen: Moving to independence and the need for flexibility

Three of the eight children interviewed were of the age to transition to independence. They expressed that the group’s home rules and structure did not help foster independence and prepared them for the transition:

C: Yup. It is, you can’t go out. You can’t even have a sleepover without your friends being police checked or sussed out by [role of staff].

The reason why is because I can’t just do my own thing I can’t have sleepovers I can’t just do independent things it has to be on your plan you know and it just gets me frustrated because I just want to be treated like everybody else out of care kind of thing

C: I don’t know actually, probably going to a place like this but where I can go out.

R: Oh ok

C: But the thing is there aren’t a lot of places like that.

R: Yup. So you like this place but you would find it better if it’s a bit more flexible?

C: mmm.. If you are going into a flat, your stress levels kind of shoot off through the roof.

R: mmm so do you feel the group home is supporting you to prepare you for the flatting?

C: Yeah but it’s hard because this is restricted.

R: mmm Ok. So it will be better if we can be less restrictive so we can prepare you better.

C: Yeah…just because I am a teenager. And teenagers expect more cause they are trying to grow up. Cause they are too old to be children but too young to be adults.

C: and it needs like you know and the staff need to make sure we can have more independence, that they can trust us they can actually do things about it, more of a family touch not a prisoner touch… everything is monitored… I think I need a
bit more freedom.

C: The rules are over the top… not normal.

Summary

Children who were older and moving to independence did not find the group homes were flexible and helping develop independence. One child described the rules as “over the top rules, not normal. Children would like more flexibility and normality to help them prepare for independent living.

Children’s views on theme fourteen: Transition plan from SGH

Two out of eight children discussed their transition plan from the SGH.

This child talks about the difference between leaving a placement to another placement compared to transitioning to independence. She expresses how stressful it is on her:

C: Oh you’re leaving, you know you are staying here and then you are leaving. Whereas this time I am staying here and then leaving to a flat… Like everyone keeps saying, oh you did so well last year and I didn’t have all the stress on me like about going independent.

This child expresses her frustration of living in the SGH without a caregiver placement in sight. She expresses that CYFS has been trying to look for a caregiver for her for a very long time:

C: If I had freedom I would have a caregiver by now but instead I’ve been waiting for over a decade feels like it, and actually overall not cutting the group home but I have been there and looking for a caregiver [for a while]… Something like that. Just looking for a caregiver.
Summary

The first child expresses how different it is for her transitioning to a caregiver placement compared to living independently. The other child expresses her frustration of living in the SGH for a long period of time without any caregiver placement in sight.

Children’s views on theme fifteen: What can make it better

Seven out of eight children interviewed commented on what they thought could make the SGH better.

This child felt that when other children are misbehaving, the children who are behaving are put in a safe room while staff deal with the ones misbehaving. Children who are behaving feel they miss out on programs and activities and negative behaviour is reinforced:

C: I mean like if the other young people were arguing, the staff just put us in here and leave us and try and sort them out and we are just stuck in here… For safety. All the staff would go and try and sort them out anyway. Even if it was three (staff)… And the rest of us who are being good just gets shoved in here and turn the TV on. I don’t want to be a potato… A couch potato.

Children need individual plans to suit their unique needs:

C: We all need our own separate plans. Ermm, my plan is going to be completely different to this persons plan because we are two completely different ages and he is going to need a lot more than I do whereas I probably have learnt what I need to learn. And then there are the people older than me who do not need to learn as much as I do, because they have already learnt it…. everybody has different needs… I would ask the young people what would work for them. And you know kind of plan a meeting with the social worker and kind of you know figure out what has worked in the past and what hasn’t and then build a plan around that.
Other children said that this would make the SGH better:

- Would like the staff to be consistent in how they treat the young people and to be fair.
- Staff to respect young people’s privacy and space and not barge into their rooms without permission.
- Treated with trust and respect.
- When a young person has an incident, staff should take away dangerous things and lock doors to keep people safe but staff should not point it out in a stern voice but use a calm voice and lock the doors they need to.
- Choose a leader in the SGH every school term.
- More shared activities and quality time with staff eg: cricket, swimming.
- Staff to be pro-active in resolving conflict or bullying in the home.
- No lock on the fridge and less locks around the SGH.
- Staff should not be able to check our rooms without young person being there.

Summary

Children would like individualised plans and when children are misbehaving, the ones who are behaving should get the attention not the other way around. Children wanted staff to be consistent, to treat them with respect and to use a calm tone of voice. They preferred it if the SGH had less locks as it felt restrictive. Children wanted to have more quality time with staff and to use positive strategies like selecting a leader at the SGH each term.

Children’s views on theme sixteen: Progress, what made the difference

Three out of eight children interviewed discussed the progress they made at the SGH and what they thought made the difference.

This child talks about what works for her at the SGH:

C: That you get to go to family, that you get to ring you parents, you get to send letters you get to, as long as it’s on your contacts list and stuff and your plan,
you get to have your cellphone just not in the home, ermm but on independent free time you can, you get to meet up with your friends you get to, you know that kind of stuff, you get to go to school like a normal person.

C: they do encourage you to do new things.

Other children talked about these things making a positive difference for them:

- Having a familiar face when I arrived at the SGH.
- Being involved in my Multi agency team (MAT) meeting and having a plan that works.
- Staff who care for me and my family.
- Staff who listen to me, they all sweet and kind, they occasionally make things happen and stuff, that makes me feel better.
- Staff who spend time to get to know me.
- Staff who trust me… it builds up my confidence.
- Get to see my family often.

Summary

Children liked being involved in their plans and having a voice. They felt positive about themselves when staff showed trust and care towards them. Children liked staff who listened to them and got things sorted on their behalf. Having regular contact with family was important in making a positive difference.
Part B- Findings from Parent Interviews

In Part B, I present the findings from the parent/guardian interviews.

**Theme one: Admission into SGH**

Only one out of eight parents interviewed had a pre-visit to the SGH before her child was admitted. Seven out of eight parents did not know anything about the SGH before their child was admitted. All eight parents said their child did not have a choice regarding being placed at the SGH. All eight parents said that their children were admitted to the SGH because of safety reasons or high risk behaviours and CYFS was not able to find them any other suitable placements.

**Parent’s views on reasons children are admitted into the group homes**

**R:** okay, that’s good. So the first time that your child was placed there did you know she was going to be at the group home?

**Parent (P):** she was waiting to appear in err the youth district court, the youth court they call now. And CYFS was rushing to try and find somewhere for her.

**R:** okay, so did you and your child have a choice in the SGH? Or how did it come about?

**P:** I think basically they were running out of options and his behaviour was escalating more and more, probably because he's been moved so much he didn’t have that settledness and boundaries. He’s had [numerous placements in the past few years].

**R:** oh wow

**P:** yup, prior to that he was with us and yeah and was rather difficult to control.

**P:** she was getting into too much trouble staying with me I was having the police on my doorstep almost every day and I hated it

**R:** yeah okay so when she was living with you there was a bit of trouble and then the plan was she go to the group home a while to settle down.

**R:** mmm okay. So the main reason for why she went there was safety
P: safety reasons yeah
R: Yeah
P: And just running away and not going to school…and police bringing her home in all hours of the morning
R: mmm hmm, so that must have been quite unsettling for you.
P: Well it was yeah, it was.

The four parents above commented on the SGH being a placement option due to the challenging and at-risk behaviours their children were presenting at the time of admission. The group home was also selected as a placement as there were no other placement options available for their child.

**Parent’s views- on child being in a different city**

P: And whoever it was the Social Worker I can’t remember who she was
R: mmm
P: Came over and told us that [child’s name] was going to X city but I can’t recall if she said the group home or not.
P: It was very rushed and very anxiety provoking. But once [child’s name] and I had a bit of a cry, accepted that was what was happening and made the best of it and separated.

Like her child, this mum also found it difficult being in a different city from her daughter. The admission into the group home was “very rushed and anxiety provoking”. However, parent 1 accepted that this was a decision made by CYFS and “made the best of it and separated” from her daughter.

**Parent’s views- What did you know about the group home before you came?**

P: So he essentially has [lived in] different places till he was placed here but he has managed with it quite well. I knew he was going into one but I didn’t know which one he was going into. So, I knew he was in the family home I thought he would be staying there, I didn’t realise he was going to be shifted. I knew there
was such a place but didn’t really know what it was like. Erm, how everything worked, didn’t know anything about it at all.

**R:** Yup

**P:** I just knew it existed but nothing else about it.

This parent’s experience was her child had shifted to different placements before he was placed at the SGH. However, did not know anything about the SGH and the fact that her child was shifting into the SGH.

**Parent’s view- Did your child have a choice in living at the group home?**

**R:** okay. So did he have a choice or a look around the home before he went?

**P:** no

**R:** so he was just admitted

**P:** that was it, that was where he was going and yup

**R:** do you think that was ideal or?

**P:** (Pause) I don’t know, ermm, probably more settling in and go and see and would probably be easier on the kids

**R:** mmm

**P:** But that’s not always an option as we say

**R:** yeah it really depends on what’s happening isn’t it?

**P:** in an ideal world, yeah. Settling in period would be better.

**R:** mmm

**P:** and ermm probably the more change, he doesn’t cope well with the change side of things

**R:** mmm yup

**P:** and now that one has left and one has come in it’s kind of like yeah,

**R:** yeah okay. I think you are right you know, change is such a big thing for these young people living in homes, that’s why it’s so important how young people come in and leave because it can be quite unsettling.
P: mmm yeah, there has been huge unsettling ones and I mean over the past months there has been a few come and go, and its often when they come and they are still finding their feet in the house.

This parent commented that her child was not given a choice regarding living at the group home and did not get a pre-visit to the home before shifting in. This parent acknowledged that it would have been better if her son had the opportunity to have a visit and a period of transition before living full-time at the SGH especially because he does not cope with change well. However, she realised that sometimes a planned visit or transition may not be a possibility depending on circumstances. This parent also highlighted the transient nature of children being admitted and discharged from the SGH over the past months has been unsettling for her son.

Parent’s view - Having a familiar face and a pre-visit helped

R: Okay, so do you think that helped that she knew someone before going there?
P: Yup, instead of just going straight there yup by herself she knew someone. But ermm she sort of gets on well with anybody
R: That’s good that she had a chance to look around the place before she moved in?
P: Yes she did yeah
R: And did she move in shortly after?
P: Yes she did, not long and then she moved in but I went with her and her Social Worker when she moved in. Really nice people.

This parent commented that it was helpful that her daughter knew someone before being admitted to the SGH. The Social Worker organised for her and her daughter to visit the SGH before shifted in and this visit was positive.

Summary of Parent’s views on theme of admission

The parents had similar views as the children on the admission process into the group homes. Parents who had children placed in a different city found it a difficult
emotionally. One parent mentioned that she had no idea her son was going to be placed in the SGH and did not have any knowledge about what it was. Parents agreed that it would be helpful if their child had a pre-visit of the SGH and a familiar face at the SGH when they were admitted to ease the transition process. Several parents acknowledged the challenging and at-risk behaviours their children were exhibiting before they were admitted to the SGH.

**Theme two: Importance of family relationships**

When parents were asked what was important to their child while he/she lived in the SGH, seven out of eight parents interviewed spoke about the importance of family relationships. Two parents interviewed from one of the SGHs commented on their improved relationship with their children.

**Parent’s views on improved relationship with child**

P: Her behaviour and attitude was really challenging and she would push the boundaries push the boundaries push the boundaries ermm this time round and I think some of it has to do with the structure some of it has to do with maturing but this time round when we are together I am always going to be mum and she’s always going to be my daughter, but it’s like we’ve become best friends.

R: Oh cool.

P: And we are really in sync and in tune with each other and I notice that. Yeah.

R: Yeah, so you enjoying spending time with her now?

P: Oh she’s a pleasure to be around.

P: Yeah. I’m trying to forget all the negative ones from years ago and I’m just trying to remember the positive ones and building my relationship back with my child. Because that is very important to me.

Both parents at one SGH commented on how the SGH has been helping to strengthen and bridge the relationship with their child. With the support of the SGH, the parents have a more positive relationship with their child.
Parent’s views on children residing in a different city

This parent expresses how difficult it is emotionally to be living in a different city to her daughter:

R: Yeah yeah I was going to ask you how was that for you having your daughter living in a different city from you?
P: Oh even now it breaks my heart. But I’m able to cope and deal with it a lot better because we have lots of phone contact and she goes out and she’s got her phone and we have lots of texting and she’s always keeping me up to date with new things that are happening.

Parent’s view on barriers to family contact

This parent mentions that her contact with her daughter is limited at present as she does not have a car:

P: … I can go out there whenever I like but I haven’t got a car at the moment so
R: Oh alright, okay
P: but we talk a lot on the phone.

Parent’s views on what is important to your child while they are living in the SGH

Majority of parents said that family was most important to their child while they were residing at the SGH.

Parent’s view:

P: Yeah what did she say to me? Friends come and go family always remain.

Summary of parent’s views on theme two: Importance of family relationships

Like the children, parents talked about how important their relationship is with their children. It was important to have regular face-to-face and phone contact with their children. Parents who lived in a different city to their child or those who lived in big cities spoke of physical distance being a barrier for family contact due to the lack of transport. Parents talked about the ideal situation would be for a child to be placed in
the same city as the parent. Parents from one SGH talked about improved and strengthened relationship with their child since their child was placed in the SGH.

**Parent’s views on theme 3: Relationships with staff**

Parents were asked their views on how they and their child found the staff at the group home and whether they felt staff cared for their child. They were also asked what their child liked and disliked about the staff. 7 out of 8 parents were able to give examples of positive relationships they and their children had with the staff at the SGH. One parent did not feel involved and could not comment on the quality of relationships she or her child had with staff at the SGH.

**Parent’s views on how they find the staff at the SGH**

P: the contact I’ve had with staff have been warm and friendly. I worry that people are going to look down their noses at me because I have mental health issues and stuff like that…But I’ve never been made to feel like that.

P: yeah brilliant, I can’t fault them on, yeah communications great you always feel welcome when you arrive and no, from the way I’ve seen how they deal with him, I can’t fault it.

P: Yeah they are really honest, oh yeah, they are honest people…staff are really nice out there [name of staff] she’s good, they are all good. The whole lot of them are good.

P: Yup, ermm, I met one guy when I first went there and his name was [staff name] and besides seeing him dropping [child’s name] off, I’ve not really talked to [staff name] again…Other than that, I spoke to the [staff position] for SGH, it was good, it was okay…it could have been better, yup.

Most parents spoke positively about the staff at the SGH commenting that they found staff to be warm, friendly, non-judgmental, honest and providing good
communication. One parent felt she was not given adequate opportunity to build a relationship with the staff and felt this could have been better.

**Parent’s views on whether they felt staff cared for their child**

P: Well that they (the staff) come to me and talk to me and not only asking about how things are going with [child’s name] they are asking how things are going with other two children in the house and how they are coping with having [child’s name] back…They are not ignoring them (other children in the family).

R: do you think the staff care for [child’s name]?

P: ermm, I think they do, the ones that I can see I think they do, to be in this line of work you can’t just be doing it for the money…You really can’t because if you are there for the money you are going to go nowhere and you are going to have crap you are not going to have really good relationships… and ermmm if you are there for the money, [child’s name] will burn them out, they won’t be there long.

R: How do you know the staff cares for [child’s name]?

P: When she comes here on a Monday, she is always perky and well dressed like how she is when she is here you know ermm her manners are slowly coming right.

One parent said she knew staff cared for her child because they showed an interest not only in her child living at the SGH but for the other siblings in her family too. Parent 8 saw that staff members needed to be in this line of work because they cared for the children they looked after and not for the money. She added that the complex behaviours of some of the children would burn out staff if they did not want to work there because they cared for the children. Another parent noticed the little things like her daughter coming to visit her in a happy mood, dressed well and positive changes in behaviour.
Parent’s views on whether their child trusted anyone while living at the SGH

P: ermm, I think [staff name] and [staff name] it was almost like a Nanny Moko sort of a thing, I knew he did take on a Nanny and he did take on a Papa at the SGH…oh yeah, definitely over there, he had probably 3 or 4 keyworkers over there that he trusted in and talked to.

Parent’s views on staff members children liked

P: little things like their tone of their voice, the sound of their attitude ermm just being warm.

P: Because [staff name] is his favourite carer… [staff name] has a really nice attitude and he seems to really ermm really has affection for [child’s name].

Other Parents were able to identify staff whom their children liked. They were:

- “warm and friendly”.
- “respectful”.
- “tone of voice is friendly”.
- “good rapport”.
- “nice attitude”.
- “they’ve got a lot of interests together”.
- “gets down to (child’s) level” eg: “plays with [child’s name] lego”, “does baking with [child’s name]”.
- “outgoing like she is”.
- “non-judgmental”.
- staff who were “the big brother role”.
- Staff who has “got a bit of a kid in him”.
- “I think it’s the staff’s attitude, their attitude, it’s really positive stuff towards her”.
- “she feels that they treat her equally”.
Parent’s views on staff member’s children disliked were:

**P:** because he is really tall...yeah, he is about 6 foot something...yeah yeah, I think that’s one of the things that scare him about him.

**P:** He, he, he’s, [child’s name] is normally a quiet child, he doesn’t like being bullied. He is not the bullying type of child and he doesn’t like being bullied... And you talk to the staff and they go, well he did this and this and this, well, [child’s name] is going to defend himself but he doesn’t like fighting.

**P:** didn’t like [staff position], he said she was a bitch. Because I don’t know, maybe they just got off on the wrong foot and [child’s name] never came back from it.

**Summary of parent’s views on theme 3 relationships with staff**

Most parents found the staff to be warm, friendly, respectful and non-judgmental. Some parents felt staff cared for them as a person and things that mattered to them. Several parents talked positively about the staff and the only things that parent’s thought their child disliked about the staff was feeling intimidated by the height of the staff member and personality clashes. Another parent also talked about her child being bullied at the group home and staff not mediating and intervening fairly. Parents appreciated regular and open communication from the SGH. Parents were able to state characteristics of staff members that their children liked and there were not many staff members children disliked. The importance of their child having a positive relationship with staff came through as a dominant theme in all interviews.

Parent’s views on theme 4: How they perceived the SGH environment

6 out of the 8 parents interviewed found the homes lovely and homely and commented on the nice environment. Several parents also talked about the SGH providing more freedom than a locked up residence and compared the SGH to being a step-down into the community:
P: It’s a step down, to re-enter back into society or the community and I understand that.
R: Yeah try to re-integrate her
P: Yeah because she can’t be institutionalised…because the real world does not function like that.

Parent’s view on food

Some of the parents commented on the good food provided for their children at the SGH:

P: She is eating really well now as I can see with her weight. She is putting on (laughs)

It was important for this mum that the SGH staff understood her son’s dietary requirements:

P: just ermm people understanding what he eats and doesn’t eat…Because he is part vegetarian but he will eat some meats…But he won’t eat all meats…he won’t eat red blooded meats.

Summary

Parents commented on the homely environment of the SGH and the benefits of it being a step-down from residence. Children would often talk about food they ate at the SGH with their parents. Parents commented on the good food provided for their children and it was important to one mum that the SGH staff took notice of her son’s special dietary requirements.

Parent’s views on theme 5: involvement and inclusion and identity

Out of the eight parents interviewed, two parents from one SGH felt involved and included in the decision-making process for their child and felt valued, 4 parents from the other SGHs felt they only got updates when things went wrong eg: their child
had run away and two parents expressed that there was a lack of communication from one SGH and they did not feel involved.

Parents who felt involved and included in the decision making process:

P: Even though I know like I say with a lot of things they could override with having the full custody... But because they’ve done that and the group home does that I feel involved, I feel like I am having a say for what’s happening to my child.

This parent values that the SGH keeps her informed regularly not just in crisis but asks her for her opinion and to sign permission slips. The result of this is she feels included and valued:

P: Yeah you know it would be a lot harder for me if the group home or someone did not let me know the things that are happening for [child’s name] that are big...I don’t mean every time she stumps her toe (Laughs). But you know not only do I get rung if she runs away, I get rung when she comes back ermm permission. Even though CYFS can override me with certain things they always ask my permission first and for me to sign papers... They make me feel and know that I am important that [child’s name]is important to me and that I am there for her and have always been... valued not judged.

This mum felt included in making decisions for her son’s health and education needs since her son was admitted into the SGH. She expresses that this was something she had not done since her son was in care:

P: I’ve been involved in a lot more since he’s been in [SGH name] to do with me like picking out his ermm medical centre like he goes to the medical centre I’m at. And ermm his optician and ermm I’m involved in a lot more things to do with his school and the day I was given a permission slip to sign for him to go to something. Yeah I thought woah, okay (laugh), I haven’t done this for a very long time.
This mum commented on being involved in regular meetings involving her son:

**P:** (In the SGH), I get to have my say and if I am not happy about something I get to say that and we work on it together in a group situation… nothing is ever hidden from me. If he has a bad day he has a bad day, I’m told about it. If it’s not immediate, it would be done in a MAT (multi-agency team) meeting… it’s really good I am hearing it first hand as I said instead of fifty million people later. He is my son, why don’t I know this?? But I’m finding out straight away if something happens. I think once I got called into the house the first ever time I ever got called in for the MAT meeting it was actually a total shock for me as I didn’t know what I was walking into. But now I am asked my opinion and I have a say and if I don’t like something I certainly tell them and they accept that and we work on it together. After walking into the first one (MAT meeting), I kind of sat there thinking. Woah, people are talking to me, people are asking me my opinion, people are listening to me. Errrrrr Am I in the right place? I haven’t had that for so so long! … as I said going into that meeting for the first time as I said I was apprehensive but I came out of them and I was really happy. Yes as I said I really appreciate the involvement I’ve been given with [child’s name] being in the group home. I really do appreciate that. It’s good that I am rung up if something happens.

This same mum speaks of her story of her son being removed from her care and not having any involvement with him. However, she expresses that since her son has been living at the SGH, this has changed and she feels supported. This is her experience of being involved:

**P:** So it’s not left up to essentially a government agency to decide the future for my son I get a say in it you know even though there are decisions there made for him by other people I still have got my opinion on it…And I like that and my opinion is not going to be boo hoo and pushed aside, it counts…Well I’d like to say that being invited to the MAT (multi-agency meeting) meeting once a fortnight and I do have a say and I’m asked my opinion and ermm that I get to
go to his parent teacher interviews and stage challenge and whatever else he’s
involved in and I haven’t had that for a very long time and it’s a really nice
feeling. Ermm, well that the group home had want to include me in his life and
that I am his mum and they are giving me that that, well I don’t suppose it’s that
right, but they are giving me that choice where I’m coming into an environment
where ones in the group home can support me. Well I like that ermm I’ve been
included in a lot of things with [child’s name]. I haven’t had that for a very long
time and with me being invited to the MAT meetings ermm it’s given me a
voice again to be an active part in [child’s name]’s life again and I haven’t had
that for a very long time.

R: Mmm. So when you say a very long time, what do you mean?
P: Ermm since [child’s name] was removed from my care since he was x age.
That was [year], I’ve had practically no say in his life at all he was removed
from my care…and I had no say about anything to do with him then.

A Sub- theme that emerged from interviews with parents that felt included and
involved in the decision-making process was that it created a new sense of identity for
them:

P: Yes, yeah that I am finally counted as his mum not just the woman who gave
birth to him I am counted as his mother and I am able to make decisions for my
son again. I feel like a mother again. I haven’t felt that in a very very long time.

P: Yeah I feel like I am her mum, I am her parent and I do have a say…and like
the other thing is you know they don’t treat me any different just because my
child is in CYFS care…You know what I mean? Yeah I am as much a mum,
well that’s how I am made to feel I am as much a mum in this situation that
[child’s name] is in as much as I would be if she was living with me.

P: I feel involved yeah, where prior to when she was in foster homes I was
never involved and until she is put into residential care that, I feel like a parent
again. Yeah and actually when we had that farewell at residence, I actually
acknowledged the staff ermm, I like to thank you because I have never had so
much support until she came into residential care you kept me informed of everything that was happening.

Not all parents felt involved in the decision-making process when their child was in the SGH. This mum expressed wanting to be involved in making a decision on which school her son attends:

P: I mean we get informed of, that he just joined a new school. And ermm, what did we think? We didn’t get asked to go and check the school out and go out and meet the principal and all that we just got informed that he was accepted into [school name]

R: mmm yeah, so I can hear that you are very hurt that you have not been included in the process. so if you could change something about that what would that be?

P: As I said to the judge, I said to her, I can’t look after them and I know I won’t get them back, but we would like to be more involved with them…We would like to be helping them and being more included in what the school is like and have a look at what we thought and meet the teachers and

R: mmm yeah, just to be part of that journey isn’t it?

P: yes that’s exactly it, to be part of that journey until they come back to me, and I know they will.

This mum goes on to talk about how lonely and isolating it has been for her since her children were removed from her care and the supports that she had disappeared as soon as her children were removed:

R: Okay, so did you have a choice around [child’s name] being at the group home?

P: I don’t have choice in anything that concerns [child’s name]…we are just told what’s happening and that’s it. We are not asked our opinion or nothing. like when they said they will put him there (SGH) and they said it was a special place for special children.. I guess it was, I kinda felt it was a special
place and it would cope with his problems (starts crying), with his ADHD and his learning problems.

**R:** Okay, so have you had much to do with the group home as a mum?

**P:** Pause. [Staff name] usually rings me once a week to inform me unless [child’s name] runs away with this other kid. Everybody who was supposed to be supporting us once they knew the kids will be taken off us and we won’t be getting them back, they all disappeared… It was like there was a place that it was released and they just disappeared!

**R:** Yup, sigh, so it must have been a really isolating and lonely place for you.

**P:** It is a very lonely place if it wasn’t for my animals.

This parent contrasted her experience with the staff at a residence and a SGH and felt that there was a lack of communication and parent involvement from the SGH:

**P:** I guess it was for him, for me, it was the lack thereof of communication…3 week reviews and for them to give me a ring and say “I thought I would give you a ring and let you know how [child’s name] is going da da da da da”. I had more of a friendship deal going on with Residence … yeah because they (SGH) were only drop off and pick-ups there was never ever a planned night where the whanau go out and spend time out there I don’t know, I don’t even know how it would work but that’s how I found my situation because I was on (the) ball the first year he was in care. And then when he transitioned over to this, to the residential home (SGH), it seemed like everything stopped and came to a standstill and but I was still doing my CYPS meetings and psychologist meetings but the interaction between us and the home, my home and the home was very minimal… And maybe that’s just me, maybe I want to be a part of it a bit more… oh there were a lot of differences. There is a lot of differences. I felt part of Residence, I felt a part of the whole process where Residence was concerned, but I did not feel that at SGH…. but there was no room for me to have a thought or opinion for the house because he would be dropped off on a Friday night and get dropped off on a Sunday afternoon…And then she will ring me every 3 weeks for a heads up on how things have been going through the week, whereas if something had happened at Residence, they were straight on
the phone to me, how are we, what is the crisis plan, what is the management plan what are we going to do? What should we do? … whereas over there, I will find out all these things in a heads up. You know.

This is what she would have preferred happen:

R: Yeah, okay. But as a parent you would have preferred if you had more involvement?
P: Yup yup… Just within you know, you know, knowing the plan was for his week you know… I didn’t have much to do with the house besides from getting updates… and [child’s name] would get dropped off and go back to the family home, I didn’t really have much to do with them
R: Would you have preferred that you would had more to do with it?
P: Oh yeah because when he was at Residence, before he left Residence, when he was over there, we were in contact like once a week, twice a week and meetings all the time, and then when he went over there, it just stopped.

Summary

Parents who were involved and included in the decision-making process for their child felt valued and empowered in their identity as a parent. It was important that parents were involved in their children’s plans and decision-making process eg: decisions about school, health and multi-agency meetings. Parents appreciated being kept informed and asked their opinion on a regular basis not just when their child was in crisis. Some parents felt that it would have been better if communication between them and the SGH improved.

Parent’s views on theme 6: Peers and mix of the home

Seven out of eight parents talked about the importance of peers and the mix of the home in their interviews.

Some parents acknowledge that the mix of the SGH could be better in terms of age and gender:
P: I know this is impossible but it would be better to have a better mix of kids in that house.

Parents commented on the pecking order in the SGH:

P: It takes him a bit to work out depending on how many are there who is the pack, who Is the oldest and who is in charge of the group and I know there has been a few changes in the last few months which has upset him quite a bit.

Parents also commented on the peer pressure within the SGH to follow behaviours such as absconding:

P: yeah but it’s more because that kid’s wanted to run and he kind of coerces the other boys into going with.

P: Which this other kid has been a really bad influence on him. [child’s name] didn’t use to run away till he got to the group home.

This mum commented on the bullying that goes on in the SGH and how physical size makes a difference:

P: He has always been a really small child. Compared to him they are really a bit bigger… he doesn’t like being bullied. He is not the bullying type of child and he doesn’t like being bullied.

Parents commented on the importance of friendships in the SGH:

R: What do you think is important to [child’s name] when he is living in a group home?
P: Even though he is a bad influence on [child’s name], I’d say his friends.

P: She knows a girl, that she gets on well with, they were primary friends from way back, [Child’s name] has helped her out heaps too and [child’s name] has
helped [child’s name] out. When they are in trouble they know where to go… She likes it there because she’s got friends there that she has made in the past.

Parents commented on the importance of their children making positive choices around friendships:

**P:** She’s got to make safe choices and choose your friends…that’s another reason, she needs to have good friends.

**Summary**

Parents acknowledged that there could be better mix of home at times eg: age range and gender mix. Some parents identified that children could pick up on negative behaviours eg: absconding. Parents discussed their concerns regarding bullying behaviours of other children and the pecking order that occurs within the SGH. Parents saw the importance of children making positive choices in friendships.

**Parent’s views on theme 7: Gender**

Two parents discussed the theme of gender in the SGH. This parent commented on the need to find a gender balance within the home:

**P:** But I know that’s impossible but I’m really pleased there are male staff … because I think that it gets too much for [child’s name]… Yeah I think that’s what he finds a struggle there all the people there are girls he has got no one to hang with and have boy time… He is really missing it. When he comes over here he really likes catching up with his friend so they can have their “BOY TIME!”.

This parent felt it was important for staff to understand which gender a child relates better to:

**P:** I think he responds better to the female staff there then to the male staff member that is there.
Summary

Parents acknowledged the role of male staff members doing activities and being role models for boys particularly. One parent expressed the difficulty of having a gender imbalance at the SGH eg: too many girls and one boy. It is important that staff members understand which gender a child relates better to.

Parent’s views on theme 8: Points system

Only 1 parent talked about the points system in the interviews and said her son responded well to the reward of the xbox:

P: The boundaries side of things took him about 8 weeks to settle into the routine and realised that if he actually behaved himself he could climb up and get rewards along the way.

Parent’s views on theme 9: Goal setting

Five out of eight parents talked about goals their children achieved while being at the SGH.

What goals has your child achieved since being at the SGH?:

- the biggest one is the violence, ermm communication… sticking at one school and being consistent with it.
- Just how to manage his behaviour himself…learning how to manage behavioural stuff of his own within himself… ermm, learning how to manage self-control… and learning, knowing when his triggers are being set.
- like one goal that ive seen her is she is trying to settle down and stop that running she is trying her hardest on that bit… getting to course is a good goal she is doing quite well at the moment… yes I think she is making a lot of good choices since she’s been there.

What changes have you seen in your child since he/she has been at the SGH?:

- “she’s not so scatty and ermm abusive and she’s settled down in that in a big way she’s more talkative”. 
• “behaviour problems, like running away, getting back into school life you know like she’s at a course, it’s really good for her, its run by Maori people”.

**What are some things your child has learnt since being at the SGH?:**

• “Self-esteem, cooking… confidence, yeah self-esteem”
• “a little bit of confidence there and some personal skills and health and hygiene, cause she looks great”.

**Summary**

Some parents did notice positive changes in their children since being at the SGH eg: managing anger, less violence, more communication, self-control, attending school, making friends, making good choices, cooking, better self-esteem, personal skills and hygiene. A Common goal for parents and children was to have the child return home.

**Parent’s views on theme 10: Social Worker’s role**

Five out of eight parents talked about the roles statutory Social Workers take on while their child lived in the SGH.

Some of these roles mentioned were:

• A support to the families eg: “they actually stopped and listened” and “got me into drug and alcohol course”.
• Making decisions on where to place the child.
• Some children had a care and protection Social Worker as well as a Youth Justice Social Worker.
• Managing court orders and custody orders.

One parent spoke positively of the relationships she has with her child’s Social Worker:
P: I do trust her and she’s a good person… She’s straight on the ball with [child’s name].

One parent acknowledged the workload the Social Worker has and appreciates the Social Worker returning her calls after 5 o’clock:

P: I acknowledge that she is extremely busy because I just know the workload that professionals… I know the government changes where they have created things with so much paper work for everything … but I really valued [Social Worker’s name] because she’s taken time out, picking that 5 o’clock is when a Social Worker finishes, but she takes time after 5 to ring me.

Summary

Like the children, parents saw the role of statutory Social Workers making decisions around where the child lived and managing court orders and custody orders. Some parents appreciated the support Social Workers gave them for their own issues eg: referral to drug and alcohol course. Some parents spoke positively about the work the Social Workers do with their children and appreciate when Social Workers make an effort to communicate with them.

Parent’s views on theme 11: Staffed facility

All the parents had positive things to say about the SGH being a staffed facility. This parent identified how a staffed facility worked well for her child due to the shift rosters:

P: maybe she needed the shifts. A lot of different staff coming in on shifts, instead of being in her mind stuck… But say [caregiver placement], some of it has been attitude, some of it has been behaviour, bad choices but I wonder if day in day out, day in day out she was with the caregivers there whoever they were at the time. Whereas at the group home, she sees lots of people’s faces and its lots more family, although its not family, the feelings like a big family instead of two people telling you what to do day and night.
This parent mentioned about the availability of a neutral person (staff) for her child to talk to:

P: Yeah to talk it through with him so he’s got someone there that’s outside that is not immediate like immediate family and all that… Yeah neutral.

This parent talked about the staffing ratio helping to provide more 1-1 intensive work for her son and the benefits of having trained staff dealing with complex behaviours:

P: Well they work more 1-1 with the kids compared to the family homes or boy’s homes and ermm try to get to the root of the issues and behaviours and problems.

She goes on to discuss how the SGH provides structured routine and activities that benefits her son:

P: Probably the outings and able to do things, I mean they are constantly, his ermm, his schedule is huge, one night they all go to… martial arts. All the boys are in it and doing it ermm but every outing they have got programmes or arts on, constantly doing stuff… instead of playing around at home getting bored, there is structured activities.

This mum acknowledged the SGH as a step-down into the community:

P: All I know it has worked for [child’s name], because he needed that stepping stone to come home… he could not have stepped out of Residence and come straight home, he needed to go to a place where he was put into situations where he could manage it and they could manage it and take him back to his safe place.

This mum values the SGH as a placement option for her daughter:
\textbf{P}: If she wasn’t in a supervised home she would be anywhere. You know and I’m being honest. She could have been in a foster home way down the line or Auckland or you know.

She goes on to acknowledge the importance of a team approach managing children with high complex needs:

\textbf{P}: I know my girl would have burnt anyone out by now, she burns people out yeah. If it is a full time situation, that’s why I am so pleased they are rostered so you have different perspectives… yup yup and they didn’t buy into a lot of her behaviours into her negativity because she will try and suck you in and spit you out. Yeah I was really impressed with them actually.

\textbf{Summary}

Parents saw the benefits of having a staffed facility as it provided a variety of staff on shift rosters so a child is not constantly with one caregiver all the time. Parents acknowledge the supports staff can give to children eg: someone neutral to talk to. Parents also spoke positively of the variety of programmes and structured activities run by the SGH to engage the children. It was acknowledged that a team approach is essential in managing children with high complex needs and this helps to prevent burn out.

\textbf{Parent’s views on theme 12: Structure and rules in the SGH}

Five out of eight parents discussed the structure and rules at the SGH. This parent expressed the importance of giving her child freedom of choice and not being forced:

\textbf{P}: Yeah and to feel safe and not forced into anything like if he does not want to talk to his father he is not going to be forced to talking to his dad and if he decides to have a bad day then maybe he is not going to be forced to do anything with me if he does not want to that he is given that freedom.

Most parents expressed how their teenage child struggled with the rules:
R: Do you think there is anything [child’s name] dislikes about the staff?
P: Ermm, maybe rules (laughs)… the rules I think it’s just those rules, yup. She just doesn’t like authority.

This parent expressed how the SGH is so structured in their activities that it does not help the transition back home:

P: I talked about it over the last week that kids in care, ermm, they are, everything is fully structured right down to what time they go to bed everything is fully structured, what time they finish school, go home from school, muck around on computers, and then they could go to the movies, got to go to [name of park]… Financially those people can do that. So when [child’s name] was coming home for the weekend, he was looking at me and saying I’m bored what are we going to do, well this is it I don’t have money to go to the movies, I don’t have money to take you to mini golf… or by the weekend, I don’t have money to send you to the pools… but he had adjusted to the lifestyle (clicks fingers) there’s always something to do, always something there and unfortunately it comes with money… and being in those residential homes ermm show these kids all the good times in life, which is a good thing but …it’s not normal.

Summary
Parents commented on how their teenage children struggled with the rules of the SGH. One parent commented on the importance of giving her son freedom of choice and not being forced to do anything he does not want to do. One parent talked about the SGH having so many structured activities that cost money which did not help her son’s transition home to her.

Parent’s views on theme 13: Moving to independence and the need for flexibility
Three out of eight parents had children who were transitioning out of care into independence and discussed the need for flexibility. This parent speaks out regarding her views about her daughter transitioning out of care:
P: She needs to feel like while she is doing it slowly she needs to feel like she has some form of control and you know like everything is not just happening around her, it’s happening with her. A good example is she feels like she is pretty much 16 living in a 10 or 12 year old environment ermm she feels like ermm like you know at 16 she does not feel she should go to bed at 830 and have lights off at 9. She’s gone from being a young person to becoming more and more and more independent and she feels she’s outgrown the group home… I think she’s always worked well with some sort of restraint and Structure… And ermm, I think that’s changing abit now and she is going in a different direction… I think she is starting to spread her wings. She’s gone from being in some ways quite insecure and at times immature to being … more focused on the real world and getting out. Like she says to me, she’s terrified at going flatting. At the same time she’s excited as hell. And ermm yeah she wants to I feel like she needs to just slow down slightly and take a breath because she is so keen to get out there and experience the world and she’s got all these dreams and ideas and stuff. I think she’s trying to run a bit you know? Well obviously there may be times the group home needs to say we need to slow down its going abit too quick here we want this to work for you and whatever else and you know most of the time allowing her, compromising with her where appropriate you know.. And making her feel like she is having some say in direction of where she is going and having people acknowledge how well she is doing. She’s trying to find her way at the moment and she pretty much knows herself and who she is and what she wants but because like I said before you know she said that you know ever since she’s been over two (years old) she’s been in CYFS care she’s always had people telling her what to do when to do it and how to do it… and even though she knows right from wrong and how to make good and bad decisions she said its 100% of the time she is going to be deciding everything from what time she goes to bed, what she eats and whether she goes to school on a particular day everything is going to be her choice. And I think it’s exciting but its mind blowing at the same time. Cause she is so used to…that intense structure.
This parent speaks of how the SGH has helped her son grow in confidence and independence:

P: Well he is out and he is riding his bike a lot more… I think he is enjoying the freedom of going out and going for a bike ride by himself and with the group. You see that’s the thing he has learnt to do. He never ever had that before. He’s never had the confidence to go out before and to get his hair done by himself. No, that’s a big stepping stone… Wow, I’m actually quite proud of that. He would not have done that this time last year. Cause he’s never had that before and for him to have the confidence to go out and get his hair done and that’s a really big thing for [child’s name].

Summary
The first parent expressed her views clearly that transitioning out of care is a huge thing for her daughter. Her daughter has been in care since the age of two and the thought of moving into independence was terrifying. In order to help this transition into independence go smoothly, this parent talks about the importance of giving some control to her child regarding decision making. The parent felt that her daughter had outgrown the structure of the SGH because the structure of the SGH environment structure was suited for younger children eg: bed times and restrictions. Her daughter has been so used to the intense structure around her that when she shifts out of care into a flatting situation, she would have to make all these decisions for herself that she has not learnt to do.

The second parent was proud of the fact that her son has grown in confidence and managed to bike down to the hairdressers to get his hair cut. She saw this as a great accomplishment.

Parent’s views on theme 14: Transition plan from SGH
Six out of eight parents discussed the importance of a transition plan from the SGH. This mum expresses the importance of having a gradual transition before her son returns to her care full-time as it has been a long time since her son was removed from her care:
P: Yes. And what the ultimate goal at the end is going to be and you know just not here’s your child take him back its going to be a big process to go through in the bigger picture and getting it all sorted out.

R: So do you think they are preparing you for X’s transition?

P: Yep, yeah so I am not just going to be stuck with a teenager and go here go for it (laughs) I don’t know what would happen then… It is a gradual process for him coming back and ermm him coming back to the family and extending his visits and me having a say it’s all been well it has been very emotional for me.

This parent saw a decline in her son’s behaviour after he had been in the SGH for more than six months. She also emphasises the importance of having a gradual transition into the next placement in order for it to work well:

P: I think I know his time should have been up, I wonder if six months for most kids is enough for what they need to be working on… and the transition period to be back into the home or wherever they are going to is long enough especially if they have quite a few issues, I mean [child’s name] has come leaps and bounds but there is still that area which he falls back to quite regularly that needs working on.

This parent does not feel that the transition goal for her son is clear and she is confused as to what the transition plan from the SGH is for her son:

R: Yeah, so is his long term goal to return here or?

P: Ermm, I’m abit confused on that one myself. We were told no, he wasn’t going to return that he and [name of child] being together wasn’t a good idea. Ermm, but recently they have been trying to force the issue. So I am not quite sure myself yet.

This parent talks about her lack of involvement with her son at the SGH impacting on his return home. She also expresses that the step from residence to her
home is a big jump and that she struggled financially to provide the same activities that the residence or SGH provided for her son:

P: Ermm, he could have quite possibly moved home a lot sooner (if she was involved more with the SGH)... he didn’t really want to leave Residence, but we had to break it down to him That he is at a point where he has to step out of here and step into somewhere new. And he was okay with that. when they come home, when [child’s name] was coming home, he has broken it down now and accepted it that this is how it is, but when he first came home, mum I’m bored, well we got no money we can’t do anything, and he will just kick around, walk around in circles you know for the first couple of months and then decided to go back on his skate board and go skating around and creating his own fun and because they make fun for children in residential care, it’s hard for the parents when they come home, to please them the same way. Yeah that’s how I found that, yup and that’s why the conversation came out because I can’t really be taking you to the movies and giving you $20 a week, well I got $14 in care but that’s in care, everything else is all managed. All your food is paid for, all your trips are paid for, now it’s coming out of my pocket and my money is down to, right down to the dime. You know these things need to be looked at... I think it’s just the key thing I found with [child’s name] being in residence was they always having things to do and when he comes home he doesn’t have things to do so his mind is clicking and he is getting bored... but he is finding things now to entertain himself whereas when he was in residence, it wasn’t like that.

This parent spoke about her child shifting home soon because she was leaving care at age 16. She expressed that she was disappointed with this plan as she felt she was not prepared for her daughter’s return home. She hopes that CYFS will continue to support her during the transition period and for a period of time after her daughter returns to her care:

P: She is shifting home in [number] months. Yeah, after she’s finished her course and done everything that CYFS needed her to do... Yes she will because that’s when [social worker’s name] and all let them go, at the age of 16. (I am)
disappointed, because he (social worker) should have told me this earlier because she will come home and then she will have to find a job because people at the house (SGH) are trying to help her out they are really supportive there of her…Yeah, I am hoping they will continue supporting me after she comes home.

This parent talks about her daughter’s goal of returning home. However, she feels that she would like to see some positive changes in behaviour before this occurs:

P: Cause her goal is to return the home so she wants to come back but she still has a little bit more to go yet… that’s what I said to her, you keep on going this well, it won’t be long till you’re back. Well, most likely it will (cautious). Increase day by day. We haven’t got to that part yet with (social worker) so, yeah, but it will happen… ermm, mainly if she stays put and doesn’t run from that home like you know if she runs away for a day or a night that pulls it back a bit more.. Because like I say its tough love, she can’t just do that and expect to come here. So that’s why we do it that way.

R: Okay, so eventually when she returns home, yeah what do you think would help?

P: Ermm (pause) ermm well her behaviour would be the most important one, to stop running away you know and settle down, keep going to course and keep getting an education.

This parent expressed the support she needs before her daughter is returned to her care:

P: And that’s why I said in the gateway meeting for X [child’s name] to come back into my care, I want her to have a bit of respect for her to go to school, or do something and I would like to have some coaching for me to have strategies on dealing with her, like how the counsellor gave me tools like just go and play games and have some interaction.

Summary
Parents acknowledged the need for a gradual transition plan home for it to work and also expressed their need for continual support after their child returns to their care. For many of the parents, it has been many years since their child has been out of their care and this is a huge adjustment for them and their child. One parent observed that her son being in the SGH for more than six months contributed to his decline in behaviour as he had no transition plan in sight. A lot of parents did not know what the transition plan was for their child or how long their child was living at the SGH for. One parent also highlighted the big gap between residence and transitioning home and talked about her lack of financial resources to run activities and programs similar to those at the residence or SGH.

Parent’s views on theme 15: What can make it better
Six out of eight parents talked about things that could make the SGH better:

- To be kept updated more and be involved more in decision making processes.
- Being more flexible around what the young people need and individual plans especially those transitioning out of care.
- Child to be placed in the same city as parent or family.
- Clearer transition plans with time-frames.
- Gradual transitions into placements.
- Support for the return of their children into their full-time care.
- The SGH not doing activities that cost money as children expect that when they return home and parents can’t afford it.
- Staff intervening and doing something about bullying when it happens.
- “I want to be heard and listened to”.

Summary
Parents expressed wanting more involvement and inclusion and having clearer transition plans around how long their child was living at the SGH for. For children returning home to their full-time care, parents expressed wanting ongoing support. Parents saw the importance of gradual transitions into placements and wanted staff to be pro-active in how they dealt with conflict in the home.
Parent’s views on theme 16: Progress, what made the difference

All eight parents discussed what they felt contributed to the progress their child has made and what has made the difference:

- Structure and support of the group home has helped child with behaviour.
- Strategies and coping skills to manage anger.
- Several staff members working with children so it is not the same person dealing with the child all the time.
- People trusting and believing in child.
- He’s treated as an individual with an opinion.
- Group home has taught him strategies to manage emotions.
- Accessing right services eg: counselling.
- The staff encourage and support her to do things.
- “The group home is like a parent, they try and cuddle all the children and give them a good life while they are there”.
- The group home providing guidance, support especially during down times.

This parent felt it was the best thing for her child:

P: While I was terrified with the idea of her going to the group home because I have no idea what it’s about, her behaviour, her attitude, her kaha, her everything, over this time has really started coming out and her relationships with people are far more positive and I do believe that going to the group home as gutting as it was and to have her out of town I believe it was the best possible thing that could have happened for her”.

She goes on to talk about the positive impact the SGH has had on her daughter:

P: I am so proud of her, I couldn’t be more proud of her. I always knew it was there it was just a matter of how people, and we were going to help her feel (pause). I don’t know, maybe safe enough and secure enough to start letting it out

R: yeah
P: that real warm, happy, loving content caring supportive young lady
R: mmm okay, so you think being in the group home we have created an environment
P: yeah
R: that has brought that out, that has created that
P: Yeah definitely.

This parent highlights the fact that her child is treated as an individual and has been given a voice:

P: Well he’s got constant adult support that which he did before but he is given his own voice, he’s given his own he’s allowed to make his own decisions within reason. He’s allowed to have an opinion. Yeah. he’s been treated as an individual, he’s been treated as a teenager not as a little kid.

Summary
Parents acknowledged the positive changes in their children and attributed the progress to several things like staff guidance, the supportive environment of the SGH, treating their children as individuals, accessing the right services and interventions for their child and teaching their child strategies and coping skills.

Parent’s views on theme 17: Parents ongoing issues
Six out of eight parents discussed their own trauma history and ongoing issues that they were struggling with.

All biological parents continued to struggle with ongoing issues in their lives:

- “mental illness”.
- “my mind can’t concentrate”.
- “stroke and the thing in my brain”.
- “since age seven I have been through a hell of a lot”.
• “I regret everyday them (children) being where they are… Some days, I regret the person I have been (sigh) and if I could go back and change the whole situation I would”.
• “my two children have passed away”.
• “she has been through a lot because of my drinking”.
• “my anxiety disorder”.
• “I am doing counselling now for my conviction and I go back to court”.
• “she is like this because of my screw ups”.
• “I can’t cope”.

Summary

Many of the parents had history of their own abuse and neglect, and were struggling with their own trauma history and ongoing issues. Many parents spoke of their regrets having their child in care because of their own mistakes, were trying to work through their own issues and get supports for themselves.

Parent’s views on theme 18: The effect of multiple placements and the message of unconditional care

Four out of eight parents discussed the effect multiple placements have on their children and the importance of unconditional care. This parent articulates the effect multiple placements have had on her child’s experience in care. She talks about how placements breaking down became a repeated pattern. This resulted in her child sabotaging placements in order to gain control over her placement ending rather than being shifted out. This mum talks about the importance of the SGH sending her child the message of unconditional care and not giving up on her child:

P: She’s always waited to move on to the next place, she goes to a caregiver knowing in her mind it’s not going to work it’s going to turn out shit. And she is going to end up somewhere else next week or the week after. And that’s not a good way to go into a new situation but it’s become what she is accustomed to.
P: I think you know over the years the more she has been moved and I am not saying its CYFS fault but the more she has moved from pillar to post its like she got to a point where she knew it was going to happen, so she made it happen anyway. So she felt she had control of the placement ending rather than it being taken away from her, you know what I mean. I’m not saying it is a conscious thing but I do think it was there.

P: Yeah, I never gave up on her she knew when I wasn’t happy and when I crossed the line but I made it clear that I was here for the long haul… I think for her in a way it was trying to prove to her that I do love her that I do care and I am not going anywhere I am in it for the long haul… I’ve persevered and it’s been worth it.

P: The fact that the group home has been able to stick with it ermm stick with the extra behaviour that she has been exhibiting, stick with the ermm stick with the consistency you know, not “right, you have done this you are out like at [name of family home] or with a caregiver”… The consequence was always she being moved on to the next place… But the group home hasn’t given up on her. If anything they have got more and more ermm they’ve ingrained it into her that she is worthwhile no one is giving up on her, she can kick up a stink but the group home is still going to be there… Yeah you can push but we are not going to send you away to the next place.

P: Yeah exactly but you know a lot of it is perseverance on the group home’s part… no one gave up on her, everything she did you stood even stronger… You know what I mean, you showed that she was actually cared about and she wasn’t going to be shipped off again.

P: Well she got to a point where she didn’t feel like anybody cared, she wasn’t good enough, she felt like she was simply not good enough, no one wanted to take the time to get to know her, everybody as soon as she went into their care was kicked out and had to move on to somewhere else. It’s really quite sad that it got to that point… mmm, it was heart-breaking see her go from placement
to placement and it could be as quick as a day or as long as if you are lucky at a
stretch a couple of weeks she’d last in a placement… I made clear to her that I
wasn’t giving up on her.

P: And she slowly become more and more trusting of you and what you were
saying and doing and like I know for a fact when she went there in her mind
there were even though back then she didn’t think of those words but they were
hidden agendas. But now, it’s not even in her head. You know everything that
happened to her had a very confused meaning to it. She always thought that
if someone was said a kind word to her, she was waiting for what is your
agenda where are you going with this… Suspicious, yes, that’s the word.

This parent speaks about the cycle of multiple placements and how her son has
learnt unhealthy behaviours to control the situation as his way of trying to return home:

P: yeah I think also when not knowing if the caregivers the next day are going
to go right that’s it, something you’ve done wrong and you are gone. Yeah
because it becomes a cycle. It is and I think what we’ve noticed with [child’s
name] over the last 2 years is that he would go into the house, he would be
settled for 2 to 4 weeks then his true nature would come out and people would
instantly go I can’t handle this, gone! To the next one. It was real bad… Yeah,
and then it just repeats over and over again. And you talked about learnt
behaviour that’s what it is that’s his way of trying to control the situations as
well and initially, it was his way of trying to get home.

Summary

Both parents spoke of the multiple placements their children have had and the
negative effect it has had on them. Both their children learnt maladaptive behaviours in
order to control the placement ending before they were shifted to a different caregiver
placement. This pattern repeated continuously over several years. The first parent
highlighted the difference one SGH made for her child when they displayed
unconditional care and did not give up on her daughter despite her challenging
behaviours. Due to perseverance of the SGH, her daughter felt cared for and started trusting relationships within the SGH.
Summary of data from children and parent interviews

Although this research was qualitative in nature, I have included two graphs that provide a visual summary of the themes presented in the children and parents/guardians interviews.

Graph 1. Summary of children and parent/guardian themes 1-10

Graph 2. Summary of children and parent/guardian themes 11-19
Part C- Findings from staff focus group discussions

Staff members in the SGH were invited to be part of a focus group discussion where the final collated findings from the interviews with children and parents/guardians were presented to them. Seven staff members attended the focus group discussion from SGH 1 and ten staff members attended the focus group discussion from SGH 2. When the focus groups were conducted, SGH 3 was no longer in operation. However, several staff members who worked in SGH 3 were present at the focus group discussion held at SGH 2. Due to time limitations, not all the focus group discussion questions could be completed at SGH 2.

Before presenting the findings to them, staff were asked what they thought were some of the things that children and parents said during interviews. SGH 1 staff members thought that parents would be negative around CYFS as an organisation due to circumstances as to why children were brought into care and lack of understanding of what CYFS does for them. Some staff thought that there could be denial as to why their child is in care and that CYFS has kept their child in care for too long. Staff members also felt that children would comment on the amount of money spent on them eg: clothing grant, groceries, nice things spent on them and they would appreciate the SGH home environment they live in.

SGH 2 Staff members felt that children would dislike the rules and boundaries of the home as it is not what they are used to eg: going to bed early, no smoking rule. Staff felt that children would express not liking being away from family. Staff thought the children would talk about the programmes they do at the SGH which they do not usually get to do. They also mentioned that the children could feel safe here compared to the environments that they have come from.

A summary of staff members’ feedback on the findings are presented according to the themes found in the children and parent/guardian interviews.
Theme one: Children’s admission into group homes

SGH 1 Staff’s view on theme one:

Staff agreed that if children did not have a say or were not involved in the process of admission that children could perceive the SGH like a residence for example being admitted because of safety reasons rather than of choice. Staff expressed that how children were admitted into the SGH was important as it could determine how they would engage with staff and the SGH programme. Staff saw the importance of a pre-visit because children would not know the staff unless staff have worked with them in the past.

Staff discussed that it may not always be feasible for children to have a pre-visit especially if they came from out of the district or were admitted under an emergency bed. However, staff concluded that placing children out of the district does not work well as the child is unable to have family access and there were cultural differences between the north and south island. One staff member suggested that if a child did come from out of district:

“Perhaps Skype calls could help so they could put a name to a face and voice. Photos of the room, of the lounge of the kitchen could be shared with the child before they come like before you look at moving into a new home or even a Skype call walk around the house”.

SGH 2 staff’s view on theme one:

Staff expressed they understood children and parent’s view on this matter and said that most children did get pre-visits to the home. Staff expressed that pre-visits helped the young people engage better as it gave them familiarity. One staff member described the children as being fearful coming into a new environment:

“Some will have a lot of fear and for some of them that fear may stay with them the whole time they are at the SGH”.
Theme two: Importance of family

SGH 1 staff’s view:

Staff members felt that children who did better in the SGH had their parents on board and had positive regular contact with family because they would not have felt cut off from their sense of belonging, which is very important for their emotional wellbeing. One staff member described it as:

“It’s working with what is around the child”.

Staff members also made the point that for some children the plan is to transition them back to family so it is important for family contact to be a major part. Staff members discussed that contact with family should not be behaviour dependent but discussed about coming up with a plan with the family to pick them up early if things don’t go well. One staff member talked about how a child was informed her contact with family was behaviour dependent due to there being a cost involved for travel. That staff member expressed:

“That child was informed it was a behaviour dependent option which I don’t agree with. For that child she felt hopeless to get to the level that was required to see her mum”.

Staff members said they have not threatened young people about cancelling visits to family but have specified that if they are not settled they won’t be able to go home at that time. However, the young person perceives the delayed visit as a threat or that staff are trying to stop the visit.

Staff pointed out that it was interesting that children want so much to do with their family even though its family that has resulted in them being in care. Staff acknowledged strengthening family contact was a wider system issue and it’s different for each child based on their circumstances. Distance and transport was acknowledged to be a factor in bigger cities:
“Since there are only six SGHs left in the country, not every city has one… Some young people are going to be out of their city… We are lucky to be in [name of city]”.

Staff concluded that if they have how important family is to children in the forefront of minds that could be taken into consideration in the planning process, where we place them and putting into a plan family contact, phone calls and visits.

“IT is a reminder to us how important family is to the young people regardless what the paper work might say at the end of the day they are still family”.

SGH 2 staff’s view on theme two:

Staff at SGH 2 believed that if family are positive and supportive about where their child is placed, the children will respond more positively in their placement. It was identified that a true team approach from family and professionals is needed as it takes a community to raise a child.

The question of “should family contact be behaviour dependent?” was discussed. Some staff felt that it should be behaviour dependent if it involves transport and cost. It was also highlighted that young people could put themselves at risk when visiting their family and it is about how staff members mitigate that risk. For example, if a child visits their family and there are a lot of parties, risk of being exposed to unsafe environment and violence.

Most of the staff members held the view that contact with family should not be purely dependent on the child’s behaviour but there are often lots of reasons why Children don’t get to visit their family, for example the child’s safety.

This staff member felt that children in the SGH did not appreciate what they have been given and were taking things for granted:

“People always want what they don’t have. Children who are at home with their family want an X box and these children who have been removed from their family
want to be back with their family because of the ties and bonds. Children in the real world don’t have half the stuff these children have but the children in the SGH don’t seem to appreciate it at the same level that other children might. Children in the SGH seem to take what they get for granted”.

The issue of transport was raised as a barrier especially when families don’t have cars. This makes family contact difficult and the child sometimes blames themselves for when the family have not come to visit.

**Theme three: relationship with staff**

SGH 1 staff’s view on theme three:

Staff from SGH 1 emphasised the importance of staff having positive relationships with the children, talked about the importance of engaging and caring for the children:

“It is our job to care for the young people but can’t just be a job because for them it’s their life”.

“Positive engagement not just leave them sitting. They need us [staff] around interacting, engaging not just babysitting”.

Staff agreed that it was important that the approach of staff from the way they wake the children up in the morning was very important:

“Being consistent and transparent right from when they wake you up, that’s the first thing they see in the morning and they need to see a happy, positive staff member it is very important”.

Staff agreed that it was important for staff to model that with each other as well by being respectful and kind to each other. They also acknowledged the importance of staff coming into work with a good attitude. One staff member highlighted the importance of responding consistently and positively:
“In my own experience, flat mates I like were those who always consistently respond to me in a positive way no matter what was going on in their own life and those I didn’t like living with were those who would sometimes be really cold, really sharp, short and I didn’t feel emotionally safe and that is the same for the young people. The importance of the consistency of a smile and positive respect”.

**SGH 2 staff’s view on theme three:**

Several of the staff members at SGH 2 saw the importance of relationships with children:

“Relationships are our bread and butter. It is the starting point for all youth, engagement is key”.

“You are not going to get anywhere with the child if you don’t have that rapport, bond or engage with them. When you get the teaching moments, nothing will get through to them if you don’t have the basis of relationship”.

“When a young person is angry or acting out, you need to have a relationship with them to be able to get through to them, understand their triggers and how to help calm them”.

The dominant theme that emerged from the discussion with staff members of SGH 2 was on behaviour change, children following the rules, routines and staff setting boundaries:

“The children have far more respect for those who are firm in their boundaries especially in the long run. Often the children will pretend they don’t have respect for those staff but they do”.
Staff felt that children felt a sense of safety when they “know the rules are the rules. When you are picking them up on the rules it helps them feel safe and helps them belong”.

“It is behaviour change and how they fit into the house. You can see it in how far they’ve come when they are in this sort of environment. When they arrive they are often out of control, they come from chaos and not a lot of rules and routines. When staff implement the rules and boundaries alongside the relationship, they leave here different young people”.

“With the routines, it helps them because they come from environments that are chaotic and unpredictable”.

The importance of staff members being consistent was raised as an important factor when working with the children:

“The children do know the boundaries and the rules but they will try and find ways to challenge those boundaries and say that certain staff members allow them to do that”.

“Sometimes you do have a staff member that gives in a lot and gives the kids what they want and there are other staff members who consistently follow the programme and boundaries. This results in the children disliking the staff member who stick to the boundaries because they are firm”.

Staff members discussed some conflicts that they experience at work. This staff member talked about the need for children to have healthy physical touch yet being unable to meet that need due to the boundaries of their role:

“One thing which was hard was the hugging the children talked about. We have boundaries and we are not supposed to be hugging or touching them… Some of the children do have needs for physical touch, and they do try. The need is especially apparent when they are young (10, 11 year olds) they do need that
sort of nurturing. When children are older, 14 or 15, they don’t need that so much but the little ones do have that need”.

One staff member was surprised that a child interpreted a staff members saying no to riding a scooter as the staff member playing games:

“Amazing what can go through a kids head because it could just be an inappropriate time to be riding a scooter, but the kid may not see that because they are age [number]. Even if you do explain it to the child sometimes, it goes right through and they misinterpret or twist what you said to them. Often because they didn’t get what they wanted, it comes out as anger”.

Theme 4: How they perceived home environment

SGH 1 staff's view:

There appeared to be two differing themes that emerged from the discussion of theme four. The first being the importance of reasoning with the children and them understanding that they are in the SGH to change their behaviour:

“It goes back to the young person understanding why they are in this home to work on their behaviours. It’s not about the child doing something wrong it’s about adjusting their behaviour”.

“Showing them that consistent good behaviour reaps good rewards as well which they do see when they are on level 3 and for them to understand that”.

The second theme that emerged in the discussion was held by majority of the staff group and this was about the importance of being relational, taking time to listen to the children and to explain if things needed to be locked away for safety reasons:

“Important to bring relational touch and fun into what you do, children are not robots”.
“A lot of things are locked away because of safety reasons and making sure they [children] understand why they are locked and why cords are put away. It is about staff communicating not just doing it”.

Staff at SGH 1 concluded that when you take time to listen to the children, they are perceptive and what they are asking for is for staff to care for them and to listen to them.

SGH 2 staff’s view on theme four:

The staff group at SGH 2 continued to emphasise the importance of children understanding that they are in the SGH because of their behaviour and the need for behavioural change. Staff members felt that children failed to see why they were placed in a SGH due to denial:

“For staff it is obvious that their behaviour needs changing. However, it’s the child’s world and perception because they are away from their family. Even if their family are unsafe, they still see it as a punishment being removed from people whom they believe care and love for them. However, the decision is made for the child”.

Staff members felt that the points system could be used as a good tool to show the children the mistakes they made for the day with the purpose of not highlighting that they are doing wrong but to explain how it happened. Staff felt that the children often asked how they lost points and that could be a good teaching point for behaviour.

Theme four sub-theme: Food
SGH 1 staff’s view on theme four sub-theme:

SGH 1 staff emphasised the importance of creating a sense of children being “looked after” and nurtured especially for children who had experienced neglect. Staff members at SGH 1 felt confident that they provided good meals and include young people in the planning or making of meals. Staff members discussed that the padlock on fridge at one of the SGH could have been there for specific reasons like the staff not
being able to lock the kitchen. However, staff felt that staff from that SGH needed to run a programme around not stealing food rather than just shutting it all off. Staff members concluded that food was a symbolic representation of kids feeling they are being nurtured.

SGH 2 staff’s view:

The staff at SGH 2 held a differing view regarding managing the children around food. The staff at SGH 2 adopted a model of controlling the issue, emphasised the importance of teaching children consequences and ultimately achieving behaviour change.

With regards to the padlock being used on the fridge, the staff group at SGH 2 felt that saying the word ‘no’ is the same as having a padlock on the fridge and that the fridge may have to be locked depending on the type of children in the home:

“It is the reality of the environment we are dealing with. We have complex kids and the safety aspect. It is easier to have the fridge locked because when children return from absconding they raid the fridge and then abscond again. It is difficult not having the fridge in the kitchen, but when we moved it into the kitchen, we had the issue of children stealing the food. Which is the lesser of two evils?”

“As a parent I used to lock my food away as children ate them all, it’s exactly the same. They often ate all the good stuff first so you find places to hide the food so your kids don’t get to it”.

Staff acknowledged that children have developed food hoarding issues because of their history of neglect:

“At [name of SGH], some of the girls had neglect issues but they would go to the fridge and steal food all the time no matter what it was right up to 2 minutes before dinner. Stating they wanted this instead and we had to do it there. We had times where we left the lock off and they would be in there”.
Staff stated that they always had fruit out but the children refused to eat fruit. Staff acknowledged that it was not the best solution having a lock on the fridge, however, felt the importance of containing this behaviour:

“We recognise that the best is not having a lock but it’s about trust and if the trust is misused then we pull it back again”.

The staff group felt that the children’s needs were well provided for in terms of food:

“The children are extremely well provided for and they have good diets. That is another thing we are trying to teach them, about a good balanced diet and when do you eat and when don’t you eat, is it a need or a want?”.

**Theme five: Involvement and inclusion**

SGH 1 staff’s view:

SGH 1 staff talked about the individual plans that children have at the SGH as well as involving all parents in MAT meetings every time. The staff group at SGH 1 were surprised that parents were not being involved in the same way at other SGHs.

SGH 2 staff’s view:

The staff group at SGH 2 talked about the lack of suitable placements for children which affects their capacity to be involved in their plans:

“Often they don’t have any placements to go, and they have burnt their bridges and no one wants them. You run out of places for them to go and they often end up in a SGH till they find somewhere to go until they make enough changes to integrate back into community”.

Staff felt that it was a big tick for the organisation that parents feel involved and included as it is in the strategic plan for CYFS to work closely with families. They also added that in the past few years being involved with the SGH that the staff and family engagement worker have included family for meals and visits and helped parents feel like this is their own home.
Theme six: Identity of parents
SGH 1 staff’s view:
Staff from SGH 1 expressed sadness that a parent said that she is finally counted as a mum and feels like a parent again.

SGH 2 staff’s view:
Did not give any comments due to time limitations.

Theme 7: Peers and mix of home
SGH 1 staff’s view:
Staff emphasised the importance of getting the dynamics right in the home as children were prone to mimic negative behaviours of peers for example absconding. Staff agreed that bullying can be a real issue in the SGH and this is a real fear for parents and can be stressful for staff to manage. Staff talked about the importance of getting the mix of the home right:

“You can have one young person going on quite nicely but if the added mix is not quite right it can tip everyone over”.

SGH 2 staff’s view on theme seven:
Staff at SGH 2 commented on the lack of placement options for children especially for boys who are younger in age. Staff acknowledged the bullying behaviour in the home where someone is always trying to be the dominant one and felt that they needed to teach the less dominant ones to speak up for themselves. Staff members discussed the importance of having positive male role models for the boys as many of them would not have positive male role models in their lives.

Theme eight: Gender
SGH 1 staff’s view on theme eight:
The staff at SGH 1 preferred a mixed gender home. They agreed that while a mixed gender home may have some risks to manage, it was more normal:
“SGH as a step down from residence to home, you want it to be normal, like a normal home environment has females and males in it. Having all females including staff will be overkill”.

SGH 2 staff’s view on theme eight:
The staff at SGH 2 was not keen on having a mixed gender home. They disagreed that the all-girls home had “cattiness” as described by the children. The staff group felt it was not “cattiness” but it was either them getting on or not getting on. One staff member found the boys were the same too.

One staff member commented on the positive effect a young boy placed with older girls had:

“In the mix, we had one of the boys from here put in with the girls and it was actually really good for the girls. They treated him like a little brother because he was so little. They loved it, they became the nurturers. They were really affected when he left”.

The staff discussed the importance of having positive male role models especially for the boys:

“It is great having females too as it’s like motherly effect. However, for real life circumstances, having male role models would help a lot as many of them did not have positive male role models in their lives”.

Theme nine: Points system
SGH 1 staff’s view on theme nine:
The staff were asked what they thought the children said about the points and levels system. The staff thought that the children “hated it, thought it was useless, arbitrary, used as a weapon against them probably and majority of young people regard it as a negative thing and don’t like it”.

Staff expressed their hesitation on the points and levels system:
“It is not right that children are having to wait seven days later before they can get rewards again on level three. I would like to see the points system gone!”

When asked what they would replace the points and levels system with, SGH 1 staff members suggested that children could earn stickers for things they have done right or well instead of losing points when they do wrong. Staff members discussed the importance of having a system which emphasises fresh start everyday rather than punishing children for something they have done four to eight days ago:

“Eight days is a long time and must feel forever for the children. I would not do it to my children at home, make them wait 8 days, children will be annoyed and a lot of things will have happened since then. It is punitive”.

Staff members preferred individual goals being used with the children rather than a generic points and levels system. However, discussed that individual goals need to be reviewed regularly and need to have meaning to the young person:

“Individual goals fits in with how they want to be treated as individuals, [it] can take into consideration their maturity level rather than their chronological age and other factors like religion and ethnicity”.

SGH 2 staff’s view on theme nine:

The staff at SGH 2 were also asked what they thought the children said about the points and levels system. The staff said “They hated it, thought it was useless, love or hate it depending on whether they were on level three or not and what they could get out of it. If they are on level one they probably think it’s the worst system in the world. If they were on level one, they don’t see any point of behaving as they have nothing to lose. Sometimes they don’t see any hope and go “nah stuff it, I’m just going to do it. You can’t do anything now because I am on level one”.
The staff at SGH 2 felt that the children did not understand the points system due to their reluctance to change behaviour:

“The children don’t understand the points system. They are never ever going to get it because they don’t want to identify it with their own behaviour. The individual goals are part of the points system so they don’t get how the point system works as individual goals are a major part of it. It is a behaviour modification programme and its alongside their behaviour. The young people are thinking rewards but they don’t realise the journey on what the staff are trying to do with them around that… making changes to their behaviours”.

The staff members struggled to understand why the children did not find the points and levels system normal and felt it was a system that was achievable for the children:

“[The points system] is normal, when a child misbehaves in your own home you won’t call it level 1 but you will remove privileges or won’t allow them to do certain things for example, grounding. It’s the mentality and the labelling of “levels” makes it not feel normal for the child. At home you won’t call it bms or a level system”.

“It is achievable for the children to go up the levels as they show they can do it all the time. They can all do it but they always just want to get what they want”.

**Theme ten: Goal setting**

SGH 1 staff’s view on theme ten:

Staff at SGH 1 saw the importance of setting meaningful goals with the children. Another discussion around the replacing the points and levels system with individual goals was made as the staff saw how children perceived it as a failure when they are stuck on a level for eight days. One staff member suggested an alternative:
“The way that it is set up, if you start with a full amount of points, the only way is to go is losing points for negative behaviour. Ends up highlighting negative behaviour rather than the other way around, where you don’t have any points, you earn points through positive behaviour. That way, anytime you talk about the points system its positive. If we reverse it, it will have a huge difference”.

Action research took place as the staff group decided that it was time to make some changes to the current system and were going to discuss how to improve the current model at their next staff meeting.

SGH 2 staff’s view on theme ten:

The staff group at SGH 2 felt they set goals regularly with the children and acknowledged that if children set goals for themselves that it would be more applicable to them compared to a staff member telling them what they needed to work on. Staff felt that it was important to be reviewing the children’s’ goals more often and reminding them what their goals actually mean.

**Theme eleven: Social Worker’s role**

SGH 1 staff’s view theme eleven:

The staff at SGH 1 felt that children having regular contact with their social workers were an important factor. Staff members observed that if social workers were not having regular contact with children it causes issues. It can be unsettling for children and their families if they don’t get on with their Social Worker and that causes a barrier in itself.

Staff believed that the quality of relationship children have with their social workers was dependant on regular positive contact. Some staff members observed that the longer children live at the SGH the less contact social workers have with them:

“One [social worker] has contact but its only for MAT meetings and this social worker is down the street. The pop in, drop in, build a relationship and rapport is not as good as it should be. We do realise they have big caseloads and are busy but the children don’t look at it that way. The social workers are very
important to them because they have the money for their clothes, for all the things that they want and need and the children hold them in high esteem”.

SGH 2 staff’s view on theme eleven:
No comments were made on this theme due to time limitations.

**Theme twelve: Staffed facility**

SGH 1 staff’s view on theme twelve:
Staff agreed to what the children and parents said.

SGH 2 staff’s view:
No comments were made on this theme due to time limitations.

**Theme thirteen: Structure and rules**

SGH 1 staff’s view on theme thirteen:
Staff at SGH 1 were surprised that the children said that the rules got more strict over time as they thought it was the other way around, for example more strict and became more lenient as children lived at the home longer. Staff felt that children’s perception on staff being inconsistent could be related to a period of honeymoon where things were going well and that changing to children testing relationships and exhibiting testing behaviours.

Staff at SGH 1 expressed shock that some things were occurring at other SGHs. For example, removing things from children’s rooms:

“That would not happen here [removal of furniture from their bedroom], we are sure of that. Even if things were removed from rooms it was not done that way and not to that extent. Will never take pillows and all from young people, only for safety were things ever removed”.

Another staff member expressed concern about the practice of doing that:
“[I] don’t know how that settles a young person [removing items and furniture from their bedroom]. Don’t know how people are allowed to do that. How are they getting away with some of these things? Imagine if you had a complaints procedure, they probably would not”.

The staff made it clear that at SGH 1 they had a complaints procedure and a suggestion box which the children had access to.

Staff also discussed the importance of running programmes at the SGH that does not cost too much money as they did not want to set the kids up to fail when they left the SGH. Staff discussed programmes they could do that do not cost big amounts of money eg: going for picnics, bike rides, going to the beach, fishing.

SGH 2 staff’s view on theme thirteen:

No comments were made on theme thirteen due to time limitations.

**Theme fourteen: Transition to independence and need for flexibility**

SGH 1 staff’s view:

This theme generated discussion amongst the staff group as to whether they do a sufficient job with preparing children for independent living. Staff members discussed the fact that they allow older children to have independent free time away from the home but in terms of helping children develop independent life skills, this was still an area that needed to be worked on. Staff felt that they were trying their best to teach the children how to cook meals and do their laundry but found the children being reliant on staff because of the locks in the home.

Staff commented on how much the children felt the SGH was a restrictive environment even though the front door is unlocked. Staff members felt conflicted that on one hand they see things from the child’s perspective yet on the other hand, they had roles that required them to provide boundaries. It was highlighted by the staff group that some children are not ready for independence even though they may be of age chronologically. Staff saw the importance of developing plans that suit the child’s
developmental age. Staff suggested running two separate homes; one for younger children and one specific for children ready to transition to independence.

SGH 2 staff’s view on theme fourteen:

No comments were made on this theme due to time limitations.

Theme fifteen: Transition

SGH 1 staff’s view:

The staff discussed the need for children to have clear transition plans so that they do not feel as if they are “stuck” at the SGH. Staff acknowledged that a child returning to the SGH for the second time does not work and children perceive it as a failure.

SGH 2 staff’s view on theme sixteen:

No comments were made on this theme due to time limitations.

Theme seventeen: Parents own trauma and on-going issues

SGH 1 staff’s view:

Staff acknowledged that for some children, going home could be still dangerous and pose care and protection concerns.

SGH 2 staff’s view:

No comments were made on this theme due to time limitations.

Theme 18: Unconditional care

SGH 1 staff’s view:

Staff acknowledged the conflict they experience of wanting to provide unconditional care to the children by not giving up on them even when children are misbehaving and discharging them for the same reasons they were admitted to the SGH. The staff group acknowledged that decisions were made to admit children to secure residences when they exhibited high risk behaviours like absconding. The staff acknowledged that moving children from placement to placement did not resolve the
underlying issues and it was important to find out the reason why the child is misbehaving.

Staff saw the importance of sending the message of “we are not giving up on you” to children on a daily basis. Staff observed from experience that children who have had multiple placements will sabotage placement before it ends so they are in control:

“Just before a young person is about to leave they try to end it negatively, [because they] don’t know how to say goodbye. She wanted to be in control of the end, not us”.

**SGH 2 staff’s view on theme seventeen:**

No comments made on this theme due to time limitations.

**Theme eighteen: What can make it better?**

SGH 1 staff’s view:

Feedback was sought from staff regarding what the children and parents thoughts were on “what can make the SGH better?” Staff members liked the idea of a leader being selected from group home each term. Staff felt that it was sad that the children were asking to do activities like going to the pools, playing cricket and the simple things that don’t cost money as it was assumed that the staff members would be doing those activities with the children. Staff expressed the difficulty in resolving conflict and bullying in the home as they did not want to take sides. Overall, the staff felt that the comments made by children and parents were fair.

SGH 2 staff’s view on theme eighteen:

No comments were made on this theme due to time limitations.

**Theme nineteen: Progress, what made the difference**

SGH 1 staff’s view on theme:
The staff at SGH 1 felt they did individual plans for children and involving children and families in MAT meetings well. The staff felt that having a familiar person at the SGH when a child arrives can be challenging at times, however, discussed the importance of gradual transitions and if the children are coming from residence to provide familiar staff members to help settle the children into a new environment. Skype calls could also be an option to help introduce the children to staff members in the SGH.

Overall, the staff group felt that the feedback was realistic and it was not as negative as they thought it would be.

The staff group also decided that at the next staff meeting they would be making changes to the points system to evidence hearing the children’s voices. Staff felt that this was an opportunity to improve the current system and make it more child-centred.

SGH 2 staff’s view on theme nineteen:

Two staff members at SGH 2 provided feedback that the focus group discussion was really good and gave them really good insight into what they could potentially do better and what the children actually liked as well. Staff members expressed that what they heard was not surprising but it brought practice issues to the front of their minds by reminding them why they do what they do and the effect it has on the children. Staff members felt that the focus group was a tool which enabled them to reflect on the thought processes of children and enabled them to understand children’s perceptions on particular issues better.

Summary of findings chapter

In this chapter, I presented the dominant themes that emerged from the interviews with children, parent and staff interviews. Sixteen dominant themes emerged in the children and parent interviews and an additional two themes emerged in the interviews with parents. The dominant themes were presented to staff members through the use of focus group discussions to hear staff members’ perspectives on the themes that arose in children and parent interviews.
Children and parents talked about the importance of being included and having a voice and when this occurs they feel empowered. Forming key relationships with staff members and keeping in regular contact with family members was significant to children and parents. Children expressed clearly that they wanted to be cared for and treated with fairness by staff members. Children who were transitioning to independence wanted more flexibility and autonomy to help prepare them for their transition-out-of-care.

The staff focus group discussions provided insight into the framework of practice used in working with children from each of the SGHs. Staff members saw the importance of relationships being the core foundation of their work and doing things for the best interest of the child; however often faced conflicting demands regarding their role as staff members and organisational policies.

In the next chapter, I discuss the knowledge from the literature and the findings from the interviews. The following chapter demonstrates how the findings from children, parent and staff interviews are supported by the evidence base of neuroscience and knowledge on attachment theory.
Chapter Five
Discussion

Introduction

In this chapter, I bring the knowledge discussed in the literature review and the findings presented from the interviews together. The research question that initiated this research journey was “does the quality of relationships with staff have a positive impact on outcomes for children who reside in group home settings?” This chapter aims to answer the research question by integrating the findings from the interviews with children, parents and staff members with the knowledge we have learnt from attachment theory and the evidence base of neuroscience. It has been observed from the findings presented that what matters to the children and parents is consistent to the evidence base of neuroscience.

In the literature review chapter, I established the link between attachment theory and neuroscience by presenting knowledge from the literature that shows how attachment relationships (particularly in the early years), affects brain development. In this discussion chapter, I carry on with this argument by demonstrating how the brains of children who have experienced insecure attachment relationships are impacted negatively. To communicate this argument clearly, I have structured this chapter according to how the brain develops sequentially from the “bottom up”; from the brainstem up to the cortex (Van Der Kolk, 2014). The knowledge gained from the interviews with children, parents and staff members as well as the latest research on neuroscience indicates that in order for therapeutic change to occur, we would need to heal traumatised brains from the base up (brainstem) and build integration between the left and right hemispheres of the brain (Siegel & Bryson, 2012). How to help traumatised children’s brains be an integrated whole will be discussed further in this chapter through the knowledge gained from the literature reviewed and the findings from the interviews.
**Healing traumatised brains from the base up**

![Diagram of the human brain divided into four interconnected areas (brainstem, diencephalon, limbic, neocortex).](image-url)


The figure above by Perry (2002a) shows how the brain develops sequentially at birth from the brainstem to the diencephalon (midbrain), to the limbic and to the cortex; from the “bottom” up and the “inside out” (Perry, 2010). The brain is also organised in a “hierarchical fashion” (Perry 2006, p. 30) “from the most simple (eg: fewest cells-brainstem) to most complex (eg: most cells and most synapses-frontal cortex)” (Perry 2006, p. 31).

I have named this section “healing traumatised brains from the base up” grounded on principles of neurodevelopment. In the literature review chapter, we have established that early stress and maltreatment causes structural and functional changes to the brain (Brainwave Trust Aotearoa, 2012; De Bellis, 2005; Hughes & Baylin, 2012; Perry 2006; Teicher et al., 2003). Brain imaging of adults who experienced maltreatment as children show abnormalities in regions of the brain like the cortex, hippocampus and corpus colossum (Teicher et al., 2003). Having the knowledge about the negative impact maltreatment, abuse, neglect and trauma has on the brain is only
the first step. Applying this knowledge into how we work with traumatised children is the key on this journey of recovery and healing.

I chose to use the term ‘healing’ as it implies that damage or hurt has been done. “Trauma is painful. Attachment trauma is tragic, creating impediments to our capacity to adapt and connect with others” (Solomon & Siegel, 2003, p. 262). The maltreatment, abuse and neglect that children in the SGH have suffered in their early years needs to be acknowledged and understood deeply in order for practitioners to help them heal their ‘wounds’ of trauma. The term ‘healing’ also gives an element of hope; that the ‘wounds’ of trauma can be healed with time, compassion and unconditional care (Solomon & Siegel, 2003).

Neuroscientists have also given us hope for change when they discovered the concept of neuroplasticity (Doidge, 2010). Neuro stands for “neuron”, the nerve cells in our brain and nervous system and “plastic” refers to changeable, malleable and modifiable (Doidge, 2010; Melillo, 2009). This new discovery means that the brain has the ability to change chemically and physically if given the proper stimulation (Melillo, 2009). When given proper stimulation, new connections form on the weaker part of the brain resulting in a child’s brain being rewired and “disconnected children becoming reconnected children” (Melillo, 2009, p. 9).

The current model at the SGH

The current points-based level system at the SGH is based on a behavioural modification model (Child Youth and Family, 2010b). The main goals of the behavioural modification model is to replace maladaptive behaviours with adaptive ones through the use of token or conditioned reinforcers (Field, Nash, Handwerk, & Friman, 2004). Teaching the child new skills and encouraging new behaviour is achieved by staff providing cognitive reasoning and verbal explanations to enable the child to reflect and connect their behaviour with the loss of points and privilege (Drumm et al., 2013). From the knowledge gained from neuroscience, learning cannot occur if a child is in a persistent state of arousal, anxiety or disassociation (Child Trauma Academy, 2005). Furthermore, in terms of brain development, the cortex does not fully mature till close to the third decade of life (Johnson, Blum, & Giedd, 2009).
This means that adolescents generally operate out of their limbic system which is the emotional part of the brain (Chamberlain, 2009); which explains why teenagers often seem moody and emotional.

The cortex is in charge of “executive functions” such as planning, working memory, and impulse control (Johnson et al., 2009). When stressed, we lose the capacity to access the frontal cortex of our brain which is the higher cognitive capacities for self-regulation, self-awareness and empathy (Hughes & Baylin, 2012). The current model of the SGH aims to access the top parts of the brain (the cortex) as the points-based level system requires cognitive reasoning, verbal explanation, and making good behavioural choices.

Children who have been raised in environments of persisting threats will have an altered baseline where the internal state of calm is rare (Perry, 2003; Perry 2006). Being in a constant state of alarm and arousal limits the ability to access the cortex to complete “executive functions” (Perry, 2006). This does not mean that children who have experienced trauma or maltreatment cannot access their cortex and make sound decisions; nor is this an excuse for bad behaviour. What this means is that before we try to access their cortex through reasoning, use of verbal explanations and teaching new skills, we need to ensure that they are regulated and in a state of calm (Perry, 2006).

Dr Bruce Perry has come up with 3Rs “regulate, relate, reason” that needs to be completed in this specific order for it to be effective (Perry, 2015). If a person is not regulated (feeling emotionally and physically settled), he/she will not be able to relate through feeling connected and comfortable (Perry, 2015). Until a person is able to relate to another, they will not have the ability to engage their cognitive reasoning and problem solving skills (Perry, 2015).

Based on the literature reviewed, the knowledge of neuroscience and the interviews from the children on what works for them; this chapter recommends working with traumatised children from the bottom (brain stem) to the top part (cortex) of the brain; to “regulate them, relate to them and then to reason with them” (Perry, 2015).
Healing traumatised brains from the base up: Starting from the brainstem

In this section I discuss the function of the brainstem and its development from birth. With the knowledge discovered about the brainstem, I link this to the themes of “relationships with staff” and “parents own trauma” in the findings chapter. I also discuss how we can integrate what we have learnt from neuroscience and attachment theory with the findings from the children, parents and staff interviews.

Figure 4 Adapted from *The human brain, divided into its four interconnected areas*. From Child Trauma Academy. Retrieved from http://www.childtraumaacademy.com. Copyright 2002 by Child Trauma Academy. Reprinted with permission.

The diagram above is an adaptation of the brainstem. The first areas to develop fully from birth are the brainstem and the midbrain as they control the autonomic functions necessary for life, like breathing, heart rate, blood pressure, appetite and sleep (Child Trauma Academy, 2005). This is the most primitive part of the brain that is already online when we are born and is also known as the reptilian brain (Van Der Kolk, 2014). Birth is a critical period of development and a baby requires an attachment figure for survival (Bowlby, 1991). A baby is born dependent on another human being to meet its basic needs in order to survive for example, feeding, protection from danger, comforting while distressed and to be looked after when ill (Howe, 2005). Relationships are key to our survival (Szalavitz & Perry, 2011).

Besides needing relationships to keep us alive, the primary relationship with a caregiver is crucial for healthy brain development. As the brain is experience-dependent from birth (Perry, 2002) the role of a primary caregiver providing a secure attachment (Bowlby, 1988) through providing “warm, sensitive and responsive parenting” (Golding, 2008, p. 25) is essential in building a child’s brain (De Haan & Gunnar, 2009). The field of epigenetics (how genes are shaped through the
environment) is evidence that early parenting affects the development of the infant’s brain (Schore, 1994).

The brain at birth is dependent on sensory stimulation from the environment in order to grow and make connections (Melillo, 2009). “All incoming sensory information first enters the central nervous system at the level of the spinal cord or brainstem” (Perry, 2006, p. 33). This incoming sensory information is then “interpreted” and matched against previous similar patterns of activation (Perry, 2006). The brain is constantly making associations with the sensory signals received (Perry, 2010).

The brainstem is also known as the survival or primitive brain as it is designed to detect threats in the environment through sensory input so that the brain can choose a “fight”, “flight” or “freeze” response (Perry, 2003; Perry 2006; Szalavitz & Perry, 2011). The ability to react to stress through an automatic “fight” or “flight” response is key to our survival (Szalavitz & Perry, 2011). The brainstem detects danger by storing previous patterns of sensory neuronal input associated with threat (Perry, 2006). Children who are exposed to continuing threats in their environment because of maltreatment become hyper vigilant to threats in their environment (Perry, 2006). Their brainstem stores “state” memories which are “memories of previous patterns of sensory input that were connected to bad experiences” (Perry, 2006, p. 33). The result is that traumatised children become “brainstem driven” (Perry, 2006) by adopting different styles of adaptation to threat (Perry, 2003). “Some children use a primary hyperarousal response (“fight” or “flight”) and some to a primary dissociative (“freeze”) response. Most use some combination of these two adaptive styles” (Perry, 2003, p. 13). These children have a baseline of arousal, alarm and fear because their brain has stored memories of the trauma experienced (Perry, 2006). The response of a traumatised child perceiving threat in the environment is fear. The fearful child is often misunderstood as being oppositional, defiant or exhibiting controlling behaviours (Perry, 2003). Ironically, the main aim of the child at this point is to achieve a sense of safety.

The key to healing traumatised brains is to provide opportunities for new experiences that will help the brainstem “break false associations or to decrease the
The importance of relationships

The first relationship that we learn to feel safe in is our relationship with our primary attachment figure. Infants are dependent on their primary caregiver to be their external stress regulator, for example when they are hungry they rely on their caregiver to be fed and to be kept safe if threatened (Szalavitz & Perry, 2011). The primary attachment relationship is the first relationship that teaches us how to regulate our stress and when our caregiver is able to do that, we feel safe (Szalavitz & Perry, 2011). Sadly, for children who have experienced maltreatment, their only source of safety was also the source of threat and danger (Perry, 2006). “Having a parent who is frightening creates an unsolvable dilemma for a child” (Kelly, 2006, p. 12).

In order for traumatised children to regulate their stress response, they need to re-experience the caregiving relationship as a source of safety (Howe, 2005) and as a secure-base where caregiving is warm, sensitive and responsive (Golding, 2008). Zelechoski et al. (2013) discusses that non-clinical programme staff in residential homes, known as Care workers at the SGH, are part of the treatment process as they facilitate and model safe, healthy and appropriate relationships for traumatised children. It is clear that relationships must be the core and foundation of any interventions with traumatised children.

In my interviews with the children, all eight children talked about the importance of having positive relationships with staff members. One child highlighted the importance of staff dealing with another child’s emotional distress. When staff members are able to manage a child’s stress in a sensitive and attuned way it creates a sense of safety and trust. Hughes and Baylin (2012) discuss the importance of caregivers providing a sensitive parental response to help the child recover from a stressed-out state and regain a sense of safety. At the SGH, the staff take on the role as ‘caregivers’ and ‘in loco parentis’ latin for “in place of a parent”(Merriam-Webster Inc, 2014). The key to helping a child recover from their stressed-out state and regaining
their sense of safety and well-being is dependent on a staff member responding to the child’s emotional distress in a timely, sensitive and attuned way (Hughes & Baylin, 2012). This continuous experience of a child’s stress being regulated by an external regulator (in this case the relationship with staff) provides the opportunities needed to help the brainstem “break false associations or to decrease the overgeneralisation of trauma-related associations” (Perry, 2006, p. 34). The safety provided within the staff relationship also protects the brain from long periods of stress that helps to stimulate growth of connections in the child’s brain for self-regulation (Hughes & Baylin, 2012).

At Seneca Center Residential Program, in California, Sprinson and Berrick (2010) refer to relationship and engagement as the treatment. The staff-client relationship and interaction is used as the treatment to promote self-regulation of emotion and behaviour” (Sprinson & Berrick, 2010, p. 6). Applying attachment theory and trauma-informed interventions will enable staff members or caregivers to develop a deeper understanding of the trauma experienced in the life of a child and the behaviours exhibited that could otherwise seem like ‘bad’ or disturbing behaviours (Sprinson & Berrick, 2010, p. 21). “Instead of reacting with anger, rejection and arbitrary interventions, the goal of providing reassuring containment and safety can inform intervention. Most importantly, it must be a response that sustains relationships and avoids disengagement” (Sprinson & Berrick, 2010, p. 22).

As mentioned previously, a child who has been exposed to long periods of threat have a brainstem that is hyper vigilant to sensory stimuli (Perry, 2006). Children in a state of alarm or fear pay more attention to ‘non-verbal’ cues such as tone, facial expression and body language (Howe, 2005; Perry, 2003). It was evident from the interviews with children and parents that these ‘non-verbal’ cues that staff displayed were very important to them. Children and parents expressed that they liked staff members who were positive in their engagement and attitude, staff members they liked were “warm and friendly”, “respectful”, “tone of voice is friendly” and staff who had a “nice attitude”. Children spoke fondly of staff members who modelled trust in the relationship, were attentive to their feelings, listened and engaged well with them. The open and engaged stance that is crucial in caregiving, is also crucial for a strong
therapeutic relationship because “without openness there can be no real trust and connection” (Hughes & Baylin, 2012, p. 104).

On the other hand, children made it clear which staff they disliked. Children described these staff members as those who had a negative or grumpy tone, those who failed to listen and attend to the child’s emotions and those whom the children felt were unfair. Perry (2003) discusses the impact that ‘non-verbal’ cues such as a grumpy tone of voice, body posture and eye contact can activated the stress-response system in the brainstem. Golding (2014) suggests the importance of “connection before correction”, which is managing behaviour whilst building security and maintaining the relationship. It is important for staff members to understand the experience of the child and their feelings in order to connect emotionally (Golding, 2014). Understanding the feeling does not mean that the behaviour is condoned (Golding, 2008), but it conveys that their feelings are understandable and manageable (Golding, 2008). Discipline or behaviour management (boundaries and consequences) is crucial but needs to be sandwiched between attunement\(^1\) and relationship repair\(^2\) (Golding, 2014).

***Theme of parents on-going issues***

“Sensitive, attuned parenting that provides children with a secure base builds resilient, caring brains that are better equipped to be nurturing and effective parents for the next generation” (Hughes & Baylin, 2012, p. 6). Sadly, all the biological parents interviewed (6 out of 8 parents) were victims of trauma themselves and did not receive the sensitive and attuned parenting they required to help them be ‘good enough’ parents to their children. For various reasons like mental health issues and care and protection concerns, their children were removed from their care and were placed in the SGH during the time when the interviews took place. One of the themes that emerged was that the biological parents of children at the SGH continued to have ongoing issues related to their unresolved trauma. During the interviews, many parents spoke of their regrets having their child in care because of their own mistakes and were trying to work

\(^{1}\) Using empathy to communicate your understanding on how the child is feeling (Golding, 2014)

\(^{2}\) Conveying to the child that the relationship is stronger than the episode and they are still cared for (Golding, 2014)
through their own issues and get supports for themselves. Egeland, Jacobvitz, and Sroufe (1988) did a study on mothers who experienced abuse and their findings indicated that abused mothers who were able to break the cycle of abuse because of these following factors- they received emotional support from a non-abusive adult during childhood, participated in therapy during any period of their lives, and had a non-abusive and more stable, emotionally supportive, and satisfying relationship with a partner. How do we break the intergenerational cycle of abuse? The answer lies in the availability of stable and emotionally supportive relationships.

**Summary of section and implications for practice**

In this section, we have discussed the function of the brainstem and the important role that secure base attachment relationships plays in helping traumatised children re-experience the caregiving relationship as sensitive, warm and responsive. When caregiving creates a secure base for children, messages are being sent to their brain that they are safe. Golding (2008) has developed “The house model of parenting” which emphasises the importance of creating a secure base for children as the foundation of our therapeutic interventions with them. By creating a secure base, children will feel safe and secure enabling them to confidently explore and learn in their world (Golding, 2008). I will refer to “the house model of parenting” and how it can be implemented in our work with children at the SGH in the next few sections and the recommendations chapter. “Healing traumatised brains from the base up” needs to start with children experiencing secure attachments first. They need to be regulated before we reason with them (Perry, 2015) and we need to connect with them emotionally before we correct their behaviour (Golding, 2014). “Children’s brain thrive when interacting with adults who have the brain capacity to love them unconditionally, experience joy from being with them, pay close attention to them, and understand them deeply” (Hughes & Baylin, 2012, p. 12). “Does the quality of relationships with staff have a positive impact on outcomes for children who reside in group home settings?” is the research question underpinning this thesis. This section highlights the knowledge from neuroscience and the findings from the interviews indicate clearly that relationships need to be the foundation of the therapeutic model at the SGH.
Healing traumatised brains from the base up: The midbrain

In this section I discuss the function of the diencephalon, also known as the midbrain. While discussing the primary functions of the midbrain, I link this in with two themes in the findings chapter, “admission”, “perception of SGH environment” and the sub-theme “the importance of food”. From the literature reviewed, as well as the findings from the interviews, there will be several key learnings that will be discussed.

The figure above is an adaptation of Dr Bruce Perry’s picture of the brain (Child Trauma Academy, 2005) which shows that the diencephalon (midbrain) is situated right above the brainstem. The diencephalon is part of the “lower” regulatory areas of the brain and is also part of the primitive part of the brain as it is not capable of conscious perception (Perry 2006). The brainstem and the diencephalon develops in the womb as they control elements key to survival (Van Der Kolk, 2014). The diencephalon also controls body temperature, hunger, sleep, arousal (Perry, 2006) and sensory integration. This lowest area of the brain takes in information from perceptions and from the body (Solomon & Siegel, 2003, p. 20).

The central nervous system, consisting of the brain and spinal cord is designed to integrate sensory information received (Siegel, 2001). “Integration is a core process essential for mental well-being within the individual and the family, and perhaps fundamental for the healthy functioning of a nurturing community” (Siegel, 2001, p.
The central nervous system’s ability to integrate sensory input enables an individual to place the body in time, space and within the environment (Kaiser, Gillette, & Spinazzola, 2010).

In the literature review chapter we discussed the importance of bonding experiences that a caregiver gives to an infant like cuddling, rocking, gazing, talking to the infant, eye-contact, holding, hugging and touch which results in neurochemical activities in the brain responsible for attachment (Perry, 2001). Infants interpret their sensations within the context of their caregiving relationship and first experiences the world through bodily sensations (Van Der Kolk, 2002). As the caregiver modulates the emotional states of the infant by rocking, feeding, stroking and making soothing noises, the infant experiences how to regulate emotions through physical sensations (Van Der Kolk, 2002). Interaction with others occurs through visual, auditory and tactile modalities (Trevarthen, 1993). These interactions which occur within a relationship organises the developing brain (Schore, 2000).

Children who are deprived or experience disruptions in the quality and quantity of these bonding experiences due to maltreatment have brains that do not develop in a systematic and orderly way (Brainwave Trust Aotearoa, 2012). One of the results of maltreatment including neglect is that children are deprived of the healthy sensory inputs necessary to develop the brain. Senses are the vehicle that drives stimulation to the brain (Melillo, 2009). The lack of adequate sensory stimuli like what the children in Romanian orphanages experienced, results in developmental delay, stunt in physical growth and cognitive deficits (Rutter et al., 2007). Individuals who experienced trauma find it difficult to integrate their senses, physical reactions and emotions (Van Der Kolk, 2002). “Chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole and sets the stage for unfocused and irrelevant responses to subsequent stress” (Streeck-Fischer, 2000, p. 903). The ability to integrate sensory experiences can be affected for children “exposed to overwhelming traumatic experiences or subjected to neglect or sensory impoverishment” (Kaiser et al., 2010, p. 701).
Van Der Kolk (2002) recommends the “bottom-up” approach in helping traumatised individuals; through providing integration and processing of disruptive emotions and sensations. The initial focus for children who have experienced trauma is to establish safety (Cook et al., 2005). In the first section, we discussed the importance of creating safety within therapeutic relationships that helps the child with self-regulation and interpersonal security (Streeck-Fischer, 2000) Another way of creating safety is through the physical environment of the SGH creating safe physical spaces for the client to engage in activities that do not trigger the body’s alarm system (Streeck-Fischer, 2000).

**Theme of admission**

From the interviews with children, five out of eight children felt they did not have a choice in living at the group home and did not know anything about the home before they shifted in. The children expressed that not having prior knowledge of the home and not having familiar relationships at the group home was a fearful experience for them. Children expressed that what helped create safety in an unfamiliar environment was having a familiar face that they knew when they first arrived.

The parents had similar views as the children on the admission process into the group homes. Parents agreed that it would be helpful if their child had a pre-visit of the SGH and a familiar face at the SGH when they were admitted to ease the transition process. Staff members expressed that how children were admitted into the SGH was important as it could determine how they would engage with staff and the SGH programme. Staff acknowledged that pre-visits helped the young people engage better as it gave them familiarity.

Cheers and Mondy (2009) discuss the experience of an agency called Centacare Broken Bay in Sydney Australia that provides a continuum-of-care approach to reduce placement instability. In their article, they discuss the importance of “staged entry and transitional arrangements” (Cheers & Mondy, 2009, p. 151) where a staff member who has worked with the young person in a pre-placement setting can facilitate a “staged entry” into the new placement and the use of pre-entry outings, meals and relationship building activities at the new placement. Centacare’s outcomes indicates that a
“continuum-of-care approach leads to enhanced placement stability which, in turn, offers the possibility of consistent, targeted therapeutic interventions that address trauma, lead to the establishment of better attachments and social functioning, and in turn stabilise behaviours contributing to placement breakdowns” (Cheers & Mondy, 2009, p. 152).

The SGH could model Centacare’s continuum-of-care approach and provide children with a pre-visit to the SGH with a familiar person they trust to help ease the transition process. From the interviews, children expressed feeling more at ease when they knew a familiar face coming into a new environment. As Streeck-Fischer (2000) mentions, it is important to create relational safety so that we can help the child with self-regulation. By allowing children a choice in where they live and a pre-visit to the SGH, this creates safety through the physical environment, ensures that the fear system within the brain is not triggered (Streeck-Fischer, 2000). When children feel a sense of safety, this increases the likelihood of placement stability and success.

**Theme of food**

I would like to discuss the theme of food in this section as the midbrain controls appetite and hunger. While interviewing children on their experiences living in the SGH, four out of eight children talked about how important food was to them. Food came up as a dominant theme during the interviews when children were asked about what they liked about living at the SGH. During the interviews with parents, parents commented on the good food provided for their children at the SGH. Staff members at SGH 1 emphasised the importance of food creating a sense of children being “looked after” and nurtured especially for children who had experienced neglect. Staff members concluded that food was a symbolic representation of kids feeling they are being nurtured.

It is interesting that food came up as an important theme in children and parent interviews. Majority of children who live in residential group homes have a history of maltreatment including neglect. The history of food deprivation could be one reason why food is such an important factor to them. This is also congruent to Maslow’s hierarchy of needs where the most basic and fundamental physiological (food, shelter, warmth) needs were at the bottom of the pyramid (Maslow, 1954). Maslow
hypothesised that if the basic needs were met adequately that it would result in better psychological health for the individual (Maslow, 1954). Rowell (2013) in an article for adopted children discussed that when children are not fed consistently, do not have adequate food or have to compete for food, it creates anxiety. She calls these children “food-insecure” and often exhibit hoarding behaviours like gobbling food, stealing or hiding food, and getting upset when food is limited or taken away; all which are survival strategies. These children have brains that don’t understand or trust that food is coming in adequate amounts. The “signal” of not being fed reliably and adequately has been stored in their implicit memory or “state” memory (Perry, 2006). Rowell (2013) recommends that children who have “food-insecure” behaviours be offered frequent reassurance with words and actions that “there will always be enough food”. The brain needs to re-learn from experience and repetition that there will be sufficient food available.

Two studies were completed on individuals with a history of childhood trauma and the link between childhood maltreatment and eating disorder symptoms (Kong & Bernstein, 2009; Tasca et al., 2013). Both studies indicated a relationship between childhood trauma having a causal link with eating disorder symptoms (Kong & Bernstein, 2009; Tasca et al., 2013). Tasca et al. (2013) added that attachment insecurity, characterized by affect dysregulation may help to explain why eating disorder symptoms may be one consequence of childhood maltreatment in a clinical sample. In Kong and Bernstein (2009) study of 73 Korean patients with eating disorders, emotional abuse, physical neglect and sexual abuse were found to be significant predictors of eating psychopathology. The findings of childhood trauma and eating disorders highlights the importance of staff at the SGH having an understanding of the trauma history of children and knowledge around how to manage eating disorders or food hoarding behaviours that may emerge.

Dorrer, McIntosh, Punch, and Emond (2010) completed an ethnographic study using food practices as a lens to describe practices in residential homes in Scotland. They discovered through their study that residential staff tried to create a ‘family-like’ environment, however, constantly came into conflict between the three spaces of ‘homely’, ‘institutional’, or work oriented practices that existed within the residential
home setting. Staff members efforts to create the ideal ‘family-like’ home was ironically experienced as “constraining by the children and as inhibiting a sense of belonging” (Dorrer, McIntosh, Punch, & Emond, 2010, p. 247). This incongruence or ambivalence experienced by the staff in Dorrer et al. (2010) study is the same incongruence and ambivalence experienced by residential staff regularly (Anglin, 2013). Discussed in the earlier chapter “setting the scene”, Anglin (2013) in his book “Pain, Normality and the Struggle for Congruence” discussed the ongoing tension that staff experience in residential homes. The ongoing conflict experienced was staff trying to create a ‘family-like’ environment, achieve what the staff believe is for the best interest of the child and adhering to the organisation’s policies and expectations. The ambivalence of trying to create a ‘family-like’ atmosphere within a workplace environment is an ongoing conflict for staff to juggle.

This struggle for congruence is evident when staff members at SGH 3 were trying to contain the behaviours of stealing food by placing a padlock on the fridge with the aim of teaching the children about “good balanced diets” and when to eat. While staff at SGH 3 had the intention of creating learning through the containment of the behaviour, the act of placing a padlock on the fridge was not experienced as learning or caring but as unfair control or imbalance of power. One child expressed in the interview that the padlock was a punishment and deprived her of one of her basic necessities, food. The impact of the padlock on the fridge made her feel like she wasn’t treated like a human. As (Ziegler, 2009, p. 2) puts “the child must not have basic needs threatened in any way or survival will be all they think about”.

**Perception of SGH environment theme**

Like the theme of food, tensions emerged from the interviews with regards to the differing viewpoints between staff, parents and children on the meaning and construction of a ‘home’ (Dorrer et al., 2010, p. 249). Seven out of eight children interviewed talked about their perception on the SGH environment. Even though children commented that the SGH environment was more homely than a residence, children struggled with everything being locked and needing to ask for staff to open rooms, fridge, toilet and to get TV cords. Children perceived this as a lack of independence, freedom and normality. The parents on the other hand found the homes
lovely and homely and commented on the nice environment. 6 out of 8 parents talked about the SGH providing more freedom than a locked up residence and referred the SGH to being a step-down into the community. Two differing perspectives emerged from the focus group discussions with staff members on the theme of “perception of SGH environment”. On one hand, some staff at SGH 1 and the majority of staff at SGH 2 emphasised the importance of children understanding that they are in the SGH because of their behaviour and the need for behavioural change.

The differing perspective that emerged in the discussion which was held by majority of the staff group at SGH 1, was the importance of being relational, taking time to listen to the children and to explain if things needed to be locked away for safety reasons. Staff members spoke about the constant tension that occurs within residential homes. As Anglin (2013) discusses, the struggle for congruence is evident when decisions are made in the best interest of the child, yet children fail to perceive decisions as being in their best interest.

From the interviews, children felt their physical needs were well provided for at the SGH. Children expressed struggling with the fact that everything was locked and wanted more normality. One child felt she was being punished by the rules and restrictions of the SGH even though she had not done anything wrong. Staff members’ attempts to contain behaviour through rules and maintain safety by locking doors and limiting access to items was intended to enhance safety and reduce risks in the physical environment. Ironically, children did not perceive this as safety enhancing but as rigid and controlling.

The importance of creating safety was discussed in the first section. One way of creating safety is within the therapeutic relationship and another way of creating safety is by through the use of physical spaces (environment) for the client to engage in activities that do not trigger the stress response in the brain (Streeck-Fischer, 2000). It has been shown that supportive positive environments can diminish the effects of trauma and genetic vulnerability (Shonkoff et al., 2009). Ziegler (2012) in his article “Optimum Learning Environments for Traumatised children” discusses the difference between providing a predictable structure versus a constricting or rigid environment.
He discusses that a constricting and rigid environment is often what adults view as methods to maintain order and structure but many children experience as constricting. He adds that traumatised children respond to restrictive and constricting settings either by acting out (fight) or shutting down (flight). Traumatised children perceive the adult in this environment to be authoritarian, inflexible and ‘mean’ (Ziegler, 2012). He suggests that the optimum learning environment for the traumatised child is to provide predictable structure. While avoiding rigidity, the environment must have comforting structure that signals to the child that safety is assured and adults are appropriately in charge (Ziegler, 2012).

Golding (2008) in “The House Model of Parenting” emphasises the importance of adults learning to stay calm and in control of their own reactions and behaviours as the key to providing an environment within which children can heal and develop. “An ongoing atmosphere of relaxed empathy, sharing, fun and predictable safety and security helps the child to experience dependable relationships within which healthy attachments can develop” (Golding, 2008, p. 126).

In summary of this section, Siegel and Bryson (2012) describes mental health like a river of well-being. On one side of the bank is rigidity, where you impose control over everything leading to inflexibility and a lack of adaptability. On the opposite side of the bank, it is chaos, where there is a total lack of control. The longer we can avoid either bank, the more we spend enjoying the river of well-being (Siegel & Bryson, 2012). This river of well-being applies to the environment created at the SGH too. It is crucial that staff members are able to provide predictable safety without getting too rigid or chaotic so that children can experience the river of well-being.

**Healing traumatised brains from the base up: The limbic system**

In the last two sections, we discussed the role of the lower brain functions; the brain stem and the diencephalon and how the themes in the interviews link in with the key functions of these parts of the brain. In this section, we discuss the limbic system and discuss the themes that highlight the importance of relationships like “importance of family”, “Social Workers role”, “peers and mix of the home” and “gender mix”. I
also introduce the theme of “inclusion and involvement” and discuss the importance of building a stairway of integration with the “upstairs” brain through involving children in decision-making. I also highlight the importance of staff members in the SGH being emotionally intelligent and highly attuned to children’s emotional states.

![Figure 6](image_url)

**Figure 6 Adapated from *The human brain, divided into its four interconnected areas.* From Child Trauma Academy. Retrieved from http://www.childtraumaacademy.com. Copyright 2002 by Child Trauma Academy. Reprinted with permission.**

**Functions of the limbic system**

The figure above is an adaptation of Dr Bruce Perry’s picture of the brain (Child Trauma Academy, 2005) which shows that limbic system is situated above the diencephalon and the brainstem. The limbic system is often known as the “emotional brain” as it is the emotional centre of the brain that processes perception, experience, memory and body chemistry (Ziegler, 2002). The limbic regions are unique to species that are social, group living, look after their young, form attachment bonds and play especially when young, all these activities are termed social interaction (Howe, 2008). Species that are interpersonal and socially interact with each other need to experience emotions and feelings as “emotions play a key role in generating information on how we are doing as we interact with others” (Howe, 2008, p. 76). The limbic system serves important emotional, motivational, self-regulatory and social functions. (Solomon & Siegel, 2003). The limbic system also controls reproduction and sexual behaviour.
necessary for survival of the human species (Ziegler, 2012; Ziegler, 2002). It also controls attachment which determines survival early in life and our ability to form meaningful relationships later on in life (Ziegler, 2002).

The function of the amygdala

While the limbic system does have different parts and functions, I would like to highlight the function of the amygdala this will help us with our understanding of children who have experienced trauma. The amygdala is known as the fear centre or the ‘smoke detector’ of the body (Ziegler, 2012). The amygdala is the size and shape of an almond and is part of the limbic area. The amygdala’s job is to process and express emotions, particularly fear and anger (Siegel & Bryson, 2012). The amygdala is on alert for times we may be threatened. When the amygdala senses danger, it takes over the cortex (thinking part of brain) and allows us to act before we think (Siegel & Bryson, 2012). Acting before thinking is a good thing in situations which requires an immediate response to keep us safe. However, reacting before we think isn’t a good thing in normal everyday situations (Siegel & Bryson, 2012). When the amygdala fires up, it prevents us from accessing of thinking capacities, leaving us unable to act calmly and reasonably (Siegel & Bryson, 2012). Emotions can help us make wise decisions but emotions on their own without a reasoning mind leads to reactive decisions (Ziegler, 2002). Children who have experienced trauma have amygdala’s that activate easily and therefore are emotionally reactive and impulsive in decision-making.

The effects of trauma on the limbic system and amygdala

The limbic system controls emotions and bodily functions in response to emotional states (Ziegler, 2002). When trauma affects an individual, it has a direct impact on the arousal, emotional and involuntary response of the body to stress. Therefore, it can be argued that the section of the brain that is most impacted by trauma is the limbic system in the middle of the brain (Ziegler, 2012). Whenever the individual perceives a threat of any kind, the amygdala sends out an internal warning signal. Children who have experienced trauma have an amygdala that is sensitive to threats in the environment and fires up easily as they experience fear and anger. This is why children who have experienced trauma are often emotionally reactive and lose their ability to use emotions effectively (Ziegler, 1994). Trauma memories are also stored in
the limbic system and all future sensory input is filtered through memories of trauma (Ziegler, 2012). Trauma prevents the limbic system in the brain to be used for anything else but survival unless through disassociation (Ziegler, 1994). “Traumatised individuals lose their ability to make effective use of their emotions as their thoughts are dictated by feelings rather than feelings arising out of thoughts” (Ziegler, 2002, p. 1565). “Trauma disconnects the brain’s thermostat that regulates emotional homeostatis” (Ziegler, 2002, p. 1565). That is why traumatised children’s reactions are inconsistent, out of proportion and extreme from one moment to the next (Ziegler, 2002). Many traumatised children have impulsive and reactive emotional problems which are often believed to be attention deficit hyperactive disorder (ADHD) (Ziegler, 2002).

Ziegler (2002) discusses the common feeling states that traumatised children often experience- irritability, negativity, sadness and defensiveness. He describes that when unexpected negative situations arise, we call this a ‘bad day’ and become irritable. However, for traumatised children, every day is perceived as a ‘bad day’ due to their experiences of the world, and irritability becomes pervasive. Irritability then leads to negativity as they look through the lens of their internal working model of themselves and the world as “the world is a dangerous place”, “nothing good happens to me”, “I am bad”, “I am unloved”. Sadness is often another emotion traumatised children experience. However, sadness is often expressed as rage and anger. The child finds it difficult to express sadness as this makes them vulnerable. Vulnerability exposes their internal world which adults can then misuse. This causes the traumatised child to take on a defensive posture as they perceive that relationships continually attack them (Ziegler, 2002).

**The importance of attachment relationships- contact with birth family**

The understanding of the limbic system and how trauma impacts this system requires us to think of intervening in neurodevelopmental ways. Perry (2002b) discusses the six core strengths necessary for healthy child development. The first is attachment, making relationships and the second is self-regulation, containing impulses (Perry, 2002b). As covered previously, the limbic system controls attachment which is essential for survival early in life and the ability to form meaningful relationships later.
In my interviews with children and their birth parents, all eight children and seven out of eight parents interviewed, talked about how important family contact is to them emphasising the importance of having regular contact (face-to-face) with each other with phone calls being additional to face-to-face visits. The importance of contact with family was also a dominant theme that emerged in Atwool’s (2010) interviews with 47 children and young people in care.

Research on children’s perspectives on contact with birth families highlights that children want contact with their family, particularly their mother and siblings and this desire for contact does not decrease over time (Munro, 2001). As it came through
In my interviews, many children do not give up hope of returning to live with their biological family (Wilson & Sinclair, 2004).

In the interviews, both children and parents who lived in a different city from each other struggled with having limited access. One child expressed in her interview that it is very difficult emotionally being in a different city to her family and that family contact needs to be accessible. Children’s views on where they are placed needs to be taken into account. In order to facilitate regular face-to-face contact with family, children should ideally be placed in the same city as their family.

Two children expressed their frustration towards staff members who used family contact as a condition for good behaviour. One child expressed missing her mum but has been denied contact due to her behaviour. Both children perceived staff members using family contact as a threat in order to get them to behave. The children felt this was not fair and instead of helping them settle down in their behaviour, being denied family contact created more anxiety and stress for them. According to number 7 of the charter for children and young people in care, children have rights to have contact with their family (Child Youth and Family, n.d.) and this contact should not be conditional on behaviour. In neurodevelopmental terms, using family contact as a threat when a child is in a state of distress will not help regulate their emotions but will escalate their distress further by firing up their amygdala as they experience fear and anger. When the amygdala is activated, it prevents them from accessing thinking parts of their brain (Siegel & Bryson, 2012).

Based on the literature, it is important that no ‘rule of thumb’ be applied when making decisions as to whether children have contact with birth parents (Atwool, 2013). A consistent message that has come through the research and the findings is that contact with the birth family is important and that children want to be consulted about this (Atwool, 2013). It is important that children’s views are taken into account during the decision-making process (Munro, 2001). Children’s voices from the interviews indicated that seven out of eight children wanted more contact with their family. There is not a one-size fits all approach in resolving the conflict of whether having access
with their parents is in the best interest of the child but it is important that children are heard and involved in the decision-making process.

Parents from SGH 1 talked about improved and strengthened relationship with their child since their child was placed in the SGH. There is little evidence of work with birth families once children come into care other than making arrangements for contact (Fernandez & Atwood, 2013). However, the interview findings indicate how the SGH played a crucial role in helping to strengthen and bridge the relationship with their child. Working with birth families continues to be a gap internationally and is an area that needs to be strengthened.

**Attachment relationships - Relationship with Social Workers**

Six out of eight children talked about their Social Workers during the interview. Children saw the role of their statutory Social Workers as having decision-making power around things that were important to them. For example, where they lived, finding a placement, managing their plans and contact with family. Some children had a strong relationship of trust with their Social Worker whereas others saw the relationship as an imbalance of power and Social Workers making the decisions for them which they were not happy with.

Five out of eight parents talked about the important role Social Workers play in their children’s lives and saw the role of statutory Social Workers making decisions around where the child lived and managing court orders and custody orders. Some parents appreciated the support Social Workers gave them for their own issues eg: referral to drug and alcohol course. Some parents spoke positively about the work the Social Workers do with their children and appreciate when Social Workers make an effort to communicate with them. The staff at the SGH also saw the importance of Social Workers having regular positive contact with the children while they were residing at the SGH.

The CYF practice centre highlights the important role Social Workers play in influencing the success of the placement and supporting it (Child Youth and Family, 2010a). From an ecological perspective, Coman and Devaney (2011) acknowledge the
central role Social Workers play in proactively building and sustaining relationships. Atwool (2010) completed a review of the quality of services for children in care for The Office of the Children’s Commissioner (OCC) in New Zealand. As part of the review, 47 children and young people, 66 caregivers, 7 caregiver Social Workers, 31 Social Workers, and a small number of managers and lawyers participated in either individual interviews or group discussions. One of the findings that emerged from the review was that children and young people wanted higher levels of engagement with their Social Workers and the importance of Social Workers listening to children and young people and involving them in planning (Atwool, 2010; Fernandez & Atwool, 2013). In this thesis, the need to be involved and included in decision-making was also a theme that emerged in the interviews with children. Five out of eight children interviewed felt they did not get a choice in living at the SGH and talked about their need to be involved in their plans and to be included in decision making. The placement at the SGH is likely to be more successful when children are involved in the decision making process and feel they have a say and a voice.

**Attachment relationships- Relationships with peers in the home**

The theme of peers and mix of the home came through as a dominant theme for the children and parents. Seven out of eight children and seven out of eight parents discussed the peer group in the home and how that has a significant impact on the child while they are residing at the SGH. Children and parents had common thoughts on the peer group mix at the SGH. Some of the dominant themes that emerged were the difficulties living with a range of children with complex behaviours and that they don’t get to choose who they live with, the mix of the home was important as there could be a lot of fighting, arguing and bullying behaviour. It was also important to have the right are range and gender mix. The parents and staff were worried about the impact of contagion behaviours like absconding.

The concerns that were raised by children, parents and staff around the peer group are not unique to the SGH. The issue of contagion behaviour within residential group environments has been a long standing issue (Osgood & Briddell, 2006). In a qualitative study completed on children and adolescents living in Flemish residential care and day treatment, the children reported being impacted by the behaviour of the
peer group in the residence (Soenen, D'Oosterlinck, & Broekaert, 2013). Children reported violence from peers, the atmosphere of the home being tense due to young people’s disruptive behaviours like slamming doors and verbal abuse (Soenen et al., 2013).

The peer group can be of negative influence; however, it could also influence children positively if channelled in the right way. An evidence base model that helps to develop positive youth cultures in youth serving organisations is the Positive Peer Culture model (Laursen, 2010). Deep therapeutic change and healing relationship trauma occurs within the context of supportive and trustworthy relationships with adults and peers (Perry 2002b). The Positive Peer Culture model targets negative peer influence into care and concern for others by meeting the developmental needs for belonging, mastery, independence and generosity. Rather than demanding obedience from authority or peers, the Positive Peer Culture Model empowers youth and encourages them to take responsibility (Laursen, 2010). “Troubled youth need more than technique; they need transformative experiences with other people” (Laursen, 2010, p. 38). With the support of adults within the SGH, the children could learn how to build healthy attachment relationships between each other.

Gender mix in home

The theme of gender came up as a common theme in the interviews with children. All the girls interviewed (5 out of 8) talked about how difficult it was living with all girls in the home. All the girls interviewed said that living with all females was difficult because of the ‘cattiness’. Children preferred a mixed gender home as it felt more normal. One child commented on the negative impact it had having an all-female environment, including staff members. Two parents raised the theme of gender in their interviews and acknowledged the role of male staff members doing activities and being role models for boys particularly. One parent expressed the difficulty of having a gender imbalance at the SGH, for example too many girls and one boy. Parents felt it was important that staff members understand which gender a child relates better to.

There has been limited research completed on the impact of single-gender and mixed-gender placements for children in care. However, the research that has been
done on mixed-gender placements indicates positive benefits. In forensic services for young people, staff felt that mixed wards provide a more developmentally appropriate environment for young people (Crutchley & O’Brien, 2012). Copley and Johnson (2014) interviewed seven residents residing in a mixed-gender residential placement in Scotland on their views regarding living in a mixed-gender environment. The main themes that emerged from Copley and Johnson’s study were that children found a mixed-gender environment more normal, and that it was more similar to the environment they would be living in post-residence. The children expressed preferring living with mixed-gender and issues that arose were related to living with other people in a group environment regardless of gender (Copley & Johnson, 2014). The findings from the two studies is similar to what the children have reported in my interviews with them.

**Enhancing emotional regulation**

The second core strength for healthy development in children that Perry (2002b) discusses is the importance of emotional regulation.

*Emotional regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goals (Thompson, 1994, pp. 27-28)*

Perry (2002b) describes emotional regulation as the ability to control primary urges such as hunger, sleep and feelings like frustration, anger and fear. Newborn babies are unable to regulate their own arousal (Howe, 2005). They need an external regulator; a caring parent that helps them to regulate their arousal when they are stressed (Perry, 2002b) by providing soothing and calming activities such as rocking, singing, making soothing noises and comforting touch. Children who have experienced maltreatment missed out on parents who were able to regulate their emotions as a baby.

Healthy emotional self-regulation is the ability to tolerate the sensations of distress that accompany an unmet need (Perry, 2011). Traumatised children have no internal regulator because the trauma has altered the brains ability to regulate emotion.
“Children who struggle with self-regulation are more reactive, immature, impressionable, and more easily overwhelmed by threats and violence” (Ziegler, 1994). For these children, the threshold for managing emotions are low and they get overwhelmed easily (Golding, 2008). It is important for children who have experienced poor parenting early in life to develop the ability to regulate their emotions (Golding, 2008). As an infant, these skills are developed through close contact with the primary caregiver (Golding, 2008). The experience of a caregiver soothing the infant successfully teaches the infant how to manage their emotions and eventually as they grow older, they learn to regulate their emotions without help (Golding, 2008). For children who have experienced trauma, this experience that they missed in their early years needs to be replicated by adults co-regulating when they get overwhelmed (Golding, 2008). Co-regulation is done by adults modelling how to be calm through words and actions (Perry, 2011). Repetitive somatosensory activities can also help to increase the regulation of the lower brain (Gaskill & Perry, 2013). Children can learn regulation skills through the use of movement, rhythmic activity, breathing and deep pressure (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). These activities help to regulate the lower brain areas that enhance relational and cognitive capabilities (Gaskill & Perry, 2013).

**Emotionally intelligent workers**

Work within the residential home environment is complex. Dealing with the emotional pain of children and their pain-based behaviours is difficult (Anglin, 2013). The work is often thought provoking, affect-laden and intellectually demanding (Howe, 2008). The field of residential work requires workers who are able to recognise the emotional nature of the work and the impact it has on the self and others (Howe, 2008). This is what Howe (2008) describes as the emotionally intelligent worker. “The emotionally intelligent person understands the part that emotions affect behaviour, beliefs, perceptions, interpretations, thoughts and actions. The ability to adjust, modify and regulate our emotions as we relate with others is also a key element of emotional intelligence” (Howe, 2008, pp. 11-12). They are intelligent about what emotions are and how they affect us, how they can be managed, developed and used in the self and others. (Howe, 2008). In order to be effective workers working with children who
exhibit complex behaviours, we need emotionally intelligent workers who are compassionate, caring and resilient (Howe, 2008).

**Integrating the ‘upstairs’ brain**

It is important to teach children how to make good decisions in high-emotion situations (Siegel & Bryson, 2012). The ‘upstairs’ brain is the prefrontal cortex which helps us make sound decisions, control emotions, have empathy, self-understanding and morality (Siegel & Bryson, 2012). It is important to remember that this part of the brain does not fully develop till around one is twenty-five years of age. Therefore, “it is unrealistic to expect children to always be rational, regulate their emotions, make good decisions, think before acting and be empathetic when they don’t have constant access to their ‘upstairs’ brain” (Siegel & Bryson, 2012, p. 784).

Not only do children have limited access to their ‘upstairs’ brain, when under stress, the part of it that can function becomes inaccessible (Siegel & Bryson, 2012). “The limbic system and prefrontal cortex are mutually inhibitory: as one increases in activation, the other decreases and vice versa” (Blaustein & Kiniburgh, 2010, p. 2706). When under stress, the primitive lower parts of the brain ‘take over’ the ‘upstairs’ brain (Siegel & Bryson, 2012). During these times, the adult needs to help soothe and calm the child. When adults do this, they are building a stairway of integration between the lower and upper brains; enabling the child to calm down (Siegel & Bryson, 2012).

Another way of building integration between the ‘upstairs’ and ‘downstairs’ brain is to exercise the ‘upstairs’ brain by using it. This means giving children the opportunities to make decisions and to problem-solve. In the interviews with children and parents, they talked about the importance of being involved and included in decision-making. Children and parents wanted to have a voice and a say in their plans. Parents who were involved and included in the decision-making process for their child felt valued and empowered in their identity as a parent. The literature from neuroscience indicates that if we want to help develop integrated brains, children need opportunities to be involved in planning, making decisions and problem-solving. The practice of using thinking and decision-making skills strengthens the pre-frontal cortex
and allows it to work better (Siegel & Bryson, 2012), making it more accessible during times of stress.

Healing traumatised brains from the base up: The cortex

![Image of the cortex divided into four interconnected areas]

Figure 7 Adapted from The human brain, divided into its four interconnected areas. From Child Trauma Academy. Retrieved from http://www.childtraumaacademy.com. Copyright 2002 by Child Trauma Academy. Reprinted with permission.

In this final section, we discuss the functions of the cortex of the brain and link in themes that emphasise executive functions such as “points system”, “goal setting”, and “transition to independence and the need for flexibility” that emerged from the interviews. I also highlight how the orbitofrontal cortex of the brain develops and discuss the brain-based way of managing behaviour with children who have attachment difficulties and trauma issues.

Functions of the cortex

The cortex is the highly developed part of the human brain and is responsible for a large range of functions like thinking, language, planning, purposeful acts,
perception and calculating (Howe, 2008). As our emotional brain develops, we need the ability to think and reflect on our emotions using language and reflective abilities (Gerhardt, 2004). Therefore, our cortex can be said to have grown from our emotional brain as it gives us the ability to navigate the complexity of emotions and respond appropriate while interacting with others (Gerhardt, 2004). “The prefrontal cortex has a unique role in the cortex as it links the sensory parts of the cortex with the emotional and survival-oriented subcortex” (Gerhardt, 2004, p. 35). One of the first parts of the prefrontal cortex to develop is the orbitofrontal cortex (Schore, 1994).

The orbitofrontal cortex is situated right in front of the brain above the eyes, and plays a major role in processing emotions (Gerhardt, 2004; Howe, 2008). Neuroscientists have studied that when the orbitofrontal cortex is not functioning properly that individuals are not able to relate socially and emotionally with others well (Gerhardt, 2004). The orbitofrontal cortex is the part that controls our ability to infer the emotional states of others (Baron-Cohen, 1995), assists social adjustment, mood control (Cavada & Schultz, 2000), ability to cope with stress and affect regulation (Schore, 1994). The orbitofrontal cortex and parts of the prefrontal cortex are responsible for emotional intelligence (Goleman, 1995).

The orbitofrontal cortex processes emotional experiences in a considered and reflective manner compared to the amygdala (Howe, 2008). The orbitofrontal cortex and amygdala are designed to work in tandem under normal conditions of everyday life as the amygdala is quick to react but the orbitofrontal cortex provides thoughtful and analytical reasoning (Howe, 2008). The orbitofrontal cortex is often known as the thinking part of the emotional brain (Hart, 2008). The fast-acting amygdala is designed to over-rule the cortex under emergency situations (Howe, 2008). However, children who have been constantly exposed to unsafe environments have an amygdala that is in a hypervigilant state (Hughes & Baylin, 2012). Their orbitofrontal cortex is constantly being over-ruled by the amygdala, making them reactive and impulsive in behaviour. Furthermore, traumatised children can experience neurological deficiencies such as the inability of the orbitofrontal cortex to integrate information and decisions from all part of the brain (Ziegler, 2012).
The brain as well as the cortex is divided into two hemispheres, the cerebral hemispheres. The left hemisphere is responsible for logic, cause-and-effect thinking, language, calculation, analysis and reflection (Howe, 2008). The right hemisphere is involved with non-verbal cues, eye contact, tone of voice, processing emotions, facial recognition and interpretation, and visual and spatial activities like art (Howe, 2008; D. Siegel & Bryson, 2012). The split in the right and left hemispheres means that in order “for the brain to function normally, activities in the left and right hemispheres must work in harmony, much like a concert orchestra” (Melillo, 2009, p. 7). Integration of the right hemisphere (emotional) and left hemisphere (logical processing) is an essential task for human development (Howe, 2008). Children who have experienced emotionally rich environments where their emotions are named, talked about, validated, contained and managed have been helped to integrate their left and right cortex (Howe, 2008). These children are able to integrate their emotions with reasoning well; creating the whole-brain child (Siegel & Bryson, 2012).

Cortical modulation ratio

“A healthy Cortical Modulation ratio (Cortical and Limbic/Midbrain and Brainstem) develops when the child experiences a variety of optimal emotional, behavioral, cognitive and social experiences at key times during their development” (Perry, 2004, p. 12). This ratio shows the ability of the mature brain to modulate the more primitive, reactive, reflexive output of the brainstem and midbrain (Perry, 2004). We have discussed in earlier sections that the brain develops sequentially from the most primitive lower parts of the brain. As the higher brain areas develop, the output of the lower primitive brain is shaped, modulated and modified in more mature fashions (Perry, 2004). Disruptions in development caused by lack of critical emotional experiences or persistent traumatic stress can “either ‘overdevelop’ the midbrain and brainstem or ‘underdevelops’ the limbic and cortical areas resulting in an imbalance in the Cortical Modulation ratio, predisposing individuals to aggressive and violent behaviour” (Perry, 2004, p. 12). An overdeveloped brainstem and midbrain results in problems such as anxiety, impulsivity, poor affect regulation and motor hyperactivity (Perry, 2004). An underdeveloped limbic and cortical areas results in lack of empathy and problem-solving abilities (Perry, 2004). Individuals who have overdeveloped lower brains lose the ability to modulate and regulate effectively (Perry, 2004).
Managing behaviour from an attachment-based and neuroscience perspective

Since we now understand the functions of the cortex and the impact that early adversity can impact on the ability to modulate and regulate effectively, it is important to discuss how to effectively manage behaviours of children who seem ‘out of control’ and have complex behavioural issues. In this section, I will discuss the literature on managing behaviour from an attachment-based and brain-based perspective. I will also provide a critique of the current points and levels system and explain why the current behavioural change model is limited.

We have established in the literature review chapter that children who have experienced insensitive caregiving do not develop secure attachments. In order to feel a sense of safety and security, the child learns to organise their behaviours in certain ways (Golding & Hughes, 2012). When a child experiences the source of safety as a threat, the child is unable to organise his behaviour to feel safe (Golding & Hughes, 2012). As this child grows up, he learns ways of managing this level of fear by developing a range of behaviours to give him a false sense of safety; including highly controlling behaviours (Golding & Hughes, 2012). These children often exhibit complex and ‘out of control’ behaviours. The focus for children whose behaviour is considered ‘out of control’ is teaching behavioural management techniques such as use of rewards and consequences, ignoring undesirable behaviour, timeout and grounding (Atwood, 2004). However, these strategies are not going to be successful if there are underlying attachment difficulties (Keck & Kupecky, 2002). “Without secure attachment there is no basis for co-operation” (Atwood, 2004, p. 39).

Understanding the attachment experience of the child and how this translates into current relationships will help you respond in ways that build security and trust (Golding & Hughes, 2012). While we may not tolerate the behaviours, it is important that we accept the experiences underneath these behaviours (Golding & Hughes, 2012). Children who have severe attachment difficulties are afraid of being parented or cared for (Golding & Hughes, 2012). We need to gently lead these children into different ways of relating to adults and through that experience a more secure attachment
relationship, providing a foundation for their exploration of the world (Golding & Hughes, 2012).

Caring for children with attachment difficulties and a history of trauma is more than behaviour management. We have to manage behaviour to teach children what is acceptable and what is not (Golding & Hughes, 2012). Boundaries and limits provided give safety (Golding & Hughes, 2012). This is one hand of parenting or caregiving (managing behaviour and setting boundaries), but parenting requires two hands. The other hand is where we provide nurturing and building a relationship with the child so they flourish emotionally (Golding, 2014; Golding & Hughes, 2012).

**Points and levels system and goal setting**

Many residential treatment facilities in the United States use the point and/or level systems based on operant conditioning and the token economy system (Mohr, Olson, Branca, Martin, & Pumariega, 2009). In New Zealand, all Child, Youth and Family residences, including care and protection residences and youth justice residences as well as SGHs utilise the behavioural change model, called the behavioural modification system (BMS) in residences and the point and levels system in SGHs. In Mohr et al. (2009, p. 8), the authors critique the points and levels system programming and “assert that continuing such programming is antithetical to individualised, culturally, and developmentally appropriate treatment”.

In the literature review chapter, a critique of the points and level system has been provided, but I would like to emphasise the views of children on the points and levels system expressed in the interviews. Six out of eight children interviewed expressed frustration and dislike toward the points and levels system. Several children talked about how staff members would take points off them if they did not adhere to the rules, misbehaved, failed to follow instructions and routines. The children expressed that they “did not care about losing points”, and many felt a sense of failure and gave up trying as it was too hard to attain level 3, the highest level on the system. Children expressed that the points and levels system did not feel normal and did not allow them to be themselves. One child said she was having a ‘bad day’ because she was missing her family and staff members made it worse for her when they said they were deducting
points due to her misbehaviour. As Drumm et al. (2013) highlights, the expectation to adhere to the model can result in increased frustration and anger from youths which inhibits their positive learning.

I would like to highlight the literature that supports what the children have said about the points and levels system. Mohr et al. (2009, p. 10) discusses some arguments as to why the points and levels system may be “counterproductive, non-therapeutic, and may result in unintended consequences”. Firstly, the way the points and levels system is structured is it focuses on the negative, behaviour problems and “what is wrong” (Mohr et al., 2009). On the points and levels system at the SGH, the language that is used is around “losing points” when a child misbehaves rather than “gaining points” when a child is doing well. This inevitably focuses on “what is wrong” rather than what the child is doing right. “Focusing on negative behaviour keeps children and clinician attention on negative behaviours, rather than teaching and demonstrating the value of positive behaviours and working to strengthen them” (Mohr et al., 2009, p. 11). While trying to get the child to behave or by containing behaviours, it is easy to misinterpret the experiences underneath these behaviours (Golding & Hughes, 2012).

While the points and levels system attempts to be fair and objective, the children have experienced it to be the opposite and punitive. Spiegler and Guevermont (2003) discuss “response cost” to be a punitive consequence. Response cost refers to the removal of some specified amount of reinforcer following undesired behaviour (Mohr et al., 2009). Within the points and levels system, children receive a loss of points and possibly demoted to a lower level if they are engaging in overt undesired behaviours (Mohr et al., 2009). Staff members verbalising to a child ‘acting out’ that they are losing points can often aggravate their behaviour (Mohr et al., 2009). From a neuroscience perspective, if a child is operating from their lower brain regions, telling a child or reasoning with them that they are ‘losing points’ is an ineffective behaviour management strategy. Cognitive-behavioural approaches presume the cortex can deal with the emotional limbic system and other lower brain regions (Howe, 2005). In fact, trying to reason with a child while they are experiencing arousal and threat will only increase their survival response of flight, fight and freeze modes (Howe, 2005). While cognitive-behavioural approaches may benefit some children, it is important to bear in
mind that children who are extremely dysregulated will not benefit from this ‘top-down’ approach (Mackinnon, 2012).

Even though children expressed frustration at the points system during their interviews, they still saw the importance of setting goals. All eight children talked about the theme of goal setting during their interviews and preferred to have individual goals rather than a ‘one-size-fits-all’ points and levels system (Bailey, Gross, & Cotton, 2011). Programming that is catered for a group is doomed to failure as it does not take into account differences among the group members (Mohr et al., 2009). In order for treatments and programmes to be effective, they need to cater to the individuals “unique needs and challenges and should be dynamic and responsive to status changes over time” (Mohr et al., 2009, p. 12).

Lastly, the points and systems level will work well for children who are functioning at their chronological age. However, it is important to remember that the population of children we are working with in residential settings are rarely functioning developmentally at their normal age-range. Children who have been raised in chaotic, neglectful, relationally deprived and cognitively impoverished environments will develop key functional capabilities at a much slower rate (Perry 2006). Therefore, when working with children, we need to have developmentally appropriate treatment plans that are individualised to their specific needs (Mohr et al., 2009). As Perry (2006) highlights it is “stage not age”. We should be targeting programmes to suit children’s developmental stages not their chronological age. This is a complete mind-set shift for professionals working in the field of residential care. In the recommendations chapter, I will elaborate how residential services can introduce an assessment of the child’s developmental needs based on the four major regions of the brain.

Managing behaviour from an attachment and brain-based perspective

In the first section on the brain stem, we have emphasised the importance of “connection before correction” and the importance of managing behaviour whilst building security and maintaining the relationship (Golding, 2014). While behaviour management and setting boundaries and consequences is crucial, it needs to be sandwiched between attunement and relationship repair for it to be effective (Golding,
The most effective consequences are those that are logically connected to the behaviour itself (Golding, 2008). Through consistent and logical consequences, this will help the child to learn that their behaviour represents a choice (Golding, 2008). Over time, this will help lead the child to more thoughtful behaviours (Golding, 2008).

Earlier in this chapter, we discussed the 3Rs “regulate, relate, reason” that needs to be completed in this specific order for it to be effective (Perry, 2015, P.12). It is important to re-cap that if a person is not regulated (feeling emotionally and physically settled), he/she will not be able to relate through feeling connected and comfortable (Perry, 2015). Until a person is able to relate to another, they will not have the ability to engage their cognitive reasoning and problem solving skills (Perry, 2015). Therefore, models that try to reason first before regulating the child will not be effective. We need to have a mind-set shift in how we work with traumatised children by providing regulatory activities first, followed by relating to them and lastly reasoning with them. These activities (completed in this specific order) needs to be seen from a neuroscience perspective and not from a perspective that we are rewarding bad behaviour.

From a brain-based perspective, good caregiving involves protecting the child’s developing brain (neuroprotective factors) and stimulating the brain growth (growth-enhancing factors) (Hughes & Baylin, 2012).

“Good parenting or caregiving from a brain-based perspective is:

- Being sensitive and emotionally responsive to children’s needs for attention
- Comforting children effectively and consistently when they are stressed out (co-regulation of affect)
- Be a good first companion as children are initially learning how to enjoy and stay connected to other people.
- Knowing when to let kids struggle and work through challenges to build their own resilience
- Protecting children from the dyregulating effects of our own negative emotions by using our powers of self-regulation and stress management by being the adult in the room” (Hughes & Baylin, 2012, p. 3)

“Highly empathic, warm and nurturing parenting alongside appropriate structure and supervision and calm and measured responses to behaviour” will help children feel safer (Golding, 2008, p. 207). This will help to grow the trust within the relationship
and help develop secure attachments.

**Transitioning to independence and the need for flexibility**

In this final section, I would like to highlight the theme of transitioning to independence that came through in the interviews. Three of the eight children were of the age where they were transitioning-out-of-care within the next year. In New Zealand, under the provisions of the Children, Young Persons, and Their Families Act 1989, custody orders expire automatically on the young person’s 17\(^{th}\) birthday (Children Young Persons and their Families Act, 1989). Majority of young people in care will transition-out-of-care between their 16\(^{th}\) and 17\(^{th}\) birthday. Post 17 years of age, the Chief Executive can exercise guardianship as opposed to custodial rights, responsibilities, powers and duties. Sole or additional guardianship orders can continue until age 20 if not discharged earlier.

Three of the children and parents interviewed discussed that transitioning to independence was a stressful experience for the child. They expressed that the rules and structure at the SGH did not help foster independence and prepare them for the transition as the rules seemed ‘over the top’ and not normal. They expressed needing more flexibility and independence so they could learn life skills that would equip them for their transition to independence. One parent highlighted that her daughter had been in care since she was two years old and was so used to all the structure and staff around her that living independently and learning new skills would be a huge challenge.

In New Zealand, there has not been any longitudinal studies completed on young people leaving care (Fernandez & Atwool, 2013) but has been one study based on analysis of case files (Ward, 2000) and small qualitative studies of young people leaving care (Coote, 2007; Yates, 2000). All three studies depict a population of young people who lack life skills and are at significant risk of poor adult outcomes such as early parenthood, criminality, mental health issues, substance problems, homelessness, lack of education and long-term unemployment. These outcomes are similar to children leaving care overseas (Yates, 2001).
The gap for children leaving care in New Zealand has been acknowledged and is currently a goal in the Children’s Action Plan to support children and young people transitioning from care (The White Paper for Vulnerable Children, 2012). The Child, Youth and Family Practice Centre has best practice guidelines for preparing a young person for independence and highlights the voices of children on their views towards independence (Child Youth and Family, 2014). Best practice guidelines for transition to independence includes an holistic plan, regular review of their plan using the Tuituia Child, Youth and Family assessment framework, a contingency option and involvement of family/whānau and other support networks (Child Youth and Family, 2014). An emphasis is made on young people having a key say in their transition plan (Child Youth and Family, 2014).

Hillan (2006) completed a report for Churchill Fellowship in Australia and explored issues of residential care in the UK, Canada and the US. (Hillan, 2006, pp. 6-7) made these recommendations for children aged 15-17 years old transitioning-out-of-care:

1. “There needs to be a renewed focus on the needs of older young people in this age range (15 to 17 years) with further model development undertaken to better ensure positive options for young people leaving care.
2. Continued higher levels of care should be available for this group if needed with specialist support offered.
3. An independent living skills program needs development in all residential care facilities to ensure that young people leave with appropriate skills that equip them to live independently into the future”.

Children aged between 15 and 17 residing in residential care and group homes have a window of opportunity to be equipped with development of living skills, support in education and employment opportunities and the building of appropriate support networks that could prepare them to live independently (Hillan, 2008). As the children have pointed out in the interviews, in order for them to learn independent living skills, there needs to be room for flexibility within the programme and structure of the SGH. The staff at SGH 1 felt that they were trying their best to teach the children how to cook meals and do their laundry as part of life skills development but found the children
being reliant on staff because of the locks in the home. Staff members saw the importance of developing individual plans that suit the child’s developmental age. Staff members suggested running two separate homes; one for younger children and one specific for children ready to transition to independence.

Hillan (2008) suggests that residential care could be flexible in providing differing models for differing needs. “This could include small group homes and access to 'granny flat' type arrangements that assist young people in transitioning to independence, while still seeking support; and independent units where staff could still stay over occasionally to combat loneliness or assist in skill development” (Hillan, 2008, p. 49). In New Zealand, Dingwall Trust runs a transition from Care to Independence service (Dingwall Trust, n.d.). Dingwall trust offers a mobile, community based support to young people aged 15 to 20 years transitioning from care to independent living (Dingwall Trust, n.d.). Each young person is paired with their own personal advisor that will support them with areas such as obtaining a licence, budgeting, living arrangements, relationships, goal settings, education and life skills. This is an example of a service that all young people around New Zealand aged between 15 to 20 years old transitioning from care need.

**Summary of section: the cortex**

In this section, I have highlighted the executive functions of the cortex with particular emphasis on the development and functions of the orbitofrontal cortex. A critique of the points and levels systems highlighted its limitations and the need for more individualised plans. Brain-based ways of managing behaviour with children who have attachment difficulties and trauma issues was also discussed. The theme of “transition to independence and the need for flexibility” was discussed at length, highlighting the current gaps within the system for children leaving care. In the next chapter, I provide recommendations for residential services and group homes and how we can improve the current service provision model.
Summary of chapter

In this chapter, I have integrated the knowledge discussed in the literature review and the main themes that emerged from the interviews with children, parents and staff members. “Does the quality of relationships with staff have a positive impact on outcomes for children who reside in group home settings?” is the research question that I have sought to answer. This chapter was titled ‘healing traumatised from the base up’, and was structured according to how the brain develops sequentially from the ‘bottom up’. The 3Rs (regulate, relate and reason) completed in this specific order is based on the ‘bottom up’ approach to working with traumatised brains (Perry, 2015). The ‘bottom up’ approach provides therapeutic opportunities we have to re-wire the brain where opportunities were missed.

The term ‘healing traumatised brains from the base up’ gives an element of hope; that the ‘wounds’ of trauma can be healed with time, compassion and unconditional care (Solomon & Siegel, 2003). One of the most important interventions that staff members can provide is to provide a secure attachment relationship where children feel nurtured and safe. Perry (2004) discusses how the human brain has an amazing quality of creating an image of the future. The ability to imagine a better place, a better way, a better life, a better world is the concept of hope. Staff members in group home settings have an amazing opportunity to instill hope into the lives of children who have experienced despair, hurt, pain, and loneliness. “We can give children hope that not all adults are inattentive or abusive or unpredictable or violent” (Perry, 2004, p. 17). We have an opportunity to re-work their internal working model of themselves and re-wire their brains through positive relationship experiences. Through experiencing relationships around them to be nurturing, safe, responsive and sensitive they will begin to see the world as a place of safety, learning and exploration.
Chapter Six

Recommendations for practice and conclusion

Introduction

In this chapter, I summarise the key points raised in the discussion chapter and provide recommendations for practice. It is important to re-cap the research question “does quality of relationships with staff members have a positive impact on outcomes for children who reside in group home settings?” which we have sought to answer throughout this thesis. It has been clearly established in the literature review, the data from the findings as well as the discussion chapter that relationships matter and need to be at the core of our work with children who have attachment difficulties and have experienced trauma. The strong connection between attachment theory and neuroscience has been demonstrated and this chapter aims to highlight the importance of integrating this into practice within a residential context. This is a practice-based research and therefore it is important that implications for practice are presented. In this chapter, I re-cap the main themes from the findings chapter and structure the recommendations for practice in the same way as the discussion chapter; according to how the brain develops sequentially from the brainstem up to the cortex. I conclude this chapter with recommendations of evidence-based models that we can adopt into the residential context.

Recommendations for healing traumatised brains from the base up: Starting from the brainstem

1. Healing trauma is from the brainstem up not the other way around

It is important that models of working with children who have experienced trauma are based on neurodevelopment, are trauma-informed and attachment-based. As mentioned in the discussion chapter, models that emphasise the use of cortical regions of the brain that involve higher executive functions like reasoning, problem-solving skills, learning and thinking which is a ‘top-down’ approach have proven to be ineffective (Mohr, Olson, Branca, Martin, & Pumariega, 2009). Unless children feel safe within the environment and within relationships (regulated), they will not be
able to relate well to others and we will not be able to reason with them (Perry, 2015). I recommend that the clinical model informing residential practice be based on the sequential development of the brain; from the brain stem up. We need to complete the 3Rs in this particular order - regulate, relate and then reason (Perry, 2015).

2. Attachment relationships as treatment

Healing traumatised brains from the base up” needs to start with children experiencing secure attachments first. Children in residential care have disorganised and insecure attachment styles, and need to re-experience adult relationships as safe, nurturing and predictable. Staff members in residential settings need to learn how to respond to children’s emotional distress and behaviours in a sensitive and attuned way (Hughes & Baylin, 2012). Children in residential homes are often emotionally dysregulated, and need to learn how to regulate their emotions by adults being their external regulator or co-regulating them. At Seneca Residential Treatment Centre, the staff-client interaction is used as the treatment to teach children self-regulation of emotion and behaviour (Sprinson & Berrick, 2010). Residential staff need to be calm and in control of their own reactions and behaviours because this is the key to providing an environment within which children can heal and develop (Golding, 2008). Staff members need to have an open and engaged stance (Hughes & Baylin, 2012) while relating to the children so that trust and connection can develop. Children who are in a state of hyper-vigilance pay more attention to ‘non-verbal’ cues and it is important that staff members are aware of their tone of voice, body posture and facial expressions when relating to a traumatised child.

3. Connection before correction

While managing behaviour, it is important to remember this phrase “connection before correction” (Golding, 2014a). This method emphasises the importance of managing behaviour whilst building security and maintaining the relationship. When a child is misbehaving, it is important for staff members to understand the experience of the child and their feelings in order to connect emotionally (Golding, 2014a). Understanding the feeling does not mean that the behaviour is acceptable but it conveys that their feelings are understandable and manageable (Golding, 2008). Behaviour management (boundaries and consequences)
is crucial but needs to be sandwiched between attunement and relationship repair (Golding, 2014a).

4. Model of unconditional care

Seneca Residential Treatment Centre has an approach to treatment based on ‘unconditional care’ or a no-fail policy where clients are never discharged for the behaviours that led to their placement (Sprinson & Berrick, 2010). In order to see lasting change, we need to have an ethos that echoes unconditional commitment to our children and provide supports to placements in order to prevent children being moved from placement to placement.

Recommendations for healing traumatised brains from the base up: The midbrain

1. Sensory assessments completed for each child in residential settings

The midbrain controls the ability of the brain to integrate our senses (touch, taste, auditory, visual, smell and spatial awareness). Children who have experienced maltreatment and neglect often have sensory processing difficulties as they have missed out on behavioural, cognitive and social experiences at key times during their development (Perry, 2004). It is important to understand if a child has a sensory system that is easily overwhelmed by certain activities or if a child has a sensory system that is under-responsive to stimulation in the environment. Children’s sensory processing deficits can often be misinterpreted as misbehaviour. While children reside in residential settings, I would recommend having an Occupational Therapist complete sensory and functional assessments and recommendations on each child so that we can increase the holistic understanding of their needs. From the recommendations from the sensory assessment, children can be given a sensory toolbox which contains different activities to help the child self-soothe. The sensory assessment and sensory toolbox could ‘travel’ with the child to their next placement and would enable caregivers to understand the child’s sensory needs well. The sensory assessment would also be helpful for schools and teachers working with these children.
2. **Staged admission and transitions**

   Children and parents expressed clearly in their interviews that they wanted pre-visits to the group home before they were admitted. The children expressed that not having prior knowledge of the home and not having familiar relationships at the group home was a fearful experience for them. Centacare Broken Bay in Sydney Australia provides a continuum-of-care approach to reduce placement instability through providing children with staged entry and transitional arrangements into placements (Cheers & Mondy, 2009). At the SGH, a staff member or social worker who has worked with the young person in a pre-placement setting can facilitate a staged entry into the new placement and the use of pre-entry outings, meals and relationship building activities. Centacare’s outcomes indicate that this approach of staged entry into placements enhances placement stability. From a neuroscience perspective, involving children in where they live and a pre-visit to the SGH, creates safety through the physical environment and ensures that the fear system within the brain is not triggered (Streeck-Fischer, 2000). When children feel a sense of safety, this increases the likelihood of placement stability and success.

3. **The importance of food from a trauma-informed perspective**

   The theme of food came up as a dominant theme when children were asked about what they liked about the SGH. The majority of children that live in residential group homes have a history of maltreatment including neglect. The history of food deprivation these children have experienced could be one reason why food is such an important factor to them. It is important that staff members understand that children who were not fed consistently, did not have adequate food or had to compete for food, creates anxiety as food is a necessity for survival (Rowell, 2013). These children may exhibit food insecure behaviours such as hoarding food, stealing food, gobbling food and getting upset when food is not available. From a trauma-informed perspective, it is necessary to understand the history underlying this behaviour and how their brain has stored “state” memories (Perry 2006) of inadequate food.

   In order to help children with their food insecurities, the brain needs to relearn from experience and repetition that there will be sufficient food available. Individualised trauma-informed plans need to be devised for each child based on their
unique history and current behaviours to manage their food insecurity behaviours appropriately. This could include a visual schedule of when meal times are, involving children in planning meals and grocery shopping, and provision of healthy snacks throughout the day. Having a padlock on the fridge to prevent children from stealing food controls the behaviour but does not address the underlying cause of the behaviour.

4. Creating an atmosphere that promotes mental well-being

Besides creating safety through the therapeutic relationship, another way of creating safety is through the use of physical spaces within the environment. In the interviews with the children, several of them commented on the rules and the locks used in the SGH. While it is necessary to maintain a predictable structure, there is a difference between that and a constricting or rigid environment. It is important that the environment provides a comforting structure that signals to the child that their safety is assured and adults are appropriately in charge (Ziegler, 2012). It is important that staff create an atmosphere that has relaxed empathy, sharing, fun and predictable safety so that the child can experience dependable relationships where healthy attachments can develop (Golding, 2008). Siegel and Bryson (2012) describe mental health a river of well-being. On one side of the bank is rigidity, where you impose control over everything leading to inflexibility and a lack of adaptability. On the opposite side of the bank, it is chaos, where there is a total lack of control. It is important that at the SGH, we avoid either bank, and enable children to enjoy the river of well-being.

Recommendations for healing traumatised brains from the base up: The limbic system

1. Importance of contact with birth family

Contact with birth family is often a point of conflict in the literature for children in care. There is not a one-size fits all approach in resolving the conflict of whether having access with their parents is in the best interests of the child. However, it is important that children are heard and involved in the decision-making process. Parents from SGH1 talked about the improved and strengthened
relationship with their child since their admission to the SGH. Working with birth families after their children have been removed from their care continues to be a gap internationally and is an area that needs to be strengthened through family work and the use of evidence-based models such as functional family therapy and multi-systemic therapy.

2. Relationships with social workers

In the interviews with children and parents, they talked about the important role social workers play while they reside at the SGH. Social workers play an important role in supporting and contributing to the success of the placement (Child Youth and Family, 2010). Coman and Devaney (2011) acknowledge the central role social workers play in proactively building and sustaining relationships. While children reside in the SGH, it is important that their social workers continue to maintain a supportive relationship with them. Children would like their social workers to include them in the decision-making process and involve them in their planning.

3. Relationships with peers in the SGH

The peer group mix of the home is important to consider as difficulties can emerge such as fighting, arguing and bullying behaviour if the right mix is not obtained. Another impact which has been a long standing issue in residential homes is the impact of contagion behaviours like absconding. Therefore, it is important that the needs of children residing within the SGH are carefully considered before another child is admitted into the group home.

In order to help children relate positively to each other, the evidence based Positive Peer Culture model could be implemented into residential settings (Laursen, 2010). The Positive Peer Culture model targets negative peer influence and redirects this into care and concern for others, empowers youth and encourages them to take responsibility (Laursen, 2010).

Gender mix in the home was another theme that was raised. More research needs to be completed on single-gender and mixed-gender placements for children in care. The main themes that emerged from this research and Copley and Johnson’s
study (Copley & Johnson, 2014) were that children found a mixed-gender environment more normal, and that it was more similar to the environment they would be living in post-residence. In my research, all the girls commented that living with all girls was “catty”. On a case-by-case basis, mixed gender placements should still be considered as an option if the risks can be adequately managed.

4. Enhancing emotional regulation

Children who have experienced neglect and maltreatment in their early years have missed out on parents who were able to regulate their emotions. These missed experiences in their early years need to be replicated by adults co-regulating when they get overwhelmed (Golding, 2008). Co-regulation is done by adults modelling how to be calm through words and actions (Perry, 2011). Repetitive somatosensory activities can also help to increase the regulation of the lower brain (Gaskill & Perry, 2013). Children can learn regulation skills through the use of movement, rhythmic activity, breathing (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013) and mindfulness grounding techniques.

5. Integrating the ‘upstairs’ brain

Under stress, the ‘downstairs’ primitive parts of the brain can take over the ‘upstairs’ brain (Siegel & Bryson, 2012). During these times, staff members need to help soothe and calm the child under distress. When adults do this, they are building a stairway of integration between the lower and upper brains; enabling the child to calm down (Siegel & Bryson, 2012). Another way of integrating the ‘upstairs’ brain is to practice using it when calm. Involving children in problem-solving, contributing to their plans and making choices when they are calm is a good way to practice using the cortex. The practice of using thinking and decision-making skills strengthens the prefrontal cortex and allows it to work better (Siegel & Bryson, 2012), making it more accessible during times of stress.
Recommendations for healing traumatised brains from the base up: The cortex

1. Managing behaviour from an attachment-based and neuroscience perspective

Caring for children with attachment difficulties and a history of trauma is more than behaviour management. There are two hands of parenting; one hand is managing behaviour and setting boundaries and the other hand is providing nurturing and building a relationship with the child (Golding & Hughes, 2012). I recommend the evidence based ‘Nurturing Attachments Training Resource’ based on Golding’s ‘House of Parenting model’ (Golding, 2014b) to be used to train staff working with children who have experienced trauma and attachment difficulties in SGH and residential care settings. This resource is an 18 session programme based on attachment theory and offers practical suggestions to help increase understanding of children’s behavioural and emotional needs through an increased understanding of attachment theory, child development and the impact of trauma.

Another tool that will help increase understanding of the origins of the child’s behaviour and help staff members make sense of what is happening for the child is the relational learning framework by Wendy Kelly (Kelly & Salmon, 2014). I would also recommend that the relational learning framework be utilised regularly in residential care as a case consultation tool, as part of clinical supervision, in multi-disciplinary team meetings and prior to the admission of a child into residential care. The relational learning framework is derived from attachment theory and was developed as a method to help “foster parents consider how their foster child’s past experiences of maltreating and impermanent relationships may influence the child’s ideas, expectations and behaviours in relationships” (Kelly & Salmon, 2014, p. 1). The relational learning framework consists of five columns relating to a child’s internal working model and helps develop a shared view of the child and their difficulties (Kelly & Salmon, 2014).

As pointed out in the discussion chapter, the current points and levels system is limited in its approach as it does not consider the experiences underneath the behaviours. From a neuroscience perspective, if a child is operating from their lower brain regions, telling a child or reasoning with them that they are ‘losing points’ is an
ineffective behaviour management strategy. With the knowledge gained from neuroscience, it is time to move beyond the points and levels system to child-centred programming like the Collaborative Problem Solving approach (Mohr et al., 2009) which I will discuss more at the end of this chapter.

2. Transition to independence and the need for flexibility

There is still currently a big gap for young people transitioning out of care between the ages of 15 to 17 years. The outcomes for young people leaving care to independent living are grim. Residential service has a window of opportunity to equip young people transitioning to independence with life skills, support in education, employment opportunities and the building of appropriate support networks that could prepare them to live independently (Hillan, 2006). The programme within the SGH needs to have room for flexibility in order to adequately prepare young people transitioning to independence. Transition to independence group homes or independent units to support young people leaving care could be set up in order to assist young people in their transition. Staff members could support young people in these transition group homes or independent units with skill development.

In New Zealand, Dingwall trust offers mobile, community based support to young people aged 15 to 20 years transitioning from care to independent living (Dingwall Trust, n.d.). Each young person is paired with their own personal advisor that will support them with areas such as obtaining a licence, budgeting, living arrangements, relationships, goal settings, education and life skills. This is an example of a service that all young people around New Zealand aged between 15 to 20 years old transitioning from care need.

Other recommended evidence-based and trauma-informed models

1. The Neurosequential Model of Therapeutics (NMT) is an evidence based model based on core principles of neurodevelopment and traumatology (Child Trauma Academy, 2013a). The NMT assessment process is a way to organise a child’s history and current functioning by reviewing history of adverse experiences and relational health factors to estimate the timing and severity of developmental risk that may have
influenced brain development (Child Trauma Academy, 2013b). I recommend that all residential staff complete the NMT case-based series and that all children in residential care and SGHs have an NMT brain map completed which will suggest specific interventions based on the NMT approach.

2. **Sanctuary Model** is a trauma-informed approach for changing organisational culture in residential treatment programs (Bloom, 2005). This model emphasises a therapeutic community environment and empowering residents to lead effective treatment strategies (Rivard et al., 2004). It emphasises a phase-oriented approach to treatment based on theoretical assumptions on the effects of trauma. The model focuses on safety, affect regulation, grieving and emancipation (SAGE) (Rivard et al., 2004) within the context of safe, supportive, stable, and socially responsible therapeutic communities (Rivard et al., 2003). I recommend the Sanctuary Model as a trauma-informed method for creating or changing an organisational culture in order to effectively provide a therapeutic environment where healing from traumatic experience can occur (Bloom, 2005).

3. **The Attachment Regulation and Competency framework** (ARC) is an evidence based and trauma informed treatment framework that has been utilised with youth in residential treatment centres (Hodgdon et al., 2013). The ARC framework is an intervention with youths and families who have experienced trauma, and focuses on three core domains: Attachment, Self-Regulation and Competency to help build future resilience. The model intervenes with the child-in-context and understands that systemic change is necessary for lasting outcomes. The ARC framework is an attachment-based and trauma-informed model that I would recommend for residential home settings.

4. **Collaborative Problem Solving (CPS)** approach was discussed previously, but I would like to highlight this model again as a recommended child-centred intervention. The philosophy of CPS is that “children do well if they can”. Under the CPS approach, externalising behaviours are treated the same way as any learning disability (Pollastri, Epstein, Heath, & Ablon, 2013). Specific skill deficits and situations where these lagging skills cause difficulty in meeting adult expectations are identified. The
skills building occurs in natural settings through problem solving and is tailored to the child’s development level (Pollastri et al., 2013). As skills improve, externalising behaviours are not triggered and decrease in frequency. The CPS model will be useful for staff in residential settings as they will be trained to identify a child’s cognitive-skills deficits and assist the child to build these skills through a process of collaboratively solving problems to find solutions that are mutually satisfactory (Pollastri et al., 2013). The CPS model has been proven to reduce externalising behaviour, reductions in the use of restraints, and school suspensions, and improvements in individual skills, including social and executive functioning (Pollastri et al., 2013). As referred to in my literature review chapter, I recommend the book by Greene and Ablon (2006) which has a chapter on collaborative problem solving in therapeutic/restrictive settings.

**Recommended therapeutic clinical model for residential care**

In order to summarise the recommendations in this thesis, I have designed a visual model that could be used as a framework for practice for residential care settings (refer to diagram below). The purpose of this model is to capture the recommended models together in a visual presentation.

The model is first viewed left to right, where “the length of stay” of children residing in residential group homes starts from “pre-admission”, to “admission”, to “transition”, and finally to “post-transition”. It is important that when children enter and exit group homes that this is done in a planned, staged and purposeful manner. Throughout the entire process from admission to post-transition, the outcomes of children can be measured using the outcomes of the CYF Tuituia assessment framework (Child Youth and Family, 2013). These outcomes could be scaled from 1 to 10 making progress and outcomes measurable.

The next part of the model is the diagram of a house which represents children living in residential homes. At the base of the house is the word “secure base” which emphasises that our interventions with children in residential care needs to be built on the foundation of workers providing a secure base for them. Within the diagram of the house, the arrow is pointing up, indicating that interventions while children reside in residential group homes need to work from the “brainstem” to the “cortex” and that the 3Rs need to be completed in
this specific order “regulate, relate, reason” (Perry, 2015, P.12). By the roof of the house, specific evidence-based models which are trauma-informed and attachment-based are mentioned. These models have been discussed in the literature review and the section above. For a bigger and clearer version of the model, please refer to appendix B.

Diagram 1. Recommended therapeutic clinical model for residential care
Conclusion

I would like to conclude my thesis with the picture below drawn by one of the child participants interviewed for this research project. This child drew this picture as a representation of what living in the SGH meant to her. This child drew a picture of a key and an adult hand holding a child’s hand. The drawing talks about how staff members at the home have supported her in her journey to discover who she is. The supportive relationships that staff members have provided for her, has enabled her to unlock new beginnings, giving her a sense of hope for the future.

Relationships matter? The drawing below captures the essence of our work. Relationships must be at the core of our work with children who have had attachment difficulties and traumatic experiences in order for treatment to be effective. Healing the pain of the past needs to be done through providing a secure base and thinking deeply about how children’s experiences are affecting them currently. Interventions need to be grounded on principles of attachment theory, neurodevelopment and must be trauma-informed. Children in residential homes need to experience that relationships can be safe. They need to experience relationships around them with unconditional care, compassion and commitment which will help to re-work their internal working models of themselves and the world around them. Staff members in residential settings have a window of opportunity to instil hope to these children and to make a positive impact in their lives.

Diagram 2 Artwork by anonymous child
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Appendix A: Consent forms and information sheets for research participants
I have been told about this study and understand what it is about. All my questions have been answered in a way that makes sense.

I know that:

1. Participation in this study is voluntary, which means that I do not have to take part if I don’t want to and nothing will happen to me. I can also stop taking part at any time and don’t have to give a reason.

2. Anytime I want to stop, that’s okay.

3. Andrea will audiotape me so that she can remember what I say, but the recording will be erased after the study has ended.

4. If I don’t want to answer some of the questions, that’s fine.

5. If I have any worries or if I have any other questions, then I can talk about these with Andrea.

6. The paper and computer file with my answers will only be seen by Andrea and my Supervisor (person who makes sure I am doing a good job). They will keep whatever I say private.

7. I will receive a small gift as thanks for helping with this study.

8. I agree to Andrea interviewing my parents or legal guardians for this study.

9. Andrea will write up the results from this study for her University work. The results may also be written up in journals and talked about at conferences. My name will not be on anything Andrea writes up about this study.

I agree to take part in the study.

…………………………………………………………………………………………... ……………………………
Signed                                      Date
Relationships Matter?
Multiple perspectives on children’s attachment experiences in group home settings

CONSENT FORM FOR
PARENTS/ GUARDIANS/ FOSTER PARENTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

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

3. The audio tape will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;

4. This project involves an open-questioning technique. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but protection of my identity is guaranteed.

• I agree to take part in this project.
• I agree that my child can take part in the project.

............................................................................................................../

(Signature of participant) .............................................. (Date)

This study has been approved by the University of Otago Human Ethics Committee.
Relationships Matter?
Multiple perspectives on children’s attachment experiences in group home settings

CONSENT FORM FOR STAFF MEMBER’S PARTICIPATION IN FOCUS GROUP

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

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

3. The audio tape will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;

4. This project involves an open-questioning technique. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the focus group develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but protection of my identity is guaranteed.

I agree to take part in this project.

.......................................................................................... ................................
(Signature of participant) (Date)

This study has been approved by the University of Otago Human Ethics Committee.
Children’s Information Sheet

1. What is this project about?

This is a project for a Masters study. This is very similar to a big school project where you find out about something you are interested in and write up about it. I am interested in talking to children, young people and their families about what it is like living in a group home.

2. Who do we want to talk to?

I would like to talk to children and young persons living in a group home to hear your views on what is important to you when you live in a group home. I am also going to talk to family members to find out their views on group homes.

3. What will I be asked to do?

You will be invited to talk about:

- How long you have been living in the group home.
- What is important to you while you are living in the group home.
- How you have found it living in the group home.
- How you find staff members in the group home.

The interview will take about an hour. If you agree to talk to someone, an audiotape will be used to record the conversation so that exactly what you say can be written in the project. This will be checked with you to make sure the record of your talk is correct and it is okay to use what you have said. You can say if there is anything you do not want to be written up in the project.

None of the things you say will be passed on to your social worker, family or any staff members. The only time this may happen is if you indicate you are not safe or are being hurt. If that happens, the person who is talking to you will tell you if she thinks the information needs to be passed on to a social worker.

You do not need to take part in this project, and nothing will happen if you say no.

4. What will happen if you agree to talk to someone?

You will not be asked a lot of set questions. You will be asked to talk about what it has been like for you living in a group home. If you feel uncomfortable or unhappy with any questions you do not need to answer...
them. You can ask that the tape be turned off at any time. If you become upset or unhappy you can talk to the person you are with or you can ask them to get someone you trust so that you can talk to them.

5. Can I change my mind?
If you agree to take part you can change your mind at any time. You can do this by telling the person you are talking to, your social worker, your parents or a staff member at the group home that you do not want to take part anymore.

6. What will happen to the things I talk about?
The information I collect from your file and from you will be used to find out what matters to children and young people when they are living in group homes. I will be writing this up in a thesis (a big book) and this will go into the university library.

7. Can I make changes to what I have said?
After your interview, I will type out what was recorded and show it to you so you can make any changes to it.

8. Who will know what I have said?
The only person reading the information is myself, Andrea Tan and my supervisor (the person who is making sure I am doing a good job), Nicola Atwool. Your real name will not be used and I will make sure that nobody knows what you have said.

At the end of the project, the tape record will be destroyed immediately. The written record will be kept in a safe locked place for five years, and then it will be destroyed.

If you have any questions about this project, either now or in the future you can contact:

Andrea Tan or Nicola Atwool
166 Kelvin Street University of Otago
Invercargill Dunedin
andrea.tan006@cyf.govt.nz nicola.atwool@otago.ac.nz
029 650 1288 03 479 5442

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Information Sheet for Parents, Guardians and Foster Parents

1. **What is this project about?**

   This is a project for a Masters study- an advanced university qualification. The aim of the research is to find out about children’s experiences of relationships while they are residing in a supervised group home. There are two parts to this study- interviewing children and their parents or guardians and focus groups with staff members.

2. **Who do we want to talk to?**

   I am interested in talking with children, their parents or legal guardians to find out their views on group homes. I am also interested in running focus groups with staff members.

3. **What will I be asked to do?**

   - If you agree to take part in this project, you will be interviewed about:
     - How long your child has been living in the group home
     - What you think is important to your child when they are living in the group home
     - Your view on children’s experiences of relationships in the group home.

4. **What will the children be asked to do?**

   Children will be asked to talk about their experiences of relationships while residing in the group home. Children will be invited to talk about:

   - How long they have been living in the group home.
   - What is important to them when they are living in the group home.
   - How they have found it living in the group home.
   - How they find staff members in the group home.
5. **What will staff be asked to do?**
Staff members will be invited to participate in a focus group where the findings of the interviews with children and parents/guardians will be presented to them. Staff focus groups will provide a form of peer review for my project.

6. **What will happen if I agree to take part?**
I, Andrea Tan will be conducting the interviews which will last approximately one hour.

You can decline to answer any questions and ask for the audio tape to be turned off at any time.

This project involves an open-questioning technique where the precise nature of the questions have not been determined but will depend on the way the interview develops. Consequently, although the University Ethics Committee is aware of the general areas to be talked about, the Committee does not know exactly what questions will be asked.

7. **Can I change my mind?**
You can change your mind at any time.

8. **What will happen to the information collected?**

If you agree to be interviewed, an audiotape will be made and transcribed. This will be checked with you to make sure the record of your talk is correct and it is okay to use what you have said. You can identify any material you do not want to include in the project.

You can decline to answer any questions and ask for the audio tape to be turned off at any time.

I will let you know what I found out from doing this project.
9. Who will know what I have said?
The only person reading the information is myself, Andrea Tan and my supervisor, Nicola Atwool. Your real name will not be used and you can choose how you would like to be identified.

Every effort will be made to ensure that confidentiality is maintained for all participants. At the end of the project, the tape record will be destroyed immediately. The written record will be kept in a secure place for five years, and then it will be destroyed.

If you have any questions about this project, either now or in the future you can contact:

Andrea Tan
166 Kelvin Street
Invercargill
andrea.tan006@cyf.govt.nz
029 650 1288

Nicola Atwool
University of Otago
Dunedin
nicola.atwool@otago.ac.nz
03 479 5442

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Information Sheet for Staff Members

9. **What is this project about?**
This is a project for a Masters study. The aim of the research is to find out about children’s experiences of relationships while they are residing in a supervised group home. There are two parts to this study - interviewing children and their parents or guardians and focus groups with staff members.

10. **Who do we want to talk to?**
I am interested in talking with children, their parents or legal guardians to find out their views on group homes. I am also interested in running focus groups with staff members. You are invited to participate in a focus group with other staff members from the group home so that I can present my findings to you and to hear your perspective on working with young people in a group home setting.

11. **What will I be asked to do?**
You will be invited to participate in a focus group with staff members. I will present my findings with you and you will be given an opportunity to comment on the findings presented and talk about your experiences working in the group home.

The focus group will be approximately one hour. You do not need to take part in this project and there will be no adverse consequences if you decline.

12. **What will the children be asked to do?**
Children will be asked to talk about their experiences of relationships while residing in the group home. Children will be invited to talk about:

- How long they have been living in the group home.
- What is important to them when they are living in the group home.
- How they have found it living in the group home.
- How they find staff members in the group home.
13. **What will parents, legal guardians or foster parents be asked to do?**
Parents, legal guardians and foster parents who consent to being interviewed will be asked about their view on children’s experiences of relationships in the group home.

14. **What will happen if I agree to take part?**
If you agree to take part you will be invited to participate in a focus group with other staff members. The focus group will be audio taped and transcribed. The purpose of the focus group is to provide a form of peer review of the data I have collected and to hear about your experiences of working with young people in a group home setting.

15. **Can I change my mind?**
You can change your mind at any time.

16. **What will happen to the information collected?**
The information collected from the focus group will be used to review the findings collected from interviews with children and parents or guardians. Final results will be reported in a thesis that will go in the University library.

**Who will know what I have said?**
The only person reading the information is myself, Andrea Tan and my supervisor, Nicola Atwool. Your real name will not be used and you can choose how you would like to be identified.

Every effort will be made to ensure that confidentiality is maintained for all participants. At the end of the project, the tape record will be destroyed immediately. The written record will be kept in a secure place for five years, and then it will be destroyed.

If you have any questions about this project, either now or in the future you can contact:

Andrea Tan
166 Kelvin Street
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andrea.tan006@cyf.govt.nz
029 650 1288

or

Nicola Atwool
University of Otago
Dunedin
nicola.atwool@otago.ac.nz
03 479 5442
This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix B- Recommended therapeutic clinical model for residential care

Therapeutic model of care © Andrea Greer, 2015

1. Brainstem
   - Healing traumatised brains from the base up
   - Attachment relationships as treatment
   - ‘Connection before correction’
   - Model of unconditional care

2. Midbrain
   - Sensory assessments
   - Creating a therapeutic milieu environment or an atmosphere that promotes mental well-being
   - Trauma-informed practices

3. Limbic
   - Strengthen family/whanau relationships through family work
   - Relationships with Social Worker
   - Positive peer culture (PPC model)
   - Enhance emotional regulation

4. Cortex
   - Managing behaviour
   - Life skills development
   - Transition to independence support
   - Involving children in their plans and goal setting

SECURE BASE

Pre-admission
  Staged transitions

Admission
  Staged admissions

Transition
  Staged transitions

Post-transition
  Post-transition follow-up

Outcomes measured by CYF Tuituia assessment framework from pre-admission to post-transition (safe, belong, healthy, achieving, participate)
Appendix C: University Human Ethics Application
HUMAN ETHICS APPLICATION: CATEGORY A

PLEASE read carefully the instructions “Filling out your Human Ethics Application” and important notes on the last page of this form. Provide a response to each question; failure to do so may delay the consideration of your application.

1. University of Otago staff member responsible for project:
   
   Atwool Nicola Dr.

2. Department: Sociology, Gender and Social Work

3. Contact details of staff member responsible:
   
   Phone: Ext 5442

   Email nicola.atwool@otago.ac.nz

4. Title of project:
   
   Relationships Matter? Multiple perspectives on children’s attachment experiences in group home settings

5. Indicate type of project and names of other investigators and students:

   | Staff Research | [ ] | [ ] |
   | Student Research | [ ] | Andrea Shu Lin Tan |
   | Level of Study (e.g. PhD, Masters, Hons) | [ ] | Masters |

   | External Research/ Collaboration |
   | Institute/Company |

6. Is this a repeated class teaching activity?
7. **Fast-Track procedure**

   Do you request fast-track consideration?

   NO

8. **When will recruitment and data collection commence?**

   March 2013

**When will data collection be completed?**

August 2013

9. **Funding of project.**

   Is the project to be funded by an external grant?

   NO

10. **Brief description in lay terms of the purpose of the project** (approx. 75 words):

   Most children who reside in care and protection residential home settings have complex behavioural issues. Using an attachment framework, this study looks at what works for young people with a history of trauma, focusing on the importance of relationships.

   This study aims to capture the voices of children regarding their experiences of staff relationships in three group homes in New Zealand. Using semi-structured in-depth interviews, children’s experiences while they reside in group homes will be explored. In order to gain multiple perspectives on this topic, parents or guardians of children will be interviewed, and focus groups will be conducted with staff members in group homes.

11. **Aim of project, including the research questions the project is intended to answer:**

   This is an exploratory study of children’s experiences of relationships while they are residing in a supervised group home and the role that relationships play in terms of children’s experiences of the group home environment. The link between relationship experiences and outcomes will be explored in this study using an attachment framework.

   Research questions:

   - What matters to children residing in group home settings?
   - What do the children SAY makes a difference to them when they are in the group home?
• What works for young people in a group home setting?
• Is there a relationship between quality of relationship between staff and children and the level of engagement of children in the supervised group home?
• What effect does positive staff engagement have on children with attachment issues?
• Attachment framework uses a nurturing, engaging, supportive stance; what effect does this have on children with attachment issues?

12. **Researcher or instructor experience and qualifications in this research area:**

   The primary researcher, Andrea Tan, is a qualified Social Worker (Bachelor of Arts, Major in Social Work) and is a Registered Social Worker and Full member of Aotearoa New Zealand Association of Social Workers. She has post-graduate experience of 6 years as a Social Worker.

   The staff member responsible for this project has more than thirty years experience in the social services. She has professional qualifications in social work and child and adolescent psychotherapy, is a full member of The Aotearoa New Zealand Association of Social, the NZ Association of Child and Adolescent Psychotherapy, and is a Registered Social Worker. She has recently returned to an academic position and has previously supervised three students through to completion of Masters research. She has particular expertise in the area of attachment theory and has completed doctoral research in this area.

13. **Participants**

   13(a) **Population from which participants are drawn:** Three Child, Youth and Family, Supervised Group Homes in New Zealand

   13(b) **Specify inclusion and exclusion criteria:** Inclusion criteria is current residents in the group home. Exclusion criteria would be any children in an active state of crisis.

   13(c) **Estimated number of participants:** 12 young people and 12 family members or legal guardians.

   13(d) **Age range of participants:** All young people will be in the age range of 10 to 17 years and adult participants.

   13(e) **Method of recruitment:**

   Recruitment of participants will be from three Supervised Group Homes in New Zealand.
Recruitment of child participants:

Before any children are approached by the researcher, they will be given an information sheet inviting them to participate. This information sheet will be distributed by the Team Leader of the Supervised Group Home that they are residing in. The information sheet will be written in age appropriate language detailing that this research project is for a Master’s thesis and the final results will be in a thesis kept in the university library. It will be emphasised that participation is completely voluntary and there will be no negative consequences if a participant chooses to decline participation. All participants will be informed that they can decline to answer any questions and ask for the tape to be turned off at any time. Before any interviews are carried out, their parents or legal guardians will be approached to give their written consent for permission to interview the children.

Recruitment of parent or legal guardian participants:

As stated above, a written consent will be sought from parents or legal guardians before any interviews are carried out with children. Parents and guardian participants will also be given an information sheet that will explain what the research project is about and will be invited to participate by a Child, Youth and Family staff member. It will be emphasised that participation is completely voluntary and there will be no negative consequences on their child’s placement if the participant chooses to decline participation. All participants will be informed that they can decline to answer any questions and ask for the tape to be turned off at any time. If parents or legal guardians would like to participate in the study, a separate consent form will be obtained from all adult participants before any interviews are carried out.

Recruitment of staff participants:

Three focus groups will be conducted with staff members from each group home to present the findings from the interviews with children and parents/guardians to them. The staff members will not have access to information provided by specific participants. The focus groups will be audio taped recorded and notes will also be taken during the focus group. All staff participants will be given an information sheet detailing what the research project is for, and separate consent will also be obtained from staff participants. No staff members will be named to protect their confidentiality.

13(f) Please specify any payment or reward to be offered:

All children participants will be given a small token for their participation in the project and if a child decides to withdraw participation, the small token will still be given.
14. **Methods and Procedures:**

This is an exploratory qualitative research design, using semi-structured in-depth interviews with 12 young people and 12 family members or legal guardians.

Three different group homes in New Zealand will be approached, and the aim is to interview 4 young people in each group home, making the total sample size 12 young people.

All interviews will be tape recorded and transcribed. A pilot test of interview questions will be completed before conducting interviews to ensure that the questions stimulate responses that address the research questions.

Three focus groups will be conducted with staff members to present the findings from the interviews with children and parents/guardians. Focus groups with staff will provide an opportunity to hear their perspectives and peer review of the findings. Information collected from focus groups will be used in the analysis of data.

15. **Compliance with The Privacy Act 1993 and the Health Information Privacy Code 1994 imposes strict requirements concerning the collection, use and disclosure of personal information. These questions allow the Committee to assess compliance.**

15(a) Are you collecting and storing personal information directly from the individual concerned that could identify the individual?

Yes.

15(b) Are you collecting information about individuals from another source? Please explain:

No.

15(c) **Collecting Personal Information:**

- Will you be collecting personal information?
  
  YES

- Will you be informing participants of the purpose for which you are collecting the information and the uses you propose to make of it?
  
  YES

- Will you be informing participants who will receive the information?
  
  YES

- Will you inform participants of the consequences, if any, of not supplying the information?
  
  N/A. Participation is voluntary.
• Will you inform the participants of their rights of access to and correction of personal information?

YES. Transcripts will be given back to the children participants and adult participants so they can make any changes to it.

**15(d) Please outline your data storage and security procedures.**

All hard copy data will be stored in a locked cabinet in my office at the Supervised Group Home. Audio recordings of interviews will be destroyed at the conclusion of the project and all other data will be handed into the university to be stored for 5 years. All information in soft copy format will be stored in a password locked laptop and deleted after the conclusion of the project. While travelling between destinations, all information and audio tapes will be stored in a password locked suitcase. All participants will not be named or have identifiable information and will be given a code by the researcher.

**15(e) Who will have access to personal information, under what conditions, and subject to what safeguards?**

Only the researcher and the supervisor.

**Will participants have access to the information they have provided?**

Yes, they will be given their transcripts and will have an opportunity to change anything from their interviews and/or specify any material they do not want included as direct quotations.

**15(f) Do you intend to publish any personal information they have provided?**

NO.

**15(g) Do you propose to collect demographic information to describe your sample? For example: gender, age, ethnicity, education level, etc.**

Yes. Gender, age, ethnicity and how long they have been residing in the group home for will be collected.

**15(h) Have you, or do you propose to undertake Māori consultation? Please choose one of the options below, and delete the options that do not apply:**

YES  We have ALREADY undertaken consultation

**16. Does the research or teaching project involve any form of deception?**
17. **Please disclose and discuss any potential problems**: (For example: medical/legal problems, issues with disclosure, conflict of interest, etc)

**Identifiable information**

No information that will make the children identifiable will be used in the research. This includes the city of the supervised group home where the child was interviewed at, name of child, and date of admission and date of discharge.

**Parental consent**

A separate consent form will be sought for all adult participants before any interviews are carried out. Family members and legal guardians will also be able to withdraw their participation at any given time. It will also be emphasised that there will be no negative consequences on them or their child if they choose not to participate in the research project or withdraw their participation.

**Limits of confidentiality regarding safety concerns**

The limits of confidentiality regarding safety concerns will be explained before research is carried out. Safety concerns are when the researcher considers the child at risk of harming themselves, harming someone else, or someone harming them. When discussing confidentiality with parents and children, it will be advised that if any information concerning safety is raised, it may be necessary to discuss this with Child, Youth and Family. All participants will be advised if it is deemed necessary for information to be passed on.

**Safety issues**

While interviewing vulnerable children, there could be potential for children to raise unresolved issues related to past experiences or their current placement. The researcher is an experienced and qualified social worker, and will negotiate an appropriate and safe action with the child. If abuse is disclosed, the child will be informed that information will be discussed with their Social Worker.

**Dual role**

As the researcher is an employee of Child, Youth and Family, it is important to clarify the difference between the role as Family Engagement Worker and as a researcher. This will occur before any interviews are conducted. It will be emphasised before interviews are conducted that the information shared will not have any implications for the child’s current placement. If any practice concerns are raised during the interviews, this will be discussed with the Supervisor in the first instance and an appropriate course of action will be decided on.
18. **Applicant's Signature:** .................................................................

[Principal Applicant: as specified in Question 1]

**Date:** ........................................

19. **Departmental approval:** *I have read this application and believe it to be scientifically and ethically sound. I approve the research design. The Research proposed in this application is compatible with the University of Otago policies and I give my consent for the application to be forwarded to the University of Otago Human Ethics Committee with my recommendation that it be approved.*

**Signature of *Head of Department:** .................................................................

**Name of Signatory (please print):** .................................................................

**Date:** .................................................................
Final Checklist

Please check:-

- **Applicant** - that the application is in the name of a University staff member and not, for example, the student researcher

- **Font** - that a font has been used which is different to that used for the information and guidance already provided in the template by the University of Otago Human Ethics Committee

- **Signatures** - that the appropriate signatures are in sections 18 and 19.

- **Page Numbers** – that each additional page follows the page numbering from the application.

- **Data storage and disposal**
  - that section 15(d) state clearly the details of the secure storage of the data (normally within a University Department) and who will be responsible for the eventual disposal of the data (which must normally be kept for at least 5 years. An appropriate member of the University staff should normally be responsible for the eventual disposal of data - not a student researcher.)
  - that if the data is to be stored other than within a University Department a detailed justification for this is given

- **Questionnaires** - that any questionnaire and/or survey to be used in the project is attached to the application

- **Information Sheet / Consent Form** - that these are attached and
  - that the language and style used is appropriate to the age and knowledge of the likely readers;
  - that no personal home contact details for a student researcher are included (unless a detailed justification for this is included in the main application);
  - that both forms conclude (in anticipation of approval) with the statement “This project has been reviewed and approved by the University of Otago Human Ethics Committee”;
  - that they have been carefully proof-read;

- **Stapled as one document** - that all components of each copy of the application are stapled together with one staple (16 copies are needed in total)
Appendix D: CYF Research Access Committee correspondence
6th March 2013

Christina Smits
Research Access Coordinator
Ministry of Social Development
PO Box 1556
Wellington 6011

Dear Christina Smits,

Re: Research Access application

Attached to this letter is a copy of my Research Access application form. This is for my Master’s research project titled “Relationships Matter? Multiple perspectives on children’s attachment experiences in group home settings”.

I am currently completing my Master’s in Social Welfare through the University of Otago. At this stage, I am enrolled in the thesis component of the programme, and have completed the consultation process with the Ngai Tahu Research Consultation Committee, and have received full ethical approval from the University Ethics Committee.

My research project is an exploratory study of children’s experiences living in three Supervised Group Homes (SGH) in New Zealand. Using semi-structured in-depth interviews, I will be exploring multiple perspectives through interviewing 12 children, parents or guardians of children and focus groups with staff members in group homes. I will be focusing on what works for children living in SGHs using an attachment framework. It is to my understanding that the SGHs are currently under review, and I hope that my research will be able to contribute positively to phase two of the review process and also contribute to the strategic plan, “Ma matou, ma tatou” as it focuses specifically on hearing children’s voices.

I have been working in [REDACTED] Supervised Group Home as a Family Engagement Worker since November 2010 and am passionate about working with children and young persons in care settings. My Manager, [REDACTED] and Supervisor, [REDACTED] are supportive of my research project. As a Master’s student, I have achieved an average of A+ grades and have recently been awarded a Master’s scholarship from the University of Otago. My current Supervisor for my thesis is Dr. Nicola Atwood who has had
30 years experience in the Social Work field. Dr Atwool has particular expertise in the area of attachment theory and has completed doctoral research in this area.

I have attached the following documents for your reference:
1. Ministry of Social Development Research Access application form
2. Research proposal which includes a literature review and list of references
3. University Ethics Application form: Human Ethics Application Category A
4. Initial decision letter from University Ethics Committee
5. Memo to University Ethics Committee
6. Final decision letter from University Ethics Committee
7. Letter from Ngai Tahu Research Consultation Committee
8. Information sheets for children, parents/guardians and staff participants
9. Consent forms for children, parents/guardians and staff participants
10. List of interview questions for child and parent/guardian interviews

Thank you for considering my application.

Yours sincerely,

Andrea Greer
Master’s Research Student
Email: andrea.tansl@gmail.com
## GENERAL INFORMATION

<p>| NAME OF APPLICANT: | Andrea Tan (Greer) |
| POSTAL ADDRESS: | 55 Wards Road, RD 4, Gore, 9774 |
| E-MAIL |  |
| | Home | <a href="mailto:andrea.tansl@gmail.com">andrea.tansl@gmail.com</a> |
| | Work | <a href="mailto:andrea.tan006@cyf.govt.nz">andrea.tan006@cyf.govt.nz</a> |
| PHONE |  |
| | Home | 0212307182 |
| | Work | 0296501288 |
| | Mobile | N/A |
| TITLE OF RESEARCH PROJECT | Relationships Matter? Multiple perspectives on children’s attachment experiences in group home settings |
| ACADEMIC INSTITUTION |  |
| | Department | Sociology, Gender and Social Work |
| | Faculty | Humanities |
| | Address | PO Box 56, Dunedin |
| SUPERVISOR |  |
| | Name | Dr. Nicola Atwool |
| | Position | Senior Lecturer in Social Work |</p>
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<tr>
<th></th>
<th>Email</th>
<th>Phone</th>
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<tbody>
<tr>
<td></td>
<td><a href="mailto:nicola.atwool@otago.ac.nz">nicola.atwool@otago.ac.nz</a></td>
<td>03 479 5442</td>
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**OR**

<table>
<thead>
<tr>
<th>NAME OF RESEARCH AGENCY</th>
<th>Project Manager</th>
<th>Email</th>
<th>Phone</th>
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<tr>
<th>FUNDING</th>
<th>Project Manager</th>
<th>Email</th>
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<td>Research is not funded but I was awarded a master's research scholarship from University of Otago.</td>
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<th>RESEARCH START DATE</th>
<th>END DATE</th>
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<tr>
<td>March 2013</td>
<td>November 2014 (when thesis is submitted)</td>
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<tr>
<td>PROJECT OVERVIEW</td>
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| RESEARCH OBJECTIVE | Most children who reside in care and protection residential home settings have complex behavioural issues. Using an attachment framework, this study looks at what works for young people with a history of trauma, focusing on the importance of relationships.  
This study aims to capture the voices of children regarding their experiences of staff relationships in three group homes in New Zealand. Using semi-structured in-depth interviews, children’s experiences while they reside in group homes will be explored. In order to gain multiple perspectives on this topic, parents or guardians of children will be interviewed, and focus groups will be conducted with staff members in group homes. |
| PURPOSE |  |
| (E.g. M.A., Ph.D, commissioned research) | Master of Social Welfare (MSW) thesis |
| VALUE OF THE RESEARCH |  |
| Please explain the value of the research in relation to the Ministry’s Vision, Purpose, and Values  
Show how the research will improve outcomes for children, young people or families | Child, Youth and Family’s vision is to ensure that children and young people are safe in strong families and responsive communities. Children who reside in supervised group homes are part of the continuum of care provided by the Ministry. The goal for children residing in supervised group homes is to transition them successfully to their families and into the community. The research project “Relationships matter?” focuses on what works for children |
when they reside in supervised group homes to ensure that they flourish in their current placement and to achieve best outcomes for them as they move along the continuum of care.

The research project is an exploratory study of children’s experiences of relationships while they are residing in a supervised group home and the role that relationships play in terms of children’s experiences of the group home environment. The link between relationship experiences and outcomes will be explored in this study using an attachment framework. The research supports the practice package and the residential framework of practice as it is young person-focused, strengths and evidence-based. This study focuses on attachment and stability for our young people in care, which supports the practice package action 5 “Intensify Social Work effort for children in care” and practice action 6, “paying attention to attachment needs”. Children’s voices are at the centre of this research project, and the aim is to strengthen child-centred practice delivery in residential services.

It is my understanding that the supervised group homes are currently under review, and I hope that this research project will be able to contribute positively to phase two of the review process and also contribute to the strategic plan, “Ma matou, ma tatou” as it focuses specifically on hearing children’s voices and strengthening quality social work practice.

This research has several implications for
services provided to children in residential care settings. Delivering quality social work practice and hearing the voices of children is the core business of Child, Youth and Family Services. Through interviewing children and hearing their perspectives on their experiences in group home settings, this research could strengthen the child-centred approach provided in residential care. Understanding children’s needs using an attachment perspective could enhance the practice skills of workers in residential care settings ensuring quality social work delivery. On a macro level, this research contributes to the Children’s Action Plan ensuring that services are child-centred and family-centred.

LITERATURE REVIEW

Brief review of key approaches to and findings about the research question/issue. Please append the list of references.

Identify how the literature supports the current research

There is limited research on children in care in New Zealand and no current research on residential services. Most of the research on residential services has been based in the U.S.A, Canada and UK.

The literature reviewed establishes the link between attachment and trauma, and looks at the effectiveness of relationship-based interventions. The literature also looks at neuroscience and the role it plays in understanding attachment in the early years and the effect of trauma on the brain. Current behaviour of children with attachment difficulties is understood from an attachment
Please refer to attached research proposal for literature review and a list of references.

**THEORETICAL APPROACH**

Outline the rationale for the theoretical approach taken

Attachment theory looks at an infant’s need to develop a relationship with at least one primary caregiver for social and emotional development to occur normally (Bowlby, 1991). All children admitted into supervised group homes have need for care and protection, and many of them have experienced neglect and abuse especially in their early years. Children who have experienced abuse and neglect fail to form secure attachments early in life which often has a negative impact on behaviour in later childhood and throughout their life (Moore, Moretti & Holland, 1997).

Therefore, to work with the complex behavioural issues that these children present when they are admitted to supervised group homes, the underlying reasons of why these behaviours exist cannot be ignored. This means that it is important to take into account the historical issues that have contributed to the present behaviours (Levy, 2000). Attachment theory helps us understand the trauma history that these children and young persons have experienced, and provides a framework for
understanding their current behaviours.

Neuroscience also provides an understanding of how attachment, trauma and behaviour are linked. When working with children who present with challenging behaviours, it is important to understand how trauma and neglect in the early years of life affects the development of the brain (Perry, 2002). This negative impact on brain development can result in emotional and social difficulties in later life (Perry, 2002), which are exhibited by children who reside in the supervised group homes.

This understanding of how trauma and neglect affects the brain, can inform our practice with children who have experienced trauma. It is important for staff to have an awareness of attachment behaviours and how stressful situations can activate stress response systems. Stress response systems can manifest in the form of violence, aggression and other troubling behaviours. When these stress response behaviours are activated an attachment framework is crucial for understanding how the interactive process of relationships can be used in managing the situation. An understanding of how trauma affects the brain will guide our practice to be more attuned to the children’s attachment dynamics, thus creating a greater sense of psychological safety (Moore et al., 1997).
<table>
<thead>
<tr>
<th>Briefly state e.g. quantitative, qualitative, sampling, data gathering, location, etc. More detail is asked for later in the form.</th>
<th>This is an exploratory qualitative research design, using semi-structured in-depth interviews with 12 young people and 12 family members or legal guardians from 3 supervised group homes in New Zealand.</th>
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<tr>
<td>PARTICIPANTS OR DATA SOUGHT</td>
<td>E.g. CYF staff, WINZ clients, MYD programme participants. 12 Young people (4 from each supervised group home), 12 parents/guardians/foster parents of young people interviewed and three focus groups run with staff from three supervised group homes in New Zealand.</td>
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<td>LOCATION OF FIELDWORK</td>
<td>E.g. regional office, geographical boundary. 3 care and protection supervised group homes, preferably due to geographical distance.</td>
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<tr>
<td>SAMPLE SIZE</td>
<td>12 Young people (4 from each supervised group home), 12 parents/guardians/foster parents of young people interviewed and three focus groups run with staff from three supervised group homes.</td>
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<td>RECRUITMENT / SAMPLING PROCEDURES</td>
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<td>Please state the criteria for inclusion in the project and how you plan to approach participants. Explain fully any assistance you are seeking from MSD staff in this process.</td>
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<th>Recruitment:</th>
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<tr>
<td>Recruitment of participants will be from three Supervised Group Homes in the South Island of New Zealand.</td>
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<th>Recruitment of child participants:</th>
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<tr>
<td>Before any children are approached by the researcher, they will be given an information sheet inviting them to participate. This information sheet will be distributed by the Team Leader of the Supervised Group Home that they are residing in. The information sheet will be written in age appropriate language detailing that this research project is for a Master’s thesis and the final results will be in a thesis kept in the university library. It will be emphasised that participation is completely voluntary and there will be no negative consequences if a young person chooses to decline. All participants will be informed that they can decline to answer any questions and ask for the tape to be turned off at any time. Before any interviews are carried out, their parents or legal guardians will be approached to give their written consent for permission to interview the children.</td>
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<td>As stated above, a written consent will be sought from parents or legal guardians before any interviews are carried out with children. Parents and guardian participants will also be</td>
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given an information sheet that will explain what the research project is about and will be invited to participate by a Child, Youth and Family staff member. It will be emphasised that participation is completely voluntary and there will be no negative consequences on their child’s placement if the parent/guardian chooses to decline. All participants will be informed that they can decline to answer any questions and ask for the tape to be turned off at any time. If parents or legal guardians would like to participate in the study, a separate consent form will be obtained from all adult participants before any interviews are carried out.

Recruitment of staff participants:

Three focus groups will be conducted with staff members from each group home to present the findings from the interviews with children and parents/guardians to them. The staff members will not have access to information provided by specific participants. The focus groups will be audio taped and notes will also be taken during the focus group. All staff participants will be given an information sheet detailing what the research project is for, and separate consent will also be obtained from staff participants. No staff members will be named to protect their confidentiality.

**Sampling:** All children interviewed will be between the ages of 10 to 17 years old. Purposive sampling will be used in this research project so as to sample cases and participants in a strategic manner (Bryman, 2012) and to ensure that those who are sampled are relevant
to the research questions posed. In order to ensure that the information collected describes a range of possible experiences, maximum variation method of sampling will be utilised. An example of maximum variation sampling would be selecting the young person who has been living at the Supervised Group Home the longest, and interviewing a young person who has been at the Supervised Group Home the shortest period of time. Another sampling method would be to interview a female resident, and a male resident. Interviews will be conducted with the oldest young person in the group home and the youngest person in the group home and young people of different ethnicities.

The parents or guardians of the young people selected for the interviews will be selected as the adult participants. Triangulation will be a method used with the young people’s family members or guardians to add another perspective to the research.

DATA COLLECTION METHODS

Give details of any instruments such as questionnaires. Please append any interview schedules and questionnaires to your application.

State how long the interviews or questionnaires will take

This is an exploratory qualitative research design, using semi-structured in-depth interviews with 12 young people and 12 family members or legal guardians.

Three different group homes in New Zealand
to be administered for each participant.

<table>
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<tr>
<th>DATA ANALYSIS</th>
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<tr>
<td>Explain how the data will be analysed and reported on, including any software programmes to be used.</td>
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will be approached, and the aim is to interview 4 young people and 4 of their parents or legal guardians in each group home, making the total sample size 12 young people and 12 parents/guardians. All interviews will last approximately one hour.

All interviews will be tape recorded and transcribed. A pilot test of interview questions will be completed before conducting interviews to ensure that the questions stimulate responses that address the research questions.

Three focus groups will be conducted with staff members to present the findings from the interviews with children and parents/guardians. Focus groups with staff will provide an opportunity to hear their perspectives and peer review of the findings. The focus group will take approximately one hour. Information collected from focus groups will be used in the analysis of data.

Please refer to appendix for examples of interview questions.

<table>
<thead>
<tr>
<th>DATA ANALYSIS</th>
</tr>
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<tbody>
<tr>
<td>Explain how the data will be analysed and reported on, including any software programmes to be used.</td>
</tr>
</tbody>
</table>

After the data are collected, the audiotapes will be transcribed verbatim. The transcripts will be read carefully and the data will be coded into categories using the thematic analysis method. The aim of coding the data is to summarise and to sort observations made to help pull together a series of statements, events or observations.

Three focus groups will be conducted with staff
members from each group home to present the findings of the project to them. The focus groups will also serve to provide peer review of interpretations.

**CULTURAL CONSIDERATIONS**

Please refer to any cultural consultation you may have undertaken on the validity and reliability, as well as acceptability, of the methodology (data collection and data analysis) for the ethnic group you are researching.

The Ngai Tahu Research Consultation Committee met on 22nd January 2013, and found this research to be of interest and of importance. As recommended by them, ethnic data will be collected and consultation will be sought from a researcher with expertise in analysing ethnic data.

Please refer to letter from attached from The Ngai Tahu Research Committee.

**DISSEMINATION PLAN**

Explain how you intend to disseminate your work and explain who it will be of interest to. It is expected that the final report or thesis is presented to MSD in a way that shares the key findings as widely as possible.

Research findings will be available in a thesis held by the University of Otago library.

The researcher will present the final findings to MSD staff as required or requested by the Ministry.

The researcher will seek opportunities to present the findings at conferences.

**PROJECT TIMELINE**

Please outline the stages of the research and the proposed timeframe for data collection/fieldwork.

January 2013 – April 2013: Application to University Ethics Committee and CYFS Research Access Committee

January 2013- June 2013: Literature review
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>April 2013</td>
<td>Distribution of information sheets</td>
</tr>
<tr>
<td>May 2013 to July 2013</td>
<td>Interviews of young people and parents/guardians</td>
</tr>
<tr>
<td>July 2013 to September 2013</td>
<td>Analysis of interviews of young people and parents/guardians</td>
</tr>
<tr>
<td>September 2013- November 2013</td>
<td>Focus groups with staff members to present final findings</td>
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<tr>
<td>December 2013 to January 2013</td>
<td>Analysis of data collected from focus groups</td>
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<tr>
<td>January 2013 onwards</td>
<td>Writing the thesis</td>
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**ETHICS**

Please provide details of how you will address issues of:
<table>
<thead>
<tr>
<th><strong>VOLUNTARY PARTICIPATION</strong></th>
<th>All participation in interviews is completely voluntary. It is clearly stated in the information sheet and consent form that participation is voluntary, and there will be no negative implications if participants choose not to take part in the research. It is also stated in the information sheets that they can choose to withdraw from the research at any time without any negative consequences.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FREE AND INFORMED CONSENT</strong></td>
<td>Free and informed consent is sought from all participants. Please refer to attached information and consent forms for children participants, parent/guardian participants and staff participants.</td>
</tr>
<tr>
<td>Attach copies of your information and consent forms</td>
<td></td>
</tr>
<tr>
<td><strong>USE OF DECEPTION</strong></td>
<td>No use of deception is involved in this research.</td>
</tr>
<tr>
<td>Does the design involve the deception of participants?</td>
<td>No use of deception is involved in this research.</td>
</tr>
<tr>
<td>If so, what is the justification?</td>
<td></td>
</tr>
<tr>
<td>What debriefing will take place?</td>
<td></td>
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<tr>
<td><strong>INCENTIVES</strong></td>
<td>No incentives are involved in this research. A small token of appreciation is given to all participants. This will be a pen under the value of $5 each.</td>
</tr>
<tr>
<td>Please note that incentives for participation will not be approved.</td>
<td></td>
</tr>
<tr>
<td><strong>PRIVACY AND CONFIDENTIALITY</strong></td>
<td><em>If interviewing people you need to describe what strategies you have planned for the following scenario:</em> &quot;it is possible that through this research possible cases of X that have not been brought to the attention of statutory agencies will be identified&quot;</td>
</tr>
<tr>
<td>This includes data storage and transmission and prevention of the identification of individuals in the research product.</td>
<td></td>
</tr>
<tr>
<td>Explain what processes are in place to cover circumstances where maltreatment may be disclosed during the course of the research</td>
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</tbody>
</table>
**Limits of confidentiality regarding safety concerns**

It is possible that through this research possible cases of X that have not been brought to the attention of statutory agencies will be identified, therefore before all interviews begin, the limits of confidentiality regarding safety concerns will be explained before research is carried out. Safety concerns are when the researcher considers the child at risk of harming themselves, harming someone else, or someone harming them. When discussing confidentiality with parents and children, they will be advised that if any information concerning safety is raised, it may be necessary to discuss this with Child, Youth and Family. All participants will be advised if it is deemed necessary for information to be passed on.

**Safety issues**

While interviewing vulnerable children, there could be potential for children to raise unresolved issues related to past experiences or their current placement. The researcher is an experienced and qualified social worker, and will negotiate an appropriate and safe action with the child. If abuse is disclosed, the child will be informed that information will be discussed with their Social Worker and if necessary notification to Child, Youth and Family. When discussing confidentiality with child and adult participants, they will be advised that any safety concerns will be notified to Child, Youth and
Family. All participants will be notified if it is deemed necessary to pass information on.

**Identifiable information**

No information that will make the children identifiable will be used in the research. This includes the city of the supervised group home where the child was interviewed, name of child, and date of admission and date of discharge.

**Parental consent**

A separate consent form will be sought for all adult participants before any interviews are carried out. Family members and legal guardians will also be able to withdraw their participation at any given time. It will also be emphasised that there will be no negative consequences on them or their child if they choose not to participate in the research project or withdraw their participation.

**Dual role**

As the researcher is an employee of Child, Youth and Family, it is important to clarify the difference between the role as Family Engagement Worker and as a researcher. This will occur before any interviews are conducted. It will be emphasised before interviews are conducted that the information shared will not have any implications for the child’s current placement. If any practice concerns are raised during the interviews, this will be discussed with the Supervisor in the first instance and an appropriate course of action will be decided on.

**Data storage**
All hard copy data will be stored in a locked cabinet in the researcher’s home. Audio recordings of interviews will be destroyed at the conclusion of the project and all other data will be handed into the university to be stored for 5 years. All information in soft copy format will be stored in a password locked laptop and deleted after the conclusion of the project. While travelling between destinations, all information and audio tapes will be stored in a password locked suitcase. The identity of all participants will be protected; transcripts will be identified by code numbers assigned by the researcher.

**EFFECTS OF RESEARCH ON PARTICIPANTS**

Sometimes research procedures may evoke distress in participants (e.g. when talking about unpleasant events). Explain what support you will arrange if your research has the potential to cause distress.

When conducting research, there could be a possibility that the research make evoke distress if unresolved issues are triggered during the course of the interview. As the researcher is a trained and qualified social worker, the researcher will negotiate with the child how best to resolve these if any issues arise during the interview.

As all interviews will be held at supervised group homes, there will also be staff members available to support the child after the interview. If necessary, the social worker of the child could also be contacted.

**SAFETY**

Please explain how you will ensure that the venue and research process provide safety for you, the researcher, and for participants.

All interviews will be held on site at the supervised group homes. This will ensure that the venue remains safe for all participants and
<table>
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<tr>
<th>APPROVAL FROM AN ACCREDITED HUMAN ETHICS COMMITTEE</th>
<th>the researcher.</th>
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<tr>
<td>This is needed before a RAC application is submitted</td>
<td>Please attach a copy of the approval letter <strong>and</strong> a copy of the ethics application to your application</td>
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<tr>
<td></td>
<td>Copy of approval letters and university ethics committee form is attached.</td>
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<th>MSD INVOLVEMENT</th>
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<tr>
<td>MSD INVOLVEMENT</td>
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<tr>
<td>Provide details of the assistance or involvement you are seeking such as access to</td>
</tr>
<tr>
<td>• Personal information held by MSD</td>
</tr>
<tr>
<td>• Staff</td>
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<tr>
<td>• Clients</td>
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<th>TIME REQUIREMENTS</th>
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<tr>
<td>TIME REQUIREMENTS</td>
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<tr>
<td>Please estimate the time required from staff for interviews, surveys, facilitating contact with clients etc.</td>
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</table>

Detail how many staff are required, where they are located, whether they are required to work outside their normal hours etc and facilitating contact with clients would take no longer than an hour. I will complete all administrative tasks and will only require the Team Leader to approach the participants initially to distribute the information sheets.

About 5 to 10 staff members will be required for the focus groups. This will be conducted on the same day as a supervised group home staff meeting so that staff do not need to work outside of their normal hours. Three separate focus groups will be held at each supervised group home location. The focus group with staff members will take up to an hour each.

OTHER IMPACT ON MSD
If you think there are other important aspects of the proposal not covered elsewhere, please state them here.

Academic Supervisor approval
I have read and approved this research proposal
Name:

When you have completed all parts of the form in detail, please send a hard copy to:

Christina Smits
Research Access Coordinator
Ministry of Social Development
PO Box 1556
Wellington 6011

Or email a copy to:

Research_access_coordinator@msd.govt.nz

Please telephone the Research Access Coordinator on 04 978 4172 if you have any questions.

Allow at least six weeks for the consultation for approval to take place.

If your project is approved, you will be asked to sign a Deed of Confidentiality with the Ministry.

Please note that not all applications are approved, and that there is no appeal process against the decision. Declined applications have in the past been re-designed and re-written and re-submitted, however this also is no guarantee that the application will be approved.

The Ministry of Social Development receives many requests for access to clients, staff or information, for research purposes. While MSD encourages good quality research and evaluation that may contribute to improving outcomes for New Zealanders, we also have a statutory duty of care to our clients and staff, and need to carefully consider and control the impact of research access. Therefore some applications may be declined if their impact on staff or clients is considered too high. This impact might be due to the research methodology or it may be due to what the researcher is requiring MSD staff to do.
22 April 2013

Andrea Tan

Dear Andrea

Re RAC Application: Relationships matter? Multiple perspectives on children's attachment experiences in group home

Thank you for submitting an application for access to children in South Island group homes. Your application was discussed with the Chief Social Worker and I am pleased to advise that your application has been approved.

Approval had been given to involve CYF staff in the following:

- The team leaders at the three supervised group homes, to distribute information sheets and consent forms to 12 young people, 12 parents/guardians and the staff members in the group home. Any work done from that point will be completed by the researcher.

- The team leader of the two supervised group homes in has given his verbal support for the research and will provide written support once he returns from leave.
• The focus groups will take up to one hour of staff members’ time. These will be held at their respective supervised group home on the same day as their staff meeting so that staff do not need to work outside their normal hours.

You will be required to complete presentations on her research to staff at the three supervised group homes and to make those presentations available to the CYF National Office in Wellington.

You have also agreed to complete two summary reports (one for children, young people and their families, and one for staff) and provide these to the participants. These also need to be made available to CYF National Office.

Access to CYF information is contingent on the researchers and research assistants signing the attached Deed of Confidentiality as an acceptance of the way in which information held by the Agency will be used by them. It also reflects the seriousness of any breach of the information privacy principles contained within the Privacy Act 1993. Please return this form to the Research Access Coordinator.

You are required to send to the Research Access Coordinator, the penultimate draft of your thesis as well as any articles based on the research you have written for publication. This is to ensure that legal and ethical concerns are adequately addressed.

Good luck with your research. Please contact me with any queries.

Yours sincerely

Christina Smits

Research Access Coordinator

Ministry of Social Development
Appendix E: Interview Questions Outline
Interview outline for parent/guardian participants

1. Introduce self
2. Describe project and outline interview process
3. Opportunity given for parents/guardians to ask questions
4. Address confidentiality and limits in relation to safety issues
5. Begin interview questions

List of possible interview questions

This project involves an open-questioning technique where the precise nature of the questions have not been determined but will depend on the way the interview develops.

1. How long has your child been living here at the supervised group home?
2. What did you know about the place before your child was placed here?
3. What do you think about this place now?
4. Did you or your child have a choice about living in the group home?
5. What do you think your child likes about living here?
6. What don’t you think your child likes about living here?
7. What do you think is working well?
8. What is important to you while your child is living in this group home?
9. What do you think is important to your child while he/she is living in this group home?
10. What relationships do you think are important to your child while he/she is living here?
11. Do you think your child feels connected to this place? What do you think helps them feel connected?
12. How do you find the staff at the group home?
13. How do you think your child finds the staff here? What does your child like about the staff? What does your child dislike about the staff?
14. Have you seen any changes in your child’s behaviour since he/she lived in the group home? What do you think has made the difference?
15. What do you think are some things your child has learnt while being here?
16. If you could make changes to this place what would that be?
17. Do you think your child has achieved any goals while being here? If yes, what are some goals they have achieved and what do you think has helped them achieve it?
Interview outline for child participants

6. Introduce self
7. Describe project and outline interview process
8. Opportunity given for child to ask questions
9. Address confidentiality and limits in relation to safety issues  
   Begin interview questions

List of possible interview questions.

18. How long have you been living here?
19. On a scale of 1 to 10, 1 being I don’t like it here at all and 10 being I love it here, where would you put it on the scale?
20. Tell me about what it is like for you living here.
21. What do you like about living here?
22. What don’t you like about living here?
23. What do you think is working well?
24. What is important to you living in this group home?
25. How many staff members work here?
26. How do you find the staff? On a scale of 1 to 10, 1 being I don’t like the staff at all and 10 being I like the staff very much, where would you put it on the scale?
27. Describe a staff member that you like, why do you like him or her?
28. Describe a staff member you don’t like, why don’t you like him or her?
29. Do you feel you can trust anyone in the group home? If yes, how does that person make you feel like you can trust them?
30. Do you feel you can trust anyone in the group home? If no, why do you feel that you can’t trust anyone?
31. Did you have a choice in living here?
32. What did you know about this place before you came?
33. What do you think about this place now?
34. How did staff make you feel when you first arrived?
35. If you are feeling worried or upset, do you feel that you can talk to a staff member about it?
36. Who do you think cares about you while you are living here? How do you know they care?
37. Do you see changes in your behaviour since being here? What do you think has made the difference?
38. Do you feel staff listen to you? Why?
39. Do you feel connected to this place? What makes you feel connected?
40. If you could make changes to this place what would that be?
41. What are some things you have learnt while being here?
42. Did you have any goals when you came here? Do you think being here has helped you achieve any of your goals?
Appendix F: Ngai Tahu consultation
Ngāi Tahu Research Consultation Committee
Te Komiti Rakahau ki Kai Tahu

Tuesday, 22 January 2013.

Dr Nicola Atwood
Department of Sociology - Gender and Social Work
DUNEDIN.

Tēnā Koe Dr Nicola Atwood

Most children who reside in care and protection residential home settings have complex behavioural issues. Using an attachment framework, this study looks at what works for young people with a history of trauma, focusing on the importance of relationships. This study aims to capture the voices of children regarding their experiences of staff relationships in three group homes in New Zealand using semi-structured in-depth interviews.

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 22 January 2013 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states "Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGeachan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of interest and importance.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project. That is the questions on self-identified ethnicity and descent, these questions are contained in the 2006 census.

The Committee suggests including in the research team a researcher with expertise in analysing and interpreting data by ethnicity.

The Committee suggests dissemination of the research findings to Māori health organisations regarding this study including Māori Groups within Child Youth and Family.

We wish you every success in your research and the Committee also requests a copy of the research findings.

The Ngāi Tahu Research Consultation Committee has membership from:
Te Rūnanga o Ōtāko Incorporated
Kāti Huirapa Rūnanga ki Puketeraki
Te Rūnanga o Meeanik!
Ngāi Tahu Research Consultation Committee

Te Komiti Rakahau ki Kāi Tahu

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 22 January 2013 to 14 July 2014.

Nāhaka noa, tā

Mark Brunton
Kaiwhakahaere Rakahau Māori
Research Manager Māori
Research Division
Te Whare Wānanga o Otago
Ph: +64 3 479 8738
Email: mark.brunton@otago.ac.nz
Web: www.otago.ac.nz

The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūnanga o Ōtākou Incorporated
Kāti Huirapa Rūnaka ki Puketereki
Te Rūnanga o Moeraki